Department of Health and Human Services Response and Recovery Operational Plan

June 2024 – updated March 2026

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1. Introductory Material

- 1.1 Promulgation Statement
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- 1.3 Plan Administration and Record of Plan Changes

1.1. Promulgation Statement

Disasters, public health emergencies, or other occurrences can disrupt the normal public health, medical, human services, or social services functions of state, tribal, or territorial (STT) jurisdictions. During response operations, timely, efficient, and coordinated delivery of necessary federal public health, medical, and human services[1] assistance is an essential function of the U.S. Department of Health and Human Services (HHS). All HHS divisions[2] must be capable of responding promptly to requests for assistance from federal and STT (FSTT) authorities to potential or actual natural or human-caused (accidental, intentional, or technological)[3] disasters or public health emergencies. In addition, some situations result in circumstances that are in the realm of federal authorities, including HHS human services and social services authorities, and, as such, require federal, including HHS, response, such as influxes or surges of unaccompanied children at border areas or federal emergency repatriation. This *HHS Response and Recovery Operational Plan* (*RROP*) is HHS's operations plan for coordinated departmental management of response to and recovery from disasters and public health emergencies in response to FSTT requests for assistance or when the situation requires federal emergency human services or social services capabilities. It establishes a comprehensive and adaptive framework for coordinated, efficient, and rapid federal public health, medical, human services, and social services assistance to support STT governments' response activities directed at saving and sustaining lives and protecting or restoring human health in response to and recovery from natural or human-caused (accidental, intentional, or technological) disasters or public health emergencies.

The *HHS RROP* applies to HHS divisions with public health and medical emergency management, disaster human services, and health, education, and human services recovery responsibilities. It describes HHS's response and recovery functional areas and functional public health and medical emergency management and disaster human services responsibilities of HHS divisions. The *HHS RROP* designates preparedness, response, and recovery activities by HHS divisions according to response core functional areas, recovery core mission areas, and cross-cutting functional areas.[4] Response core functional areas were derived from Emergency Support Function (ESF) #8: Public Health and Medical Services (FEMA 2016a) and supporting roles for (a) ESF #6: Mass Care, Emergency Assistance, Temporary Housing, and Human Services (FEMA 2008a); (b) ESF #9: Search and Rescue (FEMA 2011); (c) ESF #10: Oil and Hazardous Materials Response (FEMA 2008b); (d) ESF #11: Agriculture and Natural Resources (FEMA 2008c); and (e) ESF #15: External Affairs (FEMA 2016b). Recovery core mission areas were derived from the Health, Education, and Human Services Recovery Support Function (HEHS RSF) (FEMA 2021a, 2024; HHS 2021). Cross-cutting functional areas span response

[1] See *Glossary* entry for human services.

[2] Including the HHS Immediate Office of the Secretary.

[3] Produced by human activities, including intentional acts, negligence, or error involving a failure of a human-made system.

[4] See section *3.5. Response Core Functional Areas, Recovery Core Mission Areas and Cross-Cutting Priorities, and Cross-Cutting Functional Areas*; and *Glossary* entries for functional area, core functional area for response, core mission area for recovery, and cross-cutting functional area.

and recovery. When the *HHS Response and Recovery Operational Plan* is activated (per section *3.2. Plan Activation*), all HHS divisions will adhere to the concepts and coordinating architecture herein. These will be used to guide departmental coordination only and are separate and apart from the existing operational structures outlined in HHS divisions' operational doctrines and plans.

The *HHS RROP* outlines and describes various preparedness, and functional activities of HHS divisions. These include activities of the response core functional areas and the recovery core mission areas; preparing and maintaining ESF and HEHS RSF documents during response and recovery operations; and participating in training and exercise programs. The *HHS RROP* describes HHS divisions' support to the execution of the operational coordination function during response to and recovery from disasters or public health emergencies.[5] The *HHS RROP* also requires HHS divisions to ensure the *HHS RROP* continues to accurately reflect the scope of their responsibilities, capabilities, and functions.

The Secretary of HHS on 20 July 2022 designated the Administration for Strategic Preparedness and Response (ASPR) as an HHS operating division.[6] ASPR is under the direction of the Assistant Secretary for Preparedness and Response (the Assistant Secretary). In this document, the acronym "ASPR" refers to the operating division, while reference to the Assistant Secretary is spelled out either in full or as "Assistant Secretary."

ASPR has primary responsibility for developing and maintaining the *HHS RROP* and will conduct periodic reviews with input from responsible HHS divisions. Notification of suggested revisions shall be submitted to ASPR's Planning Division. Minor revisions will be noted in the record of changes, and a full update of the *HHS RROP* will be completed every four years.

This version of the *HHS RROP* updates it to align with revised doctrine and guidance published in the National Incident Management System (NIMS; FEMA 2017), the National Response Framework (NRF; DHS 2019), and the Federal Interagency Operational Plans (FIOPs; FEMA 2023b, 2025). The *HHS RROP* is composed of a base plan[7] and annexes, including (a) annexes describing functions requiring intradepartmental (among HHS divisions) or interagency coordination and (b) incident-specific annexes. The following annexes are associated with the base plan: *A: Operational Coordination*; *B: Logistics*; *C: Authorities*; *D: Organization and Assignment of Responsibilities/Tasks*; and *E: Extended Threats/Hazards*.

This base plan is a foundational document that defines the HHS mission and a broad concept of operations and options for how HHS may provide federal public health, medical, human services, and social services response and recovery missions in support of FSTT requests for assistance during potential or actual natural or human-caused (accidental, intentional, or technological) disasters or public health emergencies. It describes HHS's approach to federal public health, medical, human services, and social services response and recovery operations and the structures that implement them.

Annexes provide useful information beyond that in the main part of the base plan. Functional annexes expand upon various response core functional areas and recovery core mission areas and provide information on capabilities and services provided by HHS's divisions, including

[5] This includes support to operational coordination by the HHS Immediate Office of the Secretary.

[6] It was previously the Office of the Assistant Secretary for Preparedness and Response as a StaffDiv under the HHS Office of the Secretary.

[7] See *Glossary* entry for base plan.

responsibilities and tasks that facilitate response and recovery operations. Incident-specific annexes address contingency or threat- and hazard-specific situations requiring specialized application of the *HHS RROP* for response and recovery operations. To that end, incident-specific annexes describe the necessary policies, circumstances and conditions, concepts of operations, and operational coordination required. They also identify the HHS divisions involved in incident-specific response and recovery. In most situations, this responsibility will be held by two or more HHS divisions. The response core functional areas and the recovery core mission areas described in these annexes typically involve either support to or cooperation among several HHS divisions.

1.2. Approval and Implementation

The *Department of Health and Human Services Response and Recovery Operational Plan* (*HHS RROP*) is published by ASPR on behalf of HHS. ASPR maintains the *HHS RROP* and will present updates to the Secretary for approval and adoption every four years.

The *HHS RROP* was developed by ASPR in collaboration and coordination with HHS divisions and is aligned with the NIMS (FEMA 2017) and the National Planning System (NPS; DHS 2016b). The *HHS RROP* is written in accordance with the following laws and doctrine: (a) Public Health Service Act (PHS Act), as amended (Public Law 78-410); (b) the Post-Katrina Emergency Management Reform Act of 2006 (PKEMRA; Title VI of Public Law 109-295, 2006); (c) 44 C.F.R. 334.2: Emergency Management and Assistance, Policy (CFR 2023); (d) Presidential Policy Directive-8 (PPD-8; WH 2011); (e) Executive Order 12656: Assignment of Emergency Preparedness Responsibilities (OFR 2016); (f) the NRF (DHS 2019); (g) the National Disaster Recovery Framework (NDRF; DHS 2016c; FEMA 2024); and (h) the Response and Recovery FIOP (FEMA 2025).

The Secretary of HHS or other HHS senior executive-level official(s) as delegated by the Secretary is designated and authorized to coordinate federal public health, medical, human services, and social services support during response to and recovery from potential or actual natural or human-caused (accidental, intentional, or technological) disasters or public health emergencies, as outlined in this plan. Specific HHS divisions have some coordinating authorities delegated according to statutes and other directives.

The *HHS RROP* will be periodically reviewed to evaluate the need for updates based on outcomes of ongoing planning activities, exercises, and real-world responses to incidents. Periodic changes to this plan will be made as these assessments indicate. This plan supersedes previous HHS operational plans for HHS-wide responses.[8]

I hereby officially approve the *U.S. Department of Health and Human Services Response and Recovery Operational Plan*.

/S/ July 9, 2024

Xavier Becerra, Secretary **Date**

[8] The previous plans referred to here were the ASPR Playbooks that supported the HHS Secretary (or designee) in directing and coordinating the HHS ESF #8 response to disasters and public health emergencies.

1.3. Plan Administration and Record of Plan Changes

HHS divisions are expected to develop and maintain policies and procedures (e.g., standard operating procedures) in support of the activities outlined in this *HHS RROP*. In addition, HHS divisions are responsible for collaborating and coordinating with ASPR to update and maintain the *HHS RROP*, including various functional and incident-specific annexes, based upon lessons learned from exercises and actual incidents. No proposed change should contradict or override authorities or other plans contained in statutes, executive orders, regulations, or federal interagency policies.

The Administration for Strategic Preparedness and Response is responsible for coordinating and approving all proposed modifications to the *HHS RROP* with the assistance of HHS divisions and other stakeholders. Once published, the modifications are considered part of the *HHS RROP* for operational purposes and copies of revisions are then distributed as necessary and required.

All updates and revisions to this plan will be tracked and recorded in Table 1-1. This process will ensure that the most recent version of the plan is disseminated and implemented by HHS public health and emergency response and recovery personnel.

Table 1-1. Summary of changes

Date	Change Number	Summary of Changes
16 Mar 2026	1	Revised title and terminology consistent with executive orders; other minor editorial changes.

2. Purpose, Scope, Situation Overview, Planning Factors, and Mission

2.1. Purpose

The *HHS RROP* is a department-level operational plan as required by federal statute (PKEMRA; Title VI of Public Law 109-295, 2006) and by PPD-8 (WH 2011). It aligns with the NRF (DHS 2019) and the FIOPs (FEMA 2023b, 2025), as shown in Figure 2-1. The *HHS RROP* describes how HHS operationalizes support for the implementation of the NRF and the Response and Recovery FIOP (FEMA 2025) to accomplish the responsibility of the Secretary of HHS to lead the federal public health and medical response to public health emergencies and other incidents covered by the NRF. The *HHS RROP* guides HHS's activities as the ESF coordinator for ESF #8 (FEMA 2016a) and describes HHS support to STT governments under ESF #6 (FEMA 2008a), ESF #8 (FEMA 2016a), ESF #9 (FEMA 2011), ESF #10 (FEMA 2008b), and ESF #11 (FEMA 2008c) in response to requests for assistance following disasters or public health emergencies that can overwhelm STT capabilities to respond. The *HHS RROP* also guides HHS's activities providing support to ESF #15 (FEMA 2016b).

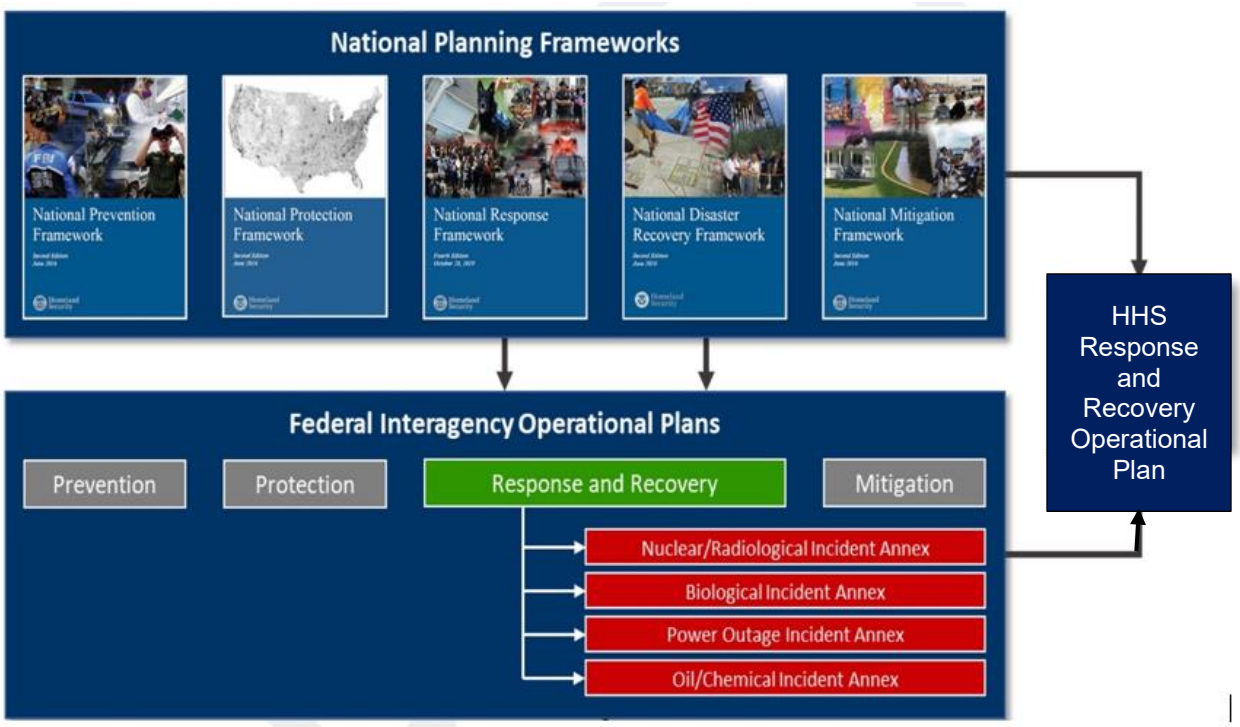

Figure 2-1. *HHS RROP* alignment with national response and recovery doctrine in national planning frameworks and FIOPs

The *HHS RROP* outlines the HHS public health and medical emergency management structure and describes essential tasks for HHS-wide organizational components involved in preparedness for, response to, and recovery from disasters and public health emergencies. It provides mechanisms for vertical and horizontal coordination and collaboration with STT authorities and accounts for integration of emergency response operations into the federal coordinating structure to ensure consistency with nationally recognized incident management policies and guidance. This integration includes coordination among HHS divisions and between HHS and public health, medical, human services, and social services stakeholders to ensure

response and recovery requirements are met. In this plan where reference to activities within an HHS division are made, the subordinate offices are not identified unless directly pertinent, to avoid obsolescence of information with organizational changes. When functions or activities of designated HHS divisions change, this information will be registered in *Table 1-1: Summary of changes* and incorporated into the next amended version of the plan.

The *HHS RROP* serves as the "umbrella plan" into which all ESF #8-supporting agencies' response activities integrate while they perform their associated functions. In addition to ESF #8-associated activities, the *HHS RROP* includes support for human services-related activities in response and recovery. The plan is designed with recognition that response and recovery activities will vary in their specifics depending on the nature and severity of the incident, with the intention that such variation can be accommodated within its framework.

2.2. Scope

The *HHS RROP* describes how HHS supports FSTT government response to the full range of natural and human-caused incidents, whether accidental, intentional, or technological, with adverse public health, medical, human services, or social services consequences severe enough to require federal involvement.[9] As HHS's emergency operations plan, the *HHS RROP* identifies roles and responsibilities of HHS divisions for carrying out specific actions during response and recovery operations, and describes the relevant lines of authority, organizational relationships, and means of coordination to unify departmental response and recovery activities. This includes integration of public health and medical support with other plans that focus on the human services and social services functions, such as those for federal emergency repatriation and unaccompanied children influx/surge missions (HHS 2009). In outlining the coordinating functionality for HHS divisions, the *HHS RROP* recognizes that internal operations for steady-state functions will be managed within their own agencies. HHS divisions also will respond under their own authorities when they support responses not requiring departmental coordination in the context of the *HHS RROP*, including those coordinated with other United States government (USG) agencies, internal or external to HHS. Once a criterion is met for activating the *HHS RROP* and it is activated (see section *3.2. Plan Activation*), it provides a framework for the coordination and execution of federal public health, medical, human services, and social services missions prior to and during response to a disaster and/or a public health emergency and during the initial stages of recovery. Restoration operations are outside of the scope of the *HHS RROP*. When the *HHS RROP* is activated (per section *3.2. Plan Activation*), all HHS divisions will adhere to the concepts and coordinating architecture herein. These will be used to guide departmental coordination only and are separate from the existing operational structures outlined in HHS divisions' operational plans.

The primary responsibility for responding to and recovering from disasters and public health emergencies is vested in the STT governing authorities. Federal engagement is typically provided (a) at their request for public health, medical, human services, or social services assistance when the severity of the consequences exceeds their immediate capabilities, and (b) for proactive risk assessment and management in addressing anticipated needs for such involvement. The operations outlined in the *HHS RROP* are designed to support, but not supersede, activities and authorities of STT governments.

[9] See *Glossary* for terminological conventions for types and levels of emergencies and incidents for this document, using the following terms: emergency (and public health emergency), incident, disaster, major disaster, catastrophic disaster.

Several types of disaster and public health emergency situations are within the scope of the *HHS RROP*, including Presidentially declared emergencies or disasters; HHS Secretary-declared public health emergencies; and incidents covered by the NRF (DHS 2019) and the National Disaster Recovery Framework (NDRF; DHS 2016c; FEMA 2024). The *HHS RROP* describes how HHS leads the federal public health and medical preparedness and response for public health emergencies (under section 2801 of the PHS Act, 42 U.S.C. § 300hh). It outlines operational coordination structures, including those that cover programmatic responses such as emergency repatriation[10] led by the Administration for Children and Families (ACF) (as required by section 1113 of the Social Security Act and Executive Order 12656, as amended), and responses involving unaccompanied children influxes,[11] or other human services emergency incidents that are covered by ACF's programmatic mission and incident-specific plans. When departmental and/or interagency coordination is required and a criterion for *Plan Activation* is met, the *HHS RROP* will apply. If a response requires public health or medical resources or capabilities outside the direct mission space or authorities of the HHS division leading the response, the plan will be activated. When the plan is activated, ASPR will marshal the critical elements of HHS, as well as appropriate FSTT and non-governmental organization (NGO) partners as appropriate (HHS 2009). The coordination structures for situations that would require HHS response are in *Annex A: Operational Coordination*, including those for (a) when HHS is the lead federal agency (LFA), (b) when the Stafford Act[12] is in effect or another agency is the LFA, (c) emergency repatriation, and (d) unaccompanied children. Operations outlined in the plan are not intended to contradict, override, or supersede HHS divisions' authorities granted or plans mandated by statutes, presidential directives, regulations, or federal interagency policies, which take precedence if any conflict arises.

The *HHS RROP* is an operational-level plan for response and recovery. Therefore, tactics, techniques, and procedures for preparing for and providing support to National Special Security Events (NSSEs)[13] are not within the scope of the *HHS RROP*. However, the operational elements of the *HHS RROP* are considered in NSSE planning and would be used in response to an incident occurring during an NSSE. Planning for management of risks during an NSSE is covered by a separate plan, the HHS Special Events Consequence Management plan (OASPR 2017). Management of HHS-specific internal operations for continuity of operations (COOP) during an incident is also out of the scope of the *HHS RROP*; this is covered by the HHS COOP Plan (HHS 2020). Operational-level tasks are included in *Annex D: Organization and Assignment of Responsibilities/Tasks* to clarify how objectives would be accomplished, but not to indicate detailed tactics of how to do so, which are left to the HHS divisions involved, with coordination as needed through the activities framed in this plan.

2.3. Audience

The *HHS RROP* has two primary audiences. The first is HHS personnel fulfilling HHS's federal public health, medical, human services, and social services roles and responsibilities in support of FSTT requests for assistance during response to or recovery from potential or actual natural, human-caused (accidental, intentional, or technological) disasters or public health emergencies.

The second is FSTT stakeholder partners and other response and recovery actors, for which the *HHS RROP* is intended to facilitate provision and coordination of HHS's response and

[10] See *Glossary* entry for emergency repatriation.

[11] Unaccompanied children influxes, when substantial, can be considered emergencies.

[12] See *Glossary* entry for Stafford Act.

[13] See *Glossary* entry for National Special Security Event.

recovery support. The *HHS RROP* informs STT public health authorities, NGOs, human services and social services providers, and the private sector about how HHS responds to requests for support during disasters and public health emergencies. The *HHS RROP* can be used as a reference for training, or to inform the development of STT contingency plans and deliberate planning products.

2.4. Situation Overview

The *HHS RROP* provides a framework for the coordination and execution of federal missions supporting public health, medical capabilities, human services, and social services in response to STT government requests for assistance within the 50 states; the federal District of Columbia; American Indian and Alaska Native communities within states or localities; and insular areas of the United States and freely associated states, comprising five territories (American Samoa, Guam, the Commonwealth of the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands) and three freely associated states (the Republic of the Marshall Islands, the Republic of Palau, and the Federated States of Micronesia).

The *HHS RROP* also guides how HHS responds to requests from federal agencies, including LFAs. For example, HHS supports the Department of State (DOS) to provide federal public health and medical support for response to all types of disasters and public health emergencies outside of the United States and its insular areas. On the domestic front, HHS supports LFAs, as it supported, for example, the U.S. Coast Guard for the Deepwater Horizon incident (USGPO 2010).

The *HHS RROP* is designed to cover the full range of hazards and threats identified in the National Health Security Strategy (NHSS; ASPR 2023c). The hazards and threats within the scope of HHS's operational response and recovery mission are varied, and novel types of hazards or threats or new forms of existing hazards or threats may emerge. Relatively recent examples are (a) the emergence of cyber threats associated with the increasing dependence on cyber systems of critical infrastructure, including that for health care and public health, and (b) the 2019 emergence of coronavirus disease (COVID-19) caused by a novel type of coronavirus.

The primary responsibility for response to incidents is first local, and then, if the need exceeds available local capabilities, progresses to STT authorities. Only when the need for resources and capabilities exceeds those available at these levels does the U.S. government become involved upon request of the STT authorities. In addition, when such requests are anticipated to be imminent, proactive preparation can facilitate effective federal support when it is requested. Because response capabilities may include private and public resources, private-public coordination of response preparation and activities is important.

2.4.1. Area of Interest/Concern

The primary HHS geographical area of interest for planning and coordination in the execution of the *HHS RROP* is depicted in Figure 2-2. It includes the ten HHS regions, which correspond to the ten Federal Emergency Management Agency (FEMA) regions (and those of many other federal agencies), with insular areas of the United States and freely associated states. As noted above, HHS may also provide assistance with incidents outside of these areas, in support of other federal activities such as those of DOS. Disasters and public health emergencies in an area of interest that require federal public health, medical, human services, and social services assistance are wide-ranging and typically result in significant disruption to or cascading failures of an impacted STT's public health, medical, human services, and social services infrastructure.

An incident that triggers an STT request for assistance may be preceded by advance notice (e.g., hurricane) or no notice (e.g., earthquake). Vulnerability to given types of hazards, naturally occurring disasters, and public health emergencies varies among the regions within the HHS area of interest. For example, regions 2, 3, 4, 6, and 9 are especially vulnerable to annual flooding, and tropical cyclones (tropical depressions, tropical storms, hurricanes, and typhoons). Large segments of regions 9 and 10 are prone to earthquakes, landslides, volcanic eruptions, and wildfires. Regions with coastal boundaries are particularly subject to the technological hazard of maritime spills of hazardous materials due to failure in human-made systems, including oil spills. Also, regions with nuclear power plants are subject to technological failures in those systems.

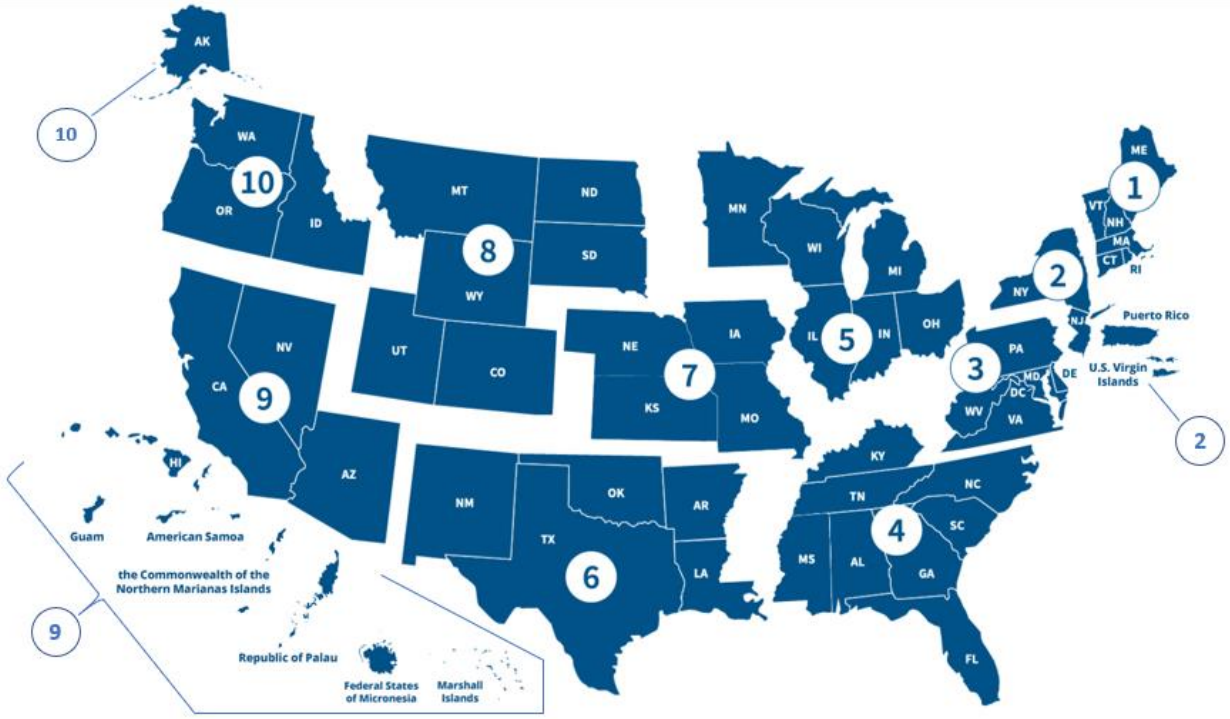

Figure 2-2. HHS geographical areas of interest

After the 9/11 terrorist attack in 2001 and the subsequent anthrax attacks, as well as Hurricane Katrina in 2005, the recognized scope of federal response and recovery changed. These changes led to the development of the Department of Homeland Security (Public Law 107-296, 2002) and enactment of the Project BioShield Act of 2004 (Public Law 108-276, 2004), the Pandemic and All-Hazards Preparedness Act (Public Law 109-417, 2006), PKEMRA (Title VI of Public Law 109-295, 2006), and other laws developing and enhancing the associated authorities and capabilities. More recently, the COVID-19 pandemic has focused the U.S. government more intensely on capabilities required for response to widespread highly communicable diseases with asymptomatic and pre-symptomatic airborne transmission. Because these capabilities are useful for other types of incidents, the insight gained can be applied to a risk-informed, capabilities-based approach to response. The following section presents an overview of various types of incidents for which federal support, and specifically an HHS response, could be requested.

HHS divisions have regional staff that work in the regions to foster and strengthen relationships among federal, state, territorial, tribal, and community stakeholders. As an example, the Centers

for Disease Control and Prevention (CDC) has regional staff that help to build, modernize, and strengthen public health programs, and that foster relationships to respond quickly and flexibly, ensuring partners are prepared to respond to public health concerns rapidly. ACF has staff in each HHS region that support its various programs aimed at promoting the economic and social well-being of families, children, individuals, and communities, including ACF's human service emergency planning, preparedness, and response activities; emergency repatriation; the influx of unaccompanied children; and refugee resettlement programs. The Centers for Medicare & Medicaid Services (CMS) has regionally placed staff who facilitate outreach, engage stakeholders, foster relationships across its programmatic areas, and ensure all national clinical, quality, and safety standards for health care facilities and providers are being met before, during, and after incidents. ASPR is represented in the HHS regions by ASPR regional administrators (RAs), who lead teams that include regional emergency coordinators (RECs) and regional medical countermeasures advisors (RMCAs), who collaborate and coordinate with other HHS regional staff to lead and facilitate coordinated response activities in support of STT authorities for public health and medical emergencies. In addition, several HHS divisions in each HHS regional office participate in a regional advisory council (RAC). The RAC, led by the HHS regional director and the ASPR RA, serves as a forum to share contingency plans and information, and preparedness and response activities among HHS regional leadership, and to coordinate emergency preparedness, response, and recovery activities.

2.4.2 Threats/Hazards/Risk Summary

After the 9/11/2001 terrorist attack, the Homeland Security Council directed an interagency working group to develop a set of 15 national planning scenarios to facilitate planning for responding to all hazards (FEMA 2009). The scenarios were subsequently categorized into eight major national scenario sets (FEMA 2009). The U.S. Department of Homeland Security (DHS) later conducted the Homeland Security National Risk Characterization (HSNRC), a risk characterization of a wide variety of scenarios,[14] including the eight national sets (Willis et al. 2018, 2019) and including those highlighted in the NHSS (ASPR 2023c). *Table 2-1* includes a summary of the parameters assessed in that analysis, substituting general levels for quantitatively specified ones and relying on public or general information for those in which specific levels are classified information or not included in the HSNRC or for which more recent experience suggested a change. This summary is intended to provide a conceptual framework for considering the threat, hazard, and risk landscape for which response may be required under this plan. The information in the table can be used for comparing the various types of scenarios in terms of their characteristics relevant to response and recovery. A more extensive version of this table is provided in *Annex E: Extended Threats/Hazards*, covering additional parameters and a wider range of specific scenario types included in the HSNRC.

Leaders can use this table to assess decisions about priorities for preparedness and response, as well as to guide responders under this plan with respect to what features are involved in types of incidents, what capabilities are needed, and in what time frame. For example, if the greatest potential number of deaths from a single incident were of concern, prioritizing preparation for a nuclear attack might be desirable. This is because the number of deaths from a nuclear attack is projected to be high, compared to medium-high or less for the other types of incidents. Likewise, concern particularly with the numbers and scope of casualties would indicate prioritization of preparation for a nuclear attack, given that it has a greater scope of injuries associated with it than other types and, for two of the categories, very many people

[14] Using methods consistent with the National Threat and Hazard Identification and Risk Assessment (THIRA; FEMA 2019a).

affected by them. However, one might note that the frequency of occurrence of a nuclear attack, as for several other types of incidents, is projected to be very low, albeit with high unpredictability.[15] In contrast, frequency of occurrence of hurricanes is high, with low unpredictability. In addition, hurricanes generally have a high economic impact, even when the number and scope of injuries are low.

This approach facilitates adaptation to the changing nature of threats and hazards. Assessment of the features presented in the table is provisional and subject to further review and refinement, recognizing that the major features are unlikely to change dramatically.

[15] The categories in the original report (Willis et al. 2019) for predictability of incident and precision of estimate were changed for this categorization to unpredictability and imprecision, to allow all applicable categories to go from low to high for less to more severe consequences, for ease of comparison.

Table 2-1. Characteristics of main incident types addressed in this plan. The first six columns of incidents are terrorist, accidental, or biological incidents. The last two, earthquakes and hurricanes, are natural hazards. Where a range of categories is indicated, the color coding is for the highest severity in the range. (a) "Transnational communicable disease" in the Homeland Security National Risk Characterization (HSNRC; Willis 2019) is "pandemic" here. (b) "Cyber attack" in the HSNRC is "cyber incident" here, and here includes accidental or technology-caused cyber incidents.

2-1-A. Homeland Security National Risk Characterization (HSNRC: Willis 2019). The risk area in the report for predictability of incident was changed for simplicity of comparison here to unpredictability, to allow all applicable categories to go from low to high for less to more severe adverse consequences.

Key: U: unknown, N: none, VL: very low, L: low, M: medium, H: high

Area: metric	Chemical attack or accident	Nuclear attack	Radiological attack or NPP accident	Small arms or explosive attack	Biological weapon attack	Pandemic [a]	Cyber incident [b]	Earthquake	Hurricane
Health, safety, security: Deaths: greatest for single incident	L	H	L	VL	M-H	H	U	L	L
Health, safety, security: Injuries/ illnesses: greatest for single incident	L	H	L	VL	M-H	H	U	L	L
Health, safety, security: Well-being reduction				M-H		M-H	M-H	M	M
Economics: Cost: greatest for single incident	L	H	M	L	M	H	H	H	H
Economics: Lifeline/infrastructure effects: Single incident	L	H	M	L	M	L-M	H	H	H
Environmental: Greatest damage	L	M	M	L	L	N	L	M	H
Governance: Greatest disruption	L	M	L	N	M	M-H	M	L	L
Risk: Frequency of incident	VL	VL	VL	H	VL	L	M-H	H	H
Risk: Unpredictability of incident	H	H	H	M-H	H	L	H	H	L

2-1-B. Cause – probability of each cause given an incident occurring

Key: L: low, M: medium, H: high, Inh: inherent

Cause	Chemical attack or accident	Nuclear attack	Radiological attack or NPP accident	Small arms or explosive attack	Biological weapon attack	Pandemic [a]	Cyber incident [b]	Earthquake	Hurricane
Natural						H		Inh	Inh
Intentional-state	M	M	M		M		H		
Intentional-terrorist	H	H	H	H	H		H		
Intentional-criminal				H			H		
Accidental	H		H				L		

2-1-C. Geographical scope

Key: L: local, R: regional, N: national, I: international

Parameter	Chemical attack or accident	Nuclear attack	Radiological attack or NPP accident	Small arms or explosive attack	Biological weapon attack	Pandemic [a]	Cyber incident [b]	Earthquake	Hurricane
Geographical scope	L	L-R	L-R	L	L-I	N-I	L-I	R	R

2-1-D. Notice

Key: y: year(s), m: month(s), w: week(s), d: day(s), h: hour(s), 0: none

Parameter	Chemical attack or accident	Nuclear attack	Radiological attack or NPP accident	Small arms or explosive attack	Biological weapon attack	Pandemic [a]	Cyber incident [b]	Earthquake	Hurricane
Notice	0-h	0-h	0-h	0-h	0-h	d-w	0-h	0-h	d-w

2-1-E. Time course

Key: h: hour(s), d: day(s), w: week(s), m: month(s), y: year(s)

Time course	Chemical attack or accident	Nuclear attack	Radiological attack or NPP accident	Small arms or explosive attack	Biological weapon attack	Pandemic [a]	Cyber incident [b]	Earthquake	Hurricane
Time course response	d-w	w-m	w-m	d-w	m-y	m-y	w-m	w-m	w-m
Time course recovery	w-m	m-y	m-y	w-m	m-y	m-y	w-m	m-y	m-y

2-1-F. Illness/injury types

Key: f: few, s: some, m: many, vm: very many, 2º: secondary illness or injury (caused indirectly)

Illness/injury type	Chemical attack or accident	Nuclear attack	Radiological attack or NPP accident	Small arms or explosive attack	Biological weapon attack	Pandemic [a]	Cyber incident [b]	Earthquake	Hurricane
Mechanical trauma		vm		s			2º-f	vm	s
Thermal burn		s-m							
Chemical/toxin trauma	m-vm								
Radiological illness/injury		vm	m						
Biological infection		2º-s	2º-s					2º-s	2º-s
• Aerial transmission					m	m			
• Non-aerial direct transmission					m	s			
• Insect vector						s			
• Animal (non-ins) vector						s			
Behavioral health effect	s-m	s-vm	s-m	s-m	s-m	m	m	s-m	s-m
Physiological								s	

2.5. Planning Factors: Facts, Assumptions, Critical Considerations

The following sections outline the planning facts, assumptions, and critical considerations used in developing this plan. Assumptions and/or considerations that pertain only to specific types of incidents are defined in the incident-specific annexes. Assumptions or considerations could, during response and recovery, be replaced by facts as the incident develops and information about it can be verified.

2.5.1. Facts

Facts are known data or information that have been substantiated.

- Consistent with federal statutes, the Secretary of HHS has authorities (with or without a Stafford Act declaration) to declare public health emergencies (PHEs),[19] lead responses to PHEs, and may be required to address public health, medical, human services, and social services issues associated with any type of incident, including under the NRF.
- When the President declares a major disaster or an emergency under the Stafford Act or an emergency under the National Emergencies Act, and when the HHS Secretary declares a public health emergency, the Secretary has the legal authority to take certain actions, including under section 1135 of the Social Security Act to waive or modify certain Medicare, Medicaid, Children's Health Insurance Program, Health Insurance Portability and Accountability Act, and Emergency Medical Treatment and Labor Act requirements as necessary.[20]
- Essential federal department and agency statutory and mission responsibilities are required to be maintained during response activities.
- The Secretary of HHS has the legal authority to prioritize distribution of federally owned or managed medical countermeasures (MCMs) and impose quarantine restrictions during applicable public health emergencies.
- The Public Readiness and Emergency Preparedness Act (PREP Act) authorizes the Secretary of the Department of Health and Human Services (Secretary) to issue a PREP Act declaration. The declaration provides immunity from liability (except for willful misconduct) for claims.
- HHS is the lead federal agency (LFA) for managing the human health impacts of incidents, including public health consequences of biological agent releases affecting humans and human infectious disease outbreaks (per the National Biodefense Strategy [WH 2022]).
- As an ESF #8-supporting agency under the NRF, the U.S. Department of War has expeditionary public health and medical capabilities for deploying on short notice and can augment STT capabilities, which is especially important in austere environments.
- As an ESF #8-supporting agency under the NRF, the U.S. Department of Veterans Affairs (VA) has responsibilities under the National Disaster Medical System (NDMS) to coordinate receipt, distribution, and medical care of civilian casualties through Federal Coordinating Centers.[21] During armed conflicts or national emergencies, the VA also coordinates receipt, distribution, and medical care of prioritized military casualties.

[19] See *Glossary* entries for public health emergency and public health emergency declaration.

[20] For other authorities associated with declaration of a public health emergency, see *Annex C: Authorities*.

[21] See *Glossary* entry for Federal Coordinating Center.

- As an ESF #8-supporting agency under the NRF, FEMA provides support with the National Medical Transport and Support Services (NMTS) Contract[22] for evacuating patients who are too seriously ill or are otherwise incapable of being safely evacuated in general evacuation conveyances.
- STT governments have different response and recovery structures and different levels of public health, medical, human services, and social services capabilities and resources to support the implementation of response and recovery activities for public health emergencies.
- STT governments have mutual aid agreements (typically through the Emergency Management Assistance Compact [EMAC]) or other mechanisms to share capabilities and resources before or in conjunction with requesting federal assistance.
- The private sector owns the majority of health care capabilities and services in the U.S. health care system, including staffing, facilities, information systems and supply chains for resources. Many are part of a health system/health care network.
- Some American Indian or Alaska Native tribes[23] are federally recognized, some are state-recognized, and some are recognized neither by federal nor by state authorities.
- The President of the United States has the authority to designate an LFA or to change the LFA to a different agency during a disaster or with a federal disaster declaration as facts and situations change.
- HHS is an ESF #6-supporting agency under the NRF, supporting DHS/FEMA by providing mass care assistance, emergency assistance, and human services support, including support for disaster case management.
- ACF is the HHS lead for disaster human services, emergency repatriation, and unaccompanied children.
- As the lead for disaster human services, ACF works with FSTT partners to determine whether disaster human services assistance is needed and, if so, to scope and implement it.
- HHS is the sector risk management agency (SRMA)[24] for the health care and public health (HPH) sector of critical infrastructure, with specialized expertise and authorities. (EOP 2013, CISA 2022)
- ASPR is the designated lead for SRMA functions in the HPH sector, led by the Critical Infrastructure Protection (CIP) program of ASPR.
- Civil rights, conscience and religious freedom rights, and health information privacy rights of all members of a community remain in effect and are required during federal response and recovery activities.
- Accurate and transparent public health and risk communication are essential to an effective response.
- CDC protects America's health at US ports of entry by detecting, responding to, and helping to prevent the spread of contagious diseases into the United States.

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[22] Often referred to as the National Ambulance Contract.

[23] "A federally recognized tribe is an American Indian or Alaska Native tribal entity that is recognized as having a government-to-government relationship with the United States, with the responsibilities, powers, limitations, and obligations attached to that designation, and is eligible for funding and services from the Bureau of Indian Affairs." (DOI 2020)

[24] Prior to 2021: sector-specific agency. See *Glossary* entry for sector risk management agency.

- The Federal Service Labor-Management Relations Statute provides that HHS may take whatever actions may be necessary to carry out its mission during emergencies. However, labor relations obligations implicated by deployments under the *HHS RROP* must be considered in consultation with the National Labor and Employee Relations Office.

2.5.2. Planning Assumptions

In the absence of facts, assumptions represent relevant and logical information deemed plausible and necessary to facilitate planning.

- An incident will occur while a response to a previous incident is still ongoing.
- A disaster will occur with little or no warning.
- Incidents requiring national-level coordination among two or more federal departments or agencies will trigger the establishment of an interagency taskforce headed by a White House coordinator under the Office of the National Security Advisor.
- Persons with disabilities[25] and others with access and functional needs in the impacted area will require physical, programmatic, and communications support or accommodation.
- Behavioral health[26] subject-matter expertise will be required to provide technical assistance to STT mental health and substance use authorities.
- Intra-departmental and inter-agency coordination will require senior executive-level leadership at the strategic and operational levels.
- Coordinated planning involving STT and private-sector personnel will be needed to facilitate a transparent transition to recovery and restoration.
- Licensure, credentialing, other regulatory waivers, and addressing liability immunity and workers' protections will be required to facilitate effective health care delivery to impacted residents.
- Initial resource availability will not be sufficient to meet STT government requests or needs.
- HHS will pursue a viable and resilient public health supply chain (including manufacturing capabilities) to support the response to public health and medical emergencies.
- ACF leadership will determine the operational support that may be required for emergency repatriation or large influxes of unaccompanied children.

2.5.3. Critical Considerations

Critical considerations provide information about circumstances that may affect execution of the plan.

- Events or incidents outside of the contiguous U.S. and those involving U.S. territories and areas of interest, including foreign countries, require additional considerations. These include the likelihood of health impacts within the U.S., cross-border trade,

[25] See *Glossary* entry for disability.
[26] See *Glossary* entry for behavioral health.

quarantine, transit, law-enforcement coordination, or legal obligations under the International Health Regulations to report public health incidents to the World Health Organization, including notifications of potential public health emergencies of international concern.[27]

- The Prepare for and Respond to Existing Viruses, Emerging New Threats, and Pandemics Act (PREVENT Pandemics Act; part of the Consolidated Appropriations Act, 2023 [Public Law 117-328, 2023]), enacted in late December 2022, establishes an an Office of Pandemic Preparedness and Response Policy within the Executive Office of the President, headed by a director within both the Domestic Policy Council and National Security Council. A priority for this office is addressing current and emerging problems of national significance related to pandemic or other biological threats. Its work may affect how the activities of this plan are coordinated and implemented.
- Human or animal disease or illness secondary to or separate from the primary incident threat may develop.
- The incident consequences may interfere with response activities, directly (e.g., responder access) or indirectly (e.g., supply chain; security).
- The Secretary of HHS may need to weigh the priority of domestic response as framed in this plan against international considerations that would require the same resources.
- Legal and policy issues could arise during response and recovery activities requiring additional or revised authorities or policies.
- Multiple simultaneous response or support scenarios for different incidents or events, including support to designated NSSEs, may require establishing incident response and supporting structures at separate facilities.
- Criminal or other investigation of potentially human-caused incidents may affect public health, medical, or human services response and recovery activities.
- The incident may affect supply chains, including those for food, medical products (including medicines and medical supplies), or other essential resources.
- Residents in an incident-impacted area may need to be relocated, which may cause severe disruption of the local economy and damage to the community's economic growth, as well as impacts on the receiving community(ies).
- HHS divisions may respond to an incident under their own existing or designated authorities; such responses may require coordination with other response activities.
- HHS may provide guidance to the private sector and critical infrastructure entities on their roles and responsibilities in a response and considerations necessary to maintain essential services.
- Implementation of regulatory mechanisms or modification of guidance (e.g., U.S. Food and Drug Administration [FDA] approvals, clearances, licensures, device classifications, investigational applications, emergency use authorizations) may be required to establish or enhance MCM capabilities.
- Decisions on response actions and priorities for resource allocation may need to be made with incomplete information, based on assessments of the risks and anticipated benefits.

[27] Legal obligations under the International Health Regulations will be considered with administration direction associated with Executive Order 14155 (WH 2025).

- Computer and communications systems used for response activities and managed by HHS's information technology personnel may include features that preclude or challenge compatibility needed for interagency and STT collaboration.
- STT governments may require assistance with developing public health, medical, human services, and social services guidance and risk communications to mitigate the effects of the incident.
- Many STT governments may not be structured, trained, or sufficiently resourced to mitigate adverse impacts to public health, medical, and human services infrastructures during response and recovery (including restoration) activities, and may require federal ESF #8 and ESF #6 support for an extended period to stabilize and assist in the restoration of HPH systems and facilities.
- STT governments can develop or modify mutual aid agreements or other means to establish capabilities and resources before or in conjunction with requesting federal assistance.
- Public health emergencies may require extensive collaboration and coordination with members of the health care and public health, human services, social services, emergency-management, and law-enforcement communities to ensure integrated operations, effectiveness of the mission, and accomplishment of strategic objectives.
- Populations in the affected area will need culturally and linguistically appropriate and accessible public messaging.
- STT authorities may require specialized support for public health services (e.g., laboratory capabilities) and for worker and responder safety.
- STT authorities may require assistance establishing contracts for medical support to hospitals and treatment facilities.
- If foreign entities offer or are asked for assistance, the International Assistance System Concept of Operations (FEMA 2022c) and the International Coordination Support Annex to the NRF (DOS 2013) provide guidance for obtaining and managing such assistance.
- CDC provides guidance concerning the health security of travelers across U.S. borders.

2.6. Mission

HHS conducts and coordinates public health, medical, human services, and social services activities to support STT governments in response to and for recovery from disasters and public health emergencies, coordinating with federal, international, and private-sector partners as applicable to save and sustain lives, mitigate adverse health effects, and restore health, human services, and social services systems.

3. Concept of Operations

3.1. Overview

Some HHS divisions (e.g., ACF, ASPR, CDC, FDA) have statutory authorities for responding to disasters and public health emergencies. ASPR has authorities, roles, and responsibilities for coordinating federal public health and medical response to public health emergencies and disasters. The Assistant Secretary for Preparedness and Response performs these activities on behalf of the Secretary of HHS, as mandated by section 2801 of the PHS Act, as amended (42 U.S.C. § 300hh), including when three or more HHS divisions with overlapping or

interdependent authorities are to be involved in a response, thus requiring coordination according to the concepts indicated in this plan. Disaster human services are led by ACF, in coordination with ASPR. The concept of operations includes performance of activities to accomplish objectives in various response core functional areas, recovery core mission areas, and cross-cutting functional areas[28] organized under defined lines of effort (LOEs).

3.2. Plan Activation

The Secretary of HHS (the Secretary), the Assistant Secretary for Preparedness and Response (the Assistant Secretary), or other HHS senior official(s) as delegated by the Secretary or the Assistant Secretary may activate this plan when federal public health, medical, or human services assistance is requested or assigned for the support of FSTT authorities during potential or actual natural or human-caused (accidental, intentional, or technological) disasters or public health emergencies. The Secretary or an authorized delegate will activate the HHS unified coordination structure[29] and operationalize the plan when one or more of the following conditions occurs:

a) The public health or medical resources of STT jurisdictions are overwhelmed, and the appropriate authorities have requested HHS assistance (see section *3.3.2. Requests for Federal Support*).

b) A federal department or agency (within or outside of HHS) acting under its authority has requested HHS departmental assistance.[30]

c) A response led by an HHS division requires support of federal public health or medical resources or capabilities outside of its own direct mission space or authorities.[31]

d) HHS has the lead for federal public health and medical response under section 2801 of the Public Health Service Act (PHS Act) (42 U.S.C. § 300hh). In some circumstances the Secretary may determine under section 319 of the PHS Act that a disease or disorder presents a public health emergency; or a public health emergency is otherwise determined to exist, including for a significant outbreak of infectious disease or a bioterrorist attack.

e) HHS is the designated LFA consistent with PPD-44: Enhancing Domestic Incident Response (WH 2016) and the Enhancing Domestic Incident Response Playbook (NSC/RRD 2023).

f) Three or more HHS divisions with overlapping or interdependent authorities are involved in a response.

g) The President directs action requiring implementation of the plan.

[28] See section *3.5. Response Core Functional Areas, Recovery Core Mission Areas and Cross-Cutting Priorities, and Cross-Cutting Functional Areas*; and *Glossary* entries for functional area, core functional area for response, core mission area for recovery, and cross-cutting functional area.

[29] The HHS unified coordination structure will employ the NRF and NIMS to enhance unity of effort, and to develop strategic objectives, priorities, and planning activities necessary to coordinate HHS incident response strategy and execution. See *Figure 5-1*.

[30] As determined by the department or agency making the request.

[31] Means of support will be determined by the requesting HHS division in coordination with ASPR, as the department's coordinator for ESF #8.

3.3. Emergency Authorities and Requests for Federal Support

3.3.1. Emergency Authorities

The PHS Act forms the foundation of HHS's legal authority for responding to public health emergencies; it authorizes the HHS Secretary to lead all federal public health and medical responses to public health emergencies (42 U.S.C. § 300hh; see ASPR 2022b). The HHS Secretary is authorized to take the following actions when a PHE is declared, consistent with regular authorities: make grants to states and local agencies, provide awards for expenses, enter into contracts, and conduct and support investigations into the cause, treatment, or prevention of the specific disease or disorder. In addition, among other things, the Secretary may allow temporary reassignment of state and local personnel whose salaries are funded by PHS Act programs; waive requirements of the Paperwork Reduction Act for voluntary collection of information when necessary to prepare and respond to the public health emergency; and when the President has also declared an emergency or major disaster under the Stafford Act or an emergency under the National Emergencies Act, the Secretary may approve temporary waivers or modifications under section 1135 of the Social Security Act.[32]

The Secretary has broad authorities under the PHS Act that can be exercised independently of a PHE declaration, including these: to make and enforce regulations to prevent the introduction, transmission, or spread of communicable diseases into the U.S., or from one state or territory to another; to activate and deploy personnel from the NDMS; to deploy select members of the Medical Reserve Corps; to activate and deploy personnel from the U.S. Public Health Service (USPHS) Commissioned Corps in support of public health and medical operations; to provide public health and medical services; to provide for the licensure of biological products; to provide public health and medical assistance during an emergency or disaster; to provide temporary assistance to needy families; and to respond to needs of "at-risk" individuals.

The Social Security Act, the Federal Food, Drug, and Cosmetic Act, and the PHS Act all contribute to HHS's responsibility for responding to public health and medical emergencies and providing human services assistance[33] during response to and recovery from natural or human-caused (accidental, intentional, or technological) disasters or public health emergencies.

Statutory authorities relevant to HHS's emergency preparedness, response, and recovery responsibilities are described in *Annex C: Authorities*.

3.3.2. Requests for Federal Support

When a response to an incident is anticipated or determined to require resources or capabilities exceeding those available to the STT authorities, a governor (state or territorial) or the appropriate Indian tribal government[34] may request federal support, including federal public health, medical, or human services assistance, through the Stafford Act[35] or other applicable means (see sections *3.3.1. Emergency Authorities* and *3.6. Operational Approach*). The Stafford Act authorizes the President to provide financial and other support to STT governments to support response, recovery, and mitigation activities following a declaration by the President

[32] For a more detailed list of the Secretary's authorities with or without a PHE declaration, please see ASPR 2022c.

[33] HHS human services activities during response and recovery are conducted under a variety of programmatic authorities, including the Social Security Act, the Federal Food, Drug, and Cosmetic Act, the PHS Act, the Stafford Act, the NDRF, and departmental policies.

[34] "Indian tribal government" means the governing body of any Indian or Alaska Native tribe, band, nation, pueblo, village, or community that the Secretary of the Interior acknowledges to exist as an Indian tribe under the Federally Recognized Indian Tribe List Act of 1994 (25 U.S.C. §§ 479a et seq.).

[35] See *Glossary* entry for Stafford Act.

of an emergency or a major disaster. Before requesting a declaration under the Stafford Act, the governor or the appropriate Indian tribal government must take appropriate response action under STT law and direct execution of the emergency operations plan. The completed request, addressed to the President, is submitted through the FEMA Administrator. The FEMA Administrator then makes a recommendation to the President. The governor, or the appropriate Indian tribal government, appropriate members of Congress, and federal departments and agencies are immediately notified of a presidential declaration.

HHS may also provide federal support to STT governments through its own authorities using funding sources other than the President's Disaster Relief Fund that do not require a Stafford Act declaration. In the event of an actual or potential need, including a natural or human-caused (accidental, intentional, or technological) incident, a public health emergency, a special event, or another non-routine need, and in the absence of, or prior to a Stafford Act or National Emergencies Act declaration of emergency or major disaster, STT authorities may request HHS federal support by contacting their respective HHS regional offices. Programmatic or liaison officers may coordinate such requests. HHS initial and escalated responses are guided by HHS divisions' authorities, including when their support to responses does not require departmental coordination in the context of the *HHS RROP*.

Prior to and during disasters, especially those that occur with little or no notice, HHS may activate and deploy resources and capabilities, including (a) FEMA-directed federal operations support, in anticipation of or in response to a formal request from an STT government for federal support, or (b) support to another authority eligible for a particular program. Deployments of federal resources and capabilities typically occur during disasters involving chemical, biological, radiological, nuclear (CBRN), or explosive weapons or other incidents (including natural disasters) affecting heavily populated areas. Proactive deployments are intended to ensure that federal resources reach the impacted area in time to assist in restoring any disruption of routine public health, medical, or social services functions in an STT jurisdiction and are done in coordination and collaboration with governmental entities, the private sector, and NGOs, when possible.

3.4. Senior Leader Intent

HHS senior leaders[36] have the following intent:

- Provide coordinated and timely public health, medical, human services, and social services response and recovery assistance for any incident requiring federal support.
- Collaborate to deliver resources to supplement and stabilize public health, medical, human services, and social services systems for STT governments, and, when applicable, international and private-sector partners.

3.4.1. Operational Goals

- Support provision of public health, medical, safety, and social service capabilities for the public and responding personnel during response and recovery.
- Provide for the continuity of human services delivery in impacted jurisdictions.
- Provide human services support and technical assistance, as appropriate, for community mass care, emergency assistance, and fatality management activities.

[36] "HHS senior leaders" refers to the Secretary of HHS, the Assistant Secretary for Preparedness and Response, or other HHS senior officials designated by the Secretary to lead coordination of HHS's incident response activities.

- Support development, provision, and use of medical countermeasures.
- Establish and maintain interoperable communications and coordination structure.
- Foster medical and public health supply chain integrity, security, and management.

3.4.2. End State

Emergency response and recovery support from HHS are no longer needed to address the public health, medical, human services, and social services needs of STT governments for response to and recovery from the given incident.[37]

3.5. Response Core Functional Areas, Recovery Core Mission Areas and Cross-Cutting Priorities, and Cross-Cutting Functional Areas

The NRF outlines agencies and core functional areas for response by ESFs and the HEHS RSF to the NDRF outlines agencies and core mission areas for recovery. HHS responds to and coordinates recovery from disasters or public health emergencies by providing resources and capabilities, including personnel and expertise, to support STT governments. These resources and capabilities can be categorized according to functional areas,[38] including core functional areas for response,[39] core mission areas for recovery,[40] and cross-cutting functional areas.[41] The core functional areas are derived from ESF #8: Public Health and Medical Services (FEMA 2016a); and supporting roles for (a) ESF #6: Mass Care, Emergency Assistance, Temporary Housing, and Human Services (FEMA 2008a); (b) ESF #9: Search and Rescue (FEMA 2011); (c) ESF #10: Oil and Hazardous Materials Response (FEMA 2008b); (d) ESF #11: Agriculture and Natural Resources (FEMA 2008c); (e) ESF #15: External Affairs (FEMA 2016b). The core mission areas for recovery are outlined in the HEHS RSF under the NDRF (FEMA 2021a, 2024; HHS 2021). Cross-cutting functional areas, which span the mission areas of response and recovery, are not all unique to HHS capabilities, but are essential to success of the missions and are performed for public health, medical, and human services aspects of response and recovery by HHS divisions.

The following sections contain descriptions of the core functional areas for response, the core mission areas for recovery, and cross-cutting functional areas, with listings of primary and supporting HHS divisions for each. In some cases, more than one entity with primary responsibility is designated, where responsibilities are for different aspects of the functional

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[37] Continued support may be provided to assist in recovery from the incident via pre-existing HHS programmatic relationships with STTs after the end-state is achieved.

[38] **Functional area:** Category comprising a set of resources and capabilities for a stated purpose in support of a mission area (in this context, response or recovery) of the National Preparedness Goal (DHS 2015). This includes (a) the core functional areas for response (i) for which HHS is the primary agency as published in the ESF #8 annex to the NRF, including human services and social services; or (ii) as published in the NRF annexes, for support to ESFs #6, #9, #10, #11, and #15; (b) the core mission areas for recovery for which HHS is the coordinating agency as codified in the HEHS RSF to the NDRF; and (c) the cross-cutting functional areas. (Adapted from DHS 2019, 2016c; FEMA 2024.)

[39] **Core functional area for response:** Category comprising a set of resources and capabilities for response (a) for which HHS is the primary agency as published in the ESF #8 annex to the NRF, including human services and social services; (b) as published in the NRF annexes, for support to ESFs #6, #9, #10, #11, and #15. (Adapted from DHS 2019.)

[40] **Core mission area for recovery**: Category for a stated purpose in recovery for which HHS is the coordinating agency as codified in the HEHS RSF to the NDRF, comprising a broad array of resources and capabilities that further that purpose.

[41] **Cross-cutting functional area**: Category that includes the resources and capabilities in both response and recovery mission areas to prevent or treat illness and injuries and meet basic human needs after an incident, including support for sustainable and resilient health, education, human services, and social services systems.

areas. The designations here are not intended to exclude supporting roles not listed when performance of the roles that are listed extends into other areas.[42] The participation of HHS divisions noted here is included in a summary in *Table 4-1*, organized according to LOEs.

3.5.1. Response Core Functional Areas

HHS provides supplemental assistance in response to a disaster, emergency, or other incident that may include or lead to a public health, medical, behavioral, or human service emergency, including those that have international implications, by leveraging the 17 core functional areas that are aligned with ESF #8 to mitigate and resolve the adverse consequences of an incident. HHS also provides support for ESF #6: Mass Care, Emergency Assistance, Temporary Housing, and Human Services; ESF #9: Search and Rescue; ESF #10: Oil and Hazardous Materials Response; ESF #11: Agriculture and Natural Resources; and ESF #15: External Affairs. The following services and activities may be needed to support lifesaving actions and to stabilize essential public health, medical, and social services infrastructure: (a) planning and coordination of federal systems for public health, health care delivery, and emergency response to prevent or mitigate adverse effects of public health emergencies; (b) detection and characterization of health incidents; (c) provision of medical care and human services to those affected; (d) mitigation of disruptive effects on public health and human services in the community; and (e) enhancement of community resiliency. The response core functional areas are summarized in Table 3-1, showing primary and supporting HHS divisions for each.

Table 3-1. Response core functional areas and primary and supporting responsible HHS divisions

Response Core Functional Areas	Responsible HHS Divisions
Assessment of Public Health/Medical Needs: Public health and medical assessments involve the continual, systematic collection, analysis, and interpretation of data essential to planning, implementation, and evaluation of public health and medical practice and support for the delivery of services to communities.[43]	**Primary:** ASPR (medical), CDC (public health) **Supporting**: OASH, CMS, ATSDR, FDA, NIH, OGA, SAMHSA, ACF, ACL, HRSA, IHS
Health Surveillance: During a disaster or public health emergency, public health surveillance aids the identification of potential threats to the public that require immediate containment and mitigation actions, such as quarantining or isolation actions to reduce the spread of certain communicable diseases. This may include providing guidance for and supporting public health screenings at points of entry and surveillance at health care facilities. HHS may help coordinate the dissemination of information to prevent or control disease or injury, provide situational awareness data, and distribute findings to improve prevention and mitigation strategies for current and future disasters and public health emergencies.[44] Health surveillance may also include monitoring of disaster shelters, including monitoring of the living environment within them.	**Primary**: CDC **Supporting**: ASPR, OGA, HRSA, IHS

[42] For example, CDC may have secondary responsibilities not listed in the tables due to the need to flex, adjust, or adapt surveillance systems to support safe, effective, and efficient utilization of limited medical resources.

[43] Further delineation of this core functional area is provided in the objectives and tasks under *Annex D: Organization and Assignment of Responsibilities/Tasks: Table D-1: LOE Public Health and Safety: FA: Assessment of public health/medical needs*.

[44] Including to adapt and leverage existing public health surveillance systems and laboratory networks, including, when indicated, with secondary responsibilities in other areas, to ensure safe/effective/efficient utilization of limited medical resources.

Response Core Functional Areas	Responsible HHS Divisions
Medical Surge: Medical surge is the ability to provide medical capabilities to deliver medical and trauma care and treatment during public health emergencies and disasters when the need for care exceeds the capacity of an impacted community's existing public health and medical infrastructure.	**Primary**: ASPR **Supporting**: OASH, CMS, IHS, CDC, SAMHSA
Health/Medical/Veterinary Equipment and Supplies: During a public health emergency or disaster, federal departments and agencies and STT health authorities may request federal assistance with providing resources, including pharmaceuticals, biological products, medical devices, or equipment that are needed to support the response, or for replenishing health care and veterinary facilities in the impacted area.	**Primary**: ASPR **Supporting**: FDA, OGA, CDC, IHS
Patient Movement: HHS provides federal support and resources to assist STT health authorities with the movement of medical patients, through the NDMS. When an STT health authority requests federal support to move patients, HHS activates and implements the patient movement system, including movement of infectious patients, which serves five functions: (a) patient evacuation (including patient reception and management); (b) medical regulating; (c) en-route medical care; (d) patient tracking; and (e) patient return or re-entry.	**Primary**: ASPR **Supporting**: OASH, CMS, CDC, ACF, ACL, IHS, SAMHSA
Patient Care: HHS may be asked to provide immediate medical and trauma care response capabilities to deliver or support the provision of patient care services. Patient support may entail pre-hospital triage and treatment, inpatient hospital care, operative care, outpatient services, behavioral health care, medical-needs sheltering, pharmacy services, and dental care to survivors with acute injuries or chronic disease conditions.	**Primary**: ASPR **Supporting**: OASH, CMS, IHS, SAMHSA, CDC
Safety and Security of Drugs, Biologics, and Medical Devices: During response missions, HHS coordinates and provides advice and support to federal departments and agencies and STT governments, as well as private-sector partners to ensure the safety, security, and efficacy of human and veterinary drugs, biologics (including blood, vaccines, and select agents),[45] medical devices (including radiation-emitting and screening devices), and other HHS-regulated products that may have been compromised during an incident. The FDA fulfills its regulatory responsibilities for the safety of medical products by providing regulatory guidance and reviewing scientific evidence in order to authorize products, as appropriate, for use through emergency use authorization, investigational new product status, or full approval. This also includes monitoring for adverse events during the use of medical products under these conditions, with the support of CDC. During disasters, CDC is responsible for confirming the safety/security of select agents located at research facilities and for monitoring for adverse events related to the use of vaccines, drugs, and other medical products in coordination with FDA. HHS also coordinates the notification to international partners of compromised drugs, biologics, and medical devices via the U.S. International Health Regulations (IHR) National Focal Point in line with international obligations under the IHR.[46]	**Primary**: FDA **Supporting**: ASPR, OASH, CDC, NIH, OGA, IHS
Blood and Tissues: HHS develops blood and tissue policies and conducts surveillance of blood and tissue safety concerns through national surveys and data tools to identify issues that affect the availability of blood, blood products, and tissue products. HHS is also responsible for policies and programs regarding bloodborne pathogens and bloodborne infectious diseases.	**Primary**: OASH **Supporting**: ASPR, CDC, FDA, NIH, CMS, HRSA, IHS
Food Safety and Defense: HHS, in support of ESF #11, works with and requests assistance from partner organizations to ensure the safety and security of federally regulated foods. HHS, through the FDA, has statutory authority for all domestic and imported food except meat, poultry, and egg products, which are under the authority of the U.S. Department of Agriculture (USDA) Food Safety and Inspection Service.	**Primary**: FDA **Supporting**: ASPR, CDC, IHS, NIH

[45] Veterinary biological products, including animal vaccines, produced and distributed in full conformance with the Virus-Serum-Toxin Act (21 U.S.C. 151-158) and its implementing regulations, are regulated by the USDA Center for Veterinary Biologics.

[46] See *Glossary* entry for IHR NFP.

Response Core Functional Areas	Responsible HHS Divisions
Agriculture Safety and Security: USDA is the coordinating agency for ESF #11. HHS collaborates to help ensure the health and safety of food-producing animals, the safety and efficacy of animal drugs, and the safety of animal food. HHS, through the FDA, has statutory authority over animal food and over animal drugs for companion animals and for therapeutic and non-therapeutic use in food-producing animals.	**Primary**: FDA **Supporting**: CDC, ASPR, IHS
Public Health and Medical Consultation, Technical Assistance, and Support: STT public health officials may request that HHS provide consultation, technical assistance, and other support on a variety of public health, medical, human services, behavioral health, and veterinary services in response to public health emergencies.	**Primary**: ASPR, CDC, FDA, NIH, ACF, SAMHSA **Supporting**: OASH, CMS, OGA, ACL, HRSA, IHS, OCR, ATSDR, IEA
Behavioral Health Care: HHS provides technical assistance, training, consultation, and operational support to FSTT authorities to address behavioral health needs, including addressing the impact of disasters and emergencies on behavioral health critical infrastructure while also supporting population-level interventions to promote coping with the stresses of the disaster or emergency.	**Primary**: SAMHSA **Supporting**: ASPR, OASH, NIH, CDC, ACF, IHS, CMS
Public Health and Medical Information: Public health messaging is routinely provided to the general public to mitigate the occurrence and severity of disease or injury. During disasters and other public emergencies, timely dissemination of critical information to the public and responders is provided to allow informed decisions that reduce the risk of injury or the spread of diseases and to mitigate stress caused by the incident. ASPA is the general lead for coordinating HHS communications; CDC leads public health risk communications.	**Primary**: ASPA, CDC, SAMHSA **Supporting**: ASPR, OASH, CMS, FDA, NIH, OGA, IEA, ACL, ASFR, AHRQ, ATSDR, IHS
Vector Control: FSTT authorities may request HHS assistance following disasters or public health emergencies with assessing the threat of vector-borne diseases, providing technical assistance and consultation on protective actions regarding vector-borne diseases, and the medical treatment of persons infected by vector-borne diseases.	**Primary**: CDC **Supporting**: ASPR, NIH, IHS
Guidance on Potable Water/Wastewater and Solid Waste Disposal: To safeguard the health of the public following an incident, FSTT authorities may require HHS assistance. HHS may task components and request assistance from ESF #8-supporting departments and agencies to provide federal assistance with assessing potable water, wastewater, solid waste disposal, and other environmental health issues related to public health in establishments holding, preparing, and providing food, drugs, or medical devices at retail and medical facilities.	**Primary**: CDC **Supporting**: ASPR, ATSDR, NIH, IHS, FDA
Fatality Management: Disasters and public health emergencies can result in significant loss of life, requiring unique and specialized resources to manage human remains in a safe, dignified, and respectful manner.	**Primary**: ASPR **Supporting**: IHS
Veterinary Medical Support: FSTT authorities may request HHS assistance for veterinary medical support needs and guidance regarding animal issues. HHS may support mitigating zoonotic diseases and care for research animals where ESF #11-primary agencies do not have the expertise to render appropriate assistance.	**Primary**: ASPR **Supporting**: CDC, FDA, NIH, IHS
Human Services: Human services support individuals' and families' social and economic well-being and their ability to maintain daily living activities safely and healthily. During disasters and public health emergencies, STT officials may require federal assistance restoring and sustaining disrupted human services programs and systems administered by HHS through the Administration for Children and Families (ACF). HHS leads human services support for the implementation of disaster assistance programs to help disaster victims recover their non-housing losses, including programs to replace destroyed personal property, and help to obtain disaster loans, food stamps, crisis counseling, disaster unemployment, disaster legal services, support and services for special needs populations, and other federal and state benefits.	**Primary**: ACF, ACL **Supporting**: ASPR, SAMHSA, OASH, CMS, CDC, HRSA, OCR, AHRQ, IHS

3.5.2. Recovery Core Mission Areas and Recovery Cross-Cutting Priorities

HHS is the coordinating agency for the HEHS RSF under the NDRF (FEMA 2021a, 2024; HHS 2021). HHS supports locally led recovery activities to restore and enhance health care systems such as health care facilities, emergency medical services, and coalitions; behavioral health supports and systems including populations experiencing post-disaster trauma; public health and environmental health infrastructures; human services; educational environments, including K-12 and institutes of higher education; and programs to promote rapid recovery. Cross-cutting priorities are integrated into HEHS RSF activities to foster coordinated assessment and intervention. The priorities include areas of focus that span across the spectrum of health, education, and human services domains, including the needs of children, youth, and families in recovery; integration of older adults and other individuals with access and functional needs; future disaster risk mitigation; and focus on rural and under-resourced communities. Table 3-2 shows the five recovery core mission areas and the four priorities that cut across them. As noted there, ASPR coordinates HEHS RSF operations across HHS, across the federal interagency, and with other organizations as appropriate.

Table 3-2. Recovery core mission areas (3-2-A) and recovery cross-cutting priorities (3-2-B), and, for each, primary and supporting responsible HHS divisions

3-2-A. Recovery core mission areas and primary and supporting responsible HHS divisions

Recovery Core Mission Area	Responsible HHS Divisions
Health Care Systems: Disasters can interfere with the operation of health care systems and services, and due to economic disruptions can create or exacerbate obstacles to health care access for community members. Health care recovery includes restoration and adaptation of systems that provide health care services to community members, including primary care, hospital services, pre-hospital and ambulatory care, rehabilitative services, dialysis, home health care, long-term care, pediatric and geriatric medicine, and dental care. Maintaining or restoring the health care workforce, connecting relocated community members to appropriate health care services, responding to disaster-exacerbated health concerns, promoting continuity of care, and addressing disaster-caused problems with insurance or other means for health care access, are all health care systems goals during recovery. Effective health, education, and human services recovery includes (a) restoring and adapting health care systems across the spectrum of care services to meet community needs in the post-disaster environment and (b) providing for access to health care services for all disaster survivors.	**Primary**: ASPR **Supporting**: OASH, CMS, SAMSHA, ACF, ACL, HRSA, CDC, IHS
Behavioral Health: Disasters can introduce significant new stressors into the lives of community members, while degrading the capacity of the clinical behavioral health care system. Disaster behavioral health during the recovery period encompasses subclinical population-level activities to mitigate post-disaster stress, to provide additional skills and supports for coping and resilience, to maintain the behavioral health clinical workforce, and to identify those whose needs require the limited resource of clinical-level intervention. Recovery issues in behavioral health include supports for those grieving losses, those exposed to traumatic incidents, those burdened by high levels of chronic stress, those with substance use issues related to the post-disaster environment, and those with pre-disaster clinical behavioral health needs. Effective health, education, and human services recovery includes (a) implementing strategic activities to manage the psychological burdens of post-disaster life and (b) promoting coping by individuals and families.	**Primary**: SAMHSA, ASPR (HEHS RSF coordinating agency) **Supporting**: CMS, IHS, HRSA, ACF, NIH, CDC

Recovery Core Mission Area	Responsible HHS Divisions
Public Health and Environmental Health: Disasters can adversely affect community systems for public health, while exacerbating or introducing infectious disease, chronic disease, and environmental health hazards due to the impacts on the external environment, on the built environment, and on human health. Communities recovering from disaster have concerns about mold, drinking water and air quality, release of hazardous substances, increased transmission of infectious diseases, and unmanaged chronic conditions that require accurate, local ascertainment of risk and burden. Recovery missions thus include activities to identify post-disaster public health risks, to communicate effectively with the population about risks; to mitigate risks to promote health and safety in the affected population and among response and recovery workers; and to sustain or rebuild the public health professional workforce and system capacity of affected communities. Health, education, and human services recovery includes helping communities rebuild in ways that promote health and safety for individuals and families.	**Primary**: CDC, ATSDR, FDA, ASPR (HEHS RSF coordinating agency) **Supporting**: OASH, NIH, HRSA, SAMHSA, IHS
Human Services: Disasters can both (a) negatively affect community public and nonprofit human services systems, and (b) create new social and economic needs for which connection to human services facilitates individual and family well-being. Human services is a diverse array of means-tested and/or status-tested programs that function to promote the economic and social well-being of individuals and families, including programs for the protection of children and vulnerable adults, prevention and support services for intimate partner violence and family violence, economic self-sufficiency programs, programs to promote independent living, energy and nutrition assistance, assistive services for older adults and persons with disabilities, child care and early childhood education programs, and rural and under-resourced communities. Effective health, education, and human services recovery includes restoring the operation of human services programs and connecting community members with social and economic needs to programs to address those needs.	**Primary**: ACF, ASPR (HEHS RSF coordinating agency) **Supporting**: ACL, AHRQ, HRSA, SAMHSA, OASH, CMS, OCR, CDC, IHS
Education: Disasters can disrupt operations of education systems, impose new responsibilities on school systems to meet students' needs, and complicate students' learning through relocation. Education systems include public and private institutions for kindergarten through 12th grade (K-12) schooling, institutions for higher education, early childhood education, and after-school programs for children and youth. Education systems are essential in the community beyond education, functioning as venues or networks for interventions that promote positive health outcomes for children, youth, and families after a disaster; such interventions are interdependent with the presence of effective behavioral health, public health, and human service programs. Effective health, education, and human services recovery includes restoration of education services to students, and adaptation of schools and other educational centers to the post-disaster environment so that learning and promotion of social and emotional well-being can continue.	**Primary**: ASPR, ACF **Supporting**: ACL, HRSA, SAMHSA, IHS, CDC

3-2-B. Recovery cross-cutting priorities and primary and supporting responsible HHS divisions

Recovery Cross-Cutting Priorities	Responsible HHS Divisions
Needs of children, youth, and families in recovery: Disasters can disproportionately burden children and youth, as well as families with children and youth in the home. Children and youth have specific health, education, and social needs that are often met through specific systems or providers that may be impacted by disaster. Additionally, children and youth are at particular risk for mental health issues post-disaster. Children and youth require specific plans for their health care; public health/environmental health, behavioral health, human services, and educational needs. The needs of children and youth are best addressed in the context of two-generation strategies and targeting challenges in the systems that serve children, youth, and families, with integrated, cross-cutting solutions.	**Primary**: ACF, ASPR (HEHS RSF coordinating agency) **Supporting**: HRSA, ACL, AHRQ, SAMHSA, OASH, CDC, CMS, IHS

Recovery Cross-Cutting Priorities	Responsible HHS Divisions
Integration of older adults and other individuals with access and functional needs: Community-level recovery from disasters requires systematic planning to meet requirements of individuals with access and functional needs—including older adults, people with home health or other medical support needs, those with limited literacy or language proficiency, and persons with disabilities requiring communication, mobility, or personal assistance supports – to ensure efficacy of recovery efforts. Involving and integrating the specific needs and considerations of those with access and functional needs into behavioral health, education, health care, human services, and public health/environmental health are essential so that all community members are included in the community's recovery planning and execution.	**Primary**: ASPR **Supporting**: ACF, ACL, SAMHSA, AHRQ, HRSA, CDC, ATSDR, IHS
Future disaster risk mitigation: Disasters often reveal that risk and resilience planning for a given community does not meet current or emerging needs due to the increased frequency of extreme weather incidents. Assessment and specific plans to adapt health care, public health/environmental health, behavioral health, human services, and education systems to respond to a complex threat matrix is key, so that communities experience greater resilience to future extreme weather incidents and other incidents.	**Primary**: ASPR **Supporting**: OASH, ACF, ACL, CDC, SAMHSA, AHRQ, IHS, ATSDR, NIH, HRSA
Focus on rural and under-resourced communities: Many disasters exacerbate pre-incident health and economic disparities. Moreover, many communities affected by disaster may be in rural areas and/or financially constrained jurisdictions where health, human services, and education providers are less extensive or more difficult to access than in more urban and more affluent areas. In rural and financially constrained areas, where there may only be one service provider, disruptions to a single facility or institution can have more devastating effects than in areas where hospitals, primary care clinics, child care providers, behavioral health treatment centers, or other service programs are more numerous. Interventions and approaches that are designed to leverage strengths of rural and under-resourced communities, and to respond to the realities of those communities, can help ensure that recovery post-disaster does not leave rural or financially constrained communities behind.	**Primary**: OCR, ASPR (HEHS RSF coordinating agency) **Supporting**: ACF, ACL, AHRQ, OASH, NIH, CDC, ATSDR, IHS, HRSA, SAMHSA

3.5.3. Cross-Cutting Functional Areas

Cross-cutting functional areas include the capabilities in response and recovery to prevent or treat illness and injuries and meet basic human needs after an incident, including support for sustainable and resilient health, education, human services, and social services systems. The cross-cutting functional areas are summarized in Table 3-3, with listing of primary and supporting HHS divisions.

Table 3-3. Cross-cutting functional areas and primary and supporting responsible HHS divisions

Cross-Cutting Functional Areas	Responsible HHS Divisions
Environmental Response/Health and Safety: Conduct appropriate measures to protect the environment and the health and safety of the public and response personnel from threats and hazards.	**Primary**: CDC, ATSDR, ASPR **Supporting**: OASH, HRSA, FDA, SAMHSA, CMS, ACF, IHS, NIH
Research and Development for Medical Countermeasures: Support or perform research and development for response- and recovery-relevant medical countermeasures.	**Primary**: NIH, ASPR, FDA **Supporting**: OASH, CDC, OGA, ATSDR

Cross-Cutting Functional Areas	Responsible HHS Divisions
Acquisition and Distribution: Employ the administration, management, and business systems required to ensure the delivery of public health supplies in support of impacted communities and survivors.	**Primary**: ASPR **Supporting**: CDC (DSLR), IHS, HRSA, OGA, FDA
Supply Chain Data, Analytics, and Support: Collect and analyze data pertaining to supply chain issues, including supply availability and demand; and mitigation of shortages.	**Primary**: ASPR, FDA **Supporting**: OGA, ASPE, AHRQ, CDC
Situational Assessment: Develop and provide decision-relevant information regarding the nature and extent of the hazard, any cascading effects, and the status of the response and recovery to decision-makers.	**Primary**: ASPR, CDC, FDA, ACF **Supporting**: HRSA, SAMHSA, CMS, ACL, OGA, IHS, NIH, ATSDR
Public Information and Warning: Deliver coordinated, timely, reliable, and actionable information to the whole community (i.e., external affairs) using clear, consistent, accessible, and culturally and linguistically appropriate methods to effectively relay information regarding any threat or hazard and, as appropriate, the actions being taken~~,~~ and the assistance being made available. ASPA is the general lead for coordinating HHS communications; CDC leads public health risk communications. FDA leads communication about its area of food and medical product regulation.	**Primary**: ASPA, CDC, FDA **Supporting**: ASPR, NIH, IHS, OASH, SAMHSA, ACF, ACL, HRSA, OCR, OGA, ATSDR
Operational Communications: Ensure the capacity for timely communications in support of security, situational awareness, and operations by any means available, among and between affected communities in the impact area and all response forces.	**Primary**: ASPR **Supporting**: CDC, FDA, OASH, IHS, ACF
Operational Coordination: Establish and maintain a unified and coordinated operational structure and process that appropriately integrates all critical stakeholders.	**Primary**: ASPR, CDC, ACF **Supporting**: FDA, IHS, OASH, ATSDR
Situational Awareness: Collect, evaluate, interpret, and provide information gathered to maintain public health, medical, and human services situational awareness to inform decisions at all levels and across sectors.[47]	**Primary**: ASPR, CDC, FDA (HHS divisions with emergency operations centers), ACF **Supporting**: All other HHS divisions

3.6. Operational Approach

HHS coordinates the provision of federal public health, medical, human services, and social services assistance and support activities during response and recovery missions. HHS supports federal departments and agencies and STT governments' and their public health and human services authorities' response activities by establishing a forward-looking preparedness posture through its regional operations program and other engagements by HHS divisions before an incident. It also employs ESF #8 pre-scripted mission assignments (PSMAs) to facilitate HHS proactively organizing and moving personnel, equipment, and supplies in anticipation of federal operations support MAs or direct federal assistance MAs. Moreover, HHS supports FSTT responses by providing capabilities and technical assistance in a timely, efficient, and targeted manner to help mitigate resource shortfalls and to stabilize, enhance, and preserve the functions of public health, health care, and human services systems. Capabilities and technical assistance include workforce, facilities, supplies, and processes, and include

[47] HHS divisions with operations centers all maintain situational awareness through their EOCs. HHS divisions without EOCs support situational awareness in their respective mission areas.

support for programs, including those for public health, human services, and social services. HHS may provide commodities at the request of an STT government or public health or other eligible authority before receipt of a presidential declaration. This provision of assistance may occur under the Secretary's authority utilizing funding sources other than the Stafford Act. This may include an STT government's agreement to reimburse HHS for resources if a Stafford Act declaration is not implemented.

HHS coordinates the provision of federal public health, medical, human services, or social services assistance and support when a threat, hazard, or incident (natural, accidental, technological, or intentional) requires federal support because it threatens or impacts an STT jurisdiction. This coordination may include the sharing of information, such as public health, medical, or case-management information, which may include sensitive information; the development of courses of action and options for the provision of assistance; the alerting and activation of HHS resources and assets; and the coordination of operations to support STT response and recovery activities.

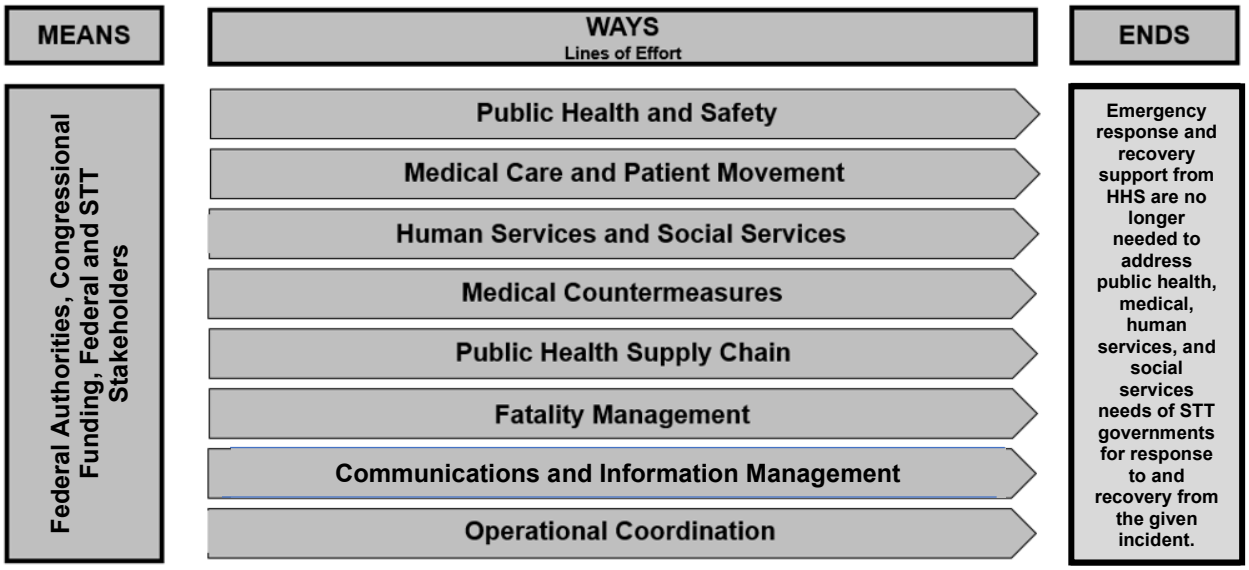

Figure 3-1. Operational approach

The approach to sustaining the execution of operations in response to a request for federal public health, medical, human services, or social services assistance is illustrated in Figure 3-1. The lines of effort (see section *3.6.1. Lines of Effort [LOEs]*) are the ways (methods) to accomplish the ends (desired outcomes), employing the means (resources, including funding, participants, and authorities). LOEs include response and recovery actions with related purposes toward achieving a desired end state. LOEs help focus responsibility for and coordination of activities during response and recovery. HHS acts in partnership with other federal departments and agencies to leverage available resources and capabilities and to ensure coordinated interagency actions to respond to and foster recovery from incidents with public health, medical, human services, or social services components requiring federal involvement.

Operational activities, associated with LOEs, may focus on (a) monitoring, detection, and characterization of public health, medical, human services, and social services issues and intervening with resources and capabilities as appropriate; (b) surging resources and executing hospital decompression missions; (c) providing resources (including personnel, medical materiel, and public health supplies), capabilities, and technical assistance to enhance and preserve the functions of public health, health care systems, social services, workforce, and

critical infrastructure; (d) leading a coordinated federal response and leveraging available departmental and interagency resources and capabilities; (e) modifying regulations and policies to sustain a whole-of-government and community response and recovery approach; and (f) providing communications, sharing of information, and strategic messaging to facilitate and enable the delivery of meaningful, understandable, and actionable information.

Execution of operations requires an operational coordination structure or, as appropriate, a unified interagency coordination structure, which leverages and harmonizes the full participation of FSTT governments and non-governmental stakeholder partners, and supports STT governments' response and recovery activities. HHS accomplishes *ends* – the desired end state; through *ways* – eight lines of effort that encompass HHS's functional areas and core capabilities for public health, medical, human services, and social services missions and support national response and recovery goals and objectives; through various *means* – interagency resources and participation, congressional funding, and established authorities. The relationship between LOEs and functional areas; and the sources of the functional areas and the recovery cross-cutting priorities are summarized in Table 3-4.

Table 3-4. Sources of the functional areas associated with the lines of effort and of the recovery cross-cutting priorities: (a) ESF #8 [*core capabilities]; (b) ESF #6; (c) ESF #9; (d) ESF #10; (e) ESF #11; (f) ESF #15; (g) HEHS RSF [** core mission areas], in which recovery cross-cutting priorities apply; per ASPR Office of Community Mitigation and Recovery (OCMR); (h) National Preparedness Goal (NPG) response mission area core capability; (i) NPG recovery mission area core capability; (j) Project BioShield Act of 2004; (k) National Strategy for a Resilient Public Health Supply Chain (USG 2021); (l) ASPR Office of Community Mitigation and Recovery. Functional area types: Rs: response core functional area; Rc: recovery core mission area; Xc: cross-cutting functional area

3-4-A: Line of effort: Public Health and Safety

Functional area	Functional area type	ESF #8 (a)	ESF #6 (b)	ESF #9 (c)	ESF #10 (d)	ESF #11 (e)	ESF #15 (f)	HEHS RSF (g)	NPG resp (h)	NPG recov (i)	Proj BioShield (j)	Nat Strat PHSC (k)	ASPR OCMR (l)
Assessment of public health/ medical needs	Rs	✓			✓								
Public health: potable water/wastewater, solid waste disposal; vector control	Rs*	✓	✓										
Public health and environmental health	Rc				✓			✓					
Health surveillance	Rs	✓			✓								
Behavioral health care	Rs	✓	✓										
Behavioral health	Rc							✓					
Food safety and defense	Rs	✓			✓	✓							
Agriculture safety and security	Rs	✓			✓	✓							
Environmental response/health and safety	Xc				✓				✓				
Public health and medical consultation, technical assistance, and support	Rs	✓		✓	✓								

* For both functional areas

3-4-B: Line of effort: Medical Care and Patient Movement

Functional area	Functional area type	ESF #8 (a)	ESF #6 (b)	ESF #9 (c)	ESF #10 (d)	ESF #11 (e)	ESF #15 (f)	HEHS RSF (g)	NPG resp (h)	NPG recov (i)	Proj BioShield (j)	Nat Strat PHSC (k)	ASPR OCMR (l)
Patient care	Rs	✓		✓									
Medical surge	Rs	✓											
Patient movement	Rs	✓											
Veterinary medical support	Rs	✓	✓	✓		✓							
Health care systems	Rc							✓					

3-4-C: Line of effort: Fatality management

Functional area	Functional area type	ESF #8 (a)	ESF #6 (b)	ESF #9 (c)	ESF #10 (d)	ESF #11 (e)	ESF #15 (f)	HEHS RSF (g)	NPG resp (h)	NPG recov (i)	Proj BioShield (j)	Nat Strat PHSC (k)	ASPR OCMR (l)
Fatality management	Rs	✓											

3-4-D: Line of effort: Human Services and Social Services

Functional area	Functional area type	ESF #8 (a)	ESF #6 (b)	ESF #9 (c)	ESF #10 (d)	ESF #11 (e)	ESF #15 (f)	HEHS RSF (g)	NPG resp (h)	NPG recov (i)	Proj BioShield (j)	Nat Strat PHSC (k)	ASPR OCMR (l)
Human services	Rs, Rc	✓	✓					✓					
Education	Rc							✓					

3-4-E: Line of effort: Medical Countermeasures

Functional area	Functional area type	ESF #8 (a)	ESF #6 (b)	ESF #9 (c)	ESF #10 (d)	ESF #11 (e)	ESF #15 (f)	HEHS RSF (g)	NPG resp (h)	NPG recov (i)	Proj BioShield (j)	Nat Strat PHSC (k)	ASPR OCMR (l)
Research and development for MCMs	Xc	✓									✓		
Safety & security of drugs, biologics, medical devices*	Rs	✓											
Blood and tissues	Rs	✓											

* Includes facilitation of effective use of medical countermeasures.

3-4-F: Line of effort: Public Health Supply Chain

Functional area	Functional area type	ESF #8 (a)	ESF #6 (b)	ESF #9 (c)	ESF #10 (d)	ESF #11 (e)	ESF #15 (f)	HEHS RSF (g)	NPG resp (h)	NPG recov (i)	Proj BioShield (j)	Nat Strat PHSC (k)	ASPR OCMR (l)
Supply chain data, analytics, and support	Xc											✓	
Market availability, acquisition, and stockpiling or provision of health/ med/ vet equipment and supplies*	Rs, Xc	✓										✓	
Deployment, distribution, and dispensing of health/ medical/ veterinary equipment and supplies*	Rs, Xc	✓		✓									

* Core functional area for response is health/medical/veterinary equipment and supplies.

3-4-G: Line of effort: Communications and Information Management

Functional area	Functional area type	ESF #8 (a)	ESF #6 (b)	ESF #9 (c)	ESF #10 (d)	ESF #11 (e)	ESF #15 (f)	HEHS RSF (g)	NPG resp (h)	NPG recov (i)	Proj BioShield (j)	Nat Strat PHSC (k)	ASPR OCMR (l)
Public information and warning	Xc*	✓					✓		✓	✓			

* Includes public health and medical information, which is Rs.

3-4-H: Line of effort: Operational Coordination

Functional area	Functional area type	ESF #8 (a)	ESF #6 (b)	ESF #9 (c)	ESF #10 (d)	ESF #11 (e)	ESF #15 (f)	HEHS RSF (g)	NPG resp (h)	NPG recov (i)	Proj BioShield (j)	Nat Strat PHSC (k)	ASPR OCMR (l)
Situational awareness	Xc								✓				
Situational assessment	Xc								✓				
Operational coordination	Xc								✓		✓		
Operational communications	Xc								✓				

3-4-I: Recovery cross-cutting priorities

Recovery cross-cutting priority	ESF #8 (a)	ESF #6 (b)	ESF #9 (c)	ESF #10 (d)	ESF #11 (e)	ESF #15 (f)	HEHS RSF (g)	NPG resp (h)	NPG recov (i)	Proj BioShield (j)	Nat Strat PHSC (k)	ASPR OCMR (l)
Needs of children, youth, and families in recovery							✓					✓
Integration of older adults and other individuals with access and functional needs												✓
Future disaster risk mitigation												✓
Focus on rural and under-resourced communities												✓

3.6.1. Lines of Effort (LOEs)

The LOEs frame the operational environment for response to and recovery from incidents requiring national level coordination or public health and medical emergencies requiring assistance in response to requests from FSTT governments. LOEs connect actions to desirable conditions and end states, facilitating the development of tasks and providing resource capabilities needed to influence conditions for achieving the desired end state. HHS's federal public health, medical, human services, and social services assistance for an HHS response and recovery operation is organized along eight LOEs, described along with associated functional areas and objectives in Table 3-5. These LOEs include the resources and capabilities necessary for leveraging HHS's response core functional areas, recovery core mission areas, and cross-cutting functional areas. The LOEs also encompass core and cross-cutting capabilities that are essential for numerous missions and functions, including monitoring, detecting, and characterizing public health, medical, and social services issues; enhancing and

preserving the functions of critical public health, health care systems, and social services infrastructure; stabilizing the public health supply chain; and providing communication and public outreach. For additional details, including functional areas, objectives, tasks, and primary and supporting HHS divisions for each line of effort, see *Annex D: Organization and Assignment of Responsibilities/Tasks*.

Table 3-5. Lines of effort, with functional areas and objectives. Rs = response core functional area; Rc = recovery core mission area; Xc = cross-cutting functional area.

3-5-A. **Public Health and Safety** – functions and activities for public health, medical, health care systems, social services, and infrastructure; and support for the health and safety of populations and communities, including food and agriculture

Functional Areas	Objectives
• Assessment of public health/medical needs (Rs) • Public health: potable water/wastewater, solid waste disposal (Rs); vector control (Rs) • Public health and environmental health (Rc)	• Assess public health and medical needs, health care systems, facilities, and infrastructure. • Coordinate provision of environmental public health support. • Provide support for mass-care services. • Provide support for meeting cross-cutting priorities that apply to response core functional areas, recovery core mission areas, and cross-cutting functional areas.
• Health surveillance (Rs)	• Conduct health surveillance of populations.
• Behavioral health care (Rs) • Behavioral health (Rc)	• Conduct needs assessment related to mental health and substance use or to behavioral health. • Coordinate and provide resources for behavioral health services. • Provide support for meeting cross-cutting priorities that apply to response and recovery mission areas and functional areas covered by this plan.
• Food safety and defense (Rs)	• Support USDA (ESF #11 coordinator) providing for safety, security, and wholesomeness of federally regulated foods. • Coordinate and support assessments of the capability of food manufacturing, food processing, food distribution, food service, and food retail to provide safe food. • Maintain or restore safety, efficacy, and availability of FDA-regulated products to protect public health. • Deter acts (intentional or not) affecting FDA-regulated products to protect consumers from potential public health hazards and threats.
• Agriculture safety and security (Rs)	• Support USDA (ESF #11 coordinator) with ensuring the health, safety, and security of livestock and food-producing animals and animal feed, drugs, and devices. • Support USDA with ensuring the safety of the manufacture and distribution of foods, drugs, therapeutics, and devices given to animals used for human food production. • Support USDA and its authority to manage a foreign animal disease response. • Support federal response involving animals to zoonotic diseases, to protect human health.

Functional Areas	Objectives
• Environmental response/health and safety (Xc)	• Coordinate and provide support for the health and safety of populations and communities, including response and recovery personnel. • Conduct long-term monitoring of responders.
• Public health and medical consultation, technical assistance, and support (Rs)	• Coordinate provision of consultation, technical assistance, and support to STT as needed.

3-5-B. **Medical Care and Patient Movement** – functions and activities for medical, trauma, and surge capabilities; declarations and waivers; health care service impacts; veterinary medical assistance; and patient movement

Functional Areas	Objectives
• Patient care (Rs)	• Provide and support medical and trauma care capabilities.[48] • Act upon STT requests for public health emergency declarations and 1135 waivers. • Provide support for mass-care services.[49]
• Medical surge (Rs)	• Coordinate federal medical surge to support STT requirements.
• Patient movement (Rs)	• Facilitate transport of critically or seriously ill or injured patients to designated facilities. • Coordinate safe return (re-entry) of patients and non-medical attendants evacuated by NDMS to their homes of record, in collaboration with STT public health agencies.
• Veterinary medical support (Rs)	• Provide veterinary medical support to treat ill or injured animals, service animals, pets, working animals, emotional support animals, laboratory animals, and livestock post-incident. • Provide veterinary support for mass-care services.
• Health care systems (Rc)	• Assess and monitor incident-related community health care systems needs and prioritize and coordinate provision of services to meet those needs. • Provide support for meeting cross-cutting priorities that apply to response and recovery mission areas and functional areas covered by this plan.

3-5-C. **Fatality Management** – functions and activities for fatality management services

Functional Area	Objective
• Fatality management (Rs)	• Coordinate and provide fatality management services.

[48] Including for those in influxes of unaccompanied children.

[49] Including for that in response to influxes of unaccompanied children.

3-5-D. **Human Services and Social Services –** functions and activities for human services, social services impacts, children in disasters, and referrals to specialized services[50]

Functional Areas	Objectives
• Human services (Rs, Rc)	• Coordinate and support human services and social services in response and recovery. • Assess incident-related community social services needs and prioritize addressing those needs, including accessibility requirements. • Coordinate and support referral to social services/disaster case management. • Provide support for children, youth, and families in disasters.[51] • Provide support for meeting cross-cutting priorities that apply to response and recovery mission areas and functional areas covered by this plan.
• Education (Rc)	• Facilitate continuation and, as needed, restoration of education services to promote social and emotional well-being in communities. • Provide support for meeting cross-cutting priorities that apply to response and recovery mission areas and functional areas covered by this plan.

3-5-E. **Medical Countermeasures** – functions and activities for research, development, safety, security, and effective use of medical countermeasures (MCMs), including biological products such as vaccines, blood products, and antibodies

Functional Area	Objectives
• Research and development for medical countermeasures (Xc)	• Coordinate and support expedited response-relevant research and development of medical countermeasures.
• Safety and security of drugs, biologics, and medical devices[52] (Rs)	• Issue emergency use authorizations needed during public health emergencies. • Provide guidance for effective use of medical countermeasures. • Assess real-world safety and effectiveness of the MCMs as they are used during a public health emergency, and as a biological threat agent evolves (e.g., emergence of variants). • Protect the public health by ensuring the availability, safety, efficacy, and security of human and veterinary drugs, biological products,[53] and medical devices.

[50] HHS's human services divisions (ACF, ACL) have primary responsibility to provide technical assistance and facilitate the continuation and restoration of human services.

[51] Including those in influxes of unaccompanied children.

[52] Includes facilitation of effective use of medical countermeasures.

[53] Veterinary biological products, including animal vaccines, produced and distributed in full conformance with the Virus-Serum-Toxin Act (21 U.S.C. 151-158) and its implementing regulations, are regulated by the USDA Center for Veterinary Biologics.

Functional Area	Objectives
• Blood and tissues (Rs)	• Coordinate and support safety, security, and availability of blood, blood products, and tissues. • Support effective and appropriately prioritized collection and availability of blood, blood products, and tissues.

3-5-F. **Public Health Supply Chain** – functions and activities for market availability, acquisition, stockpiling, deployment, distribution, and dispensing of health/medical/veterinary equipment and supplies

Functional Areas	Objectives
• Supply chain data, analytics, and support (Xc)	• Establish and sustain public health supply chain visibility. • Establish and maintain situational awareness of the public health supply chain. • Acquire and maintain capabilities (analytics and modeling) to project, mitigate, and respond to public health supply chain shortages and disruptions.
• Market availability, acquisition, and stockpiling or provision of health/ medical/ veterinary equipment and supplies[54] (Rs)	• Coordinate provision of federally managed medical equipment and supplies, including MCMs and ancillary supplies, equipment, and facility elements for providing or administering MCMs. • Provide medical logistics to support continuity of essential public health and medical operations and services. • Coordinate the acquisition and stockpiling of public health supplies. • Support robustness and resiliency of the public health supply chain. • Support restoration of disrupted public health supply chains. • Foster development of public health supply production capacity to support preparedness and response.
• Deployment, distribution, and dispensing of health/ medical/ veterinary equipment and supplies[55] (Rs)	• Develop an evidence-based approach to assess prioritization of resources and efficiency of resource allocation and provision. • Develop credible, prioritized public health supply allocation and distribution mechanisms prior to and during public health emergencies. • Coordinate and support distribution and dispensing of public health supplies. • Support deployment and delivery of MCMs, nonpharmaceutical interventions, and medical and veterinary equipment and supplies.

3-5-G. **Communications and Information Management –** functions and activities for relaying coordinated, timely, reliable, and actionable information regarding any threat or hazard to the whole community; and for providing decision makers with relevant information regarding the nature and extent of the hazard and any cascading effects

[54] Core functional area for response is health/medical/veterinary equipment and supplies.

[55] Core functional area for response is health/medical/veterinary equipment and supplies.

Functional Areas	Objectives
• Public information and warning (Xc) (includes public health and medical information [Rs])	• Provide public health and medical information to inform public health and medical response and recovery operations. • Deliver actionable, accessible, culturally and linguistically appropriate information regarding threats or hazards, actions being taken, available assistance, and individual action guidance.

3-5-H. **Operational Coordination –** functions and activities for establishment of a unified and coordinated operational structure and a process that appropriately integrates critical stakeholders, supports execution of response and recovery mission areas, and ensures communications in support of operations in and among affected communities

Functional Areas	Objectives
• Situational awareness (Xc)	• Collect, evaluate, and interpret information gathered from a variety of sources to provide a basis for decision-making. • Provide information to maintain public health, medical, and human services situational awareness to inform decisions at all levels and across sectors.
• Situational assessment (Xc)	• Provide decision-makers with decision-relevant information regarding the nature and extent of the threat, hazard, or incident, cascading effects, and the status of the response.
• Operational coordination (Xc)	• Provide operational structures and processes that support coordinated response and recovery activities. • Provide for deployment of HHS resources (personnel or material) to support FSTT authorities, international organizations, and, as appropriate, local authorities; assist with international emergency medical responses. • Maintain all mission-essential functions of HHS for continuity of operations, per the HHS Continuity of Operations Plan (HHS 2020).
• Operational communications (Xc)	• Provide capabilities for interoperable communications with all sectors involved in response and recovery operations.

3.6.2. Objectives and Key Tasks

HHS divisions maintain their roles, responsibilities, capabilities, and functional areas to sustain the provision of public health, medical, human services, and social services during incidents requiring federal support for response and recovery operations. During operations, objectives and tasks associated with HHS LOEs and functional areas should guide response and recovery activities. *Annex D: Organization and Assignment of Responsibilities/Tasks* details the organization and assignment of responsibilities for HHS divisions arranged by LOEs and functional areas, and highlights the objectives and tasks associated with each HHS division.

3.6.3. Operational Phases

In concert with FSTT partners, HHS achieves the desired end states of response and recovery operations through a phased approach, as described in the Response and Recovery FIOP (FEMA 2025). As illustrated in Figure 3-2, operational phasing facilitates alignment and

harmonization of FSTT actions and activities, including response and recovery operations. By arranging operations and activities into phases, HHS operations can be methodically and logically arranged to integrate federal resources and capabilities and harmonize activities with stakeholder partners toward achieving established goals and objectives. Each phase is a defined stage during which a specified portion of federal public health, medical, human services, or social services assistance occurs, with the resources and capabilities needed for corresponding or mutually supporting activities. A set of conditions, objectives, or events are often prescribed to facilitate transitioning from one phase to another. The following subsections and Tables 3-6 to 3-8 describe characteristic activities performed in each phase. These activity descriptions are illustrative and do not necessarily represent a comprehensive listing or definitive associations of actions or phase transition conditions for all response and recovery operations. During a major response organizations or parts of organizations may be considered to be in different phases or sub-phases based on the conditions in their particular portions of the mission space.[56]

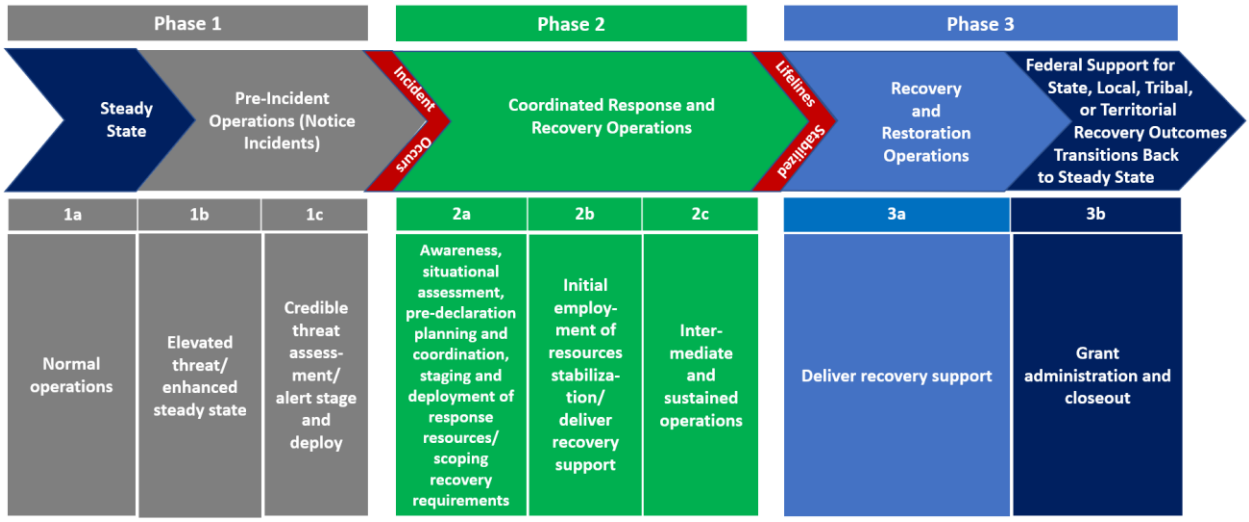

Figure 3-2. Response and recovery phasing/sub-phasing construct (adapted from FEMA 2025)

3.6.3.1. Phase 1: Pre-Incident Operations

This is a steady-state phase, in which normal operations, planning, and training occur. During this phase, HHS focuses on preparedness planning for response; building federal public health, medical, human services, and social services operational capabilities; medical countermeasures research, advance development, and acquisition; and provision of grants to strengthen the capabilities of hospitals and health care systems, including for disasters and public health emergencies. Table 3-6 lists operational sub-phasing and transition conditions for phase 1. If a threat or risk of a developing hazard becomes elevated (sub-phase 1b) or credibly imminent (sub-phase 1c) during this phase, the preparedness activities may focus on the particular emerging situation, including activities transitioning to response (a focus of phase 2).

[56] For example, for the end of sub-phase 2b, stabilization of public health, medical, and human services elements may not be synchronized.

Table 3-6. *HHS RROP* operational sub-phasing and transition conditions for Phase 1: Pre-Incident Operations

Sub-phase transitions	Typical activities
1a: Normal Operations • **Sub-phase begins**: Steady-state. • **Sub-phase ends**: Potential incident identified.	• Conduct deliberate planning. • Coordinate preparedness activities. • Monitor and gain situational awareness of potential threats or hazards.
1b: Elevated Threat/ Enhanced Steady State • **Sub-phase begins**: Potential incident identified. • **Sub-phase ends**: Threat diminishes or is recognized as credible.	• Develop situational awareness planning products. • Confirm readiness and availability of personnel and resources; consider alert or possible activation. • Begin and coordinate federal incident-specific operational planning. • Initiate contact and coordinate with STT public health authorities. • Prepare equipment sets/caches/kits.
1c: Credible Threat Assessment/ Alert, Stage, and Deploy • **Sub-phase begins**: Threat is recognized as credible. • **Sub-phase ends**: Initial onset or recognition of onset of impacts and a decision is made to establish an incident support structure for HHS response.	• Develop decision support tools and situational awareness products for a potential incident. • Coordinate with STT public health authorities to determine potential requirements. • Identify and establish staging areas. • Pre-position/stage or deploy federal public health and medical resources. • Support pre-impact patient movement/evacuation operations as requested or assigned.

3.6.3.2. Phase 2: Coordinated Response and Recovery Planning and Operations

Phase 2 begins when an incident is recognized to be in progress and a decision is made to establish an incident support structure for HHS response, and may include a decision to pre-position/stage or deploy federal public health and medical resources and capabilities. This phase includes deployment of federal public health and medical assets, activation and employment of public health, medical, human services, and social services operational resources and capabilities, and use of pre-positioned public health and disaster supplies. Phase 2 focuses on rapidly gathering credible situational awareness and providing immediate, coordinated, and effective federal public health, medical, and human services response resources and capabilities to support STT governments' life-saving and life-sustaining activities following a disaster or a public health emergency. It also includes initiating recovery planning and operations, coordinated as appropriate with response activities. This includes assessing the scope of damage and disruption to the delivery of functions and services and beginning the planning for recovery and restoration. Table 3-7 lists operational sub-phasing and transition conditions for phase 2.

Following a disaster[57] in which public health, medical, and human services systems may be disrupted, HHS response operations support stabilization and re-establishment of services, including providing federal support to augment STT capabilities.

Table 3-7. *HHS RROP* operational sub-phasing and transition conditions for Phase 2: Coordinated Response and Recovery Operations

Sub-phase transitions	Typical activities
2a: Awareness/ Situational Assessment/ Pre-Declaration Planning and Coordination/ Staging and Deployment of Response Resources/ Scoping Recovery Requirements • **Sub-phase begins**: Incident impact/disruption is ongoing or has occurred and a decision is made to establish an incident support structure for HHS response; receipt of mission assignment; HHS senior leadership decision to stage resources. • **Sub-phase ends**: Incident Management Team (IMT) coordination and situational awareness established; capabilities deployed to accomplish goals and objectives.	• Stage or deploy federal public health and medical resources. • Establish field incident management organization and coordination. • Establish situational awareness about the impacts of the incident and the status of public health, medical, and human services infrastructure and capabilities. • Coordinate with STT public health and begin mission scoping assessments. • Support STT lifesaving and life-sustaining response activities.
2b: Initial Employment of Resources and Stabilization/ Deliver Recovery Support • **Sub-phase begins**: IMT coordination and situational awareness established; capabilities deployed to accomplish goals and objectives. • **Sub-phase ends**: Stabilization of impacted public health, medical, and human services infrastructure and capabilities to support communities (reentry and repopulation) is in progress. Objectives and organization for recovery are established (per FEMA Joint Field Office [JFO], if used).	• Deploy federal public health, medical, and human services response resources and staff per mission assignments. • Support STT response activities/actions to stabilize impacted public health, medical, and human services infrastructure and capabilities. • Continue to support STT lifesaving and life-sustaining response activities; provide and track federal public health, medical, and human services capabilities as requested. • Support STT response activities/actions to facilitate population re-entry and return. • Coordinate with FEMA and STT partners to scope recovery outcome indicators and support delivery of NDRF capabilities.

[57] Of any type, including natural or human-caused (accidental, intentional, or technological). See *Glossary* entry for disaster.

Sub-phase transitions	Typical activities
2c: Intermediate and Sustained Operations • **Sub-phase begins**: Stabilization of impacted public health, medical, and human services infrastructure and capabilities to support communities (reentry and repopulation) is in progress. Objectives and organization for recovery are established (per JFO, if used). • **Sub-phase ends**: Impacted public health, medical, and human services infrastructure and capabilities to support communities (reentry and repopulation) have been stabilized; focus shifts from response-focused objectives to recovery outcomes.	• Demobilize and re-deploy federal public health, medical, and human services response resources and staff as missions are completed. • Organize/re-organize operations to support the transition to effective recovery operations. • Coordinate with STT public health and human services authorities to prioritize and plan recovery actions. • Continue to support the delivery of NDRF capabilities to STT public health and human services authorities.

3.6.3.3. Phase 3: Recovery and Restoration Operations

Phase 3 is characterized by recovery activities, which may continue for months to years. Assessment of the scope of damage and disruption to the delivery of functions and services, as well as planning for and starting to execute recovery, may continue after initiation in phase 2. In phase 3 the focus will be more exclusively on the restoration of services, providers, facilities, and infrastructure within the public health, medical, and human services sectors; and the mobilization of and collaboration with recovery organizations and resources and other stakeholder partners. During this phase, HHS recovery activities also include collaboration with community partners to achieve post-incident recovery goals, benchmarks, and metrics established by the STT governments. This phase may include restoring public health, medical, and human services infrastructure to meaningful operational capacity. As recovery goals, benchmarks, and objectives are met, HHS collaborates with FEMA and STT public health authorities to coordinate the closeout of recovery support for the incident. Table 3-8 lists operational sub-phasing and transition conditions for phase 3.

Table 3-8. *HHS RROP* operational phasing and transition conditions for Phase 3: Recovery and Restoration Operations

Sub-phase transitions	Typical activities
3a: Deliver Recovery Support • **Sub-phase begins**: Impacted public health, medical, and human services infrastructure and capabilities to support communities (reentry and repopulation) have been stabilized; focus shifts from response-focused objectives to recovery outcomes. • **Sub-phase ends**: Sustained recovery activities begin; JFO, if used, has closed.	• As appropriate, continue to demobilize and re-deploy federal public health, medical, and human services response resources and staff. • Continue to coordinate with FEMA and STT partners and facilitate the development of the recovery support strategy. • Continue to support the delivery of NDRF capabilities to STT public health and human services authorities. • Support transition to recovery offices for closeout.

Sub-phase transitions	Typical activities
3b: Grant Administration and Closeout • **Sub-phase begins**: Sustained recovery activities begin; JFO, if used, has closed. • **Sub-phase ends**: Sustained recovery teams are demobilized, and recovery facilities/offices are closed.	• Initiate transition of recovery grant programs. • Continue to support the delivery of NDRF capabilities to STT public health and human services authorities. • Closeout recovery grant programs

3.7. Key Senior Leader Decisions

Table 3-9 identifies key decisions that the HHS Secretary or designee must consider following an incident. These decisions are organized by phase and may be used to inform the development of headquarters-level incident support plans and decision support tools and to identify and prioritize information requirements. The decisions associated with a particular phase may change depending on circumstances. These key senior leader decisions are critical and could impact the timely implementation of the response and recovery concept of operations described in this plan. The decisions in this list are not all-encompassing; additional key senior leader decisions will be identified in incident-specific annexes and others may be needed according to circumstances, to be addressed in incident-related crisis and contingency planning.

Table 3-9. Summary of key leader decisions

Phase	Decision
1	• Determine Secretary's Operations Center (SOC) activation level in response to a potential incident per Incident Response Framework (OASPR 2021d). • Determine the composition of and establish a unified coordination structure. • Pre-position/stage resources into positions from which they can be deployed rapidly if an STT authority requests assistance. • Approve-requests to activate the National Patient Movement Taskforce to coordinate federal patient movement.
2	• Declare a PHE. • Determine whether changes in SOC activation level are required. • Identify and delegate authority to a federal health coordinating official (FHCO). • Determine whether activation of the Disaster Leadership Group (DLG) is required and activate as appropriate, in accordance with established procedures.[58] • In consultation with ACF, ACL, ASPR, and SAMHSA determine how human services and social services issues in the given response and recovery will be addressed. • Identify and delegate authority to a federal human services coordinating official. • Activate the NDMS. • Approve of an STT request for support/assistance in the absence of an emergency or major disaster declaration under the Stafford Act. • Activate the ESF #8 Council,[59] as needed, to adjudicate limited/scarce resource requests.

[58] See *Glossary* entry for Disaster Leadership Group (DLG).
[59] See *Glossary* entry for ESF #8 Council.

Phase	Decision
	• In consultation with HHS division labor relations staff and the National Labor and Employee Relations Officer, determine labor relations obligations of deployments and engage the affected union(s), as appropriate under federal law. • Activate and deploy personnel from the USPHS Commissioned Corps. • Prioritize distribution and use and deploy medical materiel and supplies from the Strategic National Stockpile (SNS). • Consider invoking waiver authority under Section 1135(b) of the Social Security Act, if prerequisite conditions exist. • Approve-requests for the Emergency Prescription Assistance Program. • Determine deployments of additional regional personnel or teams to the affected area or to areas with potential incidents, to initiate contact and coordinate with public health authorities. • Determine Public Readiness and Emergency Preparedness (PREP) Act declarations and other liability and compensation mechanisms. • Approve of requests for temporary reassignment of STT and local public health department or agency personnel whose positions are funded under USPHS programs.
3	• Assess SOC activation level and potential demobilization of SOC personnel. • Decide whether and when to activate and deploy HEHS RSF personnel.

3.8. Deactivation and Demobilization

Deactivation and demobilization of response resources must occur as response activities are completed.[60] Consistent with the NIMS, HHS resources and capabilities will be deactivated and demobilized when they are no longer required to support response operations. HHS will assess the need for full-time incident response support and coordination and determine when it can decrease its response posture, and implement a plan to phase down operations, demobilize and transition resources, and initiate deactivation of the Secretary's Operations Center (SOC) to normal steady-state status. This decision includes identifying whether missions supporting an STT government's lifesaving and life-sustaining response activities are complete and the LOE objectives related to the response mission area were achieved. The HHS Incident Support Director approves any plan for the phasing down, demobilization, and transition of resources and the deactivation and transition of the SOC activation levels. This includes HHS liaisons deployed to FEMA's National Response Coordination Center (NRCC). The FHCO, with concurrence from the FEMA Federal Coordinating Officer and the FEMA Regional Administrator as appropriate, approves plans for phasing down, deactivation, or demobilization and transition of resources in the field. This includes HHS resources deployed to the applicable regional response coordination center (RRCC), the incident management team (IMT),[61] and the JFO.[62]

[60] Deactivation and demobilization of recovery resources are out of the scope of this plan, as they normally occur in phase 3b.

[61] "HHS/ASPR field elements, specifically the FHCO and the Incident Management Team (IMT), are responsible for localized management of the federal public health and medical response. The primary focus of the IMT is to identify and validate [STT and local] priority unmet public health and medical needs and initiate appropriate planning, coordination, and delivery of resources to meet those needs." (OASPR 2019c) See *Glossary* entry for incident management team (IMT).

[62] "The JFO is a temporary [f]ederal multiagency coordination center established locally to facilitate field level domestic incident management activities related to prevention, preparedness, response and recovery when activated. The JFO provides a central location for coordination of [f]ederal, [s]tate, local, tribal, nongovernmental and private-sector organizations with primary responsibility for activities associated with threat response and incident support." (DHS 2006)

In addition, HHS divisions with emergency operations centers (EOCs) supporting an incident based on their individual authorities may deactivate and demobilize according to their internal standard operating procedures and provide situational awareness to the SOC. Deactivation and demobilization actions include, but are not necessarily limited to, (a) recommending resource allocation and transition resources; (b) recommending a timeline for return to normal operations; and (c) issuing deactivation and demobilization orders.

4. Organization and Assignment of Responsibilities

4.1. HHS Agency Responsibilities During Response and Recovery

HHS divisions have the following responsibilities during response and recovery:

Administration for Children and Families (ACF): ACF delivers human services to promote the social well-being of families, children, individuals, and communities. ACF fosters economic independence and productivity after an incident through its grant programs. ACF leads refugee resettlement, the U.S. repatriation program, and disaster human services case management; and supports coordination of HHS human services support for ESF #6 (mass care, emergency assistance, housing, and human services).

Administration for Community Living (ACL): ACL funds services and supports that address the independence, well-being, function, and health of persons with disabilities and of older adults. These services and supports are provided by networks of STT and community-based organizations and with investments in research, education, and innovation.

Administration for Strategic Preparedness and Response (ASPR): ASPR leads HHS's response to public health emergencies and the coordination of ESF #8 under the NRF and HHS's coordinating responsibilities for the health, education, and human services recovery support function under the NDRF. During disasters and public health emergencies ASPR also supports coordination of HHS's support to ESFs #6, #9, #10, #11, and #15.

Agency for Healthcare Research and Quality (AHRQ): AHRQ measures, tracks, and uses data to inform improvements in the US health care-delivery system, including in its response to pandemics, disasters, and other hazards. During and after disasters, AHRQ provides insights into the quality and safety of health care; and develops and tests novel solutions with the potential to improve care-system response and to address behavioral health for health care providers and the general population. AHRQ's research and analysis inform coordination for both response and recovery activities within the U.S. health care system, support after-action assessments, and enable work with HHS/ASPR to develop plans to address lessons learned.

Office of the Assistant Secretary for Public Affairs (ASPA): ASPA directs the public communications needs of the Secretary and HHS and provides public affairs guidance to HHS leaders and policymakers. ASPA leads HHS's responsibilities for emergency public health/risk communication and works closely with ASPR, CDC, and other key emergency response agencies to position HHS as a credible and trustworthy official source of information and guidance for the public.

Office of the Assistant Secretary for Planning and Evaluation (ASPE): ASPE provides evaluation, analysis, and policy development and coordination to advise senior leaders on decisions related to preparedness, response, and recovery activities.

Agency for Toxic Substances and Disease Registry (ATSDR): ATSDR protects communities from harmful health effects related to exposure to natural and human-made hazardous

substances. ATSDR does this by responding to environmental health emergencies, investigating emerging environmental health threats, conducting research on the health impacts of hazardous waste sites, and building capabilities of and providing actionable guidance to STT and local health partners.

Centers for Disease Control and Prevention (CDC): CDC works 24/7 to protect America from health, safety, and security threats, both foreign and in the U.S. Whether diseases start at home or abroad, are chronic or acute, curable or preventable, human error or deliberate attack, CDC fights disease and supports communities and citizens to do the same. CDC increases the health security of the nation. As the nation's health protection agency, CDC saves lives and protects people from health threats. To accomplish its mission, CDC conducts critical science and provides health information that protects the nation against expensive and dangerous health threats, and responds when these arise. CDC protects America's health at US ports of entry by detecting, responding to, and helping to prevent the spread of contagious diseases into the United States.

Centers for Medicare & Medicaid Services (CMS): CMS provides access to high-quality medical care for subscribers to federal medical service and insurance programs (Medicare, Medicaid, Children's Health Insurance Program, Health Insurance Marketplace programs). CMS provides data to enable care for those with special access and functional needs during response and recovery. CMS supplies regulatory waivers for federal requirements when the President declares an emergency or major disaster. CMS also provides technical assistance (a) to the Secretary of HHS for determining the need for a public health emergency and (b) for temporarily certifying facilities or portions of facilities for care.

Food and Drug Administration (FDA): FDA ensures the safety, efficacy, and security of human and veterinary drugs, biological products,[63] and medical devices. FDA also ensures the safety and security of the nation's food supply, cosmetics, and products that emit radiation. FDA helps make medical countermeasures available during public health emergencies by authorizing products for emergency use, granting investigational new drug status, and providing regulatory approvals, among other things, when appropriate for needed drugs, biological products, or medical devices. Additionally, the FDA provides technical expertise to help inform response, recovery strategy, and policy decisions.

Health Resources and Services Administration (HRSA): HRSA's mission is to improve health outcomes through access to quality services, a skilled health workforce, and innovative, high-value programs. HRSA programs provide health care to people who are geographically isolated and economically or medically vulnerable. HRSA can provide a communication channel with funded awardees, such as health centers, during response and recovery to help contribute situational awareness for resources and capabilities.

Office of Intergovernmental and External Affairs (IEA): IEA connects the federal response and recovery participants with STT and local governments and with non-governmental organizations through its communications connections. It facilitates interactions in both directions, including with regional directors, governors, tribal officials, territorial representatives, counties, the Association of State and Territorial Health Officials, and the National Association of County and City Health Officials.

[63] Veterinary biological products, including animal vaccines, produced and distributed in full conformance with the Virus-Serum-Toxin Act (21 U.S.C. 151-158) and its implementing regulations, are regulated by the USDA Center for Veterinary Biologics.

Indian Health Service (IHS): IHS provides comprehensive health services for American Indians and Alaska Natives. IHS facilitates access for members of federally recognized tribes to services and resources needed in response and recovery. IHS advises on how needs may change due to varying tribal relationships with the federal, state, and territorial governments.

National Institutes of Health (NIH): NIH provides subject-matter and technical expertise for senior leaders, health professionals, and the public, particularly to facilitate evidence-based decisions. Topics include causes, diagnosis, treatment, control, and prevention of diseases. NIH conducts and coordinates urgent laboratory and clinical research to develop and assess the safety and efficacy of vaccines, therapeutics, and diagnostics in response to public health emergencies. NIH disseminates biomedical data and information integral to supporting public health surveillance and response.

Office of the Assistant Secretary for Health (OASH): OASH directs and oversees the deployment and operations of the USPHS Commissioned Corps to support meeting federal, STT, and local public health and medical needs. OASH advises the HHS Secretary and other federal officials on evidence-based strategies to prevent and reverse chronic disease and improve health outcomes; develops policy; and integrates preventive services into response- and recovery activities, including advising on clinical preventive services such as blood and tissue safety. OASH coordinates across HHS and with interagency partners to support public health and medical operations during and after emergencies.

Office for Civil Rights (OCR): OCR enforces compliance with the nation's civil rights, conscience, religious freedom, and health information privacy and security laws to remove discriminatory barriers to participation in HHS-funded programs and to protect the privacy, security, and availability of individuals' health information. OCR's civil rights authorities prohibit discrimination based on race, color, national origin, disability, sex, age, and, in some cases, the exercise of conscience and religion. When the President declares a national emergency or disaster and the Secretary of HHS declares a public health emergency, the Secretary may waive certain provisions of the Health Insurance Portability and Accountability Act Privacy Rule in the emergency area for a limited period. The authority for such waivers includes section 1135(b)(7) of the Social Security Act, as necessary to promote effective response and recovery. However, civil rights mandates and authorities remain in effect during national emergencies and disasters.

Office of Global Affairs (OGA): OGA fosters and leverages international relationships and engagements to promote and support effective decisions and actions during response and recovery. OGA provides guidance to leadership on the global implications of domestic incidents and domestic implications of foreign incidents. OGA also contributes expertise for strategic and policy response and recovery considerations, including via the U.S. IHR National Focal Point.[64]

Substance Abuse and Mental Health Services Administration (SAMHSA): SAMHSA leads public health and service delivery efforts that treat mental illness, especially serious mental illness, prevent substance abuse and addiction, and provide treatments and supports to foster recovery while ensuring access and better outcomes for all. SAMHSA helps STT authorities and local providers plan for and respond to behavioral health needs during and after a disaster or public health emergency. This includes providing guidance to local providers and resources to address the needs of persons affected by behavioral health challenges. For eligible federally declared disaster and emergency incidents, SAMHSA has an interagency agreement with FEMA to provide technical assistance, consultation, grant administration, program oversight, and training related to the Crisis Counseling Assistance and Training Program, a federally

[64] See *Glossary* entry for IHR NFP.

funded supplemental program administrated by FEMA in cooperation with SAMHSA. In addition, Section 501 of the Public Health Service (PHS) Act authorizes the Secretary of HHS, through SAMHSA, to act immediately under emergency circumstances requiring a behavioral health response where no other resources are available. In such circumstances, SAMHSA is authorized to use up to 2.5 percent of funds appropriated under Title 5 of the PHS Act to provide Supplemental SAMHSA Emergency Response Grants (SERGs) in support of disaster behavioral health resources (NARA 2023).

4.2. Summary Table of HHS Agency Responsibilities

Table 4-1 provides an overview of primary and supporting responsibilities per agency, as laid out in section *3.5. Response Core Functional Areas, Recovery Core Mission Areas and Cross-Cutting Priorities, and Cross-Cutting Functional Areas*, with functional areas here organized by LOE. *Annex D: Organization and Assignment of Responsibilities* contains an extension of this construct to include operational-level tasks. In some cases, more than one entity with primary responsibility is designated, where responsibilities are for different aspects of the functional areas.

Table 4-1. Overview of HHS division primary and supporting responsibilities for the functional areas associated with the lines of effort and for the recovery cross-cutting priorities.

Key: P: primary responsibility; S: supporting responsibility; ·(dot): contingent responsibility

Functional area types: Rs: response core functional area; Rc: recovery core mission area; Xc: cross-cutting functional area

4-1-A: Line of effort: Public Health and Safety

Functional area	Functional area type	ASPR	OASH	CMS	CDC	ATSDR	FDA	NIH	OGA	IEA	ASPA	SAMHSA	ACF	ACL	HRSA	IHS	OCR	ASFR	ASPE	AHRQ	ASA
Assessment of public health/ medical needs	Rs	P	S	S	P	S	S	S	S			S	S	S	S	S					
Public health: potable water/wastewater, solid waste disposal; vector control	Rs*	S			P	S	S	S								S					
Public health and environmental health	Rc	P	S		P	P	P	S				S			S	S					
Health surveillance	Rs	S			P				S						S	S					
Behavioral health care	Rs	S	S	S	S			S				P	S			S					
Behavioral health	Rc	P		S	S			S				P	S		S	S					
Food safety and defense	Rs	S			S		P	S								S					
Agriculture safety and security	Rs	S			S		P									S					
Environmental response/health and safety	Xc	P	S	S	P	P	S	S				S	S		S	S					
Public health and medical consultation, technical assistance, and support	Rs	P	S	S	P	S	P	P	S	S		P	P	S	S	S	S				

* For both functional areas

4-1-B: Line of effort: Medical Care and Patient Movement

Functional area	Functional area type	ASPR	OASH	CMS	CDC	ATSDR	FDA	NIH	OGA	IEA	ASPA	SAMHSA	ACF	ACL	HRSA	IHS	OCR	ASFR	ASPE	AHRQ	ASA
Patient care	Rs	P	S	S	S							S				S					
Medical surge	Rs	P	S	S	S							S				S					
Patient movement	Rs	P	S	S	S							S	S	S		S					
Veterinary medical support	Rs	P			S		S	S								S					
Health care systems	Rc	P	S	S	S							S	S	S	S	S					

4-1-C: Line of effort: Fatality management

Functional area	Functional area type	ASPR	OASH	CMS	CDC	ATSDR	FDA	NIH	OGA	IEA	ASPA	SAMHSA	ACF	ACL	HRSA	IHS	OCR	ASFR	ASPE	AHRQ	ASA
Fatality management	Rs	P														S					

4-1-D: Line of effort: Human Services and Social Services

Functional area	Functional area type	ASPR	OASH	CMS	CDC	ATSDR	FDA	NIH	OGA	IEA	ASPA	SAMHSA	ACF	ACL	HRSA	IHS	OCR	ASFR	ASPE	AHRQ	ASA
Human services	Rs, Rc	P	S	S	S							S	P	P	S	S	S			S	
Education	Rc	P			S							S	P	S	S	S					

4-1-E: Line of effort: Medical Countermeasures

Functional area	Functional area type	ASPR	OASH	CMS	CDC	ATSDR	FDA	NIH	OGA	IEA	ASPA	SAMHSA	ACF	ACL	HRSA	IHS	OCR	ASFR	ASPE	AHRQ	ASA
Research and development for MCMs	Xc	P	S		S	S	P	P	S												
Safety & security of drugs, biologics, med devices*	Rs	S	S		S		P	S	S							S					
Blood and tissues	Rs	S	P	S	S		S	S							S	S					

* Includes facilitation of effective use of medical countermeasures.

4-1-F: Line of effort: Public Health Supply Chain

Functional area	Functional area type	ASPR	OASH	CMS	CDC	ATSDR	FDA	NIH	OGA	IEA	ASPA	SAMHSA	ACF	ACL	HRSA	IHS	OCR	ASFR	ASPE	AHRQ	ASA
Supply chain data, analytics, and support-Xc	Xc	P			S		P		S										S	S	
Market availability, acquisition, and stockpiling or provision of health/ med/ vet equipment and supplies*	Rs, Xc	P	S				S		S							S					
Deployment, distribution, and dispensing of health/ medical/ veterinary equipment and supplies*	Rs, Xc	P	S		S		S								S	S					

* Core functional area for response is health/medical/veterinary equipment and supplies.

4-1-G: Line of effort: Communications and Information Management

Functional area	Functional area type	ASPR	OASH	CMS	CDC	ATSDR	FDA	NIH	OGA	IEA	ASPA	SAMHSA	ACF	ACL	HRSA	IHS	OCR	ASFR	ASPE	AHRQ	ASA
Public information and warning	Xc*	S	S	S	P	S	P	S	S	S	P	P	S	S	S	S		S		S	

* Includes public health and medical information, which is Rs.

4-1-H: Line of effort: Operational Coordination

Functional area	Functional area type	ASPR	OASH	CMS	CDC	ATSDR	FDA	NIH	OGA	IEA	ASPA	SAMHSA	ACF	ACL	HRSA	IHS	OCR	ASFR	ASPE	AHRQ	ASA
Situational awareness	Xc	P	.	.	P	.	P	.	.	.	.	.	P	.	.	.	.	.	.	.	.
Situational assessment	Xc	P		S	P	S	P	S	S			S	P	S	S	S					
Operational coordination	Xc	P	S		P	S	S						P			S					
Operational communications	Xc	P	S		S		S						S			S					

4-1-I: Recovery cross-cutting priorities

Recovery cross-cutting priority	ASPR	OASH	CMS	CDC	ATSDR	FDA	NIH	OGA	IEA	ASPA	SAMHSA	ACF	ACL	HRSA	IHS	OCR	ASFR	ASPE	AHRQ	ASA
Needs of children, youth, and families in recovery	P	S	S	S							S	P	S	S	S				S	
Integration of older adults and other individuals with access and functional needs	P	S		S	S						S	S	S	S	S				S	
Future disaster risk mitigation	P	P		S	S		S				S	S	S	S	S				S	
Focus on rural and under-resourced communities	P	S		S	S		S				S	S	S	S	S	P			S	

5. Direction, Control, and Coordination

Section 2801 of the PHS Act (42 U.S.C § 300hh) authorizes the HHS Secretary to lead all federal public health and medical response to public health emergencies and incidents covered by the NRF. Section 2811 of the PHS Act (42 U.S.C. § 300hh-10) directs the Assistant Secretary for Preparedness and Response (Assistant Secretary) to lead emergency preparedness and response policy coordination and strategic direction within HHS. The Assistant Secretary will oversee the federal public health and medical response and recovery activities required to support response to and recovery from (a) incidents requiring national-level coordination or (b) public health emergencies, whether or not a Stafford Act declaration of an emergency is in effect. The Administration for Strategic Preparedness and Response (ASPR) will coordinate federal public health, medical, and, with support of other HHS divisions as appropriate, human services, and social services support activities during response and recovery missions through the Secretary's Operations Center (SOC). If the President declares a major disaster or an emergency under the Stafford Act and HHS is a co-lead, HHS will coordinate its activities with FEMA, which is responsible for consequence management. In the absence of a Stafford Act declaration, and when HHS is designated as the LFA, ASPR will coordinate the requests for related support from individual federal departments and agencies, possibly including FEMA for consequence management. If HHS is not designated as the LFA, HHS will coordinate its activities with the LFA.

ASPR is the lead within HHS for emergency preparedness and response, manages the SOC, coordinates HHS's provision of resources and capabilities, and facilitates implementation of HHS's incident support structure for federal public health and medical support to ESF- and RSF-coordinating agencies under the NRF and the NDRF during response and recovery operations. ASPR will coordinate HHS's support activities to FSTT requests for assistance by establishing an HHS coordination structure and an incident support team (IST) at headquarters, and an FHCO and an IMT in the field. ASPR will support HHS divisions that have statutory responsibilities for programmatic responses, such as ACF for repatriation and unaccompanied children, including, when appropriate, providing for coordinated departmental response and public health and medical resources and capabilities (see *Annex A: Operational Coordination*).

5.1. Coordination Structure and Implementation

5.1.1. Overview

Figure 5-1 illustrates the structure for unified coordination for HHS-led response activities. The SOC is the principal operations center for HHS and provides situational awareness and a common operating picture. The SOC provides a location (a) to execute operational support to deployed HHS resources and capabilities; and (b) to provide unified coordination for federal public health, medical, human services, and social services assistance activities in support of response and recovery operations. Unified coordination is organized and managed consistent with NIMS (FEMA 2017). The intent of unified coordination and oversight is to leverage established protocols and existing organizational missions and roles to provide for the full participation of all HHS divisions to achieve a common goal of supporting FSTT requests for federal public health, medical, human services, and social services assistance. Oversight of this plan will be conducted through the HHS Strategic Coordination Group (SCG). The responsibilities of the HHS SCG do not supplant or supersede any authorities or responsibilities of HHS divisions; nor do they remove or transfer the roles or functions of any HHS divisions' emergency operations centers. *Annex A: Operational Coordination* identifies additional situations for which HHS might employ specialized operational coordination

structures to support various types of responses.

During activations for response and recovery operations, the direction, control, and coordination of response and recovery activities at the HHS division program level will occur in collaboration with the HHS SCG and the IST in the SOC. Working groups may be formulated based upon the scale and scope of an incident and the need for analyses, decision support, and information requirements from senior leaders, interagency partners, and the field. The direction, control, and coordination of response and recovery activities at the workgroup level will also occur within and under the oversight of the HHS SCG and the IST.

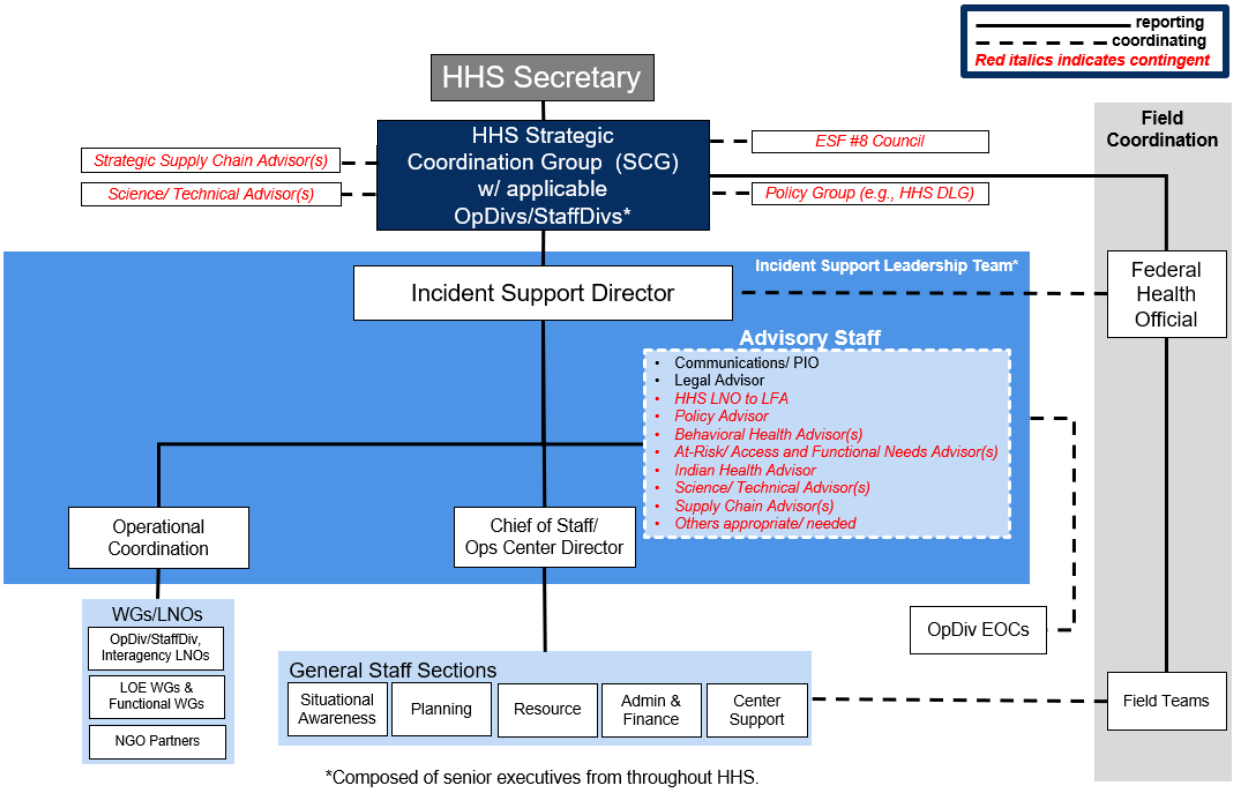

Figure 5-1. Structure for unified coordination of operational activities

5.1.2. Unified coordination structure

The HHS unified coordination structure will be established as the HHS Strategic Coordination Group (SCG) with an associated Incident Support Leadership Team (ISLT) (see *Figure 5-1*) when three or more HHS divisions have overlapping or interdependent authorities for an incident or no single HHS division has the resources to manage the incident independently. The HHS SCG is led by a senior official responsible for coordinating HHS's response to the incident and is composed of senior executive leaders from across HHS. It provides HHS's unified coordination structure during response and recovery operations, with unity of effort among multiple organizations working towards a similar objective. It facilitates unified strategic policy coordination, including establishing priorities, at the uppermost part of the headquarters-based incident support structure.

When HHS is designated as the LFA for all public health and medical responses, per PPD-44 (WH 2016) and the Enhancing Domestic Incident Response Playbook (NSC/RRD 2023), HHS will designate the Assistant Secretary for Preparedness and Response as the Senior

Response Official (SRO) to coordinate the U.S. government's response to the incident. The SRO will also lead the SCG.[65]

Depending on circumstances, the SCG may be advised by the ESF #8 Council for prioritizing resource allocation, the DLG and/or an ad-hoc policy advisory group, and strategic supply chain or scientific/technical advisors.

- ESF #8 Council: A senior level interagency group that supports the HHS Secretary and the Assistant Secretary for Preparedness and Response (Assistant Secretary) with prioritizing, allocating, and reallocating high-demand and scarce federal medical resources and capabilities during responses to disasters and public health emergencies. The ESF #8 Council comprises federal medical resource providers, including the Department of War (Office of the Secretary of War, U.S. Northern Command, National Guard Bureau); HHS (USPHS, ASPR, and CDC); the U.S. Department of Veterans Affairs (VA), and the response coordinating partner, FEMA. The ESF #8 Council is essential when multiple federal agencies with medical resources and capabilities deploy in response to disasters and public health emergencies. It provides the mechanism for the evaluation of STT requests for high-demand and limited federal medical resources. It coordinates among federal medical resource partners to prioritize and authorize the allocation and reallocation of federal medical resources and capabilities to supplement STT assets, based on validated requirements. It also provides the HHS Secretary and the Assistant Secretary with strategic policies for high-demand and scarce federal medical resources and capabilities. It is organized to enhance the ability of federal resource providers to identify the right capability and federal resources to support requested requirements.

  The ESF #8 Council makes decisions and recommendations on the allocation and relocation of limited medical capabilities and resources utilizing a consensus-building strategy among its members. The conditions requiring the allocation and reallocation of medical personnel and other resources include, but are not limited to, (a) multiple federal agencies deploying personnel and other resources to the same locations; (b) jurisdictional “hot spots” or geographical locations with significant activity in comparison to other surrounding areas and requiring assistance for additional resources and capabilities; (c) medical missions that vary by level of patient “acuity,” making the match between provider and mission crucial; and (d) multiple requests from states for limited resources, including for multiple separate simultaneous incidents. The ESF #8 Council membership may be tailored based on the nature of the disaster or public health emergency.

- Disaster Leadership Group (DLG): An HHS senior leader policy committee that may be activated (a) to serve as a forum for HHS senior leaders to deliberate and address specific policy issue(s) that require guidance, decision-making, and/or concurrence from multiple HHS divisions; (b) to provide the HHS Secretary with unified policy recommendations or options; (c) to address policy issues of national significance that impact the preparedness, response, and recovery of public health and/or medical systems, in the United States and U.S. territories; and (d) to mitigate policy gaps and challenges affecting national health security by identifying and employing the full spectrum of HHS resources, funding, and subject-matter expertise that can be leveraged.

[65] See *Annex A: Concept of Operations: HHS as the Lead Federal Agency* for additional information on the SRO.

DLG activation is triggered when the HHS Secretary or the Assistant Secretary deems that the complexity and scope of an incident require broad and targeted coordination, information sharing, and/or decision-making across multiple HHS divisions regarding policy issues that affect the nation's public health and medical systems and the health and wellbeing of the American people. The DLG may also be convened at the request of the leadership from any HHS division, the Executive Office of the President, federal interagency partners, or if an incident results in a Secretary's critical information requirement or has gained the attention of the National Security Staff, resulting in executive level meetings. Depending on the nature of the incident, the HHS Secretary or the Assistant Secretary may organize the DLG with interagency senior leaders from federal departments and agencies. The interagency senior leaders' DLG construct may be established to facilitate coordination of activities between HHS and relevant federal departments and agencies, share information and enhance situational awareness, and advise the HHS Secretary and the Assistant Secretary on policy issues of potential national significance. The goal of an interagency senior leaders' DLG is to identify and address important policy issues related to the unique nature of an incident to ensure a robust and fully coordinated response.

The DLG establishes policy priorities and resolves complex policy issues and barriers to preparedness, response, recovery, and mitigation activities through examination of applicable laws and regulations, funding priorities, and actions of government. Policy options or potential courses of action developed during DLG deliberations may serve to advance secretarial-level initiatives and programs, as well as short-term and downstream operational decision-making. Specific policy issues that have been addressed during previous DLGs include, but are not limited to, (a) decisions to recommend a public health emergency (PHE) declaration; (b) coordination of financial resource allocation; (c) coordination of department-sponsored research activities; (d) development and prioritization of specific medical countermeasures, including diagnostics; (e) development of international specimen sample-sharing protocols; (f) implementation of mandatory blood screening; (g) allocation and prioritization of assets from the Strategic National Stockpile during COVID-19, including personal protective equipment and ventilators; (h) development of a messaging plan regarding Ebola vaccines in the Democratic Republic of the Congo (DRC); and (i) development of the USG position on the use of investigational therapeutics for post-exposure prophylaxis of Ebola in the DRC.

- Strategic supply chain advisors: Subject-matter experts in public health supply chain issues who can advise HHS senior leaders on how potential decisions or policies would affect the availability of critical resources or capabilities affecting public health, medical, or human services response. Strategic supply chain advisors provide recommendations on matters of public health supply chain management including procurement planning, pipeline management, and commodity distribution. The advisors provide technical advice to resolve issues and ensure efficiency in the public health supply chain system and coordinate and collaborate with key stakeholders in the public health supply chain system, including facilitating multiagency coordination and strategic partnerships to strengthen the public health supply chain. Strategic supply chain advisors work to support the USG National Strategy for a Resilient Public Health Supply Chain (USG 2021) with an overall goal of strengthening the public health supply chain system.

- Scientific/technical advisors: Subject-matter experts in scientific and technology issues that develop recommendations on matters involving science and technology policy and inform decisions that involve scientific and technological considerations in public health-

, medical-, or human services-related response and recovery activities. They serve as scientific consultants or technical experts for projects and/or initiatives involving cross-functional teams and facilitate or lead evaluating the validity or viability of a proposed project or initiative that supports incident response or recovery operations. Scientific and/or technical advisors review and validate technical material or information and assist with establishing scientific evidence-based or validation processes and standards. They may be tasked with facilitating ad hoc support from, and potential augmentation by, scientific or technical experts from interagency, industry, or academic partners. Scientific and/or technical advisors may also facilitate, collaborate, and coordinate with research and development establishments of other government agencies and industry when appropriate to fully explore the range of potential solutions to complex problems.

5.1.3. Incident Support

HHS incident support is the coordination of federal medical resources and capabilities that support emergency response and recovery operations through operational and strategic coordination; policy guidance and senior-level decision making; resource acquisition; and information gathering, analysis, and sharing (FEMA 2017). An IST is organized to provide NIMS-compliant multi-agency coordination system (MACS) principles and a MACS structure to provide the capabilities and functions (a) to collect, analyze, and share information; (b) to support resource needs and requests; (c) to coordinate and conduct planning; and (d) to provide coordination and policy direction by integrating and coordinating with stakeholders and collaborating with HHS and interagency senior officials to facilitate the development of policy direction for incident support (FEMA 2017).

The IST comprises an incident support leadership team, command and general staff sections, and working groups/ liaison officers. The incident support leadership team is headed by an incident support director designated by the HHS Secretary, the Assistant Secretary, or other HHS senior official(s) as delegated by the Secretary or the Assistant Secretary. Consistent with NIMS, the incident support director also serves as a member of the SCG, which is the HHS unified coordination structure.

An advisory staff in the IST includes a communications/public information officer, a legal advisor, and a liaison officer (LNO) to the LFA, if HHS is not the LFA, as well as various advisors contingent on the incident. A chief of staff or operations center director oversees the general staff sections. Incident support provided by the IST includes (a) the collection, analysis, and sharing of information to provide situational awareness and a common operating picture; (b) the coordinated and prioritized deployment of national-level federal medical resources and capabilities; (c) planned activities to achieve national objectives and to support programs affected during a disaster or public health emergency, and to support emergency response and recovery operations with federal public health, medical, and human services resources, expertise, information, and guidance; and (d) operational coordination.

The HHS SCG and the IST-coordinate with (a) HHS divisions; (b) FSTT agencies and offices; (c) NGOs and international organizations; and (d) private-sector partners and stakeholders. This coordination is facilitated at the HHS headquarter level by the advisory staff and by working groups and liaison officers (see *Figure 5-1*). The HHS SCG and the IST facilitate collaborative planning and coordination to ensure interagency coordination and communication; focus on developing and communicating strategic and operational guidance; and collaborate with HHS divisions to enable execution of their support plans and the provision of resources and capabilities to sustain operations consistent with this plan, the Response and

Recovery FIOP (FEMA 2025), the NRF (DHS 2019), and the NDRF (DHS 2016c; FEMA 2024). Direction, control, and coordination activities at the interagency and department level will occur with the HHS SCG and the IST at the SOC.

5.1.4. Operational coordination working groups

Effective execution of operations requires close coordination, synchronization, and information sharing. A common approach for collaboration and integration of functional expertise from across departmental staff and the interagency to directly support mission requirements and operations is to establish working groups. The employment of working groups creates conditions that promote the unity of effort through knowledge sharing, collaboration, and the establishment of a shared perspective; facilitates the utilization of cross-functional expertise and the coordination of operations and activities; and provides for a process to enable the participation and integration of critical stakeholders.

At the height of the response to the COVID-19 pandemic, HHS identified the need for department-wide integration of HHS divisions into an operational coordination structure. HHS created working groups, comprising interdisciplinary representatives, to manage specific processes and accomplish tasks supporting new and emerging priorities and accomplishment of the operational mission. The working groups were established to achieve the strategies and objectives delineated in the National COVID-19 Strategy, served as the focal point for operationalizing the national strategic guidance, and utilized LOEs to guide their activities and work products. The HHS COVID-19 working groups were chaired by a working group leader and consisted of representatives from relevant U.S. government agencies, consistent with the working group's mission. The working groups synchronized their activities by ensuring a crossflow of planning and coordination of activities, publishing reports on their measures of performance, updating the COVID-19 Objective Management Plan via weekly collaboration and problem-solving meetings, and providing updates to the incident command senior leadership via in-progress review meetings and updates.

The *HHS RROP* furthers the working group concept and the employment of enduring cross-functional expertise in the HHS unified coordination structure by assigning them under the leadership of a senior executive who functions as the operational coordination lead. Working groups will be formed along the LOEs outlined in this plan, or specific LOEs adapted to response operations for an incident, and remain scalable, flexible, and adaptable for various types of disaster or public health emergency responses. When established, the working groups will apply the most effective strategies to help resolve the incident.

5.1.5. Field coordination

The authority to coordinate and control HHS resources and capabilities in the field during response operations flows from the HHS Secretary, through the Assistant Secretary for Preparedness and Response, to the FHCO (HHS 2009). The FHCO is normally designated by the Assistant Secretary for Preparedness and Response on behalf of the HHS Secretary and serves as the incident manager for HHS response operations in the field (HHS 2009). The FHCO is responsible for managing HHS incident response activities in the field, including field direction and coordination; facilitating federal public health, medical, and human services support via relevant emergency support functions under the National Response Framework to established National Incident Management System structure overseeing incident response operations (HHS 2009). The FHCO generally co-locates with the FEMA initial operating facility or joint field office once established and ensures that HHS incident management activities are conducted with effective and efficient coordination.

The FHCO and the IMT establish a central location for the coordination of federal public health, medical, human services, and social services assistance activities in support of federal departments' and agencies' and STT governments' requests for assistance at the location of the incident. These activities include collaboration and coordination with STT public health authorities, private-sector partners, NGOs with primary responsibility for response and recovery operations on-scene in the field environment, and HHS divisions' subject-matter experts assigned to support field activities within the IMT.

HHS incident management (on-scene operations) is typically provided by the IMT consistent with NIMS principles and incident-level organization, administration, and activities, including the coordination, delivery, and employment of federal medical resources and capabilities; and the management, collaboration, and synchronization of public health, medical, and human services activities (FEMA 2017). The IMT comprises HHS staff, including regional emergency coordinators, regional medical countermeasure advisors, National Disaster Medical System responders, U.S. Public Health Service Commissioned Corps officers, designated representatives from HHS operating and staff divisions, and various stakeholder liaisons as appropriate. The IMT structure is organized, staffed, and managed in a manner consistent with NIMS principles and is led by the FHCO/incident manager. Although the IMT uses an Incident Command System (ICS) structure, the IMT does not manage on-scene operations. Instead, the IMT focuses on coordinating, integrating, and providing support to on-scene activities. The FHCO and IMT collaborate with stakeholder partners to identify the prioritized needs and requirements of the affected communities; to identity and coordinate resources and capabilities to meet those requirements; and to coordinate the integration of deployed HHS resources and capabilities with FEMA JFO-led operations to ensure successful completion of assigned missions.

5.2. Federal Coordination

Federal departments and agencies routinely manage their responses to incidents under their statutory or executive authorities. When a federal entity with primary responsibility and authority for handling an incident requires federal assistance beyond its interagency mechanisms, the department or agency can request additional federal assistance through the Secretary of DHS. Consistent with HSPD-5 (EOP 2003), the Secretary of DHS will coordinate federal operations for domestic incident management, including for Stafford Act incidents as applicable. Federal coordination may occur within an established unified coordination structure, at the national level, at a regional operations center, or within a unified command at the incident level. FEMA is normally the coordinating entity for federal interagency partners supporting consequence-management activities and provides oversight of federal emergency response and recovery operations.

For Stafford Act incidents, HHS will collaborate closely with FEMA for federal ESF #8 public health and medical requests from STT governments for assistance. FEMA will also coordinate with HHS for the provision of support to ESFs #6, #9, #10, #11, and #15, consistent with the NRF. The federal coordination and collaboration with FEMA in these circumstances are intended to develop courses of action and define tactics for work assignments to be performed under the authorities of a mission assignment. Mission assignments allow for deployment, employment, and provision of assistance using appropriate federal resources to support disaster needs (FEMA 2022b).

For non-Stafford Act incidents, federal response or assistance may be led or coordinated by various federal departments and agencies, including HHS, consistent with their authorities. When HHS is the LFA for managing federal public health and medical response to public health

emergencies, the federal interagency will support HHS, as requested, to assist STT governments with related preparedness, response, and recovery activities. If the President declares a major disaster or an emergency under the Stafford Act, FEMA will coordinate federal support for consequence management through the NRCC and RRCC(s), as appropriate. Without a Stafford Act declaration, HHS will request and coordinate the related support from individual federal departments and agencies.

5.3. STT Coordination

Federal public health, medical, human services, and social services assistance activities in support of on-scene field-level response and recovery operations are coordinated through a collaborative FSTT construct, typically under the JFO. The response to STT requests for assistance following a disaster or public health emergency will require a significant interface and coordination among public health and other authorities, as appropriate, serving the impacted areas, HHS, the FHCO, and the IMT. The unique coordination and communication requirements will be met by two activities: (1) HHS will deploy liaisons to the JFO, to STT agencies, and to emergency management agencies' EOCs in the impacted areas; and (2) HHS will establish collegial and collaborative lines of communications and coordination among public health and human services authorities, the FHCO and the IMT on-scene in the field, and FSTT ESF and other liaisons at the JFO. During response, the FHCO will conduct coordination calls with STT public health authorities and other appropriate stakeholders. These calls are intended to provide situational awareness and understanding of (a) STT public health, medical, and human services resources, capabilities, needs, and requirements, including federally run or directed programs, and impending EMAC support as appropriate; (b) the assessment of the incident's impact on HPH sector critical infrastructure; and (c) HPH critical infrastructure and key resource requirements.

The liaisons and FHCO and IMT communications and coordination do not replace the existing HHS divisions' program-level structures or technical assistance response field deployments for collaboration and coordination with STT public health, human services, and social services agencies or providers and other authorities. Rather, they provide a temporary, specific direct means of communications and coordination among key participants, including relevant HHS division liaisons (e.g., for public health and/or human services). The FHCO and the IMT, with relevant HHS division liaisons, together serve as a point of contact for the STT requests and the resulting acquisition of supplemental federal public health, medical, and human services resources and capabilities for the impacted area. FSTT-coordinated actions will facilitate the availability of all resources and tools necessary to work toward specific response and recovery outcomes after an incident.

5.4. Non-Governmental Organizations Coordination

Consistent with the NRF, NGOs, including private, self-governing, not-for-profit, voluntary, faith-based, and community-based organizations, are critical partners in the federal response to support STT-managed and locally executed response and recovery activities for disasters and public health emergencies. Coordination and collaboration among stakeholders at various levels of government (FSTT, and local as appropriate) and the private sector are crucial to facilitate an effective whole-of-community approach. Through chapters or units of national-level associations, response and recovery coordination receives federal support while sustaining the principle that incident management and recovery operations begin and end locally. As members of the affected community, faith-based, community-based, and other nonprofit or voluntary agencies and organizations are well-positioned to partner with STT and local governments to identify, prepare for, and address unmet needs through the generosity of

donations and volunteering. Numerous benefits derive from the inclusion of these organizations in response and recovery activities, including established community trust, keen insight into specific population characteristics and needs, and the extent of commitment and duration of involvement (arrive first, leave last) of participants, many of whom live in the affected communities. They also normally provide their services free of charge, thereby providing critical economic savings to communities at a time of greatest need. Moreover, as independent entities, these organizations effectively collaborate to support the community needs without regard for a Stafford Act or other FSTT disaster or emergency declaration.

The types of services an organization may provide depend on the specific interests and values inherent to its mission. Some services may be specific to disaster relief, whereas others support various aspects of the community throughout the year. For example, the American Red Cross (Red Cross), a unique organization with a Congressional charter, has a broad range of services, including, but not limited to, mass care; family communications and support to the U.S. military; and blood supply services. The Red Cross works with FSTT authorities to ensure unity of effort and messaging, including disseminating accurate, appropriate, accessible safety, health-security, and calming messages to affected communities. The Medical Reserve Corps, a federally established program of locally managed and deployed volunteer units, is committed to improving the health and safety of communities through preparedness, response, and recovery activities, including, but not limited to, training, disaster behavioral health, medical surge, vaccination clinics, mass dispensing, and first aid. Some voluntary organizations may provide resources during disasters and public health emergencies. As an example, during the COVID-19 pandemic non-governmental organizations supported medical operations in New York and North Carolina with emergency field hospital deployments. In Puerto Rico in response to the 2017 Hurricanes Irma and Maria, non-governmental organizations deployed field hospital capabilities and small specialty teams and fielded disaster response medical teams and personnel deployments. Before, during, and after incidents, voluntary organizations may also focus on interests such as spiritual care (e.g., faith-based), animal welfare, needs of specific populations, and/or feeding (e.g., community kitchens).

Organizations may collaborate independently with STT and local officials, or through the Voluntary Organizations Active in Disasters (VOAD) organization in their state or community to increase effectiveness. They may also be part of the National VOAD (NVOAD), a nonprofit, independent organization that provides a forum for volunteer organizations to share their resources and capabilities to help communities prepare for, coordinate responses to, and recover from disasters. The Red Cross, NVOAD and other NGOs, are designated as support agencies to ESF #6. In this role, they work with STT emergency management and public health officials to determine the best ways to address the mass-care needs of communities, including (a) supporting quarantine and congregate shelters and food distribution and feeding operations; (b) connecting families; (c) distributing needed supplies; (d) supporting surveillance, health assessments, and health services, including mental health counseling; and (e) providing personnel to support temporary medical facilities, immunization clinics, morgues, hospitals, long-term care facilities, and nursing homes.

The Red Cross and faith-based, community-based, and other nonprofit or voluntary agencies and organizations respond to disasters of all types and sizes. When requested, their resources are integrated into the incident response through the STT or local emergency response framework or provided directly to the requesting entity for non-emergency collaborations. On-scene federal coordination and collaboration typically occur under the collaborative interagency coordination construct within the JFO via liaisons. Organizations may also provide liaisons to collaborate and coordinate with the FHCO and IMT to integrate their capabilities and activities with the overall federal public health, medical, human services, and social services support and assistance.

At the HHS headquarters level, liaisons coordinate with the HHS SCG and the IST to integrate their activities in the federal response. These liaisons may further collaborate with their network of volunteer organizations within the jurisdiction to ensure the requested assistance is being provided. HHS coordinates with the Red Cross to assist community health personnel as appropriate, by providing mortality information to requesting agencies and by supporting NDMS assistance to evacuation operations through the provision of services for accompanying family members or caregivers in coordination with FSTT authorities and local governments, as necessary. At the request of HHS, the Red Cross coordinates with OASH and the Association for the Advancement of Blood & Biotherapies (AABB) Interorganizational Task Force on Domestic Disasters and Acts of Terrorism (AABB Task Force) to provide blood and services as needed through regional blood centers. The Red Cross and NVOAD also collaborate and coordinate with ACF and ACL to support the provision of disaster human services for individuals and families, including services and programs for children, older adults, and individuals with access and functional needs.

5.5. Private-Sector Coordination

HHS is designated the SRMA for the HPH sector of critical infrastructure. Consistent with PPD-21 and coordinating mechanisms established in the HPH Sector-Specific Plan (DHS 2016a), HHS coordinates with elements of the private sector to ensure continuity of essential functions and services and support for responses to and recovery from disasters and public health emergencies. Among the areas with important private-sector involvement are direct patient care, including behavioral health, and health care systems; prehospital care, including emergency medical services and medical transport; laboratories, blood, and pharmaceuticals; health insurance companies and plans; local and state health departments and state emergency health organizations; and public health supply chain. Private sector organizations may also provide resources and capabilities during disasters and public health emergencies, including specialized teams, and/or equipment, through STT and local government public-private emergency support plans, mutual aid agreements, or incident-specific requests from STT government and private sector volunteer initiatives.

During incident response and recovery operations, coordination with appropriate partners' representatives may be required to collaborate on and obtain situational awareness of various national or field-level critical issues. These include infrastructure security and resilience, supply chain issues, HPH infrastructure and subsector issues, and interdependencies with other sectors. Departmental-level private-sector coordination normally occurs with the HHS SCG and the IST at the SOC via ASPR's CIP Division. During and after emergencies, communication and coordination with HPH sector partners facilitates response coordination, support of collaborative approaches to protecting HPH sector critical infrastructure, and assessment for situational awareness of damage to HPH sector critical infrastructure.

6. Information Collection, Analysis, and Reporting

6.1. Overview

This section includes functions for situational awareness (see *Figure 5-1*) to provide coordinated, timely, reliable, accessible, and actionable information related to threats, hazards, or in-progress incidents. Provision of such information to decision-makers regarding the nature and extent of the threat, hazard, or incident and cascading effects will support planning and execution of response and recovery activities.

The information management cycle illustrated in Figure 6-1 utilizes information requirements, including pre-determined essential elements of information (EEIs), to support data collection and analysis. The results are then used to produce various products, including senior leader briefs, a common operating picture, and information analysis briefs. Information management supports the needs of decision-makers at multiple levels within HHS and other federal departments and agencies for enhanced situational awareness.

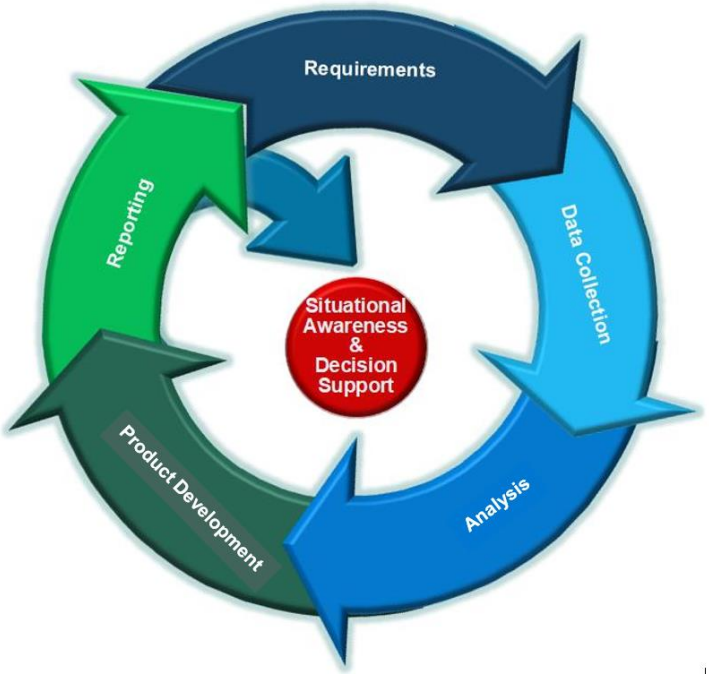

Figure 6-1. Information management cycle to support decision-making

6.2. Critical Information Requirements

Critical information requirements (CIRs) require immediate leadership notification and involvement. They are specific to an event (e.g., an NSSE) or incident response and are normally specified or approved by senior leadership. They can be changed or modified during an event or response, or new ones can be added as needed. CIRs are time-sensitive relative to situations or facts requiring ongoing monitoring and are designed to be useful for senior leadership to determine if alternate actions are necessary. The initial, most common CIRs for a disaster include these:

- Significant degradation or inundation of local emergency medical services (EMS), health care systems, public health systems,[66] or infrastructure
- Decrease in capability due to loss, malfunction, or reduction of team equipment, personnel and/or supplies
- Activation (full or partial) of consequence management plan (such as, request for movement to emergency triage locations)
- Sustained loss of communication at mission sites
- Threat of violence or attack; violent protest, civil unrest, or large demonstration in close

[66] Including delivery of preventive services (e.g., loss of lab capacity and testing, loss of vaccine programs)

proximity to HHS operations

- Suspicious person, package, material/substance or vehicle; or law enforcement investigation in proximity to HHS operations
- Current or unanticipated (unplanned) evacuations from areas or buildings; movement to alternate locations
- Unanticipated change in support or deployment timelines
- Transportation issues that will cause significant detriment to the movement of HHS personnel or assets in the accomplishment of the mission
- Injury/illness/death of deployed personnel (HHS responders)
- HHS teams have completed operations and have started "site breakdown"
- Unusually high number of patients (significant deviation from typical baseline)
- Breaking news highly critical of HHS operations; activity or action that may discredit USG operations or garner unwanted public attention
- Death or major illness/injury of HHS patient; triage red or black
- Unusual/unexpected outbreak, contagious disease, or widespread illness, or disease/injury patterns at incident/event/mission site
- Local weather advisory indicating development of potentially damaging weather system; environmental conditions
- Initial activation of STT EOC, or any change to EOC activation level

6.3. Essential Elements of Information

EEIs are pre-defined operational information requirements, specific to the event or incident, that support reporting information/data sharing and operations coordination. They are vital information about the operating environment that assist HHS staff and leadership in reaching logistical decisions. The most common EEIs for disasters include these:

Topic: Health care facility status

- Health care facility census; total number of patients, plus any changes to census
- Facility supplies status (e.g., resupply, blood, food, personal protective equipment [PPE], pharmaceuticals, oxygen, fuel, HVAC[67] systems, generators)
- Updates in power status, water status, or structural impacts/damage
- Patient treatment status (accepting new patients, open-limited, or closed)
- Evacuation status (evacuated, partially evacuated, not evacuated)
- Development of mission site and/or hospital assessments
- Increased patient load or no ability to discharge patients
- Lack of staff, doctors, or health care workers that could result in dangerous conditions
- Requests for assistance that are not being met

[67] heating, ventilation, and air conditioning

- Activation of specialized capabilities, such as HAZMAT,[68] CBRN or explosive, or biological containment
- Health care facility security concerns that could impact operations or safety of occupants

Topic: Patient movement

- Number of patients moved through official patient movement missions
- Patients moved due to transfer of care
- Federal operations support EMS locations

Topic: Fatality management

- Official number of fatalities resulting from incident reported by local jurisdiction (with reason, venue type, location of fatalities, details)
- Fatality management shortfalls (e.g., body bags, refrigeration, morgue space, PPE, transport, or other supplies)
- Total number of bodies recovered post incident
- Status of situation (e.g., developing, active, resolved, unknown)

Topic: Mission site reports

- Start/conclusion of NDMS mission operations
- Anticipated changes to existing mission timeline
- Summary of operations and mission objectives
- Patient encounter data (daily and cumulative)
- Disaster Mortuary Operational Response Team (DMORT) and Victim Information Center (VIC) support metrics
- Numbers of personnel deployed to respective mission sites (IMT, NDMS, ASPR, and HHS)

Topic: Shelter operations and vulnerable populations

- Number of shelters open to the public (including medical shelter numbers)
- Shelter population and current staff (including changes in them)
- Number of bedridden or oxygen-dependent occupants

Topic: Behavioral health status

- Behavioral health facility status (e.g., power, structural impacts, unmet needs)
- Facility supplies status (e.g., resupply, food, PPE, pharmaceuticals, HVAC systems, generators, fuel reserve)
- Behavioral health personnel status (e.g., staffing shortages, safety)
- Number and status of patients in facilities (e.g., oxygen-dependent, bedridden, detox)

[68] hazardous materials

Topic: Environmental and public health hazards

- Forecasted weather conditions and associated impacts
- Local water-boil notices
- Local reports of oil/chemical/sewage spills[69]
- Concerns related to disease or vector control; impacts to health department programs in region

Topic: Public health supply chain

- Medical supply shortages impacting the region
- Issues related to oxygen supply
- Impacts to medical suppliers (e.g., pharmaceutical manufacturers, blood banks, medical gasses, PPE, bio-waste processing)

Topic: EOC activations

- STT EOC status and activation level(s)
- FEMA RRCC status and activation level(s)
- Transition, if any, of SOC roles and responsibilities to CDC EOC

Topic: Declarations and waivers

- Emergency declaration or major disaster declaration
- Local or federally declared public health emergency
- 1135 waivers granted by CMS due to a PHE or disaster declaration

Topic: Mission assignments and requests for federal ESF #8 assistance

- Requesting institution (e.g., state, agency) and details of resources requested
- Accepted or updated mission assignments (include funding and period of performance information)

6.4. Sources of the Information

During steady-state, ASPR facilitates situational awareness through additional investigation via classified channels and makes available the information to personnel with appropriate clearances or ensures reports are sanitized before wide dissemination. Research and analysis reveal the potential or actual impacts to HHS missions and operations due to the threat, hazard, or incident. Before and after an incident occurs, ASPR collaborates and coordinates with HHS's Office of National Security to provide operational intelligence.

ASPR is also responsible for creating and disseminating response-specific information management plans (IMPs) for events, emerging threats, or at the onset of incidents. The collection, analysis, and reporting processes are illustrated in Figure 6-2. Clearly defined IMPs

[69] May include any extreme hazardous/toxic environmental conditions that could represent an immediate hazard to the health of the public or emergency responders.

outline how information is collected, compiled, shared, and stored during the response, ensuring that all involved are aware of how, when, and where to locate information.

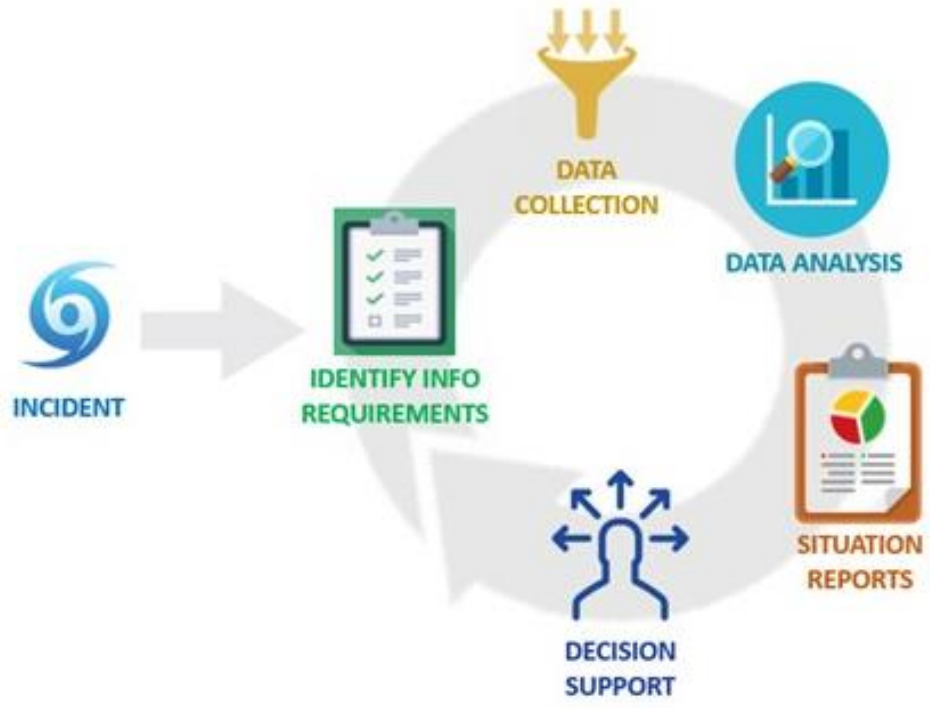

Figure 6-2. Collection, analysis, and reporting of information

6.5. Dissemination of Information

HHS typically produces seven general categories of reports for an incident as shown in Table 6-1. Ad-hoc reports may be produced and disseminated as needed.

Table 6-1 Common information products, descriptions, and data sources

Product	Description	Information Source Examples
Information management plan (IMP)	Delineation of communication channels and reporting procedures for a response, and reporting schedule for distributed response information products	• IMT-input • Product confirmation from ASPR Office of Information Management and Data Analytics (IMDA) partners • Reporting schedule • CIRs and EEIs • SOC activation details • Weather or situation details • Information products and deliverables produced during response • Points of contact for response
Information analysis brief (IAB)	Overview of anticipated or potential impacts on health care systems, compiled from information provided by the Regional Administrator, the Geospatial Integration Analysis and Visualization Branch in ASPR/IMDA, ASPR/Supply Chain Control Tower (SCCT), the ASPR Office of Planning and Exercises, and external reporting partners	• Weather: National Weather Service, NOAA • Decision-support tools (DSTs) • Baseline health and human services profile reports • Regional reporting (mission generation and mission execution reports; situation reports) • Supply chain vulnerability assessment • Open media reports and analysis • Intelligence analysis • Health care facilities reports and maps • FEMA common operating picture (COP) or situation report (SitRep) • Resource Coordination Branch reports • GeoHEALTH data • Geographic information system (GIS) mapping products
Senior leadership brief (SLB)	Summary of response operations, incident impacts, and key focus areas for leadership compiled into a concise report to provide situational overview	• IMT SitRep • GIS mapping products • Regional Administrator analysis slides • Open media reports • FEMA reports • VHA storyboard • Ad-hoc partner updates • Health care facility status updates • Compilation of other products • Partner calls
Baseline health and human services profile report	Identifies baseline public health, medical, and human services information in a geographic region to be impacted by an incident.	Demographic data are extracted from the U.S. census and the American Community Survey. Mental and behavioral health data are taken from the U.S. census, CDC's Behavioral Risk Factor Surveillance System datasets, and state public health profiles. ASPR's Geographic Information System (GIS) Group provides health care facilities spatial and threat analysis. The HHS emPOWER Program provides data for 4.3 million at-risk individuals who live independently and rely on certain life-maintaining and assistive electricity-dependent durable medical equipment and cardiac devices and health care services (e.g., oxygen tank, dialysis, home health care). Critical infrastructure and medical supply chain data is received from ASPR's CIP program. Health care coalition capabilities data is obtained from ASPR's Hospital Preparedness Program's field project officer's analysis.

Product	Description	Information Source Examples
Open media report	Consolidated report regarding open media	• Targeted areas of concern include shelter issues, medical care issues, public health concerns, human services concerns (e.g., access to child care), mortality/morbidity concerns, environmental hazards, and rumors • Social media analysis tools, including First Alert and Hootsuite • Analyst-driven searches on social media sites, including X (formerly Twitter), Facebook, Instagram, Periscope • Analyst-collected news media information through Google searches • Impacts on human services providers (e.g., child care centers, Head Start programs, shelters), including numbers open vs. closed
Trend report	Report that examines data to identify trends	• FEMA SLB • Rx Open (pharmacy status) • U.S. Department of Energy Eagle-I power status reporting • Health care facilities reports • Open/social media • STT sources
ASPR's common operating picture in GeoHEALTH *(near-real-time tool)*	Populated in near-real-time that can produce maps and captures event-specific information in a dashboard (e.g., team locations)	• Deliberate/intentional threats • Electrical power outages • Flooding predictions • Hazardous chemical plume models • Hurricane level wind speeds • Rainfall • Seismic activity • Tornado path • Water surge • Wildfire perimeters • Health care facility status • HHS division reports

7. Operational Communications and Coordination

Communication is a core capability for response to and recovery from incidents, regardless of size, location, or cause. Effective public health and medical emergency management and incident response activities rely upon effective communications among response organizations. The National Emergency Communications Plan (CISA 2019) guides emergency communications interoperability at all levels of government. Operational communications require capabilities (a) to support the timely exchange of appropriate information; and (b) to provide access to both voice and data over reliable networks, including radio, computer, and telephone systems that sustain connections with FSTT agencies and personnel in the incident area. HHS recognizes that operational communications and effective means and methods of transmitting and receiving voice, video, and data are crucial to executing response and recovery operations. However, the communications infrastructure may be lost or compromised. In disasters, operational communications support to HHS responders is critical to the success of federal public health, medical, human services, or social services assistance and support missions.

7.1. Operational Communications

Operational communications systems provide for the free flow of information necessary for response and recovery operations. This includes (a) establishing and maintaining interoperable communications linkages with stakeholders and key operational nodes, including FSTT EOCs

and deployed ISTs; and (b) providing for communications networks, systems, and tools used for data exchange.

To maintain operational communications with the other federal departments and agencies and HHS divisions' EOCs, HHS uses complex computer networks, telephones, satellite phones, and very high frequency (VHF) radio communications. These redundant and interoperable systems facilitate communications among departmental responders in the field and headquarters and among FSTT response and recovery personnel.

7.2. Communications Tools and Networks

Table 7-1. lists elements of operational communications systems.

Table 7-1. Operational communications systems for various methods of communication

Methods	Communications Tools and Networks
Voice	• Office phones • Cellular phones • Satellite phones • Priority communication services (Government Emergency Telecommunications Service [GETS], Wireless Priority Service [WPS]) • Alert HHS system for contacting government response personnel
Data	• Office email • FEMA Crisis Management System[70] • HHS Virtual Private Network (VPN) enabled • Homeland Security Information Network (HSIN)
Radio	• Federal and national interoperable radio channels: VHF, UHF
Broadcast Media	• Television and radio (AM/FM) for public warning and notification

Table 7-2 lists available mobile emergency response support equipment.

Table 7-2. Mobile emergency response support equipment

System	Model	Type	Coverage	Frequency
VHF[1] mobile radio	Motorola	LMR[2]	LOS[3]	MHz[4]
UHF[5] mobile radio	Motorola	LMR	LOS	MHz[4]

[1] Very High Frequency (VHF); [2] Land Mobile Radio (LMR); [3] Line of Sight (LOS); [4] Megahertz (MHz); [5] Ultrahigh Frequency (UHF)

[70] See *Glossary* entry for FEMA Crisis Management System.

Table 7-3 lists the equipment for IMT operations.

Table 7-3. Equipment for IMT operations

System	Model	Type	Coverage	Comments
iPhone cellular telephone WPS[1] enabled	iPhone 13	5G	NA	Verizon and AT&T
Iridium satellite phones	Inmarsat	IsatPhone 2	LOS	Unsecure

[1] Wireless Priority Service (WPS)

7.3. Key National Coordination Centers and Operational Communications

The Cybersecurity and Infrastructure Security Agency's National Coordinating Center for Communications (NCC) monitors national and international incidents and events that may affect emergency communications. The NCC performs its vital mission with the cooperation and expertise of federal and private-sector partners. The joint government and industry partnership facilitates the exchange of situational awareness, vulnerability and threat assessments, and other information related to situations or incidents that could affect communications. The NCC partnership coordinates activities to provide for the protection, restoration, and reconstitution of communications during crises and national emergencies.

NCC has the following functions and responsibilities: (a) leading emergency response and recovery activities under ESF #2 of the NRF, for communications; (b) coordinating national security and emergency preparedness communications services for FSTT and local governments during incidents; (c) serving as the communications information sharing and analysis center (COMM-ISAC) operational arm; and (d) providing technical, analytic, and liaison support to FSTT and local governments and to industry.

The HHS SOC is the departmental conduit to the NCC and facilitates, coordinates, and interacts with the NCC on matters associated with substantial disruptions to HHS operational and emergency communications. During incident response and recovery operations in the field, HHS field elements such as the FHCO and the IMT will normally coordinate with HHS headquarters staff in the SOC and with the Disaster Emergency Communications/ESF #2 entity at the JFO to mitigate challenges and issues regarding operational communications. This field emergency communications and support capability may be deployed and operationalized to stabilize the communications environment in the operations area and to provide support for whole-community response activities.

7.4. Cybersecurity

Cybersecurity can be considered a special category for communication given the essential role information and operational technology systems play, particularly for the subject of this plan as part of critical infrastructure in the health care and public health sector of the nation. As critical infrastructure, the vast majority of the resources and capabilities for the sector are within the realm of private organizations. The capabilities for functioning of the system are highly dependent on the integrity of the information and operational technology systems that compose it. The two main areas for material response to cyber incidents in the sector are (1) asset response, for addressing technical repairs for the information and operational technology affected by a cyber incident; and (2) functional response, for addressing restoration or supplementation of health care, public health, and medical resources and capabilities affected

by the incident. Additionally, HHS has a designated role in tracking, assessing, and communicating the nature and consequences of cybersecurity threats and incidents within the health care and public health critical infrastructure sector as the SRMA, a role led by ASPR's CIP Division. *The Healthcare and Public Health Sector Risk Management Agency Cyber Incident Response Plan* (HHS 2023) describes and guides this role.

Asset response in the HPH sector is the responsibility of the organizations within which the cyber systems are present, largely in private organizations. Governmental agencies provide risk-informed guidelines, regulations, and standards to foster the security, reliability, integrity, and availability of critical information, records, and communications systems and services through collaborative cybersecurity initiatives. For HHS government systems, cybersecurity asset response is the responsibility of the HHS Office of the Chief Information Officer for implementing and maintaining procedures to detect malicious activity, conduct technical and investigative-based countermeasures, and mitigate against existing and emerging cyber-based threats consistent with established protocols. For functional response and recovery for protecting, restoring, or supplementing health care and public health resources and capabilities affected by a cyber incident, the procedures established in this operational plan and its annexes for ESF #8 response and recovery apply.

8. Administration, Finance, and Logistics

This section covers general support requirements, availability of services and support for all types of public health emergencies and incidents, and general approaches for managing resources.

8.1. Administration

The HHS Incident Support Director (see section *5. Direction, Control, and Coordination* and *Figure 5-1*, showing the HHS unified coordination structure) manages HHS's response and recovery activities and administrative protocols. The Chief of Staff/Ops Center Director is responsible for administrative oversight, coordination, and communications for the incident response. Established HHS administrative policies and procedures guide most situations arising during response operations. Each IST section should establish standard operating procedures that provide further implementation directions for their specific responsibilities and needs. If unanticipated situations arise, the Chief of Staff/Ops Center Director can assemble the appropriate IST sections and if necessary, request support from the HHS Office of the Secretary to develop guidance, procedures, or policies appropriate to the situation.

8.2. Finance

This section describes finance protocols to recover the costs incurred during incident response and recovery activities. This *HHS RROP* does not alter current budgetary policies and procedures. HHS and its divisions are responsible for managing financial activities for emergency operations within their established processes.

Funding Sources

The Stafford Act establishes funding, management, and oversight responsibilities for all administrative and logistical requirements that support coordinated response and recovery operations for declared emergencies that invoke its provisions.

FEMA is the primary agency for funding associated with Stafford Act declarations. FEMA executes mission assignments (MAs) for these requests. MAs fall into two categories: federal operations support (FOS) and direct federal assistance (DFA). FOS and DFA MAs differ in when they can be used, the work they can be used to order, and the cost share.

- DFA: This type of MA is the primary tool for employing other federal agencies during response operations to provide goods and services to STT governments. It is used when an STT government has exhausted its capability to perform or contract for eligible emergency work, goods, and services. DFA is subject to a cost share with the STT government requesting assistance. The standard cost share is 75 percent federal and 25 percent STT; however, the President may amend the cost share.
- FOS: This type of MA provides federal-to-federal support allowing FEMA to execute its response and recovery missions. It is issued before or after a declaration. FOS is funded 100 percent by the U.S. government.

The PHS Act provides a general grant of authority for federal-state cooperation to control epidemics of any disease or condition and to meet other health emergencies and problems.

During emergency response and steady-state, ASPR's ASPR's Center for Administration (CA) supports ASPR as an HHS division by reviewing all signatures within any applicable interagency agreement (IAA). In addition, CA coordinates funding certification, common accounting number assignment, confirmation of availability/unavailability, and formal processing of the IAA within the Integrated Centralized Execution Platform (InCEP). Congress may appropriate special funding to federal agencies following large and widespread disasters for specific Congressionally designated disaster-related needs (e.g., Community Development Block Grant Disaster Recovery Funds).

The Economy Act, 31 U.S.C. §§ 1535-1536, provides general authority for one federal agency to place an order with another federal agency for the performance of services or the provision of goods on a reimbursable basis, usually via an interagency agreement.

The Administration and Finance Section of the IST is responsible for cataloging and analyzing all incident costs, financial considerations, and administrative matters supporting federal public health and medical activities related to the incident response. This section determines financial reporting timelines and appropriate formatting of reports; tracks all incident cost data, funds control, and procurement; and develops operational period costs summary reports. It also guides fiscally responsible practices in support of mission planning and execution. Additional tasks include timekeeping, financial and personnel accountability, compensation, and claims, and, as appropriate, travel reimbursement claims, procurement, mission assignment funds management, and coordination of various administrative support needs. The section ensures that all emergency administration/finance activities are accomplished within the parameters of existing statutes, regulations, and HHS policies.

8.3. Logistics

HHS provides coordinated federal assistance to supplement STT resources in response to disasters and public health emergencies, to potential or actual incidents requiring a coordinated federal response, or to potential public health emergencies. One of the core functions is providing supplemental assistance comprising health/medical/veterinary equipment, logistic resources, medical countermeasures, or other resources to support response operations, for situations for which HHS has the lead and oversight of this responsibility. The ability to sustain

and rapidly deploy medical logistics assets to a federal response is critical to HHS fulfilling its responsibilities. An expanded description of logistics is in *Annex B: Logistics*.

8.3.1. Resource Coordination Section

The Resource Coordination Section of the IST is responsible for sustaining and coordinating the synchronized movement of response personnel, logistics resources, field support services, and for providing management and implementation of logistics policies and procedures.

- The Resource Coordination Section is staffed with HHS personnel and contract staff to execute the logistical needs for response and recovery activities.
- The Resource Coordination Section provides strategic and operational logistical preparedness, planning, and support through preparing, sustaining, and deploying trained staff, equipment, and other response and recovery resources**.**
- The Resource Coordination Section also oversees the establishment and operation of the ASPR mobilization center. Key mobilization functions include mission briefings/debriefings (provided by NDMS or USPHS), personnel accountability, logistics, safety, security, medical oversight/assessment, occupational health functions such as respiratory protection program activities, and behavioral health support. In addition, the Resource Coordination Section oversees personnel demobilization once a handoff to STT resources is conducted by the IMT.

8.3.2. Supply Chain Logistics Operation Cell (SC-LOC)

The SC-LOC monitors, analyzes, and mitigates vulnerabilities in the supply chains associated with public health and medical resources and serves as the focal point for supply chain management and operational strategies. SC-LOC establishes a common operating picture for key public health and medical resource categories that impact the supply chain and works with federal partners, HHS stakeholders, private sector manufacturers, and distributors to analyze supply chain risks.

8.3.3. Strategic National Stockpile (SNS)

The SNS is part of the federal medical response infrastructure and can supplement medical countermeasures needed by STT and local jurisdictions during public health emergencies. The SNS manages, sustains, and deploys supplies of medicines, devices, PPE, and medical cache equipment and supplies that can be used as a short-term stopgap buffer when the immediate supply of these materials may not be available or sufficient.

As a result of the COVID-19 response, SNS has significantly expanded PPE holdings over pre-pandemic inventory levels. SNS also can leverage supply chain partnerships to acquire specific countermeasures not included in its formulary, especially including countermeasures that an STT or local jurisdiction may not be able to access independently. SNS also maintains strong relationships with third-party logistics providers to store, maintain, and distribute inventory.

If STT or local supplies are depleted or commercial supplies are unavailable to support response needs, STT authorities may request federal assistance from the SNS. Information about requesting SNS assets can be found in *Appendix 2 to Annex B: Requesting SNS Assets*.

8.3.4. Resource Allocation

The Resource Coordination Section of the SOC IST is the initial entry point for resource requirements and requests typically originating from STT authorities in the field, and serves as the central hub for tracking and coordination. Performing hybrid operations and logistics functions under the NIMS EOC structure, this section is the “common denominator” for all material, personnel, and service-related requirements. This activity requires the acquisition and provision of health and medical resources via requests for resources (RFRs) to address unmet needs validated by the ASPR incident management field structure; monitoring/tracking the mobilization, deployment, ongoing status, and redeployment of requested teams, equipment, and supplies; and identifying and filling shortfalls or gaps in the organization's ability to support operational requirements and unmet resource needs. RFRs are submitted through the ASPR Ready RFR Module and are typically internal to HHS. Resource request forms (RRFs) are typically external requests that come from HHS regions as well as local and federal agencies. They are most often entered by regional FEMA or HHS staff on behalf of states through the FEMA Crisis Management System[71] portal. The use of PSMAs can expedite the preparation of RRFs by providing template language and cost estimates for common mission sets.

The Resource Coordination Section’s activities include the acquisition and provision of health and medical resources based on validation and prioritization by the FHCO or the HHS Regional Administrator (or designee) of RFRs submitted through the standard process to address STT and local unmet needs. This process is done in coordination with the NDMS, with the USPHS, and with other resource-provider organizations, as appropriate. It involves monitoring/tracking the mobilization, deployment, ongoing status, and redeployment of requested teams, equipment, and supplies and identifying and filling shortfalls or gaps in HHS/ASPR’s ability to support operational requirements and unmet resource needs.

8.3.5. Private-Sector Resources

Complex and large-scale incidents requiring HHS to coordinate federal public health and medical response resources may require coordination with the private-sector health care support services, and medical supply chain entities. Private-sector organizations contribute to response and recovery activities through government partnerships for resource and service provision and emergency management. Private sector partners may be in communication with emergency managers and may be included in decision-making. Once resource management issues are identified by organizations or governmental authorities at any level, requirements are determined by the STT authority, submitted to the FHCO for validation, and submitted to the Resource Coordination Section. The Resource Coordination Section will coordinate with the appropriate partner for action. HHS may provide private-sector response and recovery resources through contractual relationships while retaining its authority to oversee and control, as appropriate, the infrastructure involved in an incident.

In addition to private sector resources, NGOs may provide additional resources supporting response and recovery activities. Mechanisms may include memorandums of agreement, memorandums of understanding, and contingency contracts with resource management organizations.

[71] See *Glossary* entry for FEMA Crisis Management System.

9. Plan Development and Maintenance

Planning is fundamental for national preparedness. It is a core capability that spans all five emergency management mission areas: prevention, protection, mitigation, response, and recovery (FEMA 2020). Planning is necessary for the success of the core capabilities described in the National Preparedness Goal (DHS 2015) and of the lines of effort and functional areas described in this *HHS RROP*. Planning starts with understanding the threats and hazards that affect an organization or jurisdiction because the threats and hazards shape goals, objectives, and integrating actions required to respond to or recover from an incident.

9.1 Plan Development Process and Distribution

The planning process consists of six steps (DHS 2016b), as depicted in Figure 9-1. Although planning involves a consistent set of activities, the process is not strictly linear and includes iterative cycles of review and collaboration. The development of the *HHS RROP* was a collaboration among representatives from 20 HHS divisions across HHS, overseen by a group of senior leaders within HHS.

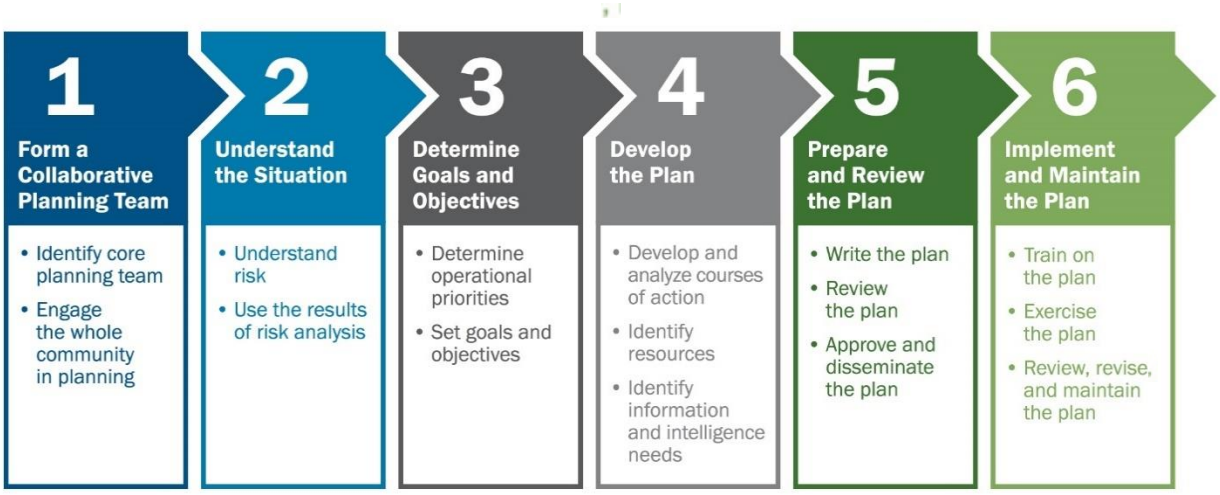

Figure 9-1. Steps in the planning process

The *HHS RROP* is to be placed on a public-facing HHS web page so the public can access it. Additionally, the *HHS RROP* is to be distributed to the HHS divisions from across HHS that participated in its development:

- Administration for Children and Families
- Administration for Community Living
- Administration for Strategic Preparedness and Response
- Agency for Healthcare Research and Quality
- Agency for Toxic Substances and Disease Registry
- Assistant Secretary for Administration
- Assistant Secretary for Health
- Assistant Secretary for Planning and Evaluation
- Assistant Secretary for Public Affairs
- Centers for Disease Control and Prevention
- Centers for Medicare & Medicaid Services
- Food and Drug Administration

- Health Resources and Services Administration
- Indian Health Service
- National Institutes of Health
- Office for Civil Rights
- Office of Global Affairs
- Office of the General Counsel
- Office of Intergovernmental and External Affairs
- Office of National Security
- Substance Abuse and Mental Health Services Administration

9.2 Exercise and Evaluation

PKEMRA (Title VI of Public Law 109-295, 2006) addressed the shortfalls in preparing for and responding to Hurricane Katrina. PKEMRA directed the President to establish and maintain a National Preparedness Goal and a National Preparedness System to prevent, respond to, recover from, and mitigate effects of disasters of all kinds, including acts of terrorism. A key component of the National Preparedness System is the National Exercise Program. Exercises are one of the critical components of the preparedness cycle (Figure 9.2), which allow plans to be cyclically evaluated and improved through planning, organizing, training, equipping, exercising, evaluating, and taking corrective action. This *HHS RROP*, with applicable annex(es), is the plan of reference for all exercises in which HHS participates. This typically includes exercises from the following programs, providing a multi-layer approach to validate the plans and promote preparedness across HHS:

- National Security Council Senior Officials Exercise Series (four to six per year)
- National Level Exercise Program (full-scale exercise every two years)
- HHS Senior Leaders Exercise Program (quarterly table-top exercise)
- HHS Nimble Challenge Exercise Series (quarterly mission-focused exercise)

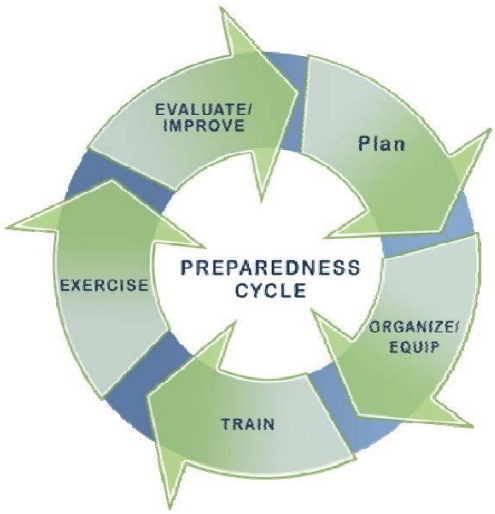

Figure 9-2. Preparedness cycle

9.3 Corrective-Action Process with After-Action Reviews of HHS Response and Recovery Activities for Public Health Emergencies and Disasters

The HHS corrective-action process for HHS's response and recovery activities associated with public health emergencies, disasters, and exercises for these, as administered by ASPR's

Exercises, Evaluations, and After-Actions Division (E2A2), is illustrated in Figure 9-3. After-action reviews (AARs) provide one of the critical components of continuous improvement through the preparedness cycle illustrated in Figure 9-2. HHS's after-action reviews document responses to large-scale incidents, which often require the deployment of substantial resources with extensive interagency coordination. The AAR document typically contains a detailed executive summary and response timeline, as well as observed strengths and areas for improvement. A vital component of the corrective action program (CAP) is incorporation of lessons learned into policies, plans, and procedures to facilitate mitigation of problems identified in association with responses to past incidents and exercises. During the planning process for events and exercises, AARs from previous events with similar characteristics (either event type or event location) are available to key planners and decision makers for review and consideration. AARs are also included in the plan development process; in the development of the *HHS RROP* lessons learned were considered and incorporated, including from the COVID-19 response (OASPR 2021a,b,c).

HHS uses three primary modalities to collect initial observation and data: the ASPR Feedback Form (ASPR 2022a), direct observation, and interviews with responders. After the data are collected, analysis is conducted to develop findings from each incident, event, or exercise. The AAR report and a formal improvement plan will document these observations and findings. Observations typically include (a) "strengths" or "potential best practices" and (b) "areas for improvement."

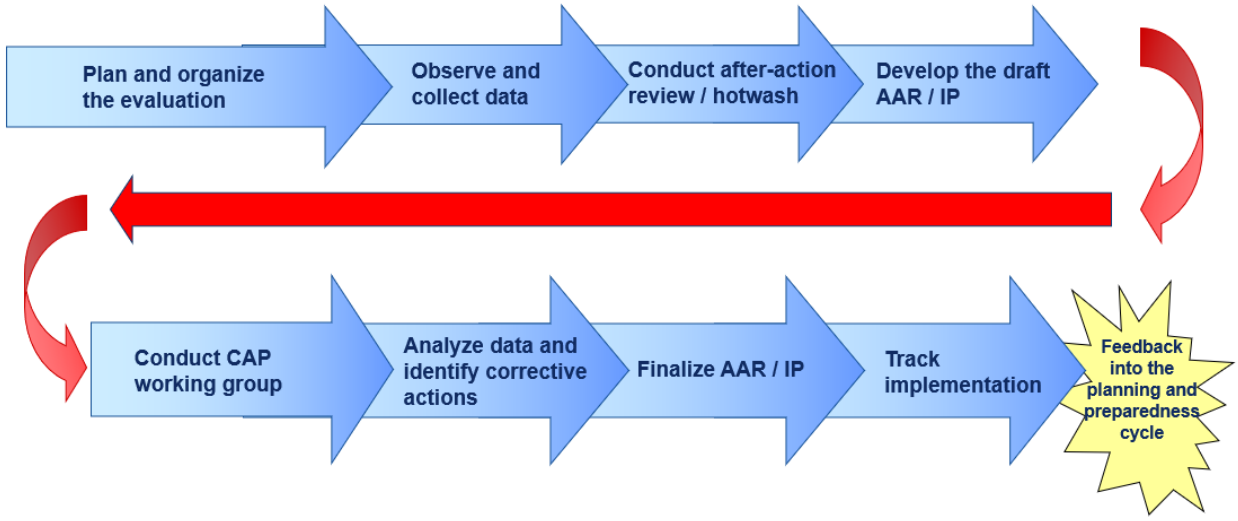

Figure 9-3. Corrective action process (CAP) with after-action review/ improvement process (AAR/ IP) of HHS response and recovery activities for disasters and public health emergencies

Lessons learned and best practices from real-world incidents and events and from previous exercises inform the development of exercise objectives and evaluation criteria. Observations contained in national-level exercise AARs are incorporated into the CAP process in the same manner as observations related to real-world incidents and events. CAP personnel facilitate the identification, tracking, and implementation of corrective actions across HHS. After the senior executive leader concurs on the recommended corrective actions, the corrective actions are implemented through inclusion in policies, plans, and procedures. All relevant documentation or artifacts about the closed actions are stored in a CAP Management Tool maintained by ASPR.

9.4 Maintenance and Periodic Review

The *HHS RROP* will be periodically reviewed to evaluate the need to incorporate new statutory, policy, and procedural changes, evolving threats and hazards, and lessons learned from exercises and incidents. A more substantial review and revision will be conducted every four years. HHS division partners will be engaged in the review and maintenance process. The review and maintenance process will include developing or updating appropriate annexes. Substantial updates to this *HHS RROP* will be vetted through an HHS senior executive group review process.

10. Abbreviations, Glossary, References

10.1 Abbreviations

This list includes initialisms (abbreviations from first letters) and acronyms (initialisms pronounceable as though words).

AABB: Association for the Advancement of Blood & Biotherapies (previously, before 2005, American Association of Blood Banks)

AABB Task Force: AABB's Interorganizational Task Force on Domestic Disasters and Acts of Terrorism

AAR(s): after-action review(s)

AAR / IP: after-action review / improvement process

ACF: Administration for Children and Families (in HHS)

ACL: Administration for Community Living (in HHS)

AHRQ: Agency for Healthcare Research and Quality (in HHS)

ASFR: Office of the Assistant Secretary for Financial Resources (in HHS)

ASPA: Office of the Assistant Secretary for Public Affairs (in HHS)

ASPE: Office of the Assistant Secretary for Planning and Evaluation (in HHS)

ASPR: the Administration for Strategic Preparedness and Response (in HHS)

Assistant Secretary: Assistant Secretary for Preparedness and Response

ATSDR: Agency for Toxic Substances and Disease Registry (in HHS)

CA: Center for Administration (in ASPR)

CAP: corrective action program

CBP: U.S. Customs and Border Protection (in DHS)

CBRN: chemical, biological, radiological, or nuclear

CDC: Centers for Disease Control and Prevention (in HHS)

CIP: Critical Infrastructure Protection program (of ASPR)

CIR(s): critical information requirement(s)

CISA: Cybersecurity and Infrastructure Security Agency

CMS: Centers for Medicare & Medicaid Services (in HHS)

COMM-ISAC: communications information sharing and analysis center

COOP: continuity of operations or the Continuity of Operations Division of ASPR or as in the HHS Continuity of Operations Plan

COP: common operating picture

COVID-19: coronavirus disease of 2019

DCM: disaster case management

DFA: direct federal assistance (a category of MA)

DHS: U.S. Department of Homeland Security

DLG: Disaster Leadership Group (of HHS)

DMORT(s): Disaster Mortuary Operational Response Team(s) (of NDMS)

DOL: U.S. Department of Labor

DOS: U.S. Department of State

DOW: U.S. Department of War

DRC: Democratic Republic of Congo

DSLR: Division of State and Local Readiness (of CDC)

DST(s): decision support tool(s)

E2A2: Exercises, Evaluations, and After-Actions Division (in ASPR)

EEI(s): essential element(s) of information

EMAC: the Emergency Management Assistance Compact

env: environmental

EMS: emergency medical services

EOC(s): emergency operations center(s)

EPAP: Emergency Prescription Assistance Program (of ASPR)

ERE(s): emergency response employees

ERF(s): emergency repatriation function(s)

ESF(s): emergency support function(s)

ESF #6: Emergency Support Function #6: Mass Care, Emergency Assistance, Temporary Housing, and Human Services (FEMA 2008a)

ESF #8: Emergency Support Function #8: Public Health and Medical Services (FEMA 2016a)

ESF #9: Emergency Support Function #9: Search and Rescue (FEMA 2011)

ESF #10: Emergency Support Function #10: Oil and Hazardous Materials Response (FEMA 2008b)

ESF #11: Emergency Support Function #11: Agriculture and Natural Resources (FEMA 2008c)

ESF #15: Emergency Support Function #15: External Affairs (FEMA 2016b)

FD&C Act: Federal Food, Drug, and Cosmetic Act

FDA: the U.S. Food and Drug Administration (in HHS)

FEMA: the Federal Emergency Management Agency (in DHS)

FHCO: federal health coordinating official or the Federal Health Coordinating Official for a specific incident

FHSCO: federal human services coordinating official

FIER WG: Federal Interagency Emergency Repatriation Working Group

FIOP(s): Federal Interagency Operational Plan(s)

FOS: federal operations support (a category of MA)

FSTT: federal and state, tribal, or territorial

FTE: full-time equivalent

GETS: Government Emergency Telecommunications Service

GIS: geographic information system or ASPR's Geographic Information System Group

HAZMAT: hazardous materials

HEHS RSF: Health, Education, and Human Services Recovery Support Function

HHS: the U.S. Department of Health and Human Services

HPH: health care and public health or the Healthcare and Public Health Sector of critical infrastructure

HRSA: Health Resources and Services Administration (in HHS)

HSDL: Homeland Security Digital Library

HSIN: Homeland Security Information Network

HSNRC: Homeland Security National Risk Characterization

HVAC: heating, ventilation, and air conditioning

IAA: interagency agreement

IAB: information analysis brief

IBMSC: Center for Industrial Base Management and Supply Chain

IBX: industrial base expansion

ICS: the Incident Command System

IEA: Office of Intergovernmental and External Affairs (in HHS)

IHR: International Health Regulations

IHR NFP: International Health Regulations National Focal Point

IHS: Indian Health Service (in HHS)

IM: information management or the Information Management section of the IST

IMDA: ASPR Office of Information Management and Data Analytics

IMP(s): information management plan(s)

IMT: incident management team or the Incident Management Team for a specific incident

InCEP: Integrated Centralized Execution Platform

ISLT: Incident Support Leadership Team

IST: incident support team or the Incident Support Team for a specific incident

JIC: joint information center

JFO: joint field office or the Joint Field Office for a specific incident (of FEMA)

LFA(s): lead federal agency(ies) or the Lead Federal Agency for a specific incident

LMR: land mobile radio

LNO(s): liaison officer(s)

LOE(s): line(s) of effort

LOS: line of sight

MA(s): mission assignment(s)

MACS: multi-agency coordination system

MCM(s): medical countermeasure(s)

mgmt: management

MHz: megahertz

MSC(s): mission support center(s) (of ASPR)

NBEOC: National Business Emergency Operations Center (of FEMA)

NCC: National Coordinating Center for Communications (of CISA)

NDMS: National Disaster Medical System

NDRF: National Disaster Recovery Framework

NFP: National Focal Point[72]

NGO(s): non-governmental organization(s)

NHSS: National Health Security Strategy

NIH: National Institutes of Health (in HHS)

NIMS: National Incident Management System

NOAA: National Oceanic and Atmospheric Administration

NPG: National Preparedness Goal

NPS: National Planning System

NRCC: National Response Coordination Center (of FEMA)

NRF: National Response Framework

NSSE(s): National Special Security Event(s)

NMTS Contract: National Medical Transport and Support Services Contract, often referred to as the National Ambulance Contract

NVRT(s): National Veterinary Response Team(s)

OASH: Office of the Assistant Secretary for Health (in HHS)

OASPR: Office of the Assistant Secretary of Preparedness and Response (subsequently, starting in 2022, the Administration for Strategic Preparedness and Response)

OCMR: Office of Community Mitigation and Recovery (in ASPR)

OCR: Office for Civil Rights (in HHS)

OGA: Office of Global Affairs (in HHS)

OGC: Office of the General Counsel (in HHS)

OHSEPR: Office of Human Services Emergency Preparedness and Response (in HHS/ACF)

OR: Office of Response (of ASPR)

ORR: Office of Refugee Resettlement (in ACF)

OSHA: Occupational Safety and Health Administration (of DOL)

[72] See *Glossary* entry for IHR NFP.

PH: public health

PHE(s): public health emergency(ies)

PHS Act: Public Health Service Act (Public Law 78-410)

PIO: public information officer

PKEMRA: Post-Katrina Emergency Management Reform Act of 2006 (Title VI of Public Law 109-295)

PPD: presidential policy directive

PPD-8: Presidential Policy Directive 8: National Preparedness

PPD-21: Presidential Policy Directive 21: Critical Infrastructure Security and Resilience

PPD-44: Presidential Policy Directive 44: Enhancing Domestic Incident Response

PPE: personal protective equipment

PREP Act: Public Readiness and Emergency Preparedness Act

PSMA(s): pre-scripted mission assignment(s)

RA(s): regional administrator(s)

RAC(s): regional advisory council(s)

RCB: Resource Coordination Branch

REC(s): regional emergency coordinator(s)

RFR(s): request(s) for resources

RRCC(s): regional response coordination center(s)

RROP: Response and Recovery Operational Plan (this one)

RSF(s): recovery support function(s)

SAMHSA: Substance Abuse and Mental Health Services Administration (in HHS)

SBCC: Southwest Border Coordination Center (in DHS)

SCG: strategic coordination group or the HHS Strategic Coordination Group

SC-LOC: Supply Chain Logistical Operations Cell (of ASPR)

Secretary: Secretary of HHS

SERG(s): Supplemental SAMHSA Emergency Response Grant(s)

SitRep: situation report

SLB: senior leader brief

SNS: Strategic National Stockpile

SOC: Secretary's Operations Center

SRMA(s): sector risk management agency(ies) – before 2021: sector-specific agency(ies) (SSA[s])

STT: state, tribal, or territorial

THIRA: Threat and Hazard Identification and Risk Assessment

TTHU: transportable temporary housing units

UHF: ultra-high frequency

USDA: U.S. Department of Agriculture

USPHS: U.S. Public Health Service

VA: the U.S. Department of Veterans Affairs

VHF: very high frequency

VIC: Victim Information Center

VOAD(s): voluntary organization(s) active in disaster; also used for National Voluntary Organizations Active in Disaster (National VOAD; an NGO association of organizations) and for STT VOADs

VPN: virtual private network

w: with

WG(s): working group(s)

WH: White House

WHO: World Health Organization

WPS: Wireless Priority Service

10.2 Glossary

access and functional needs: "[A]ny condition[s] (temporary or permanent) that [limit] [a person's] ability to act. To have access and functional needs does not require that the individual have any kind of diagnosis or specific evaluation. Individuals having access and functional needs may include, but are not limited to, individuals with disabilities, [older adults], and populations having limited English proficiency, limited access to transportation, and/or limited access to financial resources to prepare for, respond to, and recover from [an] emergency." (FEMA 2021b)

alternate care site: "[A] broad term for any building or structure of opportunity that is temporarily converted for health care use during a public health emergency to provide additional health capacity and capability for an affected community, outside the walls of a traditional established health care institution." (FHRTF 2020)

assessment: "[P]roduct or process of identifying or evaluating … potential or actual effects." (DHS 2010; adapted from "consequence Assessment" definition)

assumption: In absence of fact, relevant and logical information deemed plausible and necessary to facilitate planning.

at-risk individual(s): "[C]hildren, pregnant women, senior citizens and other individuals who have access or functional needs in the event of a public health emergency, as determined by the Secretary." [42 U.S.C. §300hh-1.(b)(4)(B)]

base plan: The core document (exclusive of annexes) of the *HHS Response and Recovery Operational Plan* that defines the HHS mission and a broad concept of operations and options for how HHS may provide federal public health, medical, human services, and social services response and recovery missions in support of FSTT requests for assistance during potential or actual natural or human-caused (accidental, intentional, or technological) disasters or public health emergencies.

behavioral health: "[T]he promotion of mental health, resilience, and wellbeing; the treatment of mental health conditions and substance use disorders; and the support of those who experience and/or are in recovery from these conditions, along with their families and communities." (SAMHSA 2023)

capability: "[M]eans to accomplish a mission, function, or objective." (DHS 2010)

capacity: Availability of adequate resources (human, material, and/or authorization), considering process rates and time, to successfully accomplish a mission, function, objective, goal, or task.

catastrophic disaster or catastrophic disaster incident: A major disaster for which initial capabilities to prevent or mitigate the adverse consequences, even at the federal level, are not adequately available, and therefore requires substantial prioritization of scarce resources. (Adapted from DHS 2019) See also "incident," "disaster," "major disaster," "disaster declaration," and "major disaster declaration."

common operating picture (COP): "A continuously updated overview of an incident compiled throughout an incident's life cycle from data shared between integrated systems for communication, information management, and intelligence and information sharing. The common operating picture allows incident managers at all levels to make effective, consistent, and timely decisions. The common operating picture also helps ensure consistency at all levels of incident management across jurisdictions, as well as between various governmental jurisdictions and private-sector and nongovernmental entities that are engaged." (USG 2018; FEMA 2008d)

core functional area for response: Category comprising a set of resources and capabilities for response (a) for which HHS is the primary agency as published in the ESF #8 annex to the NRF, including human services and social services; or (b) as published in the NRF annexes, for support to ESFs #6, #9, #10, #11, and #15. (Adapted from the NRF [DHS 2019].)

core mission area for recovery: Category for a stated purpose in recovery for which HHS is the coordinating agency as codified in the HEHS RSF to the NDRF, comprising a broad array of resources and capabilities that further that purpose.

critical consideration(s): Information that provides context about circumstances that may affect execution of the plan.

critical information requirements (CIRs): Specific types of high-priority essential elements of information (EEIs) that require immediate leadership notification and involvement. (Adapted from the FIOP [see FEMA 2023b])

cross-cutting functional area: Category that includes the resources and capabilities in both response and recovery mission areas to prevent or treat illness and injuries and meet basic human needs after an incident, including support for sustainable and resilient health, education, human services, and social services systems.

deploy/ deployment: Send/sending of personnel or material resources to a location where they can be utilized in response to or recovery from an incident. For medical countermeasures, this may be a location from which they can be further distributed and dispensed locally.

disability: "(A) [A] physical or mental impairment that substantially limits one or more of the major life activities of [an] individual; (B) a record of such an impairment; or (C) being regarded as having such an impairment." (Public Law 101-336, 1990, as amended; HHS 2015)

disaster or disaster incident: An incident involving sufficient harm as to require response at a level greater than local capabilities can provide to prevent or mitigate the adverse

consequences. May or may not require a federal response. An "adverse condition or occurrence that requires coordinated action across multiple entities and/or levels of government to resolve." (DHS 2017) See also "incident," "major disaster," "catastrophic disaster," and "disaster declaration."

disaster behavioral health: "[P]rovision of mental health, substance use, and stress management services to disaster survivors and responders. Federal disaster behavioral health also addresses the behavioral health care infrastructure, individual and community resilience, and risk communication and messaging." (ASPR 2023a)

disaster case management (DCM): "[A] time-limited process that involves a partnership between a case manager and a disaster survivor (also known as a 'client') to develop and carry out a Disaster Recovery Plan. This partnership provides the client with a single point of contact to facilitate access to a broad range of resources. The process involves an assessment of the client's verified disaster-caused unmet needs, development of a goal-oriented plan that outlines the steps necessary to achieve recovery, organization and coordination of information on available resources that match the disaster-caused unmet needs, the monitoring of progress toward reaching the Disaster Recovery Plan goals, and when necessary, client advocacy." (FEMA 2013)

disaster declaration: "[T]wo types of disaster declarations [are] provided for in the Stafford Act: emergency declarations and major disaster declarations. Both declaration types authorize the President to provide supplemental federal disaster assistance. However, the [incidents] related to the two different types of declaration and scope and amount of assistance differ." (FEMA 2022a) See "emergency declaration" and "major disaster declaration."

disaster human services: "[E]ncompasses coordinated efforts to [p]revent additional destabilization of socially vulnerable individuals and families who relied on human services programs, systems, and networks pre-disaster; [s]upport socially vulnerable individuals and families that need assistance navigating human services programs as a result of the disaster; [s]upport the continuity and restoration of human services providers and delivery systems in disaster-impacted communities; [and] [e]nhance the capability of human services providers in host communities to support displaced disaster survivors during their transition to recovery." (OHSEPR 2022)

Disaster Leadership Group (DLG): An HHS senior leader policy committee that may be activated (a) to serve as a forum for HHS senior leaders to deliberate and address specific policy issue(s) that require guidance, decision-making, and/or concurrence from multiple HHS divisions; (b) to provide the HHS Secretary with unified policy recommendations or options; (c) to address policy issues of national significance that impact the preparedness, response, and recovery of public health and/or medical systems, in the United States and U.S. territories; and (d) to mitigate policy gaps and challenges affecting national health security by identifying and employing the full spectrum of HHS resources, funding, and subject-matter expertise that can be leveraged.

emergency (declared): "[O]ccasion or instance for which, in the determination of the President, [f]ederal assistance is needed to supplement [STT] and local efforts and capabilities to save lives and to protect property and public health and safety, or to lessen or avert the threat of a catastrophe in any part of the United States." (DHS 2017)

emergency declaration: A type of disaster declaration (see "disaster declaration"). "The President can declare an emergency for any occasion or instance when the President determines federal assistance is needed. Emergency declarations supplement [s]tate and local or Indian tribal government efforts in providing emergency services, such as the protection of lives, property, public health, and safety, or to lessen or avert the threat of a catastrophe in any part of the United States. The total amount of assistance provided for in a

single emergency may not exceed $5 million. The President shall report to Congress if this amount is exceeded. / Requirements: The [g]overnor of the affected [s]tate [or territory] or [t]ribal [c]hief [e]xecutive of the affected [t]ribe must submit a request to the President, through the appropriate Regional Administrator, within 30 days of the occurrence of the incident." The request must meet certain specified requirements. "When an emergency exists for which the primary responsibility rests with the [f]ederal government, the President may declare an emergency without a request from the [g]overnor of the affected [s]tate [or territory] or the [t]ribal [c]hief [e]xecutive of the affected [t]ribe." (FEMA 2022a)

For specialized types of emergency declarations, see "pre-disaster emergency declaration" (prior to an incident for which projected consequences are anticipated) and "public health emergency declaration" (declared by the Secretary of Human Services).

emergency repatriation: Temporary assistance to U.S. citizens and their dependents whom the Department of State has identified "as having returned or been brought from a foreign country to the United States because of destitution, illness, war, the threat of war, or a similar crisis, and because they are without resources immediately accessible to meet their needs." This determination has recently included overseas evacuations and repatriations from environments with potential high-consequence infectious diseases. (Adapted from ACF 2021) See *Annex A: Emergency Repatriation* and associated sections following it.

ESF #8 Council: A group of federal medical resource providers, including the Department of War (Office of the Secretary of War, U.S. Northern Command, National Guard Bureau); HHS (USPHS, ASPR, and CDC); the U.S. Department of Veterans Affairs (VA), and the response coordinating partner, FEMA. The ESF #8 Council provides the mechanism for the evaluation of STT requests for high-demand and limited federal medical resources. It coordinates among federal medical resource partners to prioritize and authorize the allocation and reallocation of federal medical resources and capabilities to supplement STT assets, based on validated requirements, in response to a disaster or public health emergency. The ESF #8 Council membership may be tailored based on the nature of the disaster or public health emergency.

essential elements of information (EEIs): Pre-defined operational information requirements to inform timely, logical decisions by staff and leadership in planning, executing, and coordinating an operation. EEIs provide context and contribute to analysis and are included in the information management plan (IMP). (Adapted from FIOP [see FEMA 2023b])

event: In the realm of emergency preparedness, response, and recovery, a planned occurrence initiated by and mainly directed by the planner(s) (e.g., inauguration, national holiday celebration, other National Special Security Events [NSSEs]). Distinct from incident (see definition). In some specialized contexts, "event" is used more generally as meaning any type of occurrence (e.g., in modeling to project outcomes, in which events are any modeled occurrences).

fact: Known data or information that can be substantiated

Federal Coordinating Center: "[A] federal facility (DoD or VA) located in a metropolitan area of the United States, responsible for day[-]to[-]day coordination of planning, training, and operations in one or more assigned geographic NDMS [p]atient [r]eception [a]reas" (NDMS 2018)

federal health coordinating official or Federal Health Coordinating Official (FHCO): The FHCO is designated by the Assistant Secretary for Preparedness and Response and serves as the Incident Manager for HHS response operations in the field. The FHCO is responsible for managing HHS incident response activities in the field, including field direction and coordination; facilitating federal public health, medical, and human services support via

relevant Emergency Support Functions under the National Response Framework to established National Incident Management System structure overseeing incident response operations. The FHCO generally co-locates with the FEMA initial operating facility or joint field office once established and ensures that HHS incident management activities are maximized through effective and efficient coordination. (Adapted from description and intent in HHS 2009)

FEMA Crisis Management System: A web-based emergency management and daily operations system used by FEMA; also known as WebEOC

functional area: Category comprising a set of resources and capabilities for a stated purpose in support of a mission area (in this context, response or recovery) of the National Preparedness Goal (DHS 2015). This includes (a) the core functional areas for response (i) for which HHS is the primary agency as published in the ESF #8 annex to the NRF, including human services and social services, or (ii) as published in the NRF annexes, for support to ESFs #6, #9, #10, #11, and #15; (b) the core mission areas for recovery for which HHS is the coordinating agency as codified in the HEHS RSF to the NDRF; and (c) the cross-cutting functional areas. (Adapted from the NRF [DHS 2019] and the NDRF [DHS 2016c; FEMA 2024].)

hazard: "[A]ctual or potential" "source or cause of harm or difficulty; may be natural, technological, or human-caused." "[D]iffers from a threat in that a threat is directed at an entity, asset, system, network, or geographic area. A hazard is not directed." (DHS 2017)

health care system: The set of organizations that deliver a community's health care and medical services, including hospitals, assisted living and long-term care facilities, behavioral health facilities, community health centers, home care, physicians and other ambulatory care providers, specialty services (e.g., dialysis, pediatrics, woman's health, stand-alone surgery, urgent care), support services (e.g., laboratories, pharmacies, blood banks, poison control), private entities associated with health care delivery (e.g., hospital associations, regulatory boards), emergency medical services, and the various other health care providers. (Adapted from OASPR 2012, 2016a)

HHS divisions: HHS agencies, previously referred to as operating and staff divisions.

human services: Activities and programs that utilize an interdisciplinary approach to provide for basic needs, to build resilience, and to strengthen and sustain the well-being of individuals and families and their ability to maintain activities of daily living in a safe, healthy manner. Social services integrated with human services provide assistance of many types (e.g., housing, education, health services) to members of a population or community (e.g., individuals with access and functional needs, older adults, persons with disabilities, other at-risk and disaster-impacted individuals).

IHR NFP: The IHR (International Health Regulations, designated IHR 2005 for the year of the most recent revision) is a legally binding global health security framework agreed to by 196 countries (state parties to the IHR) and the WHO, which establishes a process for international collaboration and decision-making during public health emergencies and requires the state parties to the IHR to establish National Focal Points (NFPs). The U.S. IHR Program and National Focal Point were established through a U.S. government interagency process in July 2007. The IHR NFP Program is located in the HHS Office of Global Affairs, which coordinates across the U.S. government on event assessments and notifications, manages and develops IHR NFP policies and procedures, and leads IHR monitoring and evaluation for the U.S. (WHO 2023a,b)

incident: "[O]ccurrence, caused by either human action or natural phenomena, that may cause harm and that may require action." (DHS 2010) Human causes may be accidental,

technological, or intentional (criminal or terrorism). May include emergencies or disasters of all kinds and sizes. In this document we distinguish incidents, for which initiation and the main course of development is unplanned, not under our intentional control, from events (see definition). (Terrorist attacks can be considered as incidents for us and events for the terrorists.) (Note: the NRF [DHS 2019] includes events as incidents, differing from the convention here.) See also "disaster," "major disaster," "catastrophic disaster."

incident management team (IMT): The IMT, led by a designee of the Assistant Secretary for Preparedness and Response to serve as the incident manager in the field, typically the Federal Health Coordinating Official (FHCO), is responsible for managing HHS and associated field response activities, including field direction and coordination. This includes identifying and validating STT priority unmet public health, medical, and human services needs and initiating appropriate planning, coordination, and delivery of resources to meet those needs. The IMT comprises HHS staff, including regional emergency coordinators, regional medical countermeasure advisors, National Disaster Medical System responders, U.S. Public Health Service Commissioned Corps officers, designated representatives from HHS operating and staff divisions, and various stakeholder liaisons as appropriate. (Adapted from description and intent in HHS 2009)

incident support team (IST): HHS headquarters elements – including the Secretary's Operations Center, an incident support director, HHS division representatives, various stakeholder liaisons as appropriate, and ESF #8 Support Teams assigned to the National Response Coordination Center or other national-level operations centers. The IST assists the SOC in providing incident support services through the coordination of all resources (including personnel, equipment, supplies, and information technology systems) that support incident response, recovery, logistics, and mitigation. This activity also provides strategic situational awareness to HHS senior leadership and other U.S. government leadership, as directed. (Adapted from description and intent in HHS 2009)

Indian tribal government: The governing body of any Indian or Alaska Native tribe, band, nation, pueblo, village, or community that the Secretary of the Interior acknowledges to exist as an Indian tribe under the Federally Recognized Indian Tribe List Act of 1994 (25 U.S.C. §§ 479a et seq.).

information management: The collection, analysis, and dissemination of information relating to the status of current response and recovery operations, incident status, or mitigation outcomes.

information management plan (IMP): A detailed plan for the collection and sharing of information during a response. The IMP serves as the foundation for all national-level situational awareness reports and briefings, contains all EEIs and CIRs, and supports the development of the COP.

intelligence: Information or data, including complex information, that has been analyzed for presentation to planners, policy-makers, decision-makers, and others with a need to know, with assessment of the confidence in its validity.

joint field office (JFO): "A temporary multiagency coordination center established at the incident site to provide a central location for coordination of federal, state, local, tribal, nongovernmental, and private-sector organizations with primary responsibility for incident oversight, direction, or assistance to effectively coordinate protection, prevention, preparedness, response, and recovery actions." (USG 2018)

Joint Field Office (JFO): "The primary [f]ederal incident management field structure. The JFO is a temporary [f]ederal facility that provides a central location for the coordination of [f]ederal, [s]tate, tribal, and local governments and private-sector and nongovernmental

organizations with primary responsibility for response and recovery. The JFO structure is organized, staffed, and managed in a manner consistent with National Incident Management System principles and is led by the Unified Coordination Group. Although the JFO uses an Incident Command System structure, the JFO does not manage on-scene operations. Instead, the JFO focuses on providing support to on-scene efforts and conducting broader support operations that may extend beyond the incident site." (USG 2018)

jurisdiction: A range or sphere of authority, used to refer to geographical areas such as federal (entire U.S.), state, territorial, or local areas of authority. (Adapted from FEMA 2008d.)

line(s) of effort (LOE[s]): LOEs are the ways (methods) to accomplish the ends (desired outcomes), employing the means (resources, including funding, participants, and authorities). LOEs include response and recovery actions with related purposes toward achieving a desired end state. LOEs help focus responsibility for and coordination of activities during response and recovery.

major disaster or major disaster incident: A disaster involving sufficient harm that it requires a substantial federal response to prevent or mitigate the adverse consequences. See also "incident," "disaster," "catastrophic disaster," "disaster declaration," and "major disaster declaration."

major disaster declaration: "The President can declare a major disaster for any natural [incident], including any hurricane, tornado, storm, high water, wind-driven water, tidal wave, tsunami, earthquake, volcanic eruption, landslide, mudslide, snowstorm, or drought, or, regardless of cause, fire, flood, or explosion, that the President determines has caused damage of such severity that it is beyond the combined capabilities of state and local governments to respond. A major disaster declaration provides a wide range of federal assistance programs for individuals and public infrastructure, including funds for both emergency and permanent work. / Requirements: The [g]overnor of the affected [s]tate [or territory] or [t]ribal [c]hief [e]xecutive of the affected [t]ribe must submit the request to the President through the appropriate [r]egional [a]dministrator within 30 days of the occurrence of the incident." The request must meet certain specified requirements. (FEMA 2022a)

medical countermeasure: Product, measure, or action intended to prevent, mitigate, or treat injury, disease, mortality, or increased risk of these associated with a public health emergency or resulting from a disaster. The term is typically used to mean a pharmaceutical intervention involving a vaccine, antimicrobial, antidote, antitoxin, or other drug or biological product. It can also cover a non-pharmaceutical intervention or device such as ventilators, diagnostic capabilities, personal protective equipment, or patient decontamination. (Adapted from USG 2018)

National Special Security Event (NSSE): "A designated event that, by virtue of its political, economic, social, or religious significance, may be the target of terrorism or other criminal activity." (USG 2018)

nongovernmental organization (NGO): An entity with an association that is based on interests of its members, individuals, or institutions. It is not created by a government, but it may work cooperatively with government. Such organizations serve a public purpose, not a private benefit. Examples of NGOs include faith-based charity organizations and the American Red Cross. NGOs, including voluntary and faith-based groups, provide relief services to sustain life, reduce physical and emotional distress, and promote the recovery of disaster victims. Often these groups provide specialized services that help individuals with disabilities. NGOs and voluntary organizations play a major role in assisting emergency managers before, during, and after an emergency. (DHS 2019)

objective(s): Clearly defined, decisive, and attainable outcome for specific and identifiable actions carried out during the operation. It leads to achieving response and recovery goals and determining the activities that participants in the operation should accomplish. (Adapted from FEMA 2014, 2025)

partner: "An organization or individual with which/whom the Agency collaborates to achieve mutually agreed upon objectives and to secure participation of ultimate customers. Partners include host country governments, private voluntary organizations, indigenous and international non-governmental organizations (NGOs), universities, other U.S. [g]overnment agencies, the United Nations and other multilateral organizations, professional and business associations, and private businesses and individuals." (USG 2018)

personal protective equipment (PPE): "[E]quipment worn to minimize exposure to hazards that cause serious … injuries and illnesses. These injuries and illnesses may result from contact with chemical, radiological, physical, electrical, mechanical, or other workplace hazards. Personal protective equipment may include items such as gloves, safety glasses and shoes, earplugs or muffs, hard hats, respirators [and some masks], or coveralls, vests and full body suits." (OSHA 2023)

pre-disaster emergency declaration: "A [g]overnor or [t]ribal [c]hief [e]xecutive may request an emergency declaration in advance or anticipation of the imminent impact of an incident that threatens such destruction as could result in a major disaster. Such requests must meet all of the statutory and regulatory requirements for an emergency declaration request. Requests must demonstrate the existence of critical emergency protective measure needs prior to impact are beyond the capability of the [s]tate and affected local governments or Indian tribal government and identify specific unmet emergency needs that can be met through [direct federal assistance]." (FEMA 2022a)

public health emergency: An occurrence or imminent threat of an illness or health condition, either causing a significant number of human illness cases, injuries and/or fatalities or permanent or long-term disability, and/or disruption severely impacting the population, infrastructure, or environment such that routine public health and medical capabilities are at risk of being inadequate. A cause may be any human-made or naturally occurring incident, including accidental or deliberate (terrorism-related), or an epidemic or pandemic that poses a substantial risk to humans.

public health emergency declaration: A declaration by the Secretary of HHS in consultation with public health officials that (a) a disease or disorder presents a public health emergency (PHE); or (b) that a public health emergency, including significant outbreaks of infectious disease or bioterrorist attacks, otherwise exists. "A PHE declaration … can be a necessary step in authorizing the Secretary [of HHS] to take a variety of discretionary actions to respond to the PHE under the statutes HHS administers.". (OASPR 2019) See *Annex C: Authorities*.)

public health supply chain: "A supply chain is a system of organizations, people (including workers, producers, and importers), activities, information, and resources involved in providing a product or service to a consumer. The public health supply chain is the system that produces and delivers critical medical supplies to support the health care and public health (HPH) sector and other critical infrastructure (CI) sectors. These supplies include PPE, diagnostics, and other medical devices; as well as pharmaceuticals—therapeutics, biologics, and vaccines." (USG 2021)

recovery: A mission area for preparedness, included in the National Preparedness Goal (DHS 2015), and the activities included in that mission area when implemented. "Recovery includes those capabilities necessary to assist communities affected by an incident to recover effectively. Support for recovery ensures a continuum of care for individuals to

maintain and restore health, safety, independence and livelihoods, especially those who experience financial, emotional, and physical hardships. Successful recovery ensures that we emerge from any threat or hazard stronger and positioned to meet the needs of the future." (DHS 2015)

response: A mission area for preparedness, included in the National Preparedness Goal (DHS 2015), and the activities included in that mission area when implemented. "Response includes those capabilities necessary to save lives, protect property and the environment, and meet basic human needs after an incident has occurred. … Response emphasizes saving and sustaining lives, stabilizing the incident, rapidly meeting basic human needs, restoring basic services and technologies, restoring community functionality, providing universal accessibility, establishing a safe and secure environment, and supporting the transition to recovery." (DHS 2015)

restoration: An element of recovery bringing back at least to a former or normal state through repairs, rebuilding, or reestablishment "services critical to supporting the physical, emotional, and financial well-being of impacted community members," including "key systems and resource assets that are critical to the economic stability, vitality, and long-term sustainability of the communities." "These include health (including behavioral health) and human services capabilities and networks, public and private disability support and service systems, educational systems, community social networks, natural and cultural resources, affordable and accessible housing, infrastructure systems, and local and regional economic drivers." (NDRF; DHS 2016c)

sector risk management agency(ies) (SRMA[s]): "[T]he [f]ederal department[s] or agency[ies] designated under [PPD-21] to be responsible for providing institutional knowledge and specialized expertise as well as leading, facilitating, or supporting the security and resilience programs and associated activities of its [their] designated critical infrastructure sector[s] in the all-hazards environment." (PPD-21; EOP 2013) Prior to 2021: sector-specific agency(ies) (SSE[s]). (See also CISA 2022.)

situational assessment: A core capability of the response mission area: "Provide all decision makers with decision-relevant information regarding the nature and extent of the hazard [or incident], any cascading effects, and the status of the response." Includes these components: "1. Deliver information sufficient to inform decision making regarding immediate lifesaving and life-sustaining activities and engage governmental, private, and civic sector resources within and outside of the affected area to meet basic human needs and stabilize the incident. 2. Deliver enhanced information to reinforce ongoing lifesaving and life-sustaining activities, and engage governmental, private, and civic sector resources within and outside of the affected area to meet basic human needs, stabilize the incident, and transition to recovery." (DHS 2015)

situational awareness: Recognition and comprehension of information important to effective decisions and meeting of goals relative to a mission.

social services: Programs and services (e.g., housing, education, health services) that improve the well-being of individuals, families, and communities. This includes under-resourced communities, at-risk individuals, and disaster-impacted individuals.

Stafford Act: "The Robert T. Stafford Disaster Relief and Emergency Assistance Act, P.L. 93-288, as amended. This Act describes the programs and processes by which the [f]ederal [g]overnment provides disaster and emergency assistance to [s]tate and local governments, tribal nations, eligible private nonprofit organizations, and individuals affected by a declared major disaster or emergency." (FEMA 2008d)

stakeholder: "[P]erson or organization who may be impacted by a policy or action. [I]ncludes individual or organization having a right, share, claim, or interest in a system or in its possession of characteristics that meet their needs and expectations." (DHS 2017)

steady state: "[R]outine, day-to-day operations." (DHS 2017) A state in which operations and procedures are normal and ongoing. Communities are considered to be at a steady state and undergoing steady-state activities prior to incidents and after recovery is complete. (FEMA 2023a)

threat: "[O]ccurrence, individual, entity, or action that has or indicates the potential to harm life, information, operations, the environment, and/or property;" "directed at an entity, asset, system, network, or geographic area," in contrast to a hazard, which is not directed. (DHS 2010, 2017)

unaccompanied child: A child in the United States who has no lawful immigration status in the United States; has not attained 18 years of age; and for whom no parent or legal guardian is in the United States, or no parent or legal guardian in the United States is available to provide care and physical custody. Unaccompanied children are transferred to ACF/ ORR by the Department of Homeland Security (DHS). Most children are placed into ACF care because they were apprehended by immigration authorities while trying to cross the border or after coming to the attention of immigration authorities at some point after crossing the border (ACF 2022). (See *Annex A: Operational Coordination: Unaccompanied Children*.)

wholesomeness: "'[P]romoting the health of the body.' There is no official United States Department of Agriculture's (USDA) definition of the word for use in labeling a product. However, all USDA-inspected products would be considered 'wholesome.'" (USDA 2019)

working animal: A trained animal used by security or emergency personnel. Examples include rescue, patrol, and drug- and explosive-detection animals.

10.3 References

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Annex A: Operational Coordination

1. Introduction

Collaborative interactions among federal departments and agencies; state, tribal, and territorial (STT) governments; local public health departments and agencies; international organizations; nongovernmental organizations (NGOs); and the private sector (including public/private partnerships), may be required to accomplish HHS response and recovery mission-essential functions. Operational coordination is a critical capability that helps to establish a comprehensive approach to synchronizing, coordinating, and/or integrating HHS operations with the activities of governmental and nongovernmental entities and other external partners and stakeholders to achieve unity of effort. Moreover, operational coordination includes organizing, orchestrating, and providing strategic information for HHS response and recovery activities, including provision of resources, through established coordinating mechanisms. Coordination and information sharing are the essential components for effective management of resources and ensuring that STT response and recovery requirements are supported and needs are met. Effective sharing of information is integral to successful coordination and collaboration. This includes the flow of information among all critical partners and stakeholders. HHS is responsible for the coordination of a wide range of federal public health, medical, and disaster human services response and recovery activities to achieve its primary mission-essential functions and objectives during responses to and recovery from public health emergencies and disaster incidents (Public Law 109-417, 2006; WH 2011; HHS 2009).

HHS accomplishes its primary mission-essential functions to prepare for, mitigate, respond to, and recover from public health and medical emergencies through the execution of the functional areas by its divisions. Consistent with federal statutes and other authorities, some HHS divisions may lead programmatic responses to incidents. When an incident requires more than three HHS divisions for response and recovery, either because the necessary authorities extend beyond an individual HHS division's mission space, or because acting under their individual authorities they do not have sufficient resources, formal interorganizational coordination and cooperation may be required to achieve unity of effort. This interaction forges vital links among HHS divisions to achieve response and recovery goals and objectives.

2. Scope and Situation Overview

Scope

This annex describes various situations for which operational coordination structures may be needed to support the execution of public health, medical, and disaster human services functions during response and recovery operations when the plan is operationalized. The annex focuses on operational responsibilities and considerations, including threat- and capability-based responses, on how HHS could organize and orchestrate federal public health and medical, and disaster human services response and recovery activities and resources to better support federal or STT response and recovery missions to disaster incidents and public health emergencies**.**

Situation Overview

The Secretary of HHS (the Secretary) leads all federal public health and medical response to public health emergencies and disaster incidents covered by the National Response Framework (NRF; DHS 2019). Under the NRF, HHS leads Emergency Support Function (ESF) #8, Public

Health and Medical Services, coordinating federal assistance to STT jurisdictions and providing the response core functional areas, recovery core mission areas, and cross-cutting functional areas listed in section *3. Concept of Operations* of the base plan.

The Secretary of HHS also supports the Federal Emergency Management Agency (FEMA) as the coordinating agency for the execution of ESF #6, by providing disaster human services and ESF #8 support when directed by the President under the Stafford Act. Disaster human services includes coordinated activities to prevent additional destabilization of socially vulnerable individuals and families who depend on human services programs, systems, and networks post-disaster; and support socially vulnerable individuals and families that need assistance navigating human services programs as a result of the disaster. It also involves support for the continuity and restoration of human services providers and delivery systems in disaster-impacted communities and enhancing the capability of human services providers in host communities to support displaced disaster survivors during their transition to recovery. It also focuses on integrated public mental health and human services support through the following programs:

- Disaster Case Management by the Administration for Children and Families (ACF): This program provides disaster case management services, including financial assistance, through government agencies or qualified nonprofit organizations to eligible individuals. Case management ensures that a sequence of delivery is followed to streamline assistance, to prevent duplication of benefits, and to provide an efficient referral system. ACF assistance includes these elements (FEMA 2008):
    - Connecting disaster survivors to services
    - Conducting outreach to disaster survivors and performing intake assessments
    - Assisting disaster survivors to develop plans that help them recover from the disaster
    - Following up with disaster survivors to check on progress toward meeting their recovery goals
    - Conducting needs assessments to determine local capability to conduct disaster human services case management operations
    - Providing technical assistance to STT or local governments where a disaster has been declared
- The FEMA Crisis Counseling Assistance and Training Program: Managed as a partnership between FEMA and the Substance Abuse and Mental Health Services Administration (SAMHSA), this program supports provision of community-based outreach, counseling, and other mental health services to survivors of natural and human-caused disasters. Assistance provided is short-term and is at no cost to the survivor (FEMA 2008). The Crisis Counseling Assistance and Training Program supports interventions that involve the following counseling goals (SAMHSA 2023):
    - Helping disaster survivors understand their current situation and reactions
    - Reducing stress and providing emotional support
    - Assisting survivors in reviewing their disaster recovery options
    - Promoting the use or development of coping strategies
    - Connecting survivors with other people and agencies who can help them in their recovery process
- Supplemental SAMHSA Emergency Response Grants (SERGs): Section 501 of the Public Health Service (PHS) Act authorizes the Secretary of HHS, through SAMHSA, to

act immediately under emergency circumstances requiring a behavioral health response. The grant program is administered by SAMHSA in coordination with the Secretary of HHS. A SERG can be used to address new substance use treatment and prevention concerns in response to an incident or to replace services destroyed by the disaster. Generally, the SERG is awarded in the absence of a Presidential declaration of disaster under the Stafford Act. SERG monies are considered "funds of last resort" and cannot supplant or replace other private and public existing funds. SAMHSA is authorized to use up to 2.5 percent of funds appropriated under title 5 of the PHS Act to support behavioral health emergency response needs under SERG (NARA 2023).

3. Concept of Operations

HHS organizes at the national, regional, and field levels to provide incident support and incident management. Coordination among federal authorities, STT authorities, local authorities, NGOs, and private-sector partners is critical to effective disaster response and recovery operations. The key to achieving operational coordination among HHS divisions is collaboration[71] and cooperation.[72] HHS will leverage existing coordination processes and link established hubs of coordination. These linkages include, but are not limited to, the following entities:

- National Response Coordination Staff (NRCS)
- Regional Response Coordination Center (RRCC)
- Joint Field Office (JFO)
- HHS Secretary's Operations Center (SOC)
- CDC Emergency Operations Center (EOC)
- FDA EOC
- ACF Office of Human Services Emergency Preparedness and Response (OHSEPR)
- CMS Emergency Preparedness and Response Operations (EPRO)
- ASA Healthcare Cybersecurity Coordination Center (HC3)
- Federal Health Coordinating Official (FHCO)
- Incident Management Team (IMT)

HHS as the Lead Federal Agency

When a domestic incident occurs that requires extraordinary unity of effort due to severity, duration, complexity, or impact on national security, public health, or the welfare of the United States and its people, the President may designate, or departments and agencies may identify, with concurrence of the National Security Staff, a lead federal agency (LFA), based on existing statutory authorities, executive orders, and the requirements of the incident. Once determined, the LFA coordinates federal agencies active in the response and recovery activities.

Unity of effort is critical to HHS's success during response and recovery activities. HHS has established domestic incident support coordination structures to manage large-scale or complex disasters involving multiple jurisdictions or multiple HHS divisions coordinating response and recovery activities. For incidents not declared under the Stafford Act, federal response or assistance may be led or coordinated by an LFA other than FEMA. HHS is designated the LFA for all public health and medical responses for biological agent releases affecting humans and

[71] Collaboration is when organizations or people work together to attain common goals by sharing knowledge and learning and by building consensus.

[72] Cooperation is the process of acting together for a common purpose or mutual benefit. It is the alternative to working separately in competition.

human infectious disease outbreaks per Presidential Policy Directive (PPD)-44 (WH 2016), the National Biodefense Strategy (WH 2022), and the Enhancing Domestic Incident Response Playbook (NSC/RRD 2023), and covered in the Biological Incident Annex to the Response and Recovery Federal Interagency Operational Plan (FEMA 2023c). Once established as the LFA, HHS will designate the Assistant Secretary for Preparedness and Response as the Senior Response Official (SRO).

An SRO is a senior executive representative responsible for coordinating the U.S. government's response to the incident (NSC/RRD 2023). The SRO is the U.S. government's senior representative fully dedicated to the response, demonstrating national-level leadership in a time of crisis, and acts as the face and voice of the federal response when interacting with other senior federal, STT, local, private sector, non-governmental, and elected officials, as well as the media and the public. Personnel serving in this role should have (a) experience with strategic coordination of incident management or NIMS; (b) experience briefing senior leaders and elected officials across the U.S. government; (c) experience working within and across the interagency to accomplish tasks; (d) leadership experience within their department and across multiple HHS divisions; and (e) the ability to effectively communicate publicly.

When designated to lead and coordinate incident response, the SRO takes the following initial actions (NSC/RRD 2023):

- Assess the situation, impacts, and what has already been done, to understand the needs.
- Identify immediate actions to address gaps.
- Establish and oversee a unified coordination structure.
  - Identify appropriate supporting federal agencies and key capabilities needed.
  - Establish information management for situational awareness and a joint information center.
  - Initiate operational planning to develop appropriate response priorities and incident objectives.
- Establish coordination mechanisms at the appropriate level with the Executive Office of the President, to include intergovernmental affairs, communications, the Office of Legislative Affairs, the National Security Council, and the National Economic Council.
- Establish an operational tempo, to include meetings and reporting timelines.
- Coordinate with budget staff and the Office of Management and Budget to address resourcing gaps.

The LFA is responsible for determining the relevant departments and agencies required for participation in unified coordination and the level of unified coordination needed. The White House National Security Council (NSC) may direct the LFA to plan and implement unified coordination, including approving a unified coordination group (UCG)[73] structure, to ensure equities identified as critical operational areas for a given incident are represented and well-integrated. As the lead federal agency, HHS may organize as illustrated in **Figure A-1** (equivalent to *Figure 5-1* in the *HHS RROP*). This structure has several advantages, which have been identified in lessons learned (2009-2021; e.g., HHS 2012; IPER 2016; OASPR 2016b, 2021a,b,c). The HHS Strategic Coordination Group[74] (SCG) provides the structure to coordinate

[73] A federal or national unified coordination group (UCG) is composed of senior executive leaders with significant responsibility and authority within their organizations to coordinate, integrate and synchronize federal response activities when overlapping authorities exist among federal departments and agencies. (FEMA 2025)

[74] The HHS Strategic Coordination Group is composed of senior executive leaders from across HHS and serves as HHS's unified coordinating structure during response and recovery operations, providing unity of effort among multiple HHS divisions.

departmental activities by providing strategic guidance, vision, and priorities. The incident support leadership team is led by a member of the senior executive service, who is delegated responsibility for coordinating HHS-wide response activities and implementing the strategic guidance from the SCG. The working groups employ cross-functional expertise of HHS divisions into the HHS unified coordination structure by assigning them under the leadership of a senior executive who functions as the operational coordination lead. This structure can be staffed by various HHS divisions or expanded to accommodate interagency partners.

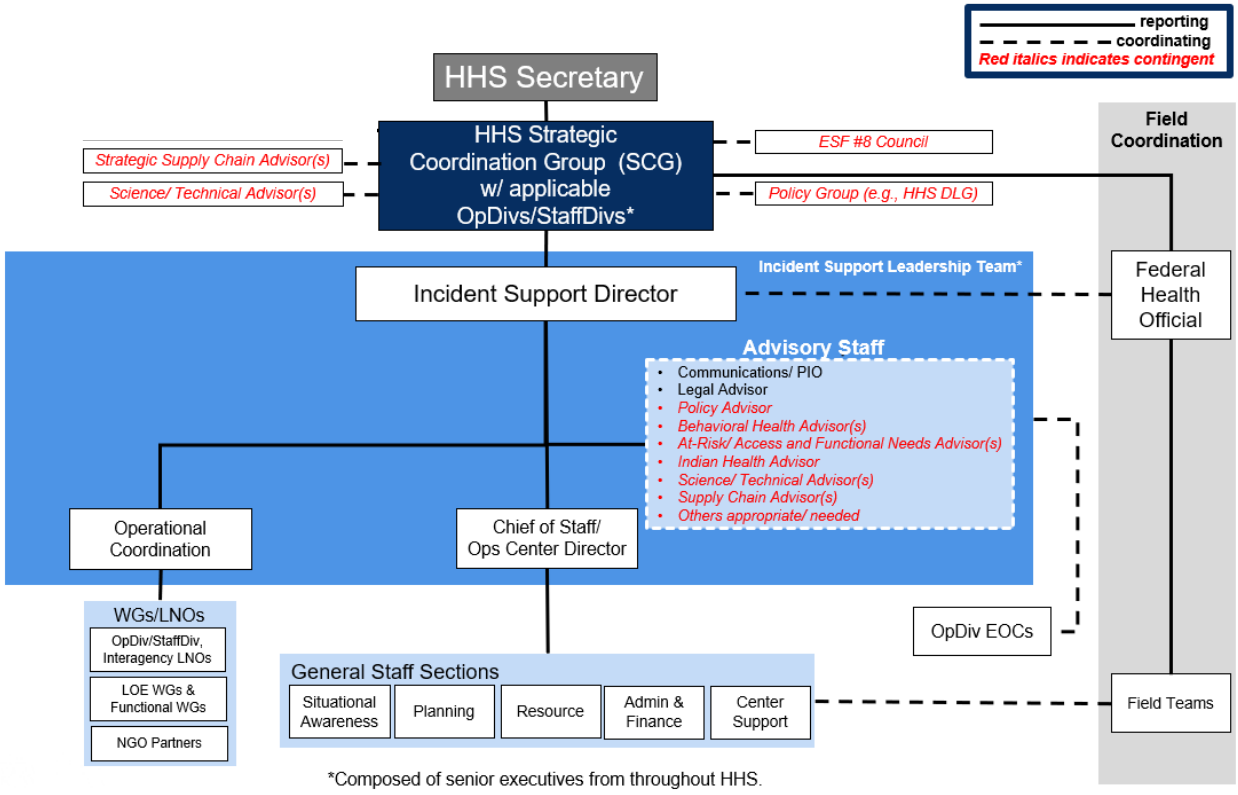

Figure A-1. Coordination structure for HHS as the lead federal agency

Escalating Responses

As incidents escalate,[75] consideration must be given to increasing levels of HHS coordination to ensure unity of effort to meet the demands of the response. Thoughtfully identifying roles, responsibilities, and coordination structures in advance can help minimize staff confusion and disruption of response activities.

In instances for which overlapping authorities and scarce resource availability may begin to complicate response operations, the Incident Support Director may recommend convening the HHS Strategic Coordinating Group. The Strategic Coordinating Group, consisting of leaders from the supporting HHS divisions, convenes to discuss public health, medical, and human services planning priorities, information sharing, and the overall HHS strategy necessary to address the escalating response. During high-consequence emerging infectious diseases and or other biological incidents, the Secretary may ask the HHS Strategic Coordination Group to

[75] Increase rapidly in complexity, level of difficulty, severity, or overall resistance the incident presents to incident management or support personnel as they work to manage it. (FEMA, 2021)

directly liaise with the White House NSC and to participate in national-level resource and strategic policy issues.

Stafford Act Emergencies

When the President issues an emergency declaration under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, the FEMA Administrator is granted statutory authority to coordinate federal resources to assist overwhelmed STT and local governments. FEMA is primarily responsible for federal emergency management response, recovery, and mitigation operations, as well as coordination of all federal interagency partners. The effectiveness of the response and recovery activities are dependent on the coordinated execution of capabilities from a wide variety of federal agencies.

Emergency support functions (ESFs) provide the structure for coordinating federal interagency support in response to an incident. Similarly, recovery support functions (RSFs) provide the structure for coordinating interagency recovery in the aftermath of an incident. As the primary ESF #8 (Public Health and Medical) coordinator, HHS deploys an ESF #8 national support team to the FEMA National Response Coordination Center (NRCC) during Stafford Act emergencies.

HHS and FEMA as co-leads during national level biological responses

A national UCG may be established when overlapping authorities exist, such as occurred during COVID-19, between the Public Health Service Act and the Stafford Act. A national-level UCG co-led by senior HHS and senior FEMA representatives ensures the integration of public health and emergency management functions, as in the structure illustrated in **Figure A-2**.

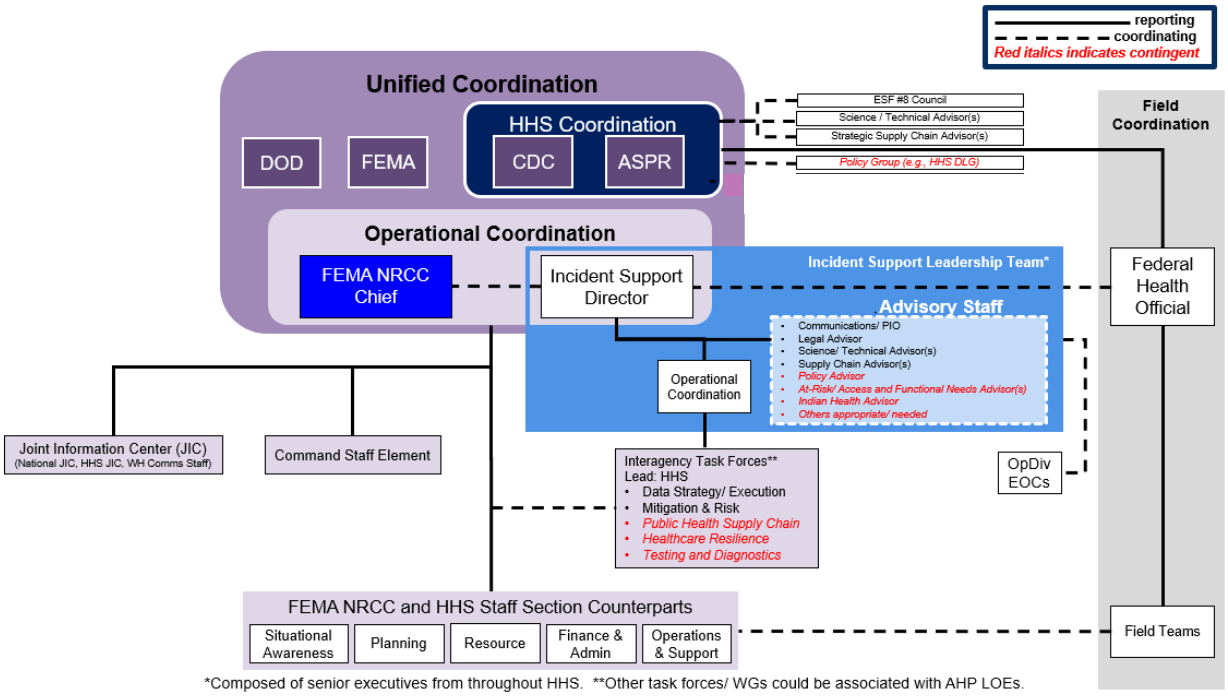

Figure A-2. HHS and FEMA as co-leads during national-level biological responses

The National UCG establishes lines of effort to focus on different aspects of the response and ensure appropriate subject-matter-experts (SMEs) are effectively integrated. During COVID-19, HHS demonstrated unprecedented organizational flexibility in working with FEMA to establish interagency working groups at the national level as an effective strategy for coordinating with other federal agencies. Within this construct, interagency working groups leverage the expertise of staff representatives who provide analysis, coordinate activities, and provide recommendations for a particular purpose, problem, or function. During COVID-19, information sharing was greatly improved through the development of the Data Strategy Execution Working Group (DSEWG). The DSEWG was an interagency group that supported data sharing, common data visualization, and data management for the entire federal response. It included representatives from many federal agencies collecting and reporting the same data, measures, and information to provide a common operating picture. In the operational coordination structure shown in **Figure A-2**, a senior executive staff member is recommended as the operational coordination lead to ensure proper integration of the working groups into the overall NIMS response structure and integration with the Incident Support Director priorities.

Finally, the President may establish an additional senior-level decision-making body or position, such as a White House Task Force/ Coordinator. A relationship then must be established between the Strategic Coordination Group and the senior-level decision-making body or position (e.g., White House Task Force/ Coordinator).

4. Capability-Based Operational Coordination Structures

Capability-based structures are those tailored to provide specific capabilities in situations requiring them, rather than to address types of incidents. HHS integrates public health, medical, and human services response requests for assistance authorized by the President to support US government interests by applying those capabilities. The focus of providing the capabilities is to prevent or mitigate distress, injury, and disease, and to meet basic human needs. ACF has primary authority and responsibility for providing and coordinating capabilities for emergency repatriation, and execution of the management function associated with unaccompanied children missions.

Emergency Repatriation

The U.S. Repatriation Program was established in 1935 under the Social Security Act to provide temporary assistance to U.S. citizens and their dependents whom the Department of State has identified as having returned or been brought from a foreign country to the United States because of destitution, illness, war, the threat of war, or a similar crisis, and because they are without resources immediately accessible to meet their needs. This determination has recently included overseas evacuations and repatriations from environments with potential high-consequence infectious diseases. (ACF 2021)

Section 801 of Executive Order 12656 (53 CFR 47491) as amended, designated HHS as the LFA responsible to "develop plans and procedures, in coordination with the heads of federal departments and agencies, for assistance to United States citizens or others evacuated from overseas areas." In 1991, the Secretary of HHS delegated the authority to administer this program to ACF. In 2018, ACF transitioned the program to the Office of Human Services Emergency Preparedness and Response (OHSEPR) to lead federal planning, coordination, and execution of domestic repatriation plans and operations. Only individuals that ACF/ OHSEPR determines to be eligible repatriates may receive temporary assistance via the U.S. Repatriation Program (ACF 2021).

Organization and Assignment of Responsibilities

The Washington Liaison Group (WLG), consisting of members of the Department of State, Department of War, and other federal agencies, is responsible for the coordination and implementation of plans for protection and evacuation in emergencies of persons abroad for whom the Secretaries of State and War are responsible. The representatives on the WLG are the points of contact for their departments on all matters of emergency evacuation planning, implementation of plans, and coordination of repatriation activities with ACF/ OHSEPR (ACF 2021).

Once the decision is made to conduct the emergency repatriation of U.S. citizens, ACF/ OHSEPR conducts repatriation planning based on assessing the incident's complexity and the anticipated engagement required from federal and STT partners. ACF/ OHSEPR utilizes a unified planning cell to facilitate multiagency planning and coordination for operations. Functions include but are not limited to the following:

- Deliberate and crisis-action planning
- Information collection, analysis, visualization, and dissemination
- Port of entry (POE) assessment and analysis

Emergency Repatriation Centers

Depending on the complexity of the incident, ACF/ OHSEPR may determine that an emergency repatriation center (ERC) needs to be established by the state(s) at the POEs selected for arrival. The main purpose of an ERC is to serve as a place where repatriates are processed, informed of services, and provided with temporary services for immediate unmet needs promptly. The state is responsible for the establishment of an ERC and necessary coordination for the reception, temporary care, and onward movement of eligible repatriates (ACF 2021).

Emergency Repatriation Functions

ACF/ OHSEPR provides federal interagency emergency repatriation support using emergency repatriation functions (ERFs) which deliver core capabilities to provide an effective response. Each ERF comprises a department or agency designated as the ERF coordinator and several primary and support agencies. Primary agencies are designated based on their authorities, resources, and capabilities, and support agencies are assigned based on supporting capabilities in each functional area (ACF 2021). The ERFs' primary agencies are listed in **Table A-1**.

Table A-1. Emergency Repatriation Functions and Primary Coordination Agencies

Emergency Repatriation Functions	Primary Coordinating Agency
ERF 1 – Evacuation and Reentry	Department of State **Members**: Department of War, Department of Homeland Security (DHS)/Customs and Border Protection, DHS/Citizenship and Immigration Services, Department of Transportation (DOT), DOT Federal Aviation Administration, HHS/Centers for Disease Control and Prevention
ERF 2 – Human Services, Case Management, and Temporary Assistance	Administration for Children and Families **Members**: American Red Cross, HHS/Office of the Assistant Secretary for Health, HHS/Substance Abuse and Mental Health Services Administration, U.S. states

ERF 3 – Public Health, Health, and Medical Support	Administration for Strategic Preparedness and Response **Members**: HHS/Centers for Disease Control and Prevention, DHS/Office of Health Affairs
ERF 4 – Legislation, Policy, and Anti-Discrimination	Office of General Counsel **Members**: HHS/Office for Civil Rights, HHS/Immediate Office of the Secretary/Office of National Security, Department of Justice
ERF 5 – Budget and Finance	ACF Office of Legislation and Budget **Members**: HHS/Office of the Assistant Secretary for Financial Resources, HHS/Office of the Assistant Secretary for Legislation, HHS/Assistant Secretary for Administration/Program Support Center
ERF 6 – Intergovernmental and External Affairs	Office of Intergovernmental and External Affairs **Members**: DHS/Federal Emergency Management Agency, HHS/Office of Global Affairs, HHS/Office of the Assistant Secretary for Public Affairs

Unified Coordination

Unified coordination is related to, but distinct from, Unified Command. Both are organized, staffed, and managed consistently with NIMS principles using an ICS structure. However, unified coordination is typically conducted by organizations seeking to align their activities, establish common situational awareness, and coordinate the delivery of resources without a single individual or entity having the authority to direct action outside their existing organizational chain. The Federal Interagency Emergency Repatriation Working Group (FIER WG) provides unified coordination for the emergency repatriation functions (ERFs), as illustrated in **Figure A-3**. The FIER WG is organized, staffed, and managed consistent with NIMS using an ICS structure. The FIER WG works to reach a consensus for coordinating, integrating, and synchronizing repatriation activities among the ERFs. The FIER WG structure enables ACF/ OHSEPR to coordinate federal support with the states (ACF 2021).

The FIER WG typically partners with NGOs, such as the American Red Cross, which will provide support in accordance with their established agreement with ACF. The American Red Cross will determine the scope and nature of its support based on available resources, sheltering, feeding, and basic first aid after the STT/federal entities have conducted initial medical screenings.

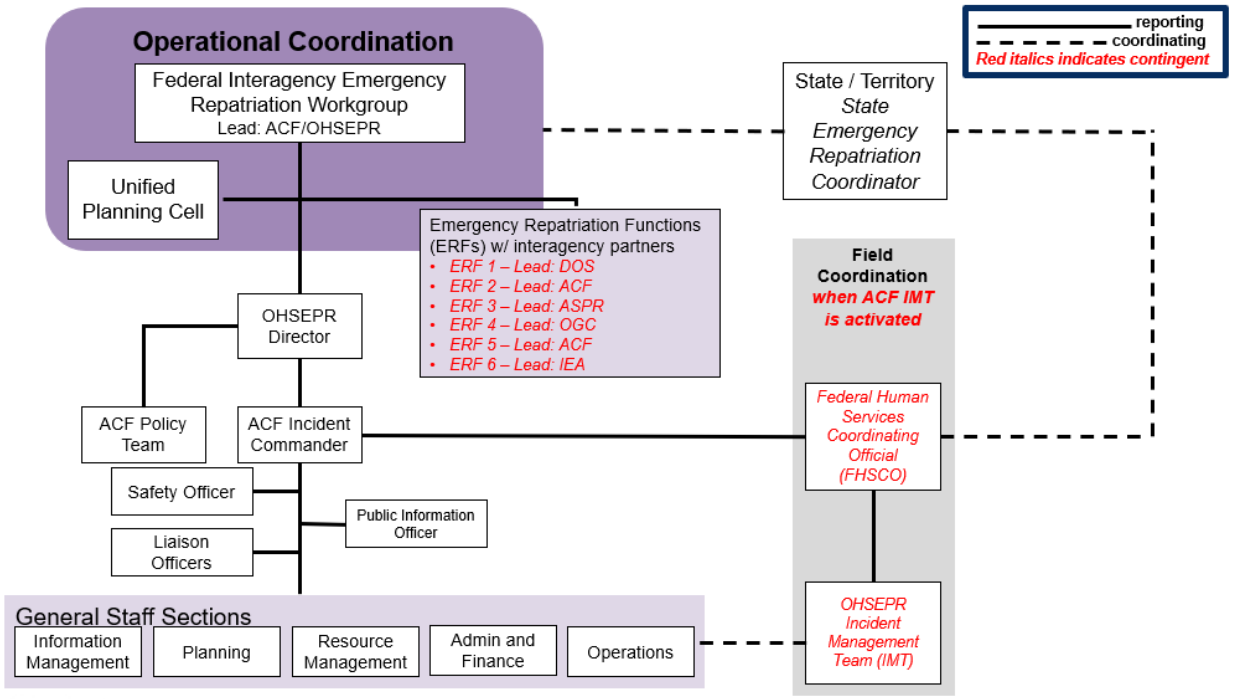

Figure A-3. Example of a repatriation Unified Coordination Structure

Unaccompanied Children

The ACF Office of Refugee Resettlement (ORR) serves unaccompanied children in two distinct programs: the Unaccompanied Refugee Minors (URM) program and the Unaccompanied Children (UC) program (ACF 2022).

Unaccompanied Refugee Minors Program

The URM program serves some of the world's most vulnerable minors fleeing persecution, violence, or abuse and entering the United States without a parent or custodian. ACF/ ORR provides foster care placement and services to unaccompanied refugee minors and other special populations of youth in the United States. Bridging child welfare experience with expertise in refugee resettlement, the URM program is uniquely designed to care for minors with forced migration and traumatic experiences (ACF 2022).

Unaccompanied Children Program

ACF/ORR also manages the UC program. By law, HHS must provide care for each unaccompanied child, defined as a child who has no lawful immigration status in the United States; has not attained 18 years of age; and for whom no parent or legal guardian is in the United States, or no parent or legal guardian in the United States is available to provide care and physical custody. Unaccompanied children are transferred to ACF/ ORR by the Department of Homeland Security (DHS). Most children are placed into ACF care because they were apprehended by immigration authorities while trying to cross the border or after coming to the attention of immigration authorities at some point after crossing the border (ACF 2022).

Organization and Assignment of Responsibilities

During normal operations, situational awareness is provided by DHS and ACF through official channels to ACF ORR and other federal interagency partners. DHS coordinates with the intelligence community to identify and monitor leading migration indicators. During an influx emergency, if an indicator is reached, a representative from ACF ORR will serve as Incident Commander and will stand-up the Incident Management Team (IMT) to facilitate coordination and communication. An example structure for unified coordination for unaccompanied children is illustrated in **Figure A-4**. The IMT coordinates resources (including personnel, equipment, supplies, facilities, and managerial, technical, and advisory services) to ensure unified humanitarian relief is provided to the unaccompanied children, including housing, care, medical treatment, and transportation. Supporting agencies may be added to the UCG or as an IMT LNO as needed.

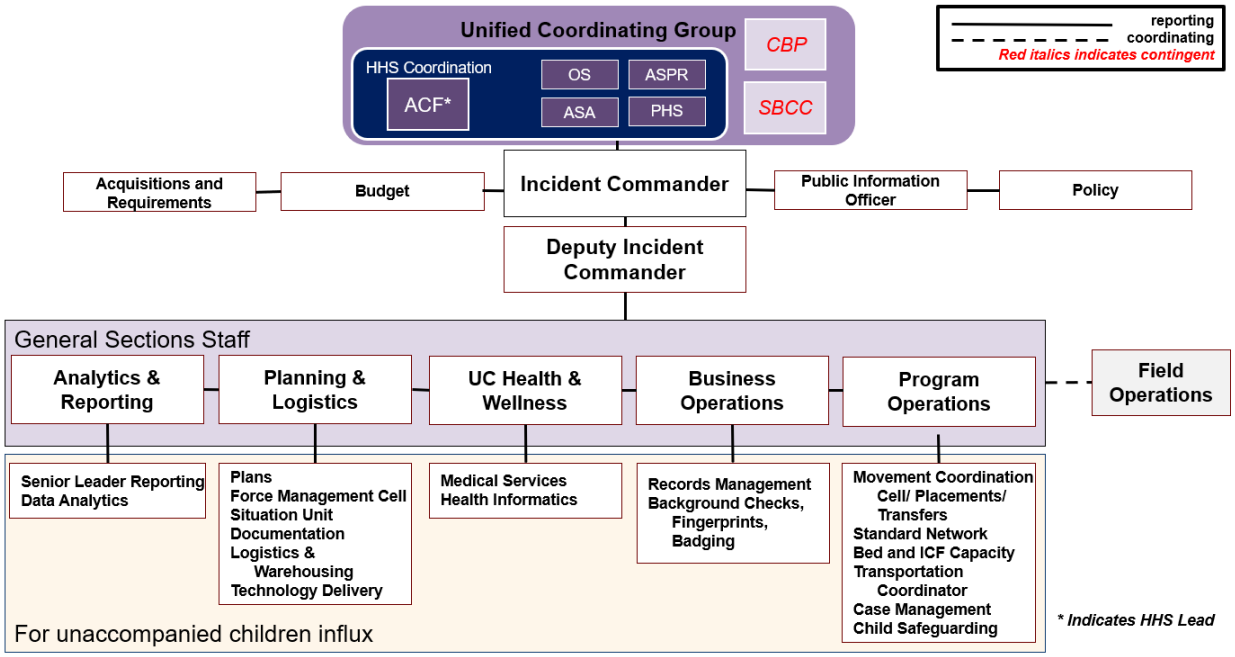

Figure A-4. Example of an unaccompanied children Unified Coordination Structure
CBP = U.S. Customs and Border Protection (in DHS); SBCC = Southwest Border Coordination Center (in DHS); ICF = International Classification of Functioning, Disability, and Health

5. Administration, Resources, and Finance

HHS and its divisions are responsible for managing their personnel augmentation and financial activities during emergency operational phases and across all mission areas within their established processes and resources. Federal funding to manage HHS's response and recovery activities will comply with applicable laws and authorities. HHS divisions should consult with their labor relations staff (in coordination with the National Labor and Employee Relations Officer) to determine any union obligations they may have during an emergency response. See section *8. Administration, Finance, and Logistics* of the base plan for more information on administration, resources, and funding.

Federal agencies supporting repatriation planning operations do so according to their existing statutory authorities. In cases where ACF requires operational support of federal or STT

partners, ACF will reimburse federal agencies for functions performed contingent upon the availability of funds (ACF 2021).

6. Oversight, Coordinating Instructions, and Communications

Under the operational coordination structures listed in this annex, HHS and its divisions will activate in a NIMS structure to coordinate and communicate during response and recovery activities, as appropriate. See section *5. Direction, Control, and Coordination* of the base plan for additional information.

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Annex B: Logistics

1. Purpose and Situation

Purpose

This annex describes the concept of support for logistics by the Administration for Strategic Preparedness and Response (ASPR), in collaboration with departmental/ interagency partners and the private sector, for plans to supplement state, tribal, and territorial (STT) and local public health, medical, and human services resources and capabilities during a public health emergency or disaster incident. Appendices include elaboration on how ASPR addresses critical core capabilities relating to transportation (*Appendix 1 to Annex B: Critical Transportation*) and to how requests for SNS resources can be submitted (*Appendix 2 to Annex B: Requesting SNS Assets*).

The ability to sustain and rapidly deploy logistical resources is critical to HHS fulfilling its responsibilities in response to a public health emergency or disaster incident. FEMA and its interagency partners may be requested to coordinate with regions and with STT, local, and insular area governments to execute a coordinated plan of action for managing the efficient distribution of supplies and services in support of HHS.

Situation

Disaster incidents, regardless of cause, may require national-level public health and medical resource support. They may cause significant environmental and public health issues, including needs for mental health services, potential isolation, quarantine, and fatality management services. Medical resource support may be required at medical facilities, victim collection and evacuation points, and evacuee and refugee points and shelters; and for support of field operations and emergency responders. In addition, potential or known contamination with hazardous materials may require increased federal technical assistance. Needs for resources and services may be beyond conventional capacities for response, either due to public health and medical infrastructure being negatively impacted by the consequences of the incident or due to the magnitude or scope of the consequences being beyond established capacities to respond.

2. Mission

As the provider of federal public health and medical capabilities and tasked with providing for and supporting disaster human services and social services capabilities and missions, HHS mobilizes, manages, and delivers governmental, nongovernmental, and private sector resources[76] within the designated area(s) to stabilize, save, and sustain lives while facilitating a successful transition to steady state conditions.

[76] Including personnel, equipment, and supplies.

Mission Objectives

ASPR is responsible for managing and implementing logistics policies and procedures to support the following capabilities:

- Manage, deploy, and sustain medical cache equipment and supplies.
- Implement response logistics.
- Coordinate planning and operational analysis among HHS, governmental, nongovernmental, and private sector entities.
- Analyze, prioritize, allocate, and mobilize HHS resources to support STT and local jurisdictions and to facilitate long-term recovery transition.
- Coordinate and implement international assistance resources and capabilities when applicable.

3. Concept of Support

The basic supply chain approach associated with incident phases is illustrated in Figure B-1. ASPR is responsible for sustaining and coordinating the synchronized movement of response personnel, logistics resources, and field support services, and for providing management and implementation of logistics policies and procedures to support the following capabilities:

1. Staff the Secretary's Operations Center (SOC) Resource Coordination Section (RCS).
2. Execute the mobilization and synchronized movement of ASPR's response resources and establish initial logistics response capability.
3. Manage, deploy, and sustain medical cache equipment and supplies.
4. Monitor and analyze supply chain vulnerabilities for public health and medical resources.
5. Establish a common operating picture for key public health and medical resource categories that impact the supply chain; leverage collaboration with federal partners, HHS-stakeholders, private-sector manufacturers, and distributors to analyze supply chain risks.
6. Oversee ASPR property management operations.
7. Provide policy guidance for the execution of response logistics; and support field wrap-around services.
8. Coordinate logistics resources and support with internal and external public health, medical, and National Disaster Medical System (NDMS) partners.
9. Process requests for and provide coordinated delivery of essential resources, equipment, and services to impacted communities and survivors in support of HHS. State requests for assistance are processed through the HHS Regions.
10. Synchronize logistics capabilities and enable, to the extent legally appropriate or stipulated, support for stabilization, sustainment, and restoration of impacted supply chains.
11. Activate the Emergency Prescription Assistance Program (EPAP) as required.

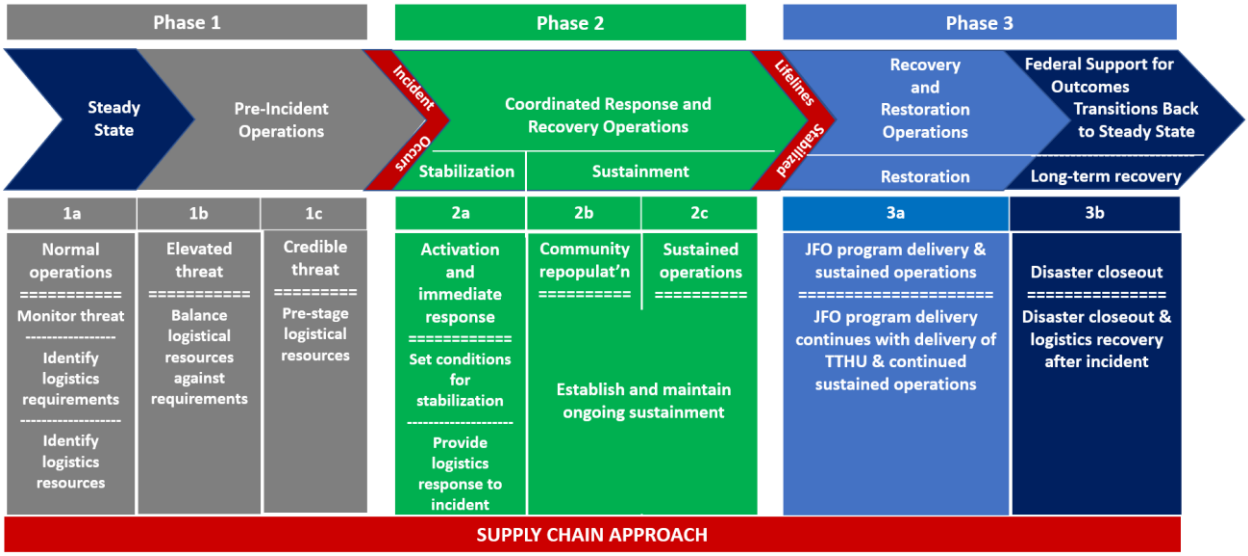

Figure B-1. Operational phases and basic supply chain approach
TTHU = transportable temporary housing units

Critical Tasks

Logistics planning-support critical tasks are as follows:

- Mobilize to coordinate the delivery of governmental, nongovernmental, and private sector resources within and outside the impacted area to save and sustain lives, meet basic human needs, set conditions, stabilize the incident, and facilitate a transition to a steady state.
- ESF #7 (Logistics) implements an interagency end-to-end supply chain system for a response as delineated by the lead federal agency (LFA). ASPR maintains resource support capability, with the ability to implement and sustain the operational tempo of response operations. This uses organic capabilities, including contracts and the resources of other federal agencies.
- Organizations supporting ESF #6 (Mass Care, Emergency Assistance, Temporary Housing, and Human Services) collaborate with nongovernmental organizations (NGOs), voluntary organizations active in disasters (VOADs), faith-based organizations, and private sector partners.
- Supply chain management integrates national supply chain processes with those at state and local levels, from planning for customer-driven requirements for resources and services to resource delivery to disaster survivors and responders.

Additionally, logistics engages FEMA's National Business Emergency Operations Center (NBEOC) and the Cybersecurity and Infrastructure Security Agency's (CISA's) National Risk Management Center to facilitate business-led, government-supported incident response to optimize survivor access to critical services and the business community.

Key Resource Support Systems

The objective of logistics/resource support is to facilitate a rapid response for deploying the most commonly requested resources. HHS resources are obtained and deployed from the

health and medical supply chain, ASPR mission support centers (MSCs), and the Strategic National Stockpile (SNS).

HHS may request the Department of War (DOW), the Department of Veterans Affairs (VA), or private-sector industry partners to provide, procure, and transport medical equipment, durable medical equipment, and supplies, including medical diagnostic, and radiation-detecting devices, medical countermeasures, and biological products in support of immediate medical response operations. When availability of supplies is short and existing production capacity is insufficient to meet the need, the President may invoke authorities in the Defense Production Act of 1950 (50 U.S.C. §§ 4501 et seq.; Public Law 115-232, 2018) to divert private sector production capacity initially for non-critical items to produce items of critical importance.

The medical countermeasure (MCM) program establishes and maintains federally supported and coordinated capabilities in support of a public health emergency where dispensing of MCMs (e.g., pharmaceuticals, PPE) is warranted. The MCM program's key tasks include (1) augmenting or supplementing federal support during mass dispensing campaigns, (2) providing an HHS point of dispensing location to provide MCMs to all HHS staff during a public health emergency, (3) managing the MCM dispensing agreement with the United States Postal Service, and (4) collaborating on the expansion of public-private partnerships facilitated at the corporate level.

Health/Medical/Veterinary Equipment and Supplies

During a public health emergency or disaster incident, the public health and medical infrastructure of an STT or local jurisdiction may become overwhelmed, leading to a shortage of public health, medical, and veterinary equipment and supplies required for a successful response. Accordingly, STT or local health authorities may request federal assistance with providing resources, including pharmaceuticals, biological products, medical devices or equipment, blood or blood products, and tissue products needed to support the response or replenish health care and veterinary facilities in the impacted area. These resources may be sourced from the HHS ASPR MSCs, the SNS, United States Department of Agriculture (USDA) National Veterinary Stockpile, or from a sourcing solution that could include an ESF #8 support agency or federal contract. **Table B-1** lists logistics responsibilities for specific resources.

Table B-1. Logistics responsibilities for specific resources. Request process for all resources is both (1) state PH to HHS and (2) state EM to FEMA.

Resource	Roles and Responsibilities
Personal protective equipment (PPE)	▪ ASPR's Center for Response (CR) ▪ IST, Resource Coordination Section (RCS) tracks all requests. Also tracked in FEMA Crisis Management System.[77] ▪ SNS
Pharmaceuticals	▪ Fulfillment options - ASPR MSCs ▪ Tracking – IST, RCS tracks all requests. Also tracked in FEMA Crisis Management System. ▪ SNS
Medical supplies	▪ Fulfillment options – ASPR MSCs and supply chains ▪ Tracking – IST, RCS tracks all requests. Also tracked in FEMA Crisis Management System.
Medical supplies (not in SNS formulary)	▪ Fulfillment options – ASPR MSCs and supply chains ▪ Tracking – IST, RCS tracks all requests. Also tracked in FEMA Crisis Management System.
Federal Medical Station (FMS)	▪ Fulfillment options – SNS | SNS Transportation ▪ Tracking options – IST, RCS tracks all requests. Also tracked in FEMA Crisis Management System.
HHS medical staff	▪ Fulfillment options – NDMS, USPHS, CDC, VA ▪ Tracking options – IST, RCS tracks all requests. Also tracked in FEMA Crisis Management System.
NDMS kits/ caches / equipment; DMAT, NVRT, DMORT, TCCT, IT/COMM equipment and caches	▪ Fulfillment options – ASPR MSCs ▪ Tracking options – IST, RCS tracks all requests. Also tracked in FEMA Crisis Management System.

4. Roles and Responsibilities

The following roles and responsibilities include ASPR and selected departmental/ interagency partners.

[77] See *Glossary* entry for FEMA Crisis Management System.

Secretary's Operations Center (SOC) Incident Support Team (IST)[78]

Resource notification, activation, mobilization, and tracking

- Coordinate the alert/notification, activation, mobilization, deployment, and demobilization of resources and track mission assignments (MAs) for the department.
    - Validated needs are identified by the field elements of HHS, including, but not limited to, the following participants:
        - FHCO/IM
        - HHS regional staff, including regional administrator(s) from the impacted region(s)
        - Regional emergency coordinators (RECs)
        - IMTs
        - National Response Coordination Center (NRCC)
        - FEMA Regional Response Coordination Center (RRCC)
        - Joint Field Office (JFO)
        - STT authorities, and local authorities as appropriate
        - HHS divisions' support teams/liaisons
        - Members of the NDMS, USPHS Commissioned Corps
        - Other deployable HHS resources (teams and individuals)

Resource Coordination Section (RCS)

The SOC IST's Resource Coordination Section performs hybrid operations and logistics functions. This includes acquiring and providing health and medical resources based on FHCO/IMT-validated and -prioritized requests for resources (RFRs) submitted through the RFR process to address unmet needs identified by the ASPR incident management field structure. The RCS conducts the following activities:

- Monitors the mobilization, deployment, ongoing status, and redeployment of requested teams, equipment, and supplies.
- Identifies and fills shortfalls or gaps in the organization's ability to support operational requirements and unmet resource needs.
- Oversees the establishment and operation of the ASPR mobilization center, including the following key mobilization and demobilization functions:
    - Mission briefings/debriefings
    - Personnel accountability
    - Logistics
    - Safety
    - Medical oversight and assessment
    - Occupational health functions such as respiratory protection program activities, and behavioral health support
- Oversees personnel demobilization once a handoff is conducted with the IMT.

Figure B-2 depicts an example of a resource coordination structure (scalable per response requirements).

[78] Until such time that the designated FHCO/IMT determines that the IMT is sufficiently established and ready to coordinate, integrate, and provide support to on-scene activities, the SOC coordinates with other ASPR headquarters elements and other HHS divisions to support the management and administration of deployed resources.

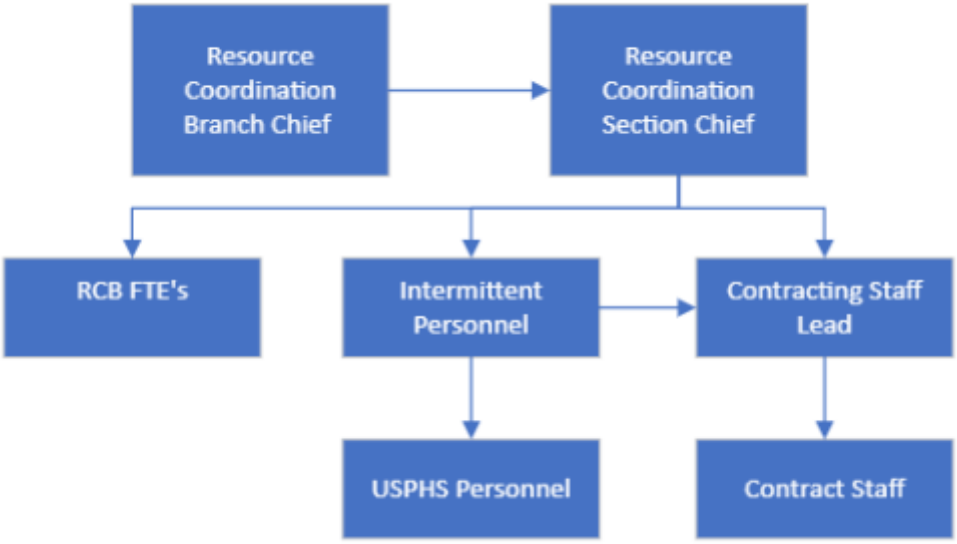

Figure B-2. Resource Coordination Section structure
RCB = Resource Coordination Branch; FTE = full-time equivalent

ASPR Mission Support Centers

The ASPR mission support centers (MSCs) manage, deploy, and sustain health and medical caches, kits, personal protective equipment (PPE), and supplies. These materials can be used as a short-term stopgap when the immediate supply of these materials may not be available or sufficient.

Center for the Strategic National Stockpile (SNS)

The SNS is part of the federal medical response infrastructure. It can supplement medical countermeasures needed by STT and local governments during public health emergencies. The SNS manages, sustains, and deploys medicines, devices, PPE, and medical cache equipment and supplies that can be used as a short-term stopgap buffer when the immediate supply of these materials may not be available or sufficient.

SNS can leverage supply chain partnerships to acquire specific countermeasures that an STT or local jurisdiction may not be able to access independently. SNS also maintains strong relationships with third-party logistics providers to store, maintain, and efficiently distribute inventory.

STT authorities and the largest metropolitan areas may request federal assistance directly from the SNS if state and local supplies are depleted and commercial supplies are not adequately available to support response needs. See *Appendix 2* to this annex for more information.

The Supply Chain Logistics Operations Cell

The Supply Chain Logistics Operations Cell (SCLOC) monitors, analyzes, and mitigates vulnerabilities in the public health supply chain.[79] It serves as ASPR's focal point for supply chain and logistics operations strategies. Key tasks include the following activities:

- Develop resourcing courses of action.
- Coordinate supply chain activities with those of STT authorities, regions, and private sector distributors.
- Make recommendations to ASPR senior leaders on resource allocations and distribution[80] while advising on opportunities for industrial base expansion (IBx).
- Identify and maximize efficiencies in federal supply chain support to federal, STT, and local partners.
- Access supply chain intelligence and leverage the Supply Chain Control Tower (SCCT) for situational awareness and early detection of issues.

Center for Industrial Base Management and Supply Chain

ASPR's Center for Industrial Base Management and Supply Chain (IBMSC) aims to build a diverse, agile public health supply chain and sustain long-term U.S. manufacturing capabilities by investing in medical product IBx capacities that can enable ASPR to respond to future public health emergencies.

IBMSC coordinates strategic IBx efforts across ASPR, federal partners, academia, and the private sector to operationalize novel solutions and practices for response and recovery operations. IBMSC coordinates the activities related to medical product industrial base expansion and sustainment as described in the following objectives:

- Promote multi-functional capabilities, including advanced manufacturing and supply chain optimization, that ensure relevant stakeholders can access necessary raw materials and components needed for domestic manufacturing.
- Establish innovative domestic industrial base programs and enduring, sustainable partnerships across the medical countermeasure ecosystem including with biotech, pharma, distribution, health care, non-profit, and for-profit organizations.
- Sustain critical medical countermeasures and public health supply advancement and capacity while prioritizing long-term, viable, adaptable domestic industrial base infrastructure to sustain commercial markets, partnerships, and life-cycle supply chain management.

The Center for Industrial Base Management and Supply Chain includes the following components: the Office of Critical Medical Equipment; the Office of Testing and Diagnostics; the Office of Enabling Innovations and Technologies; the Office of Supply Chain Optimization; and the Office of the Defense Production Act and Emergency Response Authorities.

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[79] "A supply chain is a system of organizations, people (including workers, producers, and importers), activities, information, and resources involved in providing a product or service to a consumer. The public health supply chain is the system that produces and delivers critical medical supplies to support the health care and public health (HPH) sector and other critical infrastructure (CI) sectors. These supplies include PPE, diagnostics, and other medical devices; as well as pharmaceuticals—therapeutics, biologics, and vaccines." (USG 2021) (See *Glossary* entry for public health supply chain.)

[80] Especially under scarce-resource conditions (when supply is inadequate to meet the needs).

Indian Health Service (IHS)

The IHS, an agency within HHS, is responsible for providing federal health services to American Indians and Alaska Natives. The IHS National Supply Service Center (NSSC) coordinates the procurement and distribution of health care assets, including pharmaceuticals, medical surgical items, PPE, lab supplies, and other essential products to IHS, tribal, and urban Indian organization health care facilities nationwide. The NSSC distribution network can also be leveraged to assist in distributing SNS assets to these facilities.

Department of Veterans Affairs (VA)

The VA provides staff as liaisons to support ESF #8 and provides medical equipment and supplies, including pharmaceuticals; and acquisition and logistical support as requested. In addition, it designates and deploys available medical, surgical, mental health, and other health service support assets as requested.

Centers for Disease Control and Prevention (CDC)

CDC is an operational component of HHS responsible for the nation's health protection. CDC tracks diseases, researches outbreaks, and responds to emergencies to protect the nation from threats and hazards to health, safety, and security, both foreign and domestic. ASPR may support CDC’s activities by deploying personnel to provide rapid and sustained public health assessment, leadership, and expertise to the impacted area(s) upon request and approval. CDC also provides regulatory-compliant diagnostic kits, high-quality laboratory reagents, and monoclonal and polyclonal antibody production for public health laboratories during outbreaks.

Food and Drug Administration (FDA)

FDA works closely with manufacturers and interagency partners to expedite the development and availability of biologics (including vaccines), drugs, veterinary products, and devices (including diagnostic tests and personal protective equipment). ASPR may support the deployment of vaccines, drugs, devices, and personal protective equipment upon request and approval.

Administration for Children and Families (ACF)

The HHS Administration for Children and Families (ACF), Office of Refugee Resettlement (ORR), is responsible for the care of unaccompanied children, who can be referred to ORR by any federal agency. Within the logistics structure, support may include, but is not limited to, developing, and maintaining the roster and activation and deployment of ASPR response personnel as requested. Logistics will also coordinate field lodging with interagency partners as required. Upon request and approval, requirements and the types of support required will be identified for ACF medical capabilities during a surge. Examples of requests may include, but are not limited to, provision of supplies for the medics at the Customs and Border Protection (CBP) stations, deployment of medical personnel to support medical clearance, and provision of nursing support for Immigrations and Customs Enforcement and ACF.

5. Direction, control, and coordination

Pre-Staged Resources

The primary locations for pre-staged resources are the ASPR MSCs and the SNS, with mass care and other lifesaving/life-sustaining resources available from interagency and external partners (for example, FEMA Distribution Centers – DC) storage areas or vendors.

Allocation and Adjudication of Resources

Resource requests from the STT governments are processed through the appropriate HHS region and determined by the HHS ASPR headquarters for consideration for sourcing and engagement. The allocations will need to be adapted based on the actual incident impact assessment and planning factors.

Critical Considerations

Resource phasing should reflect the critical considerations in ***Figure B-3*** for the movement of resources.

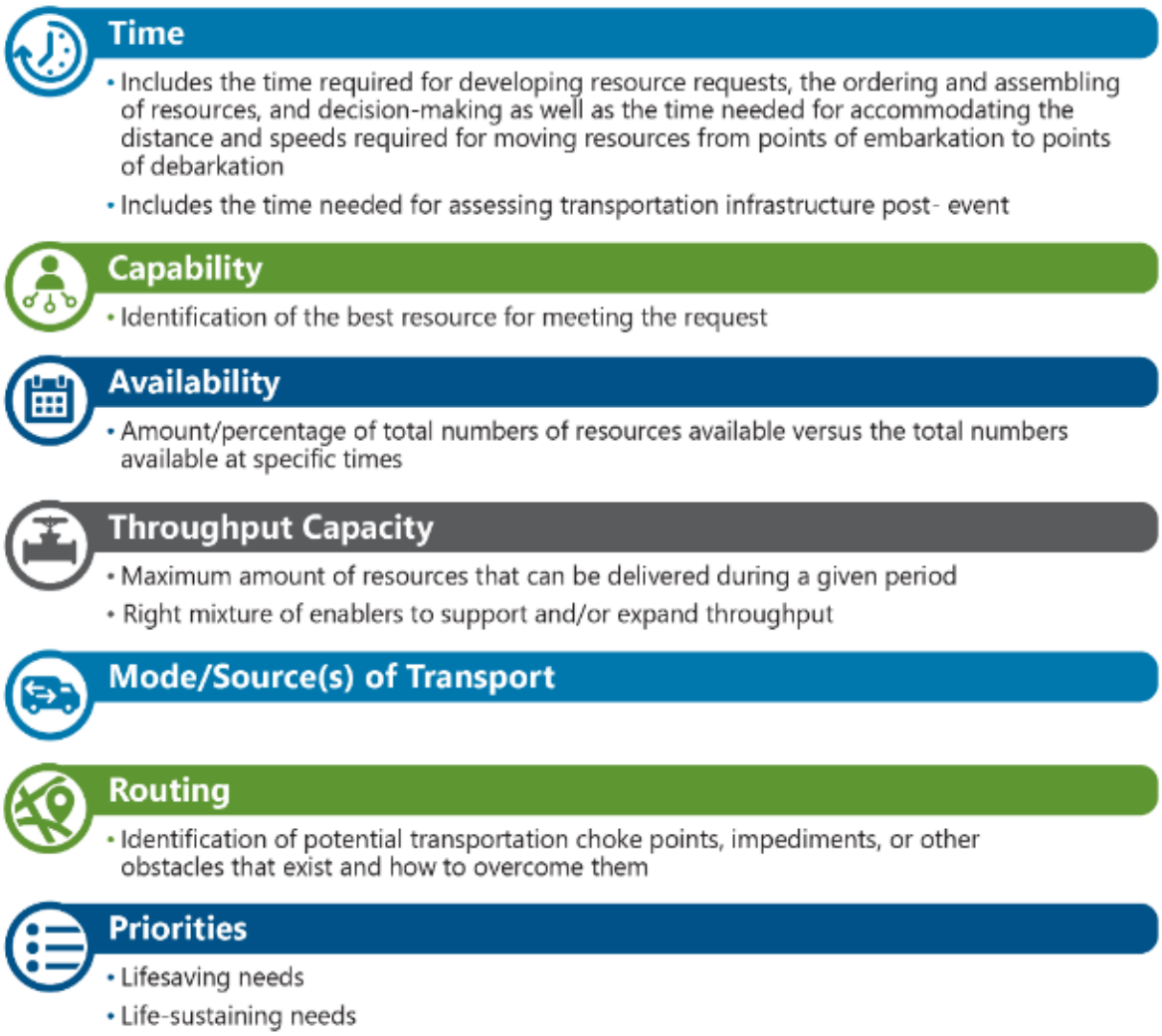

Figure B-3: Resource movement critical considerations

Considerations for Sourcing National-Level Resources to Achieve Stabilization of Lifelines

ASPR MSCs and the SNS will prioritize distribution to identified areas while preserving an appropriate allocation availability for all affected states and balancing the need to maintain a standing strategic reserve.

Community lifelines facilitate identification of critical business and government functions. These functions are essential for human health and safety or economic security. Lifelines are designed to highlight priority areas and interdependencies, focus attention on actions being taken, communicate coordination activities toward stabilization, and integrate information.[81]

Logistics relies on an integrated, interagency approach to source and allocate resources during catastrophic and non-catastrophic incidents to support requirements driven by lifelines. ESF #7 (Logistics) has capabilities for supporting other ESFs that serve a primary role in an incident, depending upon the nature of the incident and resources required through the Resources Management Group. ESF #8 depends upon other ESFs for support in incidents where ESF #8 has a primary role. In all cases, numerous factors could impact the allocation of resources. Relevant considerations are listed in Table B-2.

Table B-2. Major considerations for the allocation of national-level resources.

ESF	Major ESF #7 Considerations
All ESFs	• Number of states affected • Affected population
ESF #1 Transportation	• Major highways/bridges/airports/ports damaged/closed to traffic • Estimated time to repair/restore transportation critical infrastructure • Transportation infrastructure assessments
ESF #2 Communications	• Location of deployed intermediate staging base/ federal staging area teams • Support to incident management assessment teams and state EOCs • Support to the initial operating facility and joint field office (JFO)
ESF #3 Public Works and Engineering	• Major transportation routes with non-functioning equipment, e.g., traffic lights • Major transportation routes blocked by debris • Status of power grid/critical facilities and estimated time until restoration; generator requirements • Status of navigation infrastructure
ESF #6 Mass Care, Emergency Assistance, Temporary Housing, and Human Services	• Population requiring lifesaving/life-sustaining support, to include food and emergency supplies • Affected populations - Survivors requiring food/meals, water, and sheltering - Survivors requiring only food/meals and water
ESF #7 Logistics	• Commodity requirements for shelter-seeking population, as determined by ESF #6 • Number of responders requiring shelter support • Number of generators required for supporting critical infrastructure • Maintenance of situational awareness and management of logistical movements • Integration of private sector capabilities and resources • Other disaster survivor resource support needs
ESF #8 Public Health and Medical Services	• Number of injured that require medical care; demand for consumable medical supply and durable medical equipment • Number of fatalities; body bag demand • Number of potentially exposed individuals who may require prophylaxis, with demographic information

[81] The seven community lifelines identified in the Response and Recovery FIOP (FEMA 2025) are (1) Safety and Security, (2) Food, Water, and Shelter, (3) Health and Medical, (4) Energy (Power and Fuel), (5) Communications, (6) Transportation, and (7) Hazardous Materials.

ESF	Major ESF #7 Considerations
ESF #10 Oil and Hazardous Materials	• Federal support provided in response to an actual or potential discharge and/or uncontrolled release of oil or hazardous materials

National Level

The HHS SOC serves as the single integrator for federal logistics resources, synchronizing federal logistics activities with other federal agencies, NGOs, faith-based organizations, and national VOADs, NGOs, and ESF #6 during response and recovery operations as part of a unity of effort.

The U.S. Northern Command and the U.S. Pacific Command represent the DOW and coordinate Defense Support of Civil Authorities. HHS may request DOW support to assist in the augmentation of logistics support sites or operational capabilities when applicable.

HHS may also use pre-scripted MAs and MAs directed to the General Services Administration (GSA) to provide emergency leasing services for space.

Office of Business, Industry, and Infrastructure Integration (B3I)

Our increasingly interdependent society requires the public and private sectors to share risk and responsibility before, during, and after disasters. Effective cross-sector collaboration for all hazards is critical and can foster operational resilience for survivors and their communities during disaster response and recovery. Cross-sector collaboration requires transforming how private-public partnerships develop, collaborate, and align to confront societal shared hazard risks.
FEMA has established the Office of Business, Industry, and Infrastructure Integration (B3I) to build unity of effort that is more inclusive of nongovernmental capabilities as described in the fourth edition of the National Response Framework (NRF; DHS 2019) and the establishment of ESF #14 (Cross-Sector Business and Infrastructure; FEMA 2019b). B3I's mission is connecting private and public sector capabilities before, during, and after disasters, enabling efficient response operations, and shaping community economic resilience and recovery.
B3I will advance the FEMA Strategic Plan goals in three areas:

1. *Community lifelines.* Stabilize community lifelines to expedite recovery by establishing the necessary business-related relationships, processes, and doctrine before and effective public and private alignment after disasters.
2. *Cross-sector collaboration.* Serve as the FEMA lead for ESF #14 as a primary agency to fulfill the outcomes listed in the NRF ESF #14 Annex.
3. *Agency operations.* Ensure agency-wide cohesion for supporting non-procurement business/industry/infrastructure-related partnership activities to enable effective economic response and resilience for impacted communities.

An additional aim of HHS is to delineate activities during response operations with oversight and coordination with the CISA for ESF #14 (Cross-Sector Business and Infrastructure; FEMA 2019b). CISA, as the co-primary agency with FEMA, plays a key role in supporting coordination, information sharing, and analysis and reporting on matters of infrastructure and cybersecurity. They manage and coordinate with stakeholders through the National Risk Management Center and the Protective Security Advisor Program.

For recovery activities, the primary recovery support functions (RSFs) that would require

assistance from FEMA Logistics would be as follows:

- Housing
- Health, Education, and Human Services
- Economic
- Infrastructure Systems

The CISA Integrated Operation Coordinating Center currently works with the 16 critical infrastructure sectors and serves as the coordinating mechanism for critical infrastructure and the private sector. Other coordinating structures include the NBEOC, the Small Business Administration, and chambers of commerce.

Regional Level

HHS regions are integrated decision-makers for all logistics functions before, during, and following an incident. Regional personnel staff JFOs and intermediate staging bases/staging areas and identify, develop, and coordinate regional resource requirements and capabilities distribution with STT and local responders.

6. Administration and Support

Each Op/Div/ StaffDiv supporting response and recovery operations will follow its standard protocols for activation, notification, deployment, and deactivation while continuing to execute its roles and responsibilities provided for within federal laws and regulations.

Federal Acquisition Regulation Part 18 identifies acquisition flexibilities that may be available during an emergency, including when an emergency declaration or major disaster declaration has been issued under the authority of the Stafford Act.

7. References

References are designated as in the *HHS RROP*. A letter after the year of a reference distinguishes it from other references of the same author and year in the *HHS RROP*.

[FEMA] Federal Emergency Management Agency, 2019b. Emergency Support Function #14 – Cross-Sector Business and Infrastructure. URL: https://www.fema.gov/sites/default/files/2020-07/fema_ESF_14_Business-Infrastructure.pdf. Accessed 2 February 2023.

[FEMA] Federal Emergency Management Agency, 2025. Response and Recovery Federal Interagency Operational Plan: Second Edition: March 2025. URL: https://www.fema.gov/sites/default/files/documents/fema_rd_response-recovery-fiop-npb-042025.pdf. Accessed 5 March 2026.

Public Law 115-232, 2018. The Defense Production Act of 1950, as amended. URL: https://www.fema.gov/sites/default/files/2020-03/Defense_Production_Act_2018.pdf. Accessed 22 June 2023.

[USG] U.S. Government (DOD, DHS, HHS, VA), 2021. National Strategy for a Resilient Public Health Supply Chain: July 2021. URL: https://aspr.hhs.gov/MCM/IBx/2022Report/Documents/National-Strategy-for-Resilient-Public-Health-Supply-Chain.pdf. Accessed 5 March 2026.

Appendix 1 to Annex B: Critical Transportation

1. Purpose

The purpose of this appendix is to describe the delivery of the critical transportation core capability within ASPR's Center for Response (CR). ASPR/ CR provides transportation services for response priority objectives, including evacuation of people and delivering vital response personnel, equipment, and services into the affected area. Critical transportation, in other instances, is coordinated through the FEMA NRCC utilizing the Movement Coordination Center, Response Operations, Department of Transportation, and other interagency partners.

Critical transportation critical tasks are as follows:

- Establish physical access through appropriate transportation corridors and deliver crucial resources to save lives and meet the needs of disaster survivors in support of the LFA.
- Ensure basic human needs are met, stabilize the incident, facilitate a transition to recovery, and restore basic services and community functionality in the affected area.
- Support the movement of lifesaving and life-sustaining resources and services through support of assessment and reconstitution of the transportation infrastructure to meet operational response priorities.
- Mobilize assessment teams before fully deploying resources for the response.

2. Concept of Support

Within the affected area, HHS and federal interagency partners will establish physical access through appropriate transportation corridors to deliver the required resources to save and sustain lives and facilitate a seamless transition to recovery, in conjunction with state and local whole-community partners, as appropriate.

Transportation Tasks

- Coordinate planning and operational analysis to deliver transportation requirements.
- Conduct assessments of the condition and safety of transportation routes and plan accordingly.
- Prioritize the restoration of damaged/unusable routes, identify alternate routes, and coordinate rapid repairs to facilitate responder access and provide basic services.
- Assess resource requirements to support the reconstitution of the transportation infrastructure.
- Prioritize, adjudicate, and allocate resources for the delivery of transportation requirements.
- Support the evacuation of disaster survivors not under acute medical care (not patients), including special considerations for those with access and functional needs.
- Provide vital response personnel, equipment, and services to the affected area.
- Respond to, coordinate, and prioritize the delivery of resources to disaster survivors and responders in the affected area.

Patient Movement

HHS provides federal support and resources to assist STT and local health authorities with the movement of medical patients through the NDMS. When a STT health authority requests federal support to move patients, HHS activates and implements the patient movement system, which serves five functions: (1) patient evacuation (including patient reception and management), (2) medical regulating, (3) en-route medical care, (4) patient tracking, and (5) patient return or re-entry.

Federal support may include providing patient movement to reception facilities at their destination and providing definitive care through a nationwide network of approximately 1800 to 2000 civilian hospitals that have signed agreements with NDMS to accept patients during a disaster incident or public health emergency. HHS coordinates the transportation of seriously ill or injured patients and patients with special medical needs from casualty collection points in the impacted area to designated reception facilities. This could include movement from areas such as the incident scene, the patient's home, a hospital, a long-term care facility, or a nursing home, to a facility within a specific hospital network. Considerations may be necessary for those with access and functional needs and for those with transmissible diseases, including suspected or proven special pathogens. HHS will coordinate with partners to ensure that individuals with medical needs that do not require acute care are integrated into general population sheltering systems. HHS also coordinates the federal response in support of emergency triage and pre-hospital treatment, patient tracking, distribution, and patient return. This activity is carried out with federal and STT and local emergency medical services officials.

The federal patient movement system may be activated when the number of patients required to be moved exceeds jurisdictional patient movement capabilities. The federal patient movement system is an interagency partnership among HHS, DHS, DOW, and the VA. Federal assistance may include transportation resources provided by DOW and FEMA. HHS may request DOW to execute federal patient movement from a disaster site to designated areas elsewhere in the nation. FEMA may also contract civilian air and ground ambulances during a disaster to support federal patient movement through the National Medical Transport and Support Services (NMTS) Contract.[82] The contract is often the first resource made available directly to STT officials for response activities.

3. Administration and Support

Each federal department or agency that supports critical transportation will follow its standard protocols for activation, notification, permits and waivers, deployment, and deactivation while continuing to maintain their roles and responsibilities provided for within federal laws and regulations.

[82] Often referred to as the National Ambulance Contract.

Appendix 2 to Annex B: Requesting SNS Assets

Adapted from ASPR 2023b.

Who can request SNS assets?

In the face of a public health threat, state, tribal, territorial, or local health officials may request federal assistance for emergency medical countermeasures from the Strategic National Stockpile (SNS). Requests can come from a governor or a governor's designee or senior health officials in a state, tribal entity, territory, or directly funded city. Cities funded through the Public Health Emergency Preparedness cooperative agreement include Chicago, Los Angeles, New York City and Washington, D.C.

What can they request?

Jurisdictional health officials can request support for accessing medical countermeasures, including antibiotics, antitoxins, antidotes, and vaccines, as well as supplemental medical supplies and equipment. Needed products and supplies may be available direct from the SNS inventory or they may be procured or quickly made available from commercial supplies or other federal agencies.

How to make a request

When a need arises, the Department of Health and Human Services (HHS) Secretary's Operations Center (SOC) is the initial contact for requesting emergency supplies. The SOC is staffed by the Administration for Strategic Preparedness and Response (ASPR) 24 hours a day, 7 days a week, and 365 days a year.

A request may also come through the Centers for Disease Control and Prevention (CDC) Emergency Operations Center, particularly for incidents that require clinical consultation. CDC's operations center is staffed 24 hours a day, 7 days a week and 365 days a year and can coordinate with the SOC to begin the request process, especially for Category A threats like anthrax or smallpox that require rapid response.

Emergency Contacts to Request Assistance

HHS Secretary's Operations Center at 202-619-7800
CDC Emergency Operations Center at 770-488-7100

What to expect once a request is made

When a request for support is received, ASPR watch officers will first gather critical information. Once that happens, coordination will begin immediately between the watch officers, the requesting officials, SNS leadership, subject matter experts (SMEs), ASPR regional staff and other federal agencies. Together, officials will either schedule a conference call with all involved parties (generally to occur within 15 minutes of the request being received) or directly connect the requestor with appropriate technical experts. These SMEs will discuss the request and confirm the nature of the public health threat, any human impacts already observed, the anticipated public health response, and the specific materiel requested. Requesting officials should be prepared to provide the following information:

- Location of the event or incident
- Nature of the threat, and any known human impact (morbidity or mortality), if known
- Size and type of population potentially affected
- Summary of events leading up to the threat discovery

Depending on the scale and nature of the threat and whether a deployment from the SNS is needed, the following coordinating information may be included: desired delivery locations and individual points of contact with mobile phone numbers for each delivery location; the jurisdiction's site staffing timeline and ability to receive and store product; whether there is security staffing and any potential security threats; availability of a Drug Enforcement Agency registrant; and any local transportation challenges.

You can also expect ASPR's regional emergency coordinators (RECs) assigned to each of the HHS regions throughout the country to further help identify needs and assist with resolution.

Factors considered for deployment

While no two requests are exactly alike, ASPR considers factors including the following when a request is made: available resources at the state and local levels, commercial availability, similar requests from other jurisdictions, and SNS inventory and available funding if new acquisitions are needed.

ASPR strives to satisfy all requests for support from jurisdictions – both through direct product deployment and further technical assistance. Satisfying a request might not always result in deploying product from the SNS. ASPR can also assist in sourcing scarce products throughout the regions, navigating the commercial supply chain, and making further connections across ASPR and the U.S. government.

Individual or small-scale requests

Sometimes an isolated, time-critical incident, such as an individual patient with naturally occurring anthrax or botulism may occur, and the SNS is the only source for critical, life-saving medical countermeasures. These requests may originate from a clinician contacting CDC for consultation, from a notification by a jurisdictional public health official, or from an ASPR regional emergency coordinator assisting the jurisdiction with the request process. Regardless of how a request for assistance originates, ASPR and CDC work closely together to ensure a streamlined process, especially in time-sensitive situations.

Reference

The reference is designated as in the *HHS RROP*. The letter after the year of the reference distinguishes it from other references of the same author and year in the *HHS RROP*.

[ASPR] Administration for Strategic Preparedness and Response, 2023b. Requesting SNS Assets. URL: https://aspr.hhs.gov/SNS/Pages/Requesting-SNS-Assets.aspx. Accessed 22 August 2023.

Annex C: Authorities

The *HHS Response and Recovery Operational Plan* (*RROP*) is developed, promulgated, and maintained pursuant to appropriate federal statues, regulations, and directives. It is applicable for HHS coordination of the provision of federal public health, medical or human services assistance, and support to state, tribal, and territorial (STT) governments in response to disaster incidents or public health emergencies. The *HHS RROP* supports HHS's response and recovery roles, functions, and missions as outlined in the National Response Framework (NRF; DHS 2019) and National Disaster Recovery Framework (NDRF; DHS 2016c; FEMA 2024). It is a reference to be used in combination with existing HHS divisions' directives, contingency plans, and standard operating procedures (SOPs). It does not alter or impede STT, or federal entities from conducting their specific authorities, or performing their responsibilities under all applicable laws, executive orders, regulations, and directives. The authorities and references include these, with internal hyperlinks to specific summaries in this annex of significant emergency response authorities of HHS:

- The Public Health Service Act (PHS Act) as amended (Public Law 78-410) (42 U.S.C., §§ 201, et seq.)
- The Social Security Act (42 U.S.C. §§ 301 et seq.)
- The Federal Food, Drug, and Cosmetic Act (21 U.S.C. §§ 301-392)

1. Public Health Service Act

The Public Health Service (PHS Act) authorizes the Secretary, acting both at the departmental level and through agencies of the U.S. Public Health Service (USPHS) (e.g., the Centers for Disease Control and Prevention [CDC], the Food and Drug Administration [FDA], the National Institutes of Health (NIH), the Administration for Strategic Preparedness and Response [ASPR], the Health Resources and Services Administration [HRSA], the Substance Abuse and Mental Health Services Administration [SAMHSA], the Indian Health Service [IHS], the Agency for Healthcare Research and Quality [AHRQ], and the Agency for Toxic Substances and Disease Registry [ATSDR]) to protect the health of the public and provide public health and medical services during emergencies. Under the PHS Act, 42 U.S.C. §§ 201 et seq., the Secretary is authorized to, among other things, declare a public health emergency and take appropriate discretionary actions to respond to the emergency, take actions to prevent the introduction, transmission, and spread of communicable diseases, deploy the Public Health Service Commissioned Corps, and develop and stockpile medical countermeasures that could be used in a bioterrorist incident.

Statute and Topic	Public Health Service Act - Topic Summary
42 U.S.C. § 204, § 214: Commissioned Corps and USPHS Personnel	Section 203 of the PHS Act establishes Commissioned Regular Corps and a Ready Reserve Corps for duty in time of emergency. Commissioned Corps officers must be citizens and are appointed and compensated under a separate personnel system without regard to civil service laws. Commissioned Officers of the Regular Corps and of the Ready Reserve Corps are appointed by the President. Under section 214 of the PHS Act, the Secretary is authorized to detail personnel of the U.S. Public Health Service to other federal departments to cooperate in, or conduct work related to, the function of that department or of the Service, upon request of the head of that department. Personnel of the Service may also be detailed to state health and mental health authorities, upon request, to assist the state or political subdivision thereof to conduct work related to functions of the Service, and to committees of Congress, or to nonprofit educational research or other institutions engaged in health activities for special studies of scientific problems and for the dissemination of information relating to public health.
42 U.S.C. § 233: Defense of Certain Malpractice and Negligence Suits, Smallpox Compensation	Section 224 of the PHS Act provides that remedies under the Federal Tort Claims Act are the exclusive remedy for malpractice and negligence claims against Commissioned Corps officers and employees of the Public Health Service for performance of their official duties. Section 304 of the Department of Homeland Security Act amended section 224 of the Public Health Service Act to provide an exclusive remedy under the Federal Tort Claims Act for injury or death attributable to smallpox countermeasures, meaning those substances that the Secretary specifies in a declaration that are used to prevent or treat smallpox (including the smallpox vaccine) or that are used to control or treat the adverse effects of vaccinia inoculation or another covered countermeasure.
42 U.S.C. § 241: Research and Development	Under section 301 of the PHS Act, the Secretary is authorized to conduct and support research, investigations, experiments, demonstrations, and studies relating to the causes, diagnosis, treatment, control, and prevention of physical and mental diseases and impairments of man, including water purification, sewage treatment, and pollution of lakes and streams. These authorities are further carried out under Title IV of the PHS Act.

Statute and Topic	Public Health Service Act - Topic Summary
42 U.S.C. § 243: Quarantine Enforcement and Temporary Assistance to States	Under section 311(a) of the PHS Act, the Secretary is authorized to accept from state and local authorities any assistance in the enforcement of quarantine federal regulations, to assist states and their political subdivisions in the prevention and suppression of communicable diseases, to cooperate with and aid state and local authorities in the enforcement of their quarantine and other health regulations, and to advise the states on matters relating to the preservation and improvement of the public health. Section 311(c) of the PHS Act allows the Secretary to cooperate with public and private entities to control epidemics and meet other health emergencies and problems, and render temporary assistance to states and localities to meet health emergencies.
42 U.S.C. § 247d: Declaration of a Public Health Emergency	The Secretary may declare a public health emergency under section 319(a) of the PHS Act and take appropriate actions in response to that emergency. Prior to a declaration, the Secretary must determine, after consultation with such public health officials as may be necessary, that (1) a disease or disorder presents a public health emergency; or (2) a public health emergency, including significant outbreaks of infectious disease or bioterrorist attacks, otherwise exists. The Secretary may then take action appropriate to respond to the public health emergency, including making grants, providing awards for expenses, and entering into contracts and conducting and supporting investigations into the cause, treatment, or prevention of the disease or disorder that presents the emergency, and may use resources from the Public Health Emergency Fund. Funds may be appropriated as necessary to the emergency fund, and supplement, rather than supplant, other federal, state, and local public funds provided for such activities. These funds generally remain available until expended.

Statute and Topic	Public Health Service Act - Topic Summary
42 U.S.C. § 247d-6b: Strategic National Stockpile	Section 319F-2(a) of the PHS Act authorizes the Secretary, in collaboration with the Assistant Secretary for Preparedness and Response (Assistant Secretary) and the Director of the Centers for Disease Control and Prevention, and 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 (including personal protective equipment, ancillary medical supplies, and other applicable supplies required for the administration of drugs, vaccines and other biological products, medical devices, and diagnostic tests in the stockpile) in such numbers, types, and amounts as are determined consistent with authorities of the Assistant Secretary by the Secretary to be appropriate and practicable, taking into account other available sources, to provide for and optimize the emergency health security of the United States, including the emergency health security of children and other vulnerable populations, in the event of a bioterrorist attack or other public health emergency and, as informed by existing recommendations of, or consultations with, the Public Health Emergency Medical Countermeasures Enterprise, make necessary additions or modifications to the contents of such stockpile or stockpiles based on an annual threat-based review.

Statute and Topic	Public Health Service Act - Topic Summary
42 U.S.C. § 247d-6b: Project BioShield's Special Reserve Fund	The Project BioShield Act of 2004 (Public Law 108-276, 2004) amended the PHS Act to provide additional and more flexible authorities and funding to financially support the development and procurement of medical countermeasures (MCMs) against chemical, biological, radiological, and nuclear (CBRN) threats. Under sections 319F-1 and 319F-2 of the PHS Act, the Secretary of Health and Human Services (the Secretary) is authorized (1) to conduct and support research and development activities regarding qualified countermeasures (a drug, biological product, or device to treat, identify, or prevent harm from any biological, chemical, radiological, or nuclear agent that may cause a public health emergency affecting national security), including by entering into interagency agreements for research and development; and (2) to provide that bio-contaminant laboratories and specialized research facilities under such agreements shall be available to the Secretary to respond to public health emergencies affecting national security. Allows the Secretary to expedite procurement to respond to pressing research and development needs by (1) using simplified procurement procedures for products and services that cost more than the simplified acquisition threshold; (2) allowing other than full and open competition in certain instances; (3) increasing the micro-purchase threshold to allow the Secretary to use those procedures; and (4) limiting review of the Secretary's procurement decisions. Allows the Secretary to employ other procedures to respond to pressing qualified countermeasure research and development needs, including expediting peer review procedures in certain instances, contracting with experts or consultants, and appointing professional and technical employees to positions at the National Institutes of Health.

Statute and Topic	Public Health Service Act - Topic Summary
42 U.S.C. § 247d-6d, § 247d-6e: Public Readiness and Emergency Preparedness Act	The Public Readiness and Emergency Preparedness Act of 2005 (PREP Act) (Public Law 109-148, 2005, Division C, § 2), PHS Act § 319F-3 and § 319F-4, authorizes the Secretary to issue a declaration to provide immunity from liability for certain claims that are causally related to development, distribution, administration, or use of "covered countermeasures" and authorizes an emergency fund in the U.S. Department of the Treasury for compensation for injuries from covered countermeasures. The PREP Act is different from, and not dependent on, other emergency declarations. The PREP Act established a program to provide compensation for serious countermeasure injuries. This program, the Countermeasures Injury Compensation Program provides compensation for covered serious injuries or deaths that occur as the result of the administration or use of certain countermeasures. Compensation may include unreimbursed medical expenses (e.g., expenses that health insurance did not cover), lost employment income, and the survivor death benefit. Covered countermeasures are identified by the HHS Secretary in declarations published under the PREP Act, 42 U.S.C. § 247d-6d, § 247d-6e: Public Readiness and Emergency Preparedness Act.
42 U.S.C. § 247d-6(e): Accelerated Research and Development on Priority Pathogens and Countermeasures	Section 319F(e) of the PHS Act permits the Secretary to give priority funding to research and studies related to countermeasures to pathogens of potential use in a bioterrorist attack and other agents that may cause a public health emergency. In addition, the Secretary may designate medical products for counterterrorism for priority review under 42 U.S.C. § 247d-6(e). In addition, the Secretary may designate medical products for counterterrorism for priority review under the Federal Food, Drug, and Cosmetic Act, 21 U.S.C. § 356, § 356-1, § 360e(d)(5). The term "priority countermeasure" means a drug, biological product, device, vaccine, antiviral, or diagnostic test that the Secretary determines to be a priority (1) to treat, identify, or prevent infection by a biological agent or toxin listed as a select agent under section 351A of the PHS Act or harm from any other agent that may cause a public health emergency; or (2) to diagnose conditions that may result in adverse health consequences or death and may be caused by the administering of a drug, biological product, device, vaccine, antiviral, or diagnostic test that is a priority under item 1. Section 304 of the Department of Homeland Security Act directs the Secretary, HHS to coordinate with the Department of Homeland Security in research and development activities related to countermeasures for emerging agents of terrorism and in developing specific benchmarks and outcome measurements for evaluating progress toward achieving research goals.

Statute and Topic	Public Health Service Act - Topic Summary
42 U.S.C. § 247d-7b: Emergency System for Advance Registration of Volunteer Health Professionals	Section 319I of the PHS Act authorizes the Secretary to establish and maintain a system for advance registration of health professionals to verify credentials, licenses, accreditations, and hospital privileges when such professionals volunteer to provide services during public health emergencies. This verification system may be carried out directly, or through a grant, contract, or cooperative agreement. In establishing the system, Secretary is directed to provide for an electronic database, and to establish provisions for promptness and efficiency of the system in collecting, storing, updating, and disseminating information on the credentials, licenses, accreditations, and hospital privileges of the volunteers. The Secretary may award grants and provide technical assistance to states and other public or nonprofit private entities for activities relating to the verification system and may encourage each state to provide legal authority during a public health emergency for health professionals authorized in another state to provide such services in the state. However, the Secretary is not authorized under this section to issue requirements regarding provision by states of credentials, licenses, accreditations, or hospital privileges.
42 U.S.C. § 247d-7c: Supplies and Services in lieu of Award Funds	Under section 319J of the PHS Act, the Secretary may provide supplies, equipment, and services and detail HHS officers or employees to recipients of awards made under sections 319 through 319I and 319K of the PHS Act, which deal with, among other things, action in response to public health emergencies; capacity building of state and local public health systems to detect and respond to public health threats; assessment of state and local public health needs; grants to improve state, tribal, and local public health agencies; improving capabilities of the CDC; antimicrobial resistance; education of personnel; grants to address shortages of personnel; credentialing of health professionals; and priority countermeasures.
42 U.S.C. § 248: Control and Management of Hospitals	Section 321 of the PHS Act enables the Surgeon General to operate Public Health Service hospitals, including management of the hospitals and treatment of patients, transfer patients between hospitals, dispose of articles produced by patients in the course of treatment, dispose of money and effects of deceased patients, and, to the extent the Secretary determines that other public or private funds are not available, pay expenses of preparing and transporting remains of, or payment of reasonable burial expenses for, any patient dying in a public health service hospital or station. Implementing regulations may be found at 42 C.F.R. Part 35.

Statute and Topic	Public Health Service Act - Topic Summary
42 U.S.C. § 249: Care and Treatment for Persons Under Quarantine	Sections 322(a) and (c) of the PHS Act provide for care and treatment by the Public Health Service for persons under quarantine, or care and treatment at the expense of the Public Health Service from public or private medical or hospital facilities when authorized by the officer in charge of the quarantine station. Section 322(b) also provides for temporary treatment and care of individuals at Public Health Service hospitals and stations in the event of an emergency. Implementing regulations are provided at 42 C.F.R. 32.111.
42 U.S.C. § 262: Regulation of Biological Products	Section 351 of the PHS Act states that no person may introduce or deliver for introduction into interstate commerce any biological product unless it is licensed and plainly marked with the name of the product, identity of the manufacturer, and expiration date. The Secretary is authorized to establish, by regulation, requirements for approval, suspension, and revocation of licenses. See 21 C.F.R. Part 601. Such licenses are approved based on a demonstration that the biological product is safe, pure, and potent; a demonstration that the facility in which the product is manufactured, processed, packed, or held meets applicable standards to assure the continued safety, purity and potency of the biological product; and consent by the manufacturer to FDA inspection. The FDA may conduct inspections of facilities that manufacture and prepare biological products during all reasonable hours. Upon a determination that a batch, lot, or other quantity of a product licensed under the section presents an imminent or substantial hazard to the public health, the Secretary shall issue an order immediately ordering the recall of such batch, lot, or other quantity of such product. As used in section 351 of the PHS Act, “biological product” means a virus, therapeutic serum, toxin, antitoxin, vaccine, blood, blood component or derivative, allergenic product, or analogous product, or arsphenamine or derivative arsphenamine (or any other trivalent organic arsenic compound) applicable to the prevention, treatment, or cure of a disease or condition of human beings.

Statute and Topic	Public Health Service Act - Topic Summary
42 U.S.C. § 264: Regulations to Control Communicable Diseases	Under section 361 of the PHS Act, the Secretary may quarantine individuals (1) arriving into the United States; (2) moving from one state or possession into another; or (3) that are a probable source of infection to other individuals moving between states. Section 361 authorizes the "apprehension, detention, or conditional release" of individuals to prevent the spread of communicable diseases that are specified in executive orders of the President that are based on a recommendation of the Secretary in consultation with the Secretary. The current list of quarantinable communicable diseases is contained in Executive Order 13295 (April 4, 2003) as amended by Executive Order 13375 (April 1, 2005), Executive Order 13674 (July 31, 2014), and Executive Order 14047 (Sept. 17, 2021). This list includes cholera, diphtheria, infectious tuberculosis, measles, plague, smallpox, yellow fever, viral hemorrhagic fevers (Lassa, Marburg, Ebola, Crimean-Congo, and others not yet isolated or named), severe acute respiratory syndromes, and influenza caused by novel or reemergent influenza viruses that are causing, or have the potential to cause, a pandemic. COVID-19 is quarantinable because it falls under the definition of severe acute respiratory syndromes. Implementing regulations at 42 C.F.R. Part71 permit HHS to detain, isolate, put into isolation, or place under surveillance any arriving person reasonably believed to be infected with or exposed to the diseases listed under the most recent executive order. Implementing regulations at 42 C.F.R. Part 70 also allows HHS to take such measures as are necessary to prevent the interstate spread of diseases whenever the measures taken by a state or local health authority are inadequate. See, also, FDA regulations at 21 C.F.R. Part 1240. Customs and Coast Guard officers are authorized to aid in the enforcement of federal quarantine rules and regulations, 42 U.S.C. § 268, and the Secretary may request assistance from Customs, Coast Guard, and military officers in the execution of state quarantine actions. 42 U.S.C. § 97.

Statute and Topic	Public Health Service Act - Topic Summary
42 U.S.C. § 265: Prohibition of Entries and Imports to Prevent Spread of Communicable Diseases	Under section 362 of the PHS Act, whenever the Secretary determines that by reason of the existence of any communicable disease in a foreign country there is a serious danger of the introduction of such disease into the United States, and that this danger is so increased by the introduction of persons or property from such country that a suspension of the right to introduce such persons and property is required in the interest of the public health, the Secretary, in accordance with regulations approved by the President, can prohibit, in whole or in part, the introduction of persons and property from such countries or places as he or she shall designate in order to avert such danger, and for such period of time as he or she may deem necessary for such purpose. Separate regulations specifically implementing this section have not been promulgated. Under Executive Order 13295, the functions of the President under section 362 of the PHS Act have been assigned to the Secretary.
42 U.S.C. § 266: War-Time Quarantine	Under section 363 of the PHS Act, to protect the military and naval forces and war workers of the United States in time of war against any communicable disease specified in executive orders and provided in section 361(b) of the PHS Act, the Secretary, in consultation with the Surgeon General, is authorized to provide by regulations for the apprehension and examination, in time of war, of any individual reasonably believed (1) to be infected with such disease and (2) to be a probable source of infection to members of the armed forces of the United States or to individuals engaged in the production or transportation of arms, munitions, ships, food, clothing, or other supplies for the armed forces. Such regulations may provide that if upon examination any such individual is found to be so infected, he or she may be detained for such time and such manner as may be reasonably necessary.
42 U.S.C. § 267(a): Quarantine Stations	Under section 364(a) of the PHS Act, the Secretary shall control, direct, and manage all United States quarantine stations, grounds, and anchorages, designate their boundaries, and designate the quarantine officers to be in charge thereof, except as provided in 50 U.S.C. §§ 191, 192, 194, and 195 (which establish Presidential and Transportation authorities to govern anchorage and movement of any vessel in the territorial waters of the United States in response to actual or threatened war, insurrection, invasion or disturbance of international relations or mass migration). Section 364(a) of the PHS Act further states that, with approval of the President, the Secretary shall from time to time select suitable sites for and establish such additional stations, grounds, and anchorages in the states and possessions of the United States as in his judgment are necessary to prevent the introduction of a communicable disease into the states and possessions of the United States. 42 U.S.C. § 267(a). Under Executive Order 13295, the functions of the President under section 364(a) of the PHS Act have been assigned to the Secretary.

Statute and Topic	Public Health Service Act - Topic Summary
42 U.S.C. § 290aa: Substance Abuse and Mental Health Services Administration	Under section 501(o) of the PHS Act, the Secretary may make awards to public entities to address emergency substance abuse or mental health needs. Under implementing regulations, 42 C.F.R. 51d, an emergency must be the direct consequence of a clear precipitating event that has a sudden, rapid onset and a definite conclusion, such as a natural disaster, technological disaster or criminal act that results in significant death, injury, exposure to life-threatening circumstances, hardship, suffering, loss of property, or loss of community infrastructure.
42 U.S.C. § 300aa-10: National Vaccine Injury Compensation Program	Section 2110 of the PHS Act establishes the National Vaccine Injury Compensation Program, administered by the Secretary, under which compensation may be paid for a vaccine-related injury or death from covered vaccines. Sections 2111-23 of the PHS Act address the process for filing claims under the program with the U.S. Court of Federal Claims, eligibility for filing such claims, limits on civil actions brought regarding such claims, jurisdiction, and compensation. Section 2114 of the PHS Act and regulations at 42 C.F.R. Part 100, provide the Vaccine Injury Table, which lists vaccines and describes, including required timing of onset, injuries, disabilities, illnesses and conditions and deaths which may be presumed to be caused by those vaccines for purposes of receiving compensation under the program. Only vaccines that are recommended by the CDC for routine administration to children and/or pregnant women are eligible for compensation.
42 U.S.C. § 300ff-131 et seq.: Notification of Possible Exposure to Infectious Diseases	The HHS Secretary is authorized to establish and facilitate a notification process for emergency response employees who may have been exposed to certain potentially life-threatening infectious diseases while attending, treating, assisting, or transporting people during emergencies. The Secretary is authorized to develop a list of potentially life-threatening infectious diseases to which emergency response employees may be exposed, as well as guidelines describing circumstances in which emergency response employees may be exposed to listed diseases in emergencies and the way exposure determinations should be made by medical facilities that receive and treat those affected by the emergency. The HHS Secretary is authorized to investigate alleged violations and pursue civil injunctions, as appropriate. Additionally, the HHS Secretary is authorized to accept a state's certification that the law of that state is substantially consistent with the reporting and notification requirements.
42 U.S.C. § 300hh: Public Health and Medical Preparedness and Response Functions	Under section 2801 of the PHS Act, the HHS Secretary leads all federal public health and medical response to public health emergencies and incidents covered by the National Response Framework.

2. Social Security Act

When the President declares a major disaster or an emergency under the Stafford Act or an emergency under the National Emergencies Act, and the HHS Secretary declares a public health emergency, the Secretary is authorized to take certain actions in addition to his regular authorities under section 1135 of the Social Security Act. He or she may waive or modify certain Medicare, Medicaid, Children's Health Insurance Program, and Health Insurance Portability and Accountability Act requirements as necessary to ensure to the maximum extent feasible that, in an emergency area during an emergency period, sufficient health care items and services are available to meet the needs of individuals enrolled in Social Security Act (SSA) programs and that providers of such servs in good faith who are unable to comply with certain statutory requirements are reimbursed and exempted from sanctions for noncompliance other than fraud or abuse.

3. Federal Food, Drug, and Cosmetic (FD&C) Act

The Food and Drug Administration (FDA) is responsible for protecting the public health by ensuring the safety, efficacy and security of human and veterinary drugs, biological products,[83] and medical devices; ensuring the safety of animal food, cosmetics, and products that emit radiation; and ensuring the safety and security of the nation's human food supply.[84] The FDA is also responsible for advancing the public health by facilitating rapid medical product innovations and by helping the public get the accurate, science-based information they need to use medical products and foods to improve their health.

Topic and Statute	Federal Food, Drug, and Comestic Act - Topic Summary
21 U.S.C. § 331: Prohibited Acts	Section 331 specifies a number of prohibited acts, including introducing into interstate commerce any food, drug, device, tobacco product, or cosmetic that is adulterated or misbranded.
21 U.S.C. § 334: Detention and Seizure of FDA-Regulated Products	FDA may, by administrative order, detain drugs, medical devices, or food (which includes live food animals), if it makes certain findings. FDA may seize adulterated articles of food, drugs, or medical devices under certain circumstances.
21 U.S.C. § 342: Adulterated Food	Food is adulterated if, inter alia, it bears or contains any added poisonous or deleterious substance that may render it injurious to health; is unfit for food; or has been prepared, packed or held under insanitary conditions whereby it may have been rendered injurious to health.

[83] Veterinary biological products, including animal vaccines, produced and distributed in full conformance with the Virus-Serum-Toxin Act (21 U.S.C. 151-158) and its implementing regulations, are regulated by the USDA Center for Veterinary Biologics.

[84] FDA also regulates the manufacturing, marketing, and distribution of tobacco products to protect health.

Topic and Statute	Federal Food, Drug, and Comestic Act - Topic Summary
21 U.S.C. § 350c, § 372, § 374: Inspections and Investigations	FDA is authorized to inspect any establishment or vehicle where foods or medical products are manufactured, processed, packed or held, for introduction into interstate commerce or after such introduction, and this inspection extends to records located at such establishments (with certain exceptions) (21 U.S.C. § 374(a)(1)). FDA is authorized to inspect and copy certain records of persons (with certain exceptions) who manufacture, process, pack, distribute, receive, hold, or import an article of food if either of the above standards are met (21 U.S.C. § 350c). FDA is also authorized to collect samples (21 U.S.C. § 372).
21 U.S.C. § 351: Adulterated Drugs and Devices	Drugs and devices are deemed to be adulterated if, among other things, they include any filthy, putrid, or decomposed substance; they are prepared, packed or held under insanitary conditions; they are not manufactured, processed, packed, or held in conformance with current good manufacturing practice; or their strength differs from, or their purity and quality falls below, that which it purports to possess.
21 U.S.C. § 352: Misbranded Drugs and Devices	Drugs and devices are deemed to be misbranded if their labeling is false or misleading or fails to contain information required by this section. Section 352 includes other factors that can cause a drug or device to be deemed misbranded, such as being manufactured, prepared, propagated, compounded, or processed in an unregistered establishment.
21 U.S.C. § 355(i): Investigational Drugs	Authorizes “expanded access” of certain drugs, biologics, and medical devices in accordance with an investigational new drug (IND) or investigational device exemption (IDE) application for patients with a serious or immediately life-threatening disease or condition for treatment outside of clinical trials when no comparable or satisfactory alternative therapy options are available.

Topic and Statute	Federal Food, Drug, and Comestic Act - Topic Summary
21 U.S.C. § 356j: Discontinuance or interruption in the production of medical devices	Section 506J of the FD&C Act provides the FDA with new authorities intended to help prevent or mitigate medical device shortages "during, or in advance of, a public health emergency declared by the Secretary under section 319 of the Public Health Service (PHS) Act. Under section 506J(a), manufacturers of certain devices are required to notify FDA "of a permanent discontinuance in the manufacture of the device" or "an interruption in the manufacture of the device that is likely to lead to a meaningful disruption in supply of that device in the United States" during or in advance of a declared PHE. Section 506J(a) also requires manufacturers to inform FDA of "the reasons for such discontinuance or interruption." Section 2514(c) of the FY 2023 Omnibus directed FDA to issue or revise guidance regarding requirements under section 506J and include a list of each device product code for which a manufacturer of such device is required to notify the Secretary in accordance with section 506J. Additionally, section 2514 of the FY 2023 Omnibus amended section 506J to add section 506J(h), "Additional Notifications" and directed FDA to issue guidance "to facilitate voluntary notifications."
21 U.S.C. § 360n-2: Ensuring cybersecurity of devices	Section 524B of the FD&C Act requires that certain information be included in the premarket submission for a subset of medical devices defined as “cyber devices” to demonstrate reasonable assurance that such devices and related systems are cybersecure. 524B entered into force on March 29, 2023, requiring that all cyber device submissions submitted after that date comply with its provisions.
21 U.S.C. § 360bbb-3: Emergency Use Authorization	Permits FDA to authorize the emergency use of an unapproved medical product or an unapproved use of an approved medical product for certain emergency circumstances after the HHS Secretary has made a declaration of emergency or threat justifying authorization of emergency use. FDA may issue an emergency use authorization to allow a medical countermeasure to be used in an emergency to diagnose, treat, or prevent serious or life-threatening diseases or conditions when no adequate, approved, and available alternatives exist. The HHS declaration to support such use must be based on one of four types of determinations of threats or potential threats by the Secretary of HHS, the Secretary of Homeland Security, or the Secretary of Defense.

Topic and Statute	Federal Food, Drug, and Comestic Act - Topic Summary
21 U.S.C. § 360bbb-3a: Emergency Use of Medical Countermeasures	Permits FDA to extend the expiration date of an eligible FDA-approved medical countermeasure stockpiled for use in an emergency and to establish appropriate conditions relating to such extensions, such as appropriate storage, sampling, and labeling. Permits FDA to waive otherwise-applicable current good manufacturing practice (CGMP) requirements (e.g., storage or handling) to accommodate emergency response needs. Allows emergency dispensing of medical countermeasures during an emergency incident without requiring an individual prescription for each recipient of the medical countermeasure or all of the information otherwise required or by responders who may not otherwise be licensed to dispense, if permitted by state law in the state where such dispensing occurs or if in accordance with an order issued by FDA.
21 U.S.C. § 360bbb-3b: Pre-Positioning of Medical Countermeasures	Permits government stakeholders to pre-position (e.g., stockpile, forward-deploy) medical countermeasures in anticipation of FDA approval or clearance, authorization of an investigational use, or the issuance of an emergency use authorization, to enable these stakeholders to prepare for potential rapid deployment during an actual emergency.
21 U.S.C. § 381, 21 U.S.C. § 382: Imports and Exports	Imports of medical products, food, or cosmetics that appear to be adulterated, or appear to violate the FD&C Act in other ways, are subject to refusal of admission into the United States (21 U.S.C. § 381(a)(3)). In addition, certain unapproved products are authorized to be exported from the U.S. if certain circumstances are met.

4. References

References are designated as in the *HHS RROP*. A letter after the year of a reference distinguishes it from other references of the same author and year in the *HHS RROP*.

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Annex D: Organization and assignment of Responsibilities/Tasks

1. Introduction

This annex is a list of operational-level tasks organized by associated lines of effort (LOEs), functional areas (FAs), and objectives, in the framework summarized in *Tables* *3-1*, *3-2*, and *3-3* (association of HHS divisions' primary and supportive roles in functional areas by lines of effort), *Table 3-4* (association of objectives with the functional areas by lines of effort; recovery cross-cutting priorities; and sources of the functional areas and priorities), and *Table 4-1* (summary table of the primary and supportive roles in Tables 3-1 to 3-3), under the LOEs:

- Public Health and Safety
- Medical Care and Patient Movement
- Fatality Management
- Human Services and Social Services
- Medical Countermeasures
- Public Health Supply Chain
- Communications and Information Management
- Operational Coordination

In Table D-1 below, HHS divisions may have tactical tasks that result in primary or supporting roles designated at the LOE, FA, or objective levels, but not captured in designation of primary or supporting roles indicated for the (operational level) tasks here.

2. Table D-1.

Overview of HHS division primary and supporting responsibilities with associated objectives and operational-level tasks for the functional areas associated with the lines of effort and for the recovery cross-cutting priorities. This table includes primary and supporting responsibilities at the functional area level tabulated also in *Table 4-1*.

Abbreviations: FA: functional area; Obj: objective

Key: P: primary responsibility; S: supporting responsibility; ·(dot): contingent responsibility

Functional area types: Rs: response core functional area; Rc: recovery core mission area; Xc: cross-cutting functional area

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D-1-A. Line of effort: Public Health and Safety

D-1-A-1. Functional areas: (1) assessment of public health/medical needs (Rs); (2) public health: potable water/wastewater, solid waste disposal (Rs) and vector control (Rs); (3) public health and environmental health (Rc)

Functional area (FA), objective (Obj), or task	ASPR	OASH	CMS	CDC	ATSDR	FDA	NIH	OGA	IEA	ASPA	SAMHSA	ACF	ACL	HRSA	IHS	OCR	ASFR	ASPE	AHRQ	ASA
FA: Assessment of public health/medical needs	P	S	S	P	S	S	S	S			S	S	S	S	S					
FA: Public health: potable water/wastewater, solid waste disposal; vector control	S			P	S	S	S								S					
FA: Public health and environmental health	P	S		P	P	P	S				S			S	S					
Obj 1: Assess public health and medical needs, health care systems, facilities, and human services and social services infrastructure.	P		S	P	S	S	S				S	P	S	S	S					
Obj 1, task 1: Support public health assessments and disease control (e.g., emergency environmental health services, disease surveillance, prevention, and control).	S			P		S														
Obj 1, task 2: Coordinate with STT partners to rapidly identify public health and medical needs.	P			P		S					P			S						
Obj 1, task 3: Assess public health, medical needs, and health care systems.	P		S	P										S	P					
Obj 1, task 4: Assess health care, human services, and social services facilities and infrastructure.	P		S	S								P		S	P					
Obj 1, task 5: Arrange, conduct, and/ or support research to develop and test disease prevention and control, health promotion programs, and interventions to reduce morbidity and mortality.	S			P			P													
Obj 1, task 6: Assess incident-related structural, functional, operational impacts to health care facilities.[85]	P		S	S							S			S	P					
Obj 1, task 7: Implement strategies to assess and monitor public health, disease surveillance, and injury prevention of the affected community to identify and mitigate health problems.	S			P																
Obj 1, task 8: Provide public health guidance during domestic or international incidents, including serving on interagency or interdepartmental advisory teams, as appropriate.				P	S	S														
Obj 1, task 9: Utilize available data and modeling to conduct risk assessments, impact projection, and identification of at-risk populations at earliest indication of a potential public health emergency; update periodically.	S			P			S													
Obj 1, task 10: Assess incident-caused impacts to health care systems and health care facilities to determine immediate needs supportable by the U.S. government.	P		S								S			S	P					
Obj 1, task 11: Provide technical expertise in issues related to assessing health and medical needs of shelter occupants.	P			S																
Obj 1, task 12: Provide personnel for liaisons and to support assessment of PH and medical needs.	P	S	S	S		S									S					
Obj 1, task 13: Assess impact of incident on human services providers and disaster human services.												P	S							
Obj 1, task 14: Provide case management when requested by FEMA, including for shelter occupants.												P								

[85] e.g., hospitals, clinics, nursing homes, assisted living centers, blood banks, dialysis centers, substance abuse treatment facilities, poison control centers, medical and dental offices

Functional area (FA), objective (Obj), or task	ASPR	OASH	CMS	CDC	ATSDR	FDA	NIH	OGA	IEA	ASPA	SAMHSA	ACF	ACL	HRSA	IHS	OCR	ASFR	ASPE	AHRQ	ASA
Obj 2: Coordinate provision of environmental public health support.	S			P	S		S													
Obj 2, task 1: Support assessment, stabilization, and restoration of potable water availability and wastewater systems.	S			P			S								S					
Obj 2, task 2: Assess & provide technical consultation and support associated w vector-borne diseases.	S			P											S					
Obj 2, task 3: Assess presence, distribution, and transmission characteristics of vector-borne diseases and support vector control activities as needed.	S			P											S					
Obj 2, task 4: Support surveillance of the environment in an affected community to determine if post-disaster conditions may cause adverse public health effects.	S			P	S															
Obj 2, task 5: Provide technical assistance (e.g., scientific data, models) and env health trainings.	S			P	S															
Obj 2, task 6: Provide support on public health issues related to solid waste debris disposal and mgmt.	S			P	S										S					
Obj 2, task 7: Support biological and environmental sampling, data collection, and assessment of potential environmental contamination associated with the incident.				P			S													
Obj 2, task 8: Provide environmental health and engineering services to tribes; support design, construction, and maintenance of health care and water/sewer infrastructure, facilities, and equipment per negotiated contracts.															P					
Obj 2, task 9: Provide technical assistance for shelter operations related to food, vectors, water supply, and waste disposal.				P																
Obj 3: Provide support for mass-care services.	P			S	S		S													
Obj 3, task 1: Monitor PH conditions that can affect health of shelter occupants, including workers.	S			P	S		S													
Obj 3, task 2: Coordinate w core capability service providers to ensure ESF #6 service delivery locations are appropriately provisioned and operate in a safe, sanitary, secure, and timely manner.	P																			
Obj 3, task 3: Facilitate and coordinate provision for public health support to sheltering operations.	S			P																
Obj 3, task 4: Provide technical assistance and support implementing a health surveillance system to detect, respond to, and mitigate health threats to shelter occupants.	S			P																
Obj 4: Provide support for meeting cross-cutting priorities that apply to response and recovery mission areas and functional areas covered by this plan.	P	S	S	S							S	S	S	S	S	S			S	
Obj 4, task 1: Facilitate and provide focused consideration for (a) needs of children, youth, and families; (b) integration of older adults and other individuals with access and functional needs; and (c) focus on rural and under-resourced communities.	P	S	S	S	S	S	S				S	P	S	S	S	P			S	
Obj 4, task 2: Support and provide focused consideration for resilience to potential or likely future extreme weather incidents as appropriate.	P	P		S	S		S				S	S	S	S	S				S	

D1-A-2. Functional area: health surveillance (Rs)

Functional area (FA), objective (Obj), or task	ASPR	OASH	CMS	CDC	ATSDR	FDA	NIH	OGA	IEA	ASPA	SAMHSA	ACF	ACL	HRSA	IHS	OCR	ASFR	ASPE	AHRQ	ASA
FA: Health surveillance	S			P				S						S	S					
Obj 1: Conduct health surveillance of populations.				P																
Obj 1, task 1: Use or expand public health surveillance systems and networks-to monitor impacts on health of the population and responders and to identify disease and injury trends.				P																
Obj 1, task 2: Identify and investigate disease outbreaks and other health conditions.				P																
Obj 1, task 3: Support establishment or restoration of public health surveillance systems for communicable and non-communicable diseases.				P																
Obj 1, task 4: Conduct short- and long-term PH surveillance for monitoring, detection, and control of health issues with potential to impact health and well-being of the affected population(s).				P																
Obj 1, task 5: Provide guidance for and support public health screenings at points of entry.				P																
Obj 1, task 6: Coordinate activities supporting identification of potential threats to the public that require immediate containment and mitigation actions (e.g., quarantining or isolation[86]).	S			P																
Obj 1, task 7: Use public health surveillance techniques (including data collection) to monitor the public health needs of the affected population(s).	S			P																

D-1-A-3. Functional areas: (1) behavioral health care (Rs); (2) behavioral health (Rc)

Functional area (FA), objective (Obj), or task	ASPR	OASH	CMS	CDC	ATSDR	FDA	NIH	OGA	IEA	ASPA	SAMHSA	ACF	ACL	HRSA	IHS	OCR	ASFR	ASPE	AHRQ	ASA
FA: Behavioral health care	S	S	S	S			S				P	S			S					
FA: Behavioral health	P		S	S			S				P	S		S	S					
Obj 1: Conduct needs assessment related to mental health and substance use.	S										P									
Obj 1, task 1: Engage with community behavioral health partners to assess mental health and substance abuse needs, provide technical assistance, identify best practices,[87] connect them with resources.	S										P									
Obj 1, task 2: Support behavioral health assessments.	S		S	S							P									
Obj 1, task 3: Engage with federal and national behavioral health partners-to assess needs, address gaps, provide technical assistance, and share information and resources.	S		S	S							P									

[86] To reduce spread of communicable diseases.

[87] Including for prevention

Functional area (FA), objective (Obj), or task	ASPR	OASH	CMS	CDC	ATSDR	FDA	NIH	OGA	IEA	ASPA	SAMHSA	ACF	ACL	HRSA	IHS	OCR	ASFR	ASPE	AHRQ	ASA
Obj 1, task 4: Evaluate impacts of incident response requirements on health of federal response staff and, when requested, provide such assistance to STT.	P			S							P									
Obj 1, task 5: Direct, provide, or align resources for deployment-related health assessment, workers' compensation documentation, mental health and crisis counseling, and family support services, when requested by STT.	P			S							P									
Obj 1, task 6: Evaluate the need for and, as appropriate, grant and track waivers to opioid treatment centers.	S		S								P									
Obj 2: Coordinate and provide resources for behavioral health services.	P			S							P				S					
Obj 2, task 1: Promote strategies to mitigate adverse physical and behavioral health impacts.	S			S							P									
Obj 2, task 2: Support behavioral health programs and preparedness, and coordinate intervention- and response to behavioral health needs among American Indians and Alaskan Natives.	S		S	S							P			S	P					
Obj 2, task 3: Administer Crisis Counseling Assistance and Training Program grants in coordination with FEMA.											P									
Obj 2, task 4: Administer Supplemental SAMHSA Emergency Response Grants in situations in which they are appropriate.	S										P				S					
Obj 2, task 5: Coordinate provision of behavioral health services for impacted populations, including in and outside shelter locations in support of mass-care services.	P		S								P			S	S					
Obj 2, task 6: Support behavioral health programs and preparedness, and coordinate intervention and response to suicide clusters in Indian Country.	S										S				P					
Obj 3: Provide support for meeting cross-cutting priorities that apply to response and recovery mission areas and functional areas covered by this plan.	P	S	S	S							S	S	S	S	S	S			S	
Obj 3, task 1: Facilitate and provide focused consideration for (a) needs of children, youth, and families; (b) integration of older adults and other individuals with access and functional needs; and (c) focus on rural and under-resourced communities.	P	S	S	S	S		S				S	P	S	S	S	P			S	
Obj 3, task 2: Support and provide focused consideration for resilience to potential or likely future extreme weather incidents as appropriate.	P	P		S	S		S				S	S	S	S	S				S	

D-1-A-4. Functional area: Food safety and defense (Rs)

Functional area (FA), objective (Obj), or task	ASPR	OASH	CMS	CDC	ATSDR	FDA	NIH	OGA	IEA	ASPA	SAMHSA	ACF	ACL	HRSA	IHS	OCR	ASFR	ASPE	AHRQ	ASA
FA: Food safety and defense	S			S		P	S								S					
Obj 1: Support USDA (ESF #11 coordinator) providing for safety, security, and wholesomeness of federally regulated foods	S			S		P														
Obj 1, task 1: Provide guidelines and technical consultation to partners, including USDA, to facilitate disposal of food and food sources (meat, poultry, egg products) deemed unfit for human consumption.				S		P														
Obj 1, task 2: Provide support for assessment of impacted community's(ies') food supply networks to ensure food safety.	S			S		P									S					
Obj 1, task 3: Provide guidance on steps to restore human foods to a condition fit for use.						P														
Obj 2: Coordinate and support assessments of the capability of food manufacturing, food processing, food distribution, food service, and food retail to provide safe food.				S		P	S													
Obj 2, task 1: Provide technical assistance to establishments providing FDA-regulated human food to protect public health.				S		P														
Obj 2, task 2: Assist STT and local agencies, as appropriate, inspecting incident- impacted retail food establishments.				S		P														
Obj 2, task 3: Provide STT and local agencies technical assistance or subject matter expertise related to food safety and defense.				S		P														
Obj 2, task 4: Make available relevant sequence data through the National Library of Medicine's biomedical information services to aid in public health response for pathogen detection to support surveillance of and response to foodborne illnesses.							S													
Obj. 3: Maintain or restore safety, efficacy, and availability of FDA-regulated products to protect public health.						P		S												
Obj 3, task 1: Collaborate with EPA and USDA to ensure proper disposal of contaminated food or animal feed associated with the incident.						P														
Obj 3, task 2: Provide effective[88] public health risk communication messages and advisories with relevant information on health hazards or other situations that could threaten public health.				S		P														
Obj 3, task 3: Provide technical assistance to establishments providing FDA-regulated biologics, devices, drugs, and animal feed to protect public health.						P														
Obj 3, task 4: Inspect or investigate FDA-regulated facilities and collect and analyze samples of FDA-regulated products as needed.						P														
Obj 3, task 5: Facilitate notification of potential health threats to foreign countries or respond to potential health threats from foreign countries as appropriate and required by IHR.	S			S		S		P												

[88] Communicated in a culturally and linguistically appropriate and accessible manner.

Functional area (FA), objective (Obj), or task	ASPR	OASH	CMS	CDC	ATSDR	FDA	NIH	OGA	IEA	ASPA	SAMHSA	ACF	ACL	HRSA	IHS	OCR	ASFR	ASPE	AHRQ	ASA
Obj 4: Deter acts (intentional or not) affecting FDA-regulated products to protect consumers from potential public health hazards and threats.						P														
Obj 4, task 1: Conduct incident-related inspections, investigations, sample collections, and laboratory analyses to support STT and local agencies (e.g., inspections of retail food establishments).						P														
Obj 4, task 2: Disseminate vital information, emergency messages, and other communication information rapidly to the FDA.gov website.						P														
Obj 4, task 3: Trace and intercept imported and domestic products suspected of contamination.						P														
Obj 4, task 4: Facilitate and coordinate recall of food products that could cause serious health problems or death, a temporary health problem, or a slight threat of a serious nature.						P														
Obj 4, task 5: Employ import controls to prevent unsafe products from entering the United States.						P		S												

D-1-A-5. Functional area: Agriculture safety and security (Rs)

Functional area (FA), objective (Obj), or task	ASPR	OASH	CMS	CDC	ATSDR	FDA	NIH	OGA	IEA	ASPA	SAMHSA	ACF	ACL	HRSA	IHS	OCR	ASFR	ASPE	AHRQ	ASA
FA: Agriculture safety and security	S			S		P									S					
Obj 1: Support USDA (ESF #11 coordinator) with ensuring the health, safety, and security of livestock and food-producing animals and animal feed and drugs.				S		P														
Obj 1, task 1: Coordinate with USDA to support protection, safety, and wholesomeness of food and food sources through constant monitoring, early detection, and assessment of potential threats.				S		P														
Obj 1, task 2: Assess impacted communities' food supply networks to identify the status of and actions required to ensure food safety				S		P									S					
Obj 2: Support USDA (ESF #11 coordinator) with ensuring the safety of the manufacture and distribution of foods, drugs, and therapeutics for animals used for human food production.				S		P														
Obj 2, task 1: Provide technical advice and assistance for assessing potentially affected animal drugs, devices, or feed products.						P														
Obj 2, task 2: Provide guidance on use of drugs as potential medical countermeasures in animals.						P														
Obj 2, task 3: Provide for safety of animal feed and safety and effectiveness of animal drugs & devices.						P														
Obj 2, task 4: Provide guidance on steps to restore animal drugs and/or animal foods to be fit for use.						P														

Functional area (FA), objective (Obj), or task	ASPR	OASH	CMS	CDC	ATSDR	FDA	NIH	OGA	IEA	ASPA	SAMHSA	ACF	ACL	HRSA	IHS	OCR	ASFR	ASPE	AHRQ	ASA
Obj 3: Support USDA and its authority to manage a foreign animal disease response.						P														
Obj 3, task 1: Conduct incident-related inspections, sample collections, and laboratory analyses to support STT and local agencies.						P														
Obj 4: Support federal response involving animals to zoonotic diseases, to protect human health.				S		P														
Obj 4, task 1: Provide technical advice and assistance associated with zoonotic diseases, as required.				S		P														
Obj 4, task 2: Coordinate with ESF #11 to support zoonotic disease management issues and activities.				S		P														

D-1-A-6. Functional area: Environmental response/health and safety (Xc)

Functional area (FA), objective (Obj), or task	ASPR	OASH	CMS	CDC	ATSDR	FDA	NIH	OGA	IEA	ASPA	SAMHSA	ACF	ACL	HRSA	IHS	OCR	ASFR	ASPE	AHRQ	ASA
FA: Environmental response/health and safety	P	S	S	P	P	S	S				S	S		S	S					
Obj 1: Coordinate and provide support for the health and safety of populations and communities, including response and recovery personnel.	S			P	P	S	S			S			S							
Obj 1, task 1: Support provision of public health information and guidance to safeguard the health and safety of affected populations and communities, including response personnel.	S			P	S	S	S			S			S							
Obj 1, task 2: Provide guidance to FSTT and local authorities as appropriate, to ensure safety and health of affected populations and communities, including response and recovery workers.	S			P	P	S	S													
Obj 1, task 3: Develop recommended occupational safety and health standards.				P	P		S													
Obj 1, task 4: Coordinate with DOL/OSHA on responder safety guidance, as appropriate.	S			P																
Obj 2: Conduct long-term monitoring of responders.	S			P	P		S													
Obj 2, task 1: Conduct long-term monitoring, detection, and control of health issues with potential to impact health and well-being of emergency responders and disaster workers.				P	P															
Obj 2, task 2: Determine which groups of responders should be included in a health care or disease registry program to monitor long-term physical and behavioral health.	S			P	P															
Obj 2, task 3: When needed, establish and implement long-term tracking of responder health, with appropriate duration and content.	S			P	P															
Obj 2, task 4: Provide assistance on matters related to assessment of health hazards associated with response and protection of response workers and public health.				P	P		S													
Obj 2, task 5: Determine whether illnesses, diseases, or complaints may be attributable to exposure to hazardous materials.				P	P															

Functional area (FA), objective (Obj), or task	ASPR	OASH	CMS	CDC	ATSDR	FDA	NIH	OGA	IEA	ASPA	SAMHSA	ACF	ACL	HRSA	IHS	OCR	ASFR	ASPE	AHRQ	ASA
Obj 2, task 6: Establish disease/exposure registries and conduct appropriate clinical testing.				P	P															
Obj 2, task 7: Develop, maintain, and provide information on the health effects of toxic substances.				P	P															

D-1-A-7. Functional area: Public health and medical consultation, technical assistance, and support (Rs)

Functional area (FA), objective (Obj), or task	ASPR	OASH	CMS	CDC	ATSDR	FDA	NIH	OGA	IEA	ASPA	SAMHSA	ACF	ACL	HRSA	IHS	OCR	ASFR	ASPE	AHRQ	ASA
FA: Public health and medical consultation, technical assistance, and support	P	S	S	P	S	P	P	S	S	-	P	P	S	S	S	S	-	-	-	-
Obj 1: Coordinate provision of consultation, technical assistance, and support to STT as needed.	P	-	S	S	-	P	P	-	S	-	P	-	S	S	S	S	-	-	-	-
Obj 1, task 1: Provide technical assistance for site-specific hazard awareness-related to response and recovery.	P	-	-	P	-	-	S	-	-	-	-	-	-	-	S	-	-	-	-	-
Obj 1, task 2: Provide technical assistance and consultation as needed and requested to STT authorities for response and recovery.	P		S	S		S	S				P	P	S	S	S	S	-	-	-	-
Obj 1, task 3: Facilitate and maintain functionality of HRSA programs that improve health through access to quality services, a skilled workforce, and innovative programs.	S													P						

D-1-B. Line of effort: Medical Care and Patient Movement

D-1-B-1. Functional area: Patient care (Rs)

Functional area (FA), objective (Obj), or task	ASPR	OASH	CMS	CDC	ATSDR	FDA	NIH	OGA	IEA	ASPA	SAMHSA	ACF	ACL	HRSA	IHS	OCR	ASFR	ASPE	AHRQ	ASA
FA: Patient care	P	S	S	S							S				S					
Obj 1: Provide and support medical and trauma care capabilities.[89]	P	S		S							S				S					
Obj 1, task 1: Provide clinical, trauma care, and other medical services as required.	P	S									S				S					
Obj 1, task 2: Provide and coordinate support in response to STT requests for temporary reassignment of federally funded staff and other resources to PHE response activities as allowed by law.	P	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S

[89] Including for those in influxes of unaccompanied children.

Functional area (FA), objective (Obj), or task	ASPR	OASH	CMS	CDC	ATSDR	FDA	NIH	OGA	IEA	ASPA	SAMHSA	ACF	ACL	HRSA	IHS	OCR	ASFR	ASPE	AHRQ	ASA
Obj 1, task 3: Provide life-saving and life-sustaining medical and trauma care services as necessary and appropriate.	P	S													S					
Obj 1, task 4: Provide clinical, trauma, and preventive medical services to federally recognized American Indian and Alaskan Native tribes per negotiated contracts.															P					
Obj 1, task 5: Activate & deploy emergency mgmt, medical, & public health staff, & other personnel as needed, along with medical systems, command and control, & logistics resources.	P	S		S											S					
Obj 1, task 6: Provide personnel to support medical field operations.	P	S													S					
Obj 1, task 7: Coordinate with STT authorities to integrate federal ESF #8 resources with out-of-jurisdiction resources that are provided through EMAC.	P			S											P					
Obj 1, task 8: Provide public health expertise and assistance to STT and local health depts, health care facilities, and federal agencies on health care and patient safety topics, such as (a) infection prevention and control guidance and (b) monitoring for health care-associated infections.				P																
Obj 2: Act upon STT requests for public health emergency declarations and 1135 waivers.	P		P											S						
Obj 2, task 1: Coordinate public health emergency declarations for the Secretary of HHS.	P													S						
Obj 2, task 2: Facilitate availability and use of waiver options and systems to expand flexibilities for response and recovery activities when a public health emergency is declared.			P											S						
Obj 3: Provide support for mass-care services.[90]	P	S													S					
Obj 3, task 1: Provide medical support as needed to survivors sheltering in place in congregate facilities and medical shelters.	P	S													S					
Obj 3, task 2: Provide personnel for liaisons and support for medical field operations.	P	S													S					
Obj 3, task 3: Provide medical care for impacted populations either in or outside shelter locations in support of mass-care services.	P	S													S					
Obj 3, task 4: Coordinate emergency medical care in shelters, as needed.	P														S					
Obj 3, task 5: Coordinate with ESF #1 and ESF #5 for relocation of individuals with acute medical needs that cannot be met within the impacted area, to where their needs can be met.	P																			
Obj 3, task 6: Coordinate with ESF #6 to identify patients who have been evacuated to hospitals in host jurisdictions to determine the types of mass care support services required.	P																			

[90] Including for that in response to influxes of unaccompanied children.

D-1-B-2. Functional area: Medical surge (Rs)

Functional area (FA), objective (Obj), or task	ASPR	OASH	CMS	CDC	ATSDR	FDA	NIH	OGA	IEA	ASPA	SAMHSA	ACF	ACL	HRSA	IHS	OCR	ASFR	ASPE	AHRQ	ASA
FA: Medical surge	P	S	S	S							S				S					
Obj 1: Coordinate federal medical surge to support STT requirements.	P	S									S				S					
Obj 1, task 1: Provide medical resources and capabilities to support search and rescue operations.	P	S																		
Obj 1, task 2: Provide clinical, trauma care, and preventive medical services to federally recognized American Indian and Alaskan Native tribes per negotiated contracts.	P	S													P					
Obj 1, task 3: Provide medical and trauma care services to support STT authorities during incidents where needs exceed the capacities of existing medical infrastructure.	P										S									

D-1-B-3. Functional area: Patient movement (Rs)

Functional area (FA), objective (Obj), or task	ASPR	OASH	CMS	CDC	ATSDR	FDA	NIH	OGA	IEA	ASPA	SAMHSA	ACF	ACL	HRSA	IHS	OCR	ASFR	ASPE	AHRQ	ASA
FA: Patient movement	P	S	S	S							S	S	S		S					
Obj 1: Facilitate transport of critically or seriously ill or injured patients and populations with access or functional needs to designated facilities.	P	S		S			S				S	S	S		S					
Obj 1, task 1: Coordinate and provide pre-hospital triage and initial stabilization, patient tracking, patient staging, en-route treatment, and distribution to receiving health care facilities.	P	S									S		S		S					
Obj 1, task 2: Coordinate with ESF #6 and support meeting health and social services needs of evacuated patients.	P											S	S		S					
Obj 1, task 3: Coordinate transportation support with DOW and other federal agencies.	P																			
Obj 1, task 4: Request activation of the National Medical Transport and Support Services Contract,[91] as appropriate.	P																			
Obj 1, task 5: Activate the patient movement components of the NDMS and enablers as appropriate.	P																			
Obj 1, task 6: Coordinate with STT public health and emergency management agencies to support STT patient movement.	P																			
Obj 1, task 7: Convene the ESF #8 Patient Movement Coordination Cell to determine which Federal Coordinating Centers will be activated.	P																			
Obj 1, task 8: Provide guidance for the movement of infectious patients as appropriate.	S			P			S													

[91] Often referred to as the National Ambulance Contract.

Functional area (FA), objective (Obj), or task	ASPR	OASH	CMS	CDC	ATSDR	FDA	NIH	OGA	IEA	ASPA	SAMHSA	ACF	ACL	HRSA	IHS	OCR	ASFR	ASPE	AHRQ	ASA
Obj 2: Coordinate safe return (re-entry) of patients and non-medical attendants evacuated by NDMS to their homes of record, in collaboration with STT public health agencies.	P																			
Obj 2, task 1: Coordinate the return of individuals evacuated by NDMS	P																			
Obj 2, task 2: Coordinate with STT authorities to support meeting health and social services needs and, reintegration of individuals evacuated by NDMS.	P																			
Obj 2, task 3: Provide information to ESF #6 on the location of patients evacuated to host jurisdictions to facilitate family reunification.	P																			

D-1-B-4. Functional area: Veterinary medical support (Rs)

Functional area (FA), objective (Obj), or task	ASPR	OASH	CMS	CDC	ATSDR	FDA	NIH	OGA	IEA	ASPA	SAMHSA	ACF	ACL	HRSA	IHS	OCR	ASFR	ASPE	AHRQ	ASA
FA: Veterinary medical support	P			S		S	S								S					
Obj 1: Provide veterinary medical support to treat ill or injured animals, service animals, pets, working animals, emotional-support animals, laboratory animals, and livestock post-incident.	P	S		S			S													
Obj 1, task 1: Coordinate with appropriate interagency stakeholders to provide effective federal veterinary medical assistance.	P	S		S																
Obj 1, task 2: Provide technical and veterinary assistance to USDA (ESF #11 coordinator) for the care of research animals.	P			S			S													
Obj 1, task 3: Screen working animals (canine and equine) to determine day-to-day fitness for duty and identify possible performance-limiting health conditions.	P																			
Obj 1, task 4: Provide preventive care to working animals (canine and equine).	P																			
Obj 1, task 5: Provide working animals[92] veterinary medical services and provide recommendations to FSTT teams deployed during a response, event, or incident to maintain readiness.	P																			
Obj 1, task 6: Support pain management and euthanasia for working animals, as needed.	P																			
Obj 1, task 7: Treat ill and injured small animals (companion and service).	P																			
Obj 1, task 8: Mitigate infectious disease transmission and injury among small animals[93] in sheltering facilities; prevent exposure of zoonotic disease to evacuees, responders, & the environment.	P			S																

[92] canine and equine

[93] companion and service

Functional area (FA), objective (Obj), or task	ASPR	OASH	CMS	CDC	ATSDR	FDA	NIH	OGA	IEA	ASPA	SAMHSA	ACF	ACL	HRSA	IHS	OCR	ASFR	ASPE	AHRQ	ASA
Obj 1, task 9: Provide preventive care,[94] health history review, and health screening for small animals (companion, service) and animals of eligible repatriates returning to the U.S from abroad.	P			S																
Obj 1, task 10: Provide veterinary, public and herd health services to livestock, herd, zoological, and other large animals during a disaster incident or public health emergency.	P																			
Obj 1, task 11: Assist USDA with examination, testing, and treatment of livestock/large animals to facilitate identification and management of a herd and/or foreign animal disease outbreak that affects livestock, poultry, or wildlife.	P																			
Obj 1, task 12: Provide large-animal preventive care (e.g., rabies vaccinations) & health history review.	P																			
Obj 1, task 13: Provide large-animal subject-matter expertise & med support to U.S. zoological parks.	P			S																
Obj 1, task 14: Conduct/support veterinary public health, medical, and health care system needs assessment for STT, local, and private-sector authorities to determine initial priority requirements.	P			S																
Obj 1, task 15: Provide recommendations for follow-up ESF #8 NVRT staffing, equipment, and other logistical support requirements as appropriate.	P																			
Obj 1, task 16: Work with ASPR regional emergency coordinators (RECs) to determine alternative methods of assistance for veterinary support as appropriate (e.g., local contracts).	P																			
Obj 1, task 17: Observe, investigate, and report increased incidence(s) of illness, disease, or injuries among sheltered animals, including indication of zoonotic disease or other PH threat.	P			S																
Obj 1, task 18: Provide recommendations for mitigation of Illness, disease, or injury in animals.	P																			
Obj 1, task 19: Collect, handle, and process diagnostic samples for domestic and foreign animal disease outbreaks according to STT and federal guidelines.	P			S																
Obj 1, task 20: Inform animal cleaning procedures from CBRN or explosive hazards; make recommen-dations to on-scene responders (working animal handlers) to prevent human exposure.	P			S																
Obj 1, task 21: Highlight and report animal welfare concerns	P																			
Obj 1, task 22: Provide qualified veterinary medical personnel for incidents requiring veterinary medical services or public health support for household pets and service animals.	P																			
Obj 1, task 23: Provide emergency and incident-related veterinary medical care services to impacted animal populations.	P																			
Obj 1, task 24: Provide veterinary public health, zoonotic disease control, environmental health, and related services.	P			S																

[94] i.e., rabies/other vaccinations, deworming

Functional area (FA), objective (Obj), or task	ASPR	OASH	CMS	CDC	ATSDR	FDA	NIH	OGA	IEA	ASPA	SAMHSA	ACF	ACL	HRSA	IHS	OCR	ASFR	ASPE	AHRQ	ASA
Obj 1, task 25: Provide personnel for liaisons and support for veterinary support.	P	S				S														
Obj 1, task 26: Collaborate with USDA and the US Department of the Interior to deliver an effective "one health" response that integrates human, animal, and environmental health.	P			S																
Obj 1, task 27: Coordinate with ESF #11 to ensure that animal/veterinary health issues (including both disease management and medical management) are supported.	P																			
Obj 2: Provide veterinary support for mass-care services.	P																			
Obj 2, task 1: Provide veterinary support to pets and livestock sheltering operations.	P																			

D-1-B-5. Functional area: Health care systems (Rc)

Functional area (FA), objective (Obj), or task	ASPR	OASH	CMS	CDC	ATSDR	FDA	NIH	OGA	IEA	ASPA	SAMHSA	ACF	ACL	HRSA	IHS	OCR	ASFR	ASPE	AHRQ	ASA
FA: Health care systems	P	S	S	S							S	S	S	S	S					
Obj 1: Assess and monitor incident-related community health care systems needs and prioritize and coordinate provision of services and resources to meet those needs.	P	S	S	S							S		S	S	S					
Obj 1, task 1: Assess and monitor community health needs and capabilities and capacities in the affected area to determine where enhancement is needed for all major service categories.[95]	P	S	S								S	S	S	S	S					
Obj 1, task 2: Facilitate continued health care services to individuals in areas impacted by the incident.	P	S	S								S	S	S	S	S					
Obj 1, task 3: Provide technical assistance regarding applicability of fed program flexibilities, waivers	P	S	S								S	S	S	S	S					
Obj 1, task 4: Develop a comprehensive recovery plan, with priorities and a schedule for addressing community health capabilities and capacities to meet needs.	P	S									S	S	S	S	S					
Obj 1, task 5: Provide technical expertise in issues related to the assessment of health and medical needs, health care systems, facilities, and infrastructure.	P	S	S	S							S		S	S	S					
Obj 1, task 6: Provide support for assessed goals for the health care system, including maintaining or restoring workforce, health care services for relocated persons, responding to incident-related health concerns, promoting continuity of care, and addressing issues with insurance and health care access.	P	S	S	S							S		S	S	S					
Obj 1, task 7: Provide technical assistance in assessing health care needs of incident-impacted persons and applicability of flexibilities and waivers to enhance the capacity to meet the needs.	P		S	S										S	S					

[95] In the following sectors: pre-hospital, hospital (including emergency department), non-hospital (e.g., clinical, pharmacy), home care, long-term care, assisted living care, mental health care, substance abuse care, blood banks, chronic care (e.g., dialysis centers), poison-control centers, medical and dental offices.

Functional area (FA), objective (Obj), or task	ASPR	OASH	CMS	CDC	ATSDR	FDA	NIH	OGA	IEA	ASPA	SAMHSA	ACF	ACL	HRSA	IHS	OCR	ASFR	ASPE	AHRQ	ASA
Obj 1, task 8: Monitor and coordinate tribal support and response to local, regional, national, and global health concerns and emerging issues.	S			S										S	P					
Obj 1, task 9: Provide health care awareness, information, and support to tribes during disaster incidents and public health emergencies in accordance with IHS policy and procedures.	S			S											P					
Obj 2: Provide support for meeting cross-cutting priorities that apply to response and recovery mission areas and functional areas covered by this plan.	P	S	S	S							S	S	S	S	S	S			S	
Obj 2, task 1: Facilitate and provide focused consideration for (a) needs of children, youth, and families; (b) integration of older adults and other individuals with access and functional needs; and (c) focus on rural and under-resourced communities.	P	S	S	S	S		S				S	P	S	S	S	P			S	
Obj 2, task 2: Support and provide focused consideration for resilience to potential or likely future extreme weather incidents as appropriate.	P	P		S	S		S				S	S	S	S	S				S	

D-1-C. Line of effort: Fatality Management

D-1-C-1. Functional area: Fatality management (Rs)

Functional area (FA), objective (Obj), or task	ASPR	OASH	CMS	CDC	ATSDR	FDA	NIH	OGA	IEA	ASPA	SAMHSA	ACF	ACL	HRSA	IHS	OCR	ASFR	ASPE	AHRQ	ASA
FA: Fatality management	P														S					
Obj 1: Coordinate and provide fatality management services.	P																			
Obj 1, task 1: Support identification of human remains using scientific means (e.g., dental, pathology, anthropology, fingerprints, and, as indicated, DNA samples).	P																			
Obj 1, task 2: Provide technical assistance and consultation on fatality mgmt and mortuary services.	P																			
Obj 1, task 3: Coordinate fatality management resource transportation support with federal departments and agencies if commercial contract carriers are not available.	P																			
Obj 1, task 4: Deploy HHS personnel appropriate to the response requirements, including regional emergency coordinators, subject-matter experts, or mortuary resources.	P																			
Obj 1, task 5: Coordinate with national associations of funeral directors, coroners, and medical examiners to advocate for and facilitate support from these organizations to provide personnel surge capabilities and capacity as appropriate.	P																			
Obj 1, task 6: Deploy, employ, and maintain shared situational awareness on DMORT, Disaster Portable Morgue Units, and other mortuary assistance teams.	P																			

Functional area (FA), objective (Obj), or task	ASPR	OASH	CMS	CDC	ATSDR	FDA	NIH	OGA	IEA	ASPA	SAMHSA	ACF	ACL	HRSA	IHS	OCR	ASFR	ASPE	AHRQ	ASA
Obj 1, task 7: Coordinate with STT and local agencies as appropriate to determine changes in fatality management capabilities, capacities, requirements, and anticipated shortfalls.	P																			
Obj 1, task 8: Provide technical guidance regarding methods to reduce the hazard presented by chemically, biologically, or radiologically contaminated human remains (when indicated).	P			S																

D-1-D. Line of effort: Human Services and Social Services

D-1-D-1. Functional area: Human services (Rs, Rc)

Functional area (FA), objective (Obj), or task	ASPR	OASH	CMS	CDC	ATSDR	FDA	NIH	OGA	IEA	ASPA	SAMHSA	ACF	ACL	HRSA	IHS	OCR	ASFR	ASPE	AHRQ	ASA
FA: Human services	P	S	S	S							P	P	P	S	S	S			S	
Obj 1: Coordinate and support human services and social services in response and recovery.	P	S									S	P	S	S	S	S				
Obj 1, task 1: Assess incident-related structural, functional, and operational impacts to social services facilities[96] and programs.[97]	P											P	S		S	S				
Obj 1, task 2: Assess incident-related impacts to at-risk individuals.[98]	P	S									S	P	S		S					
Obj 1, task 3: Assess incident-related impacts to human services infrastructure to determine immediate needs that can be met by the U.S. government.	P											P	S							
Obj 1, task 4: Identify incident-related social services needs that cannot be met with available community resources.	P										S	P	S							
Obj 1, task 5: Facilitate continued provision of disaster human services support for ESF #6.	P										S	P	S							
Obj 1, task 6: Coordinate with STT partners to rapidly identify human services needs.	P										S	P	S							
Obj 1, task 7: Provide assistance to address non-housing needs of individuals and families.	P										S	P	S							
Obj 1, task 8: Provide technical assistance (subject-matter expertise, consultation) to STT and area agencies that administer emergency human services programs.	S											P	S							
Obj 1, task 9: Ensure STT ESF #6 partners are engaged in recovery.	P											P	S		S					

[96] e.g., community congregate care, child care provider facilities, Head Start centers, day service centers, senior centers, homeless shelters

[97] e.g., domestic violence services, child support enforcement, home- and community-based services, foster care, accessible transportation, family support programs

[98] children, older adults, pregnant women, individuals experiencing homelessness, people living with disabilities and others who may have additional access and functional needs, people with pre-existing mental disorders and substance abuse disorders, people with limited English proficiency and other groups with limited or no access to resources

Functional area (FA), objective (Obj), or task	ASPR	OASH	CMS	CDC	ATSDR	FDA	NIH	OGA	IEA	ASPA	SAMHSA	ACF	ACL	HRSA	IHS	OCR	ASFR	ASPE	AHRQ	ASA
Obj 1, task 10: Coordinate with ESF #6 partners for disaster human services planning to promote seamless transition to HHS-led HEHS RSF under the NDRF.	P										S	P	S							
Obj 1, task 11: Coordinate with ESF #6 for the purpose of reunifying family members with missing persons/human remains.	P											P								
Obj 1, task 12: Coordinate with ESF #6 to assess the need to implement EPAP in the impacted area.	P											S	S							
Obj 1, task 13: Coordinate and provide for emergency grants in support of populations of older adults and persons with intellectual and developmental disabilities.				S									P							
Obj 2: Assess incident-related community social services needs and prioritize addressing those needs, including accessibility requirements.	P	S									S	P	S	S	S					
Obj 2, task 1: Conduct and support assessments and monitoring of social services needs in areas impacted by the incident, in cooperation with relevant FSTT and, as appropriate, local partners, including specific assessments of programs and services for at-risk individuals.[99]	P	S									S	P	S	S	S					
Obj 2, task 2: Conduct and support assessments and monitoring of incident impacts on STT and, as appropriate, local social services delivery systems.[100], [101]	P	S									S	P	P	S	S					
Obj 2, task 3: Facilitate the continued provision of social services[102] to individuals in areas impacted by the incident.	P	S									S	P	P	S	S					
Obj 2, task 4: Provide technical assistance regarding applicability of federal programs' flexibilities and waivers.	P	S									S	P	P	S	S					
Obj 2, task 5: Develop a comprehensive recovery plan, with priorities and a schedule for addressing community social services capabilities and capacities to meet needs.	P	S									S	P	P	S	S					
Obj 3: Coordinate and support referral to social services or disaster case management.	S										S	P	S							
Obj 3, task 1: Implement system(s) for referral of individuals and families with unmet incident-related needs to appropriate social services to mitigate social disruption and foster self-sufficiency.	S										S	P	S							

[99] children, older adults, pregnant women, individuals experiencing homelessness, people living with disabilities and others who may have additional access and functional needs, people with pre-existing mental disorders, people with limited English proficiency, other groups with limited or no access to resources

[100] Includes community congregate care, child care provider facilities, Head Start centers, senior centers, homeless shelters; and programs such as domestic violence services, child support enforcement, foster care, family support programs.

[101] ASPR is listed as primary here in coordination. For implementation of assessments, ACF and ACL are primary.

[102] Includes child welfare, self-sufficiency, vocational rehabilitation, and assistance to older adults and persons with access and functional needs.

Functional area (FA), objective (Obj), or task	ASPR	OASH	CMS	CDC	ATSDR	FDA	NIH	OGA	IEA	ASPA	SAMHSA	ACF	ACL	HRSA	IHS	OCR	ASFR	ASPE	AHRQ	ASA
Obj 3, task 2: Facilitate federally supported disaster case management, through the FEMA DCM State Grant, ACF-led Immediate Disaster Case Management Program, or by other mechanisms.[103]	S										S	P								
Obj 3, task 3: Fulfill the requirements of the Disaster Case Management Program to assist survivors with developing and carrying out a disaster recovery plan.	S										S	P								
Obj 4: Provide support for children, youth, and families in disasters.[104]	P											P								
Obj 4, task 1: Facilitate expeditious reunification of children and families displaced due to the incident.	S											P			S					
Obj 4, task 2: Support continuation or reestablishment of systems, programs, and services that serve the needs of children, youth, and families.	P											P			S					
Obj 5: Provide support for meeting cross-cutting priorities that apply to response and recovery mission areas and functional areas covered by this plan.	P	S	S	S							S	S	S	S	S	S			S	
Obj 5, task 1: Facilitate and provide focused consideration for (a) needs of children, youth, and families; (b) integration of older adults and other individuals with access and functional needs; and (c) focus on rural and under-resourced communities.	P	S	S	S	S		S				S	P	S	S	S	P			S	
Obj 5, task 2: Support and provide focused consideration for resilience to potential or likely future extreme weather incidents as appropriate.	P	P		S	S		S				S	S	S	S	S				S	

D-1-D-2. Functional area: Education (Rc)

Functional area (FA), objective (Obj), or task	ASPR	OASH	CMS	CDC	ATSDR	FDA	NIH	OGA	IEA	ASPA	SAMHSA	ACF	ACL	HRSA	IHS	OCR	ASFR	ASPE	AHRQ	ASA
FA: Education	P			S							S	P	S	S	S					
Obj 1: Facilitate continuation and, as needed, restoration of education services to promote social and emotional well-being in communities.	P										S	P	S	S	S					
Obj 1, task 1: Support continuation and, as needed, restoration of the learning environment for students and staff, including daycare services in impacted communities.	P			S							S	P	S	S	S					
Obj 1, task 2: Facilitate provision of social services offered in schools and other educational and daycare facilities, including support for child health and nutrition.	P											P	S		S					

[103] As described in the FEMA DCM Program Guidance.

[104] Including those in influxes of unaccompanied children.

Functional area (FA), objective (Obj), or task	ASPR	OASH	CMS	CDC	ATSDR	FDA	NIH	OGA	IEA	ASPA	SAMHSA	ACF	ACL	HRSA	IHS	OCR	ASFR	ASPE	AHRQ	ASA
Obj 1, task 3: Coordinate provision of federal support for educational services and health and social services to students who are displaced due to the incident or public health emergency.	P											P	S		S					
Obj 1, task 4: Coordinate provision of technical assistance to daycare facilities, schools, and higher education institutions in impacted communities, as appropriate.	P			S							S	P	S		S					
Obj 1, task 5: For incidents with increased likelihood of extreme weather incidents, support mitigation and resilience interventions for future hazards to educational and daycare facilities.	P	S									S	P	S		S					
Obj 2: Provide support for meeting cross-cutting priorities that apply to response and recovery mission areas and functional areas covered by this plan.	P	S	S	S							S	S	S	S	S	S			S	
Obj 2, task 1: Facilitate and provide focused consideration for (a) needs of children, youth, and families; (b) integration of older adults and other individuals with access and functional needs; and (c) focus on rural and under-resourced communities.	P	S	S	S	S		S				S	P	S	S	S	P			S	
Obj 2, task 2: Support and provide focused consideration for resilience to potential or likely future extreme weather incidents as appropriate.	P	P		S	S		S				S	S	S	S	S				S	

D-1-E. Line of effort: Medical Countermeasures

D-1-E-1. Functional area: Research and development for medical countermeasures (Xc)

Functional area (FA), objective (Obj), or task	ASPR	OASH	CMS	CDC	ATSDR	FDA	NIH	OGA	IEA	ASPA	SAMHSA	ACF	ACL	HRSA	IHS	OCR	ASFR	ASPE	AHRQ	ASA
FA: Research and development for medical countermeasures	P	S		S	S	P	P	S												
Obj 1: Coordinate and support expedited response-relevant research and development of MCMs.	P	S		S		S	S	S												
Obj 1, task 1: Coordinate research and development of innovative medical countermeasures, including for at-risk populations.	P	S					S													
Obj 1, task 2: Support research and development of innovative medical countermeasures, including for at-risk populations.	P	S		S		S	S	S												

D-1-E-2. Functional area: Safety and security of drugs, biologics, and medical devices (Rs)

Functional area (FA), objective (Obj), or task	ASPR	OASH	CMS	CDC	ATSDR	FDA	NIH	OGA	IEA	ASPA	SAMHSA	ACF	ACL	HRSA	IHS	OCR	ASFR	ASPE	AHRQ	ASA
FA: Safety and security of drugs, biologics, and medical devices[105]	S	S		S		P	S	S							S					
Obj 1: Issue emergency use authorizations needed during public health emergencies.	S			S		P														
Obj 1, task 1: Provide for a declaration of a public health emergency.	P			S		S														
Obj 1, task 2: Determine whether an emergency use authorization is appropriate.	P			S		S														
Obj 1, task 3: Facilitate preparation and submission of application for emergency use authorization.	P			P		P														
Obj 1, task 4: Authorize emergency use of medical countermeasures as appropriate.						P														
Obj 2: Provide guidance for effective use of medical countermeasures.	P			P		P	P													
Obj 2, task 1: Develop and implement strategies, policies, and guidance to support appropriate use of MCMs during the public health emergency, including for at-risk populations.	P	S		S		S	S													
Obj 2, task 2: Develop and coordinate use of talking points for public messaging.	P			P		P	P			S										
Obj 2, task 3: Develop and publish guidance documents for use by public.	P			P		P	P			S										
Obj 2, task 4: Develop, coordinate, and promulgate policies for safety and security of drugs, biologics, and medical devices.	P			P		P	P													
Obj 3: Assess real-world safety and effectiveness of the MCMs as they are used during a public health emergency, and as a biological threat agent evolves (e.g., emergence of variants).	P			P		S	S													
Obj 3, task 1: Implement a tracking system for assessing safety and effectiveness of the MCMs used during response.	P			P		S	S													
Obj 3, task 2: Collect and analyze data regarding safety and effectiveness of the MCMs used during response.	P			P		P	S													
Obj 3, task 3: Implement regulation and guidance based on safety and effectiveness of the MCMs used during response.	P			P		P	S													
Obj 4: Protect the public health by ensuring the availability, safety, efficacy, and security of human and veterinary drugs, biological products,[106] and medical devices.	P			P		P	P													
Obj 4, task 1: Facilitate the safety, efficacy, and security of human and veterinary drugs, biological products,[107] medical devices, nation's food supply, cosmetics, and products that emit radiation.						P														

[105] Includes facilitation of effective use of medical countermeasures.

[106] Veterinary biological products, including animal vaccines, produced and distributed in full conformance with the Virus-Serum-Toxin Act (21 U.S.C. 151-158) and its implementing regulations, are regulated by the USDA Center for Veterinary Biologics.

[107] Veterinary biological products, including animal vaccines, produced and distributed in full conformance with the Virus-Serum-Toxin Act (21 U.S.C. 151-158) and its implementing regulations, are regulated by the USDA Center for Veterinary Biologics.

Functional area (FA), objective (Obj), or task	ASPR	OASH	CMS	CDC	ATSDR	FDA	NIH	OGA	IEA	ASPA	SAMHSA	ACF	ACL	HRSA	IHS	OCR	ASFR	ASPE	AHRQ	ASA
Obj 4, task 2: Ensure safety and security of biological select agents and toxins located at research facilities within the affected area.	S			P		S	S													
Obj 4, task 3: Coordinate the notification to international partners of compromised drugs, biologics, and medical devices via the U.S. IHR National Focal Point.[108]	P			S		S		S												

D-1-E-3. Functional area: Blood and tissues (Rs)

Functional area (FA), objective (Obj), or task	ASPR	OASH	CMS	CDC	ATSDR	FDA	NIH	OGA	IEA	ASPA	SAMHSA	ACF	ACL	HRSA	IHS	OCR	ASFR	ASPE	AHRQ	ASA
FA: Blood and tissues	S	P	S	S		S	S							S	S					
Obj 1: Coordinate and support safety, security, and availability of blood, blood products, and tissue.	S	P	S	S		S								S						
Obj 1, task 1: Conduct surveillance based on blood and tissue safety concerns.		P		S		S														
Obj 1, task 2: Monitor and manage (and establish when appropriate) policies and programs regarding bloodborne pathogens and bloodborne infectious diseases.		P	S	P		S								S						
Obj 1, task 3: Monitor and ensure the safety, availability, and logistical requirements of blood, blood products, and tissue.	S	P				S														
Obj 2: Support effective and appropriately prioritized collection and availability of blood, blood products, and tissues.	S	P				S														
Obj 2, task 1: Identify issues that affect the availability of blood, blood products, and tissue products, and establish mitigation measures as appropriate.	S	P				S														
Obj 2, task 2: Coordinate public information announcements with the AABB[109] regarding adequacy and safety of the nation's blood supply.	S	P				S				S										

[108] See *Glossary* entry for IHR NFP.

[109] Association for the Advancement of Blood & Biotherapeutics

D-1-F. Line of effort: Public Health Supply Chain

D-1-F-1. Functional area: Supply chain data, analytics, and support (Xc)

Functional area (FA), objective (Obj), or task	ASPR	OASH	CMS	CDC	ATSDR	FDA	NIH	OGA	IEA	ASPA	SAMHSA	ACF	ACL	HRSA	IHS	OCR	ASFR	ASPE	AHRQ	ASA
FA: Supply chain data, analytics, and support	P			S		P		S									S	S		
Obj 1: Establish and sustain public health supply chain visibility.	P																			
Obj 1, task 1: Acquire and employ tools, technology, and capabilities to enable improved situational awareness of the public health supply chain.	P																			
Obj 1, task 2: Build and establish end-to-end visibility of the supply chain.	P																			
Obj 1, task 3: Maintain capabilities to monitor and manage the public health supply chain, including vulnerabilities, bottlenecks, and other inefficiencies.	P																			
Obj 1, task 4: Monitor and project need for equipment and supplies.	P																			
Obj 1, task 5: Monitor and project availability of needed equipment and supplies.	P																			
Obj 1, task 6: Monitor and project the supply chain capability and capacity to provide needed equipment and supplies.	P																			
Obj 1, task 7: Engage key partners and stakeholders to foster coordination, collaboration, and data sharing.	P																			
Obj 2: Establish and maintain situational awareness of the public health supply chain.	P																			
Obj 2, task 1: Develop a consolidated and integrated information system and network for increased visibility, data collection, analytics, and information sharing across the entire supply chain.	P																			
Obj 2, task 2: Establish a common operating picture of supplies in the public health supply chain.	P																			
Obj 3: Acquire and maintain capabilities (analytics and modeling) to project, mitigate, and respond to public health supply chain shortages and disruptions.	P																			
Obj 3, task 1: Maintain data analytics, and modeling tools to conduct risk assessments, facilitate forecasting and support mitigation measures.	P																			
Obj 3, task 2: Collect and analyze data pertaining to supply chain issues, including supply availability and demand; and mitigation of shortages.	P																			
Obj 3, task 3: Support prioritization in supply chain management.	P																			

D-1-F-2. Functional area: Market availability, acquisition, and stockpiling or provision of health/ medical/ veterinary equipment and supplies (Rs)

Functional area (FA), objective (Obj), or task	ASPR	OASH	CMS	CDC	ATSDR	FDA	NIH	OGA	IEA	ASPA	SAMHSA	ACF	ACL	HRSA	IHS	OCR	ASFR	ASPE	AHRQ	ASA
FA: Market availability, acquisition, and stockpiling or provision of health/ medical/ veterinary equipment and supplies[110]	P	S				S		S							S					
Obj 1: Coordinate provision of federally managed medical equipment and supplies, including MCMs and ancillary supplies, equipment, and facility elements for providing or administering MCMs.	P																			
Obj 1, task 1: Coordinate rapid and effective allocation, deployment, employment, and release as necessary of SNS resources, including MCMs,[111] medical materiel, and PPE.	P																			
Obj 1, task 2: Coordinate and support deployment, integration, coordination, and sustainment of public health and medical equipment and supplies needed for response and recovery.	P														S					
Obj 2: Provide medical logistics to support continuity of essential public health and medical operations and services.	P																			
Obj 2, task 1: Develop, test, and maintain effective processes and approaches for emergency allocation of medical logistics.	P																			
Obj 2, task 2: Coordinate and support continuity of pharmaceutical and medical supplies[112] and distribution to the health care infrastructure, medically vulnerable populations, and persons with disabilities or others with access and functional needs.	P																			
Obj 2, task 3: Manage the IHS Medical Supply Center to augment routine and emergency distribution of medicines and medical material.															P					
Obj 3: Coordinate the acquisition and stockpiling of public health supplies.	P																			
Obj 3, task 1: Foster and sustain private-public partnerships to enable reliable product availability and product access.	P																			
Obj 3, task 2: Develop and maintain a common operating picture of public health and medical equipment and supplies, and MCM stockpiles.	P																			
Obj 3, task 3: Acquire, stockpile, and make readily available and deployable, MCMs that are necessary to prevent, diagnose, and treat diseases.	P			S																
Obj 3, task 4: Support acquisition of medical countermeasures, including for at-risk populations.	P	S		S		S	S													
Obj 4: Support robustness and resiliency of the public health supply chain.	P																			
Obj 4, task 1: Monitor and manage the public health supply chain.	P																			

[110] Core functional area for response is health/medical/veterinary equipment and supplies.

[111] Includes biologics, pharmaceuticals, blood products, vaccines, and antitoxins.

[112] Includes durable medical equipment, assistive technology and backup power for power-dependent individuals.

Functional area (FA), objective (Obj), or task	ASPR	OASH	CMS	CDC	ATSDR	FDA	NIH	OGA	IEA	ASPA	SAMHSA	ACF	ACL	HRSA	IHS	OCR	ASFR	ASPE	AHRQ	ASA
Obj 4, task 2: Identify and maximize efficiencies in the federal supply chain to support federal, STT, and local partners.	P																			
Obj 4, task 3: Enhance supply chain transparency and coordination with and among STT, local, and private-sector partners on the status of supply chain and stockpile levels.	P																			
Obj 5: Support restoration of disrupted public health supply chains.	P																			
Obj 5, task 1: Coordinate availability of and access to quality medical supplies.	P																			
Obj 5, task 2: Activate and coordinate Emergency Prescription Assistance Program services.	P																			
Obj 5, task 3: Monitor and manage the public health supply chain including vaccines, therapeutics, biologics, diagnostics, and PPE.	P																			
Obj 5, task 4: Foster efficiencies in the federal supply chain, with emphasis on resiliency and scalability of supply and manufacturing capabilities to support FSTT and local partners.	P																			
Obj 6: Foster development of public health supply production capacity to support preparedness and response.	P																			
Obj 6, task 1: As needed, support maintenance of or surge in production capacity of health/ medical/ veterinary equipment and supplies.	P																			
Obj 6, task 2: Foster development of public health supply production capacity and stockpiles to support preparedness and response.	P																			
Obj 6, task 3: Collaborate and coordinate with industry and stakeholder partners to establish capacity and emergency stockpiles of public health supplies including non-pharmaceutical items.	P																			

D-1-F-3. Functional area: Deployment, distribution, & dispensing of health/ medical/ veterinary equipment and supplies (Rs)

Functional area (FA), objective (Obj), or task	ASPR	OASH	CMS	CDC	ATSDR	FDA	NIH	OGA	IEA	ASPA	SAMHSA	ACF	ACL	HRSA	IHS	OCR	ASFR	ASPE	AHRQ	ASA
FA: Deployment, distribution, & dispensing of health/ medical/ veterinary equipment and supplies[113]	P	S		S		S		S						S	S					
Obj 1: Develop an evidence-based approach to assess prioritization of resources and efficiency of resource allocation and provision.	P																			
Obj 1, task 1: Develop and implement tools for data collection and analysis.	P																			
Obj 1, task 2: Conduct data collection and analysis to inform decision-making.	P																			

[113] Core functional area for response is health/medical/veterinary equipment and supplies.

Functional area (FA), objective (Obj), or task	ASPR	OASH	CMS	CDC	ATSDR	FDA	NIH	OGA	IEA	ASPA	SAMHSA	ACF	ACL	HRSA	IHS	OCR	ASFR	ASPE	AHRQ	ASA
Obj 2: Develop credible, prioritized public health supply allocation and distribution mechanisms prior to and during public health emergencies.	P																			
Obj 2, task 1: Facilitate and coordinate the federal prioritization of allocation and distribution of public health supplies.	P																			
Obj 3: Coordinate and support distribution and dispensing of public health supplies.	P	S						S							S					
Obj 3, task 1: Provide medical materiel (including medical and veterinary equipment and supplies) to sustain public health and medical operations.	P																			
Obj 3, task 2: Facilitate the distribution of public health supplies and ensure communities' access.	P							S												
Obj 3, task 3: Support the provision of medical supplies and services, including durable medical equipment.	P	S													S					
Obj 3, task 4: Coordinate provision of medical pharmaceuticals, supplies, and services, including durable medical equipment, through the EPAP.	P	S													S					
Obj 3, task 5: Provide personnel for liaisons and support for medical equipment, supplies, and pharmaceuticals.	P	S						S							S					
Obj 4: Support deployment and delivery of MCMs, nonpharmaceutical interventions, and medical and veterinary equipment and supplies.	P	S		S		S	S	S												
Obj 4, task 1: Provide support for medical countermeasure point-of-distribution operations, including vaccines, diagnostics, therapeutics, and personal protective equipment.	P	S		S																
Obj 4, task 2: Coordinate and facilitate emergency use authorization of medical countermeasures.	P	S		S		S	S													
Obj 4, task 3: Facilitate rapid and easy delivery of vaccines and therapeutics by proactively addressing challenging requirements for transportation and storage.	P	S		S																
Obj 4, task 4: Coordinate and facilitate the distribution of public health supplies and ensure communities' access.	P							S												

D-1-G. Line of effort: Communications and Information Management

D-1-G-1. Functional area: Public information and warning (Xc) (includes public health and medical information [Rs])

Functional area (FA), objective (Obj), or task	ASPR	OASH	CMS	CDC	ATSDR	FDA	NIH	OGA	IEA	ASPA	SAMHSA	ACF	ACL	HRSA	IHS	OCR	ASFR	ASPE	AHRQ	ASA
FA: Public information and warning (includes public health and medical information)	S	S	S	P	S	P	S	S	S	P	P	S	S	S	S		S		S	
Obj 1: Provide public health and medical information to inform public health and medical response and recovery operations.	S	.	.	S	.	S	.	.	.	P	S	.	.	.	.	.	.	.	.	.
Obj 1, task 1: Coordinate public health and medical messaging and risk communication to foster accurate, consistent, timely information for affected individuals and communities making decisions about protecting health.	S	.	.	S	.	S	.	.	.	P	.	.	.	.	.	.	.	.	.	.
Obj 1, task 2: Coordinate communications activities with STT and local public health, medical, and emergency response agency communications staffs, including regional or local communications centers as appropriate	S	.	.	S	.	S	.	.	.	P	.	.	.	.	.	.	.	.	.	.
Obj 1, task 3: Communicate with the public, particularly in affected communities, on real vs perceived public health and medical impacts of the incident.	S	.	.	S	.	S	.	.	.	P	.	.	.	.	.	.	.	.	.	.
Obj 1, task 4: Promptly respond to rumors, inaccurate information, social disruption, stigmatization.	S	.	.	S	.	S	.	.	.	P	.	.	.	.	.	.	.	.	.	.
Obj 1, task 5: Coordinate international information exchange and communication strategies.	S	.	.	S	.	S	.	S	.	P	.	.	.	.	.	.	.	.	.	.
Obj 1, task 6: Communicate relevant public health and medical needs information to survivors including those in facilities where mass care services are provided.	S	.	.	S	.	S	.	.	.	P	.	.	.	.	.	.	.	.	.	.
Obj 1, task 7: Communicate to core capability providers public health and medical requirements of survivors and their household pets and service animals in congregate care facilities.	S	.	.	S	.	S	.	.	.	P	S	.	.	.	.	.	.	.	.	.
Obj 1, task 8: Educate and inform the public, health care professionals, policymakers, partner organizations, and media in a timely, accurate, and coordinated way during response and recovery.	S	.	.	S	.	S	.	.	.	P	S	.	.	.	.	.	.	.	.	.
Obj 2: Deliver actionable, culturally and linguistically appropriate information regarding threats or hazards, actions being taken, available assistance, and guidance for individual action.	S	.	.	S	.	S	.	.	.	P	S	.	.	.	.	.	.	.	.	.
Obj 2, task 1: Provide to the public clear information accessible to persons with disabilities and to those with limited English proficiency, about available assistance and resources.	S	.	.	S	.	S	.	.	.	P	.	.	.	.	.	.	.	.	.	.
Obj 2, task 2: Provide to the public clear information accessible to all, about important actions for residents to take to avoid or mitigate incident-related risk to themselves and others.	S	.	.	S	.	S	.	.	.	P	.	.	.	.	.	.	.	.	.	.
Obj 2, task 3: Conduct outreach with public health and medical leadership and other authorities within the impacted communities, as appropriate.	P	.	.	P	.	P	.	.	.	P	P	.	.	.	.	.	.	.	.	.
Obj 2, task 4: Provide public health and disease prevention information to members of the public and responders who are in or near affected areas.	S	.	.	P	.	P	.	.	.	P	.	.	.	.	.	.	.	.	.	.

Functional area (FA), objective (Obj), or task	ASPR	OASH	CMS	CDC	ATSDR	FDA	NIH	OGA	IEA	ASPA	SAMHSA	ACF	ACL	HRSA	IHS	OCR	ASFR	ASPE	AHRQ	ASA
Obj 2, task 5: Maintain and update HHS web sites.	P	.	.	P	.	P	.	.	.	P	.	.	.	.	.	.	.	.	.	.
Obj 2, task 6: Support a joint information center in the release of general medical and public health response information to the public.	S	.	.	S	.	S	.	.	.	P	S	.	.	.	.	.	.	.	.	.

D-1-H. Line of effort: Operational Coordination

D-1-H-1. Functional area: Situational awareness (Xc)

Functional area (FA), objective (Obj), or task	ASPR	OASH	CMS	CDC	ATSDR	FDA	NIH	OGA	IEA	ASPA	SAMHSA	ACF	ACL	HRSA	IHS	OCR	ASFR	ASPE	AHRQ	ASA
FA: Situational awareness	P	.	.	P	.	P	.	.	.	.	.	P	.	.	.	.	.	.	.	.
Obj 1: Collect, evaluate, and interpret information gathered from a variety of sources to provide a basis for decision-making.	P	S	S	P		P	S								S					
Obj 1, task 1: Collect, analyze, summarize, and display actionable information periodically to show existing and projected impact of the incident on health and life, including, but not necessarily limited to, injuries, illnesses, hospitalizations, and deaths.	P	S		P		P	S													
Obj 1, task 2: Collect, analyze, summarize, and display actionable information periodically to show existing and projected need for and availability status of key health care system elements.	P	S		P		P	S								S					
Obj 1, task 3: Provide STT health care facility data in affected area(s).	S		P												S				S	
Obj 2: Provide information to maintain public health, medical, and human services situational awareness to inform decisions at all levels and across sectors.	P	S	S	P		P					S	P	S							
Obj 2, task 1: Develop and share situational awareness through collaboration and information exchange with interagency partners.	P			P		P					S	P	S		S					
Obj 2, task 2: Develop, maintain, and convey information analysis products[114] containing key actionable information for situational awareness to decision-makers and incident managers.	P	S	S	P		P					S	P	S		S					

[114] Such as senior leadership briefs, executive summaries, and planning tools.

D-1-H-2. Functional area: Situational assessment (Xc)

Functional area (FA), objective (Obj), or task	ASPR	OASH	CMS	CDC	ATSDR	FDA	NIH	OGA	IEA	ASPA	SAMHSA	ACF	ACL	HRSA	IHS	OCR	ASFR	ASPE	AHRQ	ASA
FA: Situational assessment	P		S	P	S	P	S	S			S	P	S	S	S					
Obj 1: Provide decision makers with decision-relevant information regarding the nature and extent of the threat, hazard, or incident, cascading effects, and the status of the response.	P	S	S	P		P	S	S				S			S					
Obj 1, task 1: Identify incident-specific response and recovery EEIs and CIRs.	P	S	S	P		P	S	S				S			S					
Obj 1, task 2: Provide for and support collection and reporting of incident-specific response and recovery EEIs and CIRs.	P	S	S	P		P	S	S				S			S					
Obj 1, task 3: Conduct analysis of incident specific EEIs and CIRs and provide to senior leaders.	P	S	S	P		P	S	S				S			S					
Obj 1, task 4: Monitor social media and public media sources for EEIs and incident information.	P	S	S	P		P	S	S				S			S					
Obj 1, task 5: Establish a common operating picture to reflect situational assessment of identified EEIs and modify as needed.	P	S	S	P		P	S	S				S			S					

D-1-H-3. Functional area: Operational coordination (Xc)

Functional area (FA), objective (Obj), or task	ASPR	OASH	CMS	CDC	ATSDR	FDA	NIH	OGA	IEA	ASPA	SAMHSA	ACF	ACL	HRSA	IHS	OCR	ASFR	ASPE	AHRQ	ASA
FA: Operational coordination	P	S		P	S	S						P			S					
Obj 1: Provide operational structures and processes that support coordinated response and recovery activities.	P			P		P						P								
Obj 1, task 1: Activate the Secretary's Operation Center and other agencies' operations centers as needed and commensurate with the projected impact of an incident.	P			P		P														
Obj 1, task 2: Establish an incident command structure at the earliest opportunity based on the extent and type of emergency resources required.	P			P		P						P								
Obj 1, task 3: Engage in and support HHS coordination activities for incident response and recovery operations as needed.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Obj 1, task 4: Provide professional and technical assistance for response and recovery mission areas and functional areas covered by this plan.	P	P	P	P		P	P	P		P	P	P	P		P	P				P
Obj 1, task 5: Establish and maintain required communications and coordination links with ESF #8-supporting agencies and partners, other federal department and agency representatives, STT, NGO and private sector partners, as appropriate.	P			P		P					S	S	S		S					

Functional area (FA), objective (Obj), or task	ASPR	OASH	CMS	CDC	ATSDR	FDA	NIH	OGA	IEA	ASPA	SAMHSA	ACF	ACL	HRSA	IHS	OCR	ASFR	ASPE	AHRQ	ASA
Obj 1, task 6: Establish and provide for continued communications to and coordination with aging and disability networks.	S												P							
Obj 1, task 7: Coordinate assistance to HRSA-supported health care facilities and providers during disaster incidents and public health emergencies.	S													P						
Obj 2: Provide for deployment of HHS resources to support FSTT authorities, int'l organizations, and, as appropriate, local authorities; assist with international emergency medical responses.	P	S		S		S	S	S				S			S					
Obj 2, task 1: Appoint a federal health official as the HHS representative to the JFO (if any).	P																			
Obj 2, task 2: Coordinate use of HHS resources that support FSTT and international organizations' response and recovery activities.	P	S		S		S	S	S				S			S					
Obj 2, task 3: Deploy HHS resources that support FSTT and international organizations' response and recovery activities.	P	S		S		S	S	S				S			S					
Obj 2, task 4: Coordinate with international partners and the World Health Organization.	S			S		S	S	P			S									
Obj 2, task 5: Provide consultation and assistance to other nations and international agencies to assist in improving country-specific disease prevention and control, environmental health, and other public health activities.	S			P		P	P	P												
Obj 2, task 6: Share critical information with international partners and the World Health Organization and identify or activate mechanisms to coordinate global response activities as needed.	P			P		P	P	P												
Obj 3: Maintain all mission-essential functions of HHS for continuity of operations.	P																			P
Obj 3, task 1: See *Department of Health and Human Services Continuity of Operations Plan, September 2020, Annex A: Essential Functions* (HHS 2020).	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.

D-1-H-4. Functional area: Operational communications (Xc)

Functional area (FA), objective (Obj), or task	ASPR	OASH	CMS	CDC	ATSDR	FDA	NIH	OGA	IEA	ASPA	SAMHSA	ACF	ACL	HRSA	IHS	OCR	ASFR	ASPE	AHRQ	ASA
FA: Operational communications	P	S		S		S						S			S					
Obj 1: Provide capabilities for interoperable communications with all sectors involved in response and recovery operations.	P	S		S		S					S	S								S
Obj 1, task 1: Provide for and support communications connectivity for departmental responders to support public health, medical, and human services operations in the field.	P	S		S		S					S	S			S					S
Obj 1, task 2: Facilitate communications connectivity and interoperability between departmental responders in the field and headquarters and among FSTT response and recovery personnel.	P	S		S		S					S	S			S					S

Annex E: Extended Threats/Hazards

1. Overview

Table E-1 is an extended version of *Table 2-1* in the *HHS Response and Recovery Operational Plan* (*RROP*). It includes the information in Table 2-1 plus a summary of results for additional (a) incident types and (b) parameters included in the Homeland Security National Risk Characterization (HSNRC) (Willis et al. 2018, 2019). Like Table 2-1, the summary in Table E-1 substitutes general levels for quantitatively specified ones and relies on public or general information for those in which specific levels are classified information or not included in the HSNRC. This summary is intended to provide a conceptual framework for considering the threat, hazard, and risk landscape for which a response may be required. The table can be used for comparing the various types of scenario characteristics relevant to response and recovery, as noted in the *Situation Overview* section of the *HHS RROP*.

2. Table E-1.

Characteristics of various incident types. This table is an extension of *Table 2-1*. The first nine columns of incidents are terrorist, accidental, or biological incidents (biological are sixth through ninth, which can be terrorist [sixth] or natural [seventh through ninth]). [a] "Transnational communicable disease" in the Homeland Security National Risk Characterization (HSNRC; Willis 2019) is "pandemic" here. [b] The 10th column, "cyber incident in …," is "cyber attack on …" in the HSNRC, and here includes accidental or technology-caused cyber incidents. The 11th and 12th columns (mass migration and drug crisis) are illegal activity. [c] "Drug crisis" is based on the "transnational drug trafficking" section of the HSNRC. The last eight columns are natural hazards. The names of the main categories of incidents framed in the national planning scenarios and subsequent DHS categorizations are in ***bold italic*** font.

E-1-A. Homeland Security National Risk Characterization (HSNRC: Willis 2019). The risk areas in the report for incident predictability and estimate precision were changed for simplicity of comparison here to incident unpredictability and estimate imprecision, to allow all applicable categories to go from low to high for less to more severe adverse consequences.

Abbreviations: HSS: Health, safety, security; Econ: Economics; Gov: Governance

Key: U: unknown, N: none, VL: very low, L: low, M: medium, H: high

Area: metric	***Chemical attack or accident***	***Nuclear attack***	***Radiological attack or NPP accident***	***Small arms or explosive attack***	Attack on critical infrastructure	***Biological weapon attack***	***Pandemic*** [a]	Foreign animal disease outbreak	Agricultural plant disease outbreak	***Cyber incident in critical infrastructure networks*** [b]	Mass migration (surge in illegal immigration)	Drug crisis (surge in illicit drug use or abuse) [c]	Drought	***Earthquake***	Flooding	***Hurricane***	Tsunami	Volcano	Wildfire	Space weather
HSS: Deaths: average annual				VL	VL		L	VL	N	U	N	H	N	VL	VL	VL	VL	VL	L	N
HSS: Deaths: greatest for single incident	L	H	L	VL		M-H	H	VL	N	U	N		N	L	VL	L	M	VL	VL	U
HSS: Injuries/ illnesses: average annual				VL	VL		H	VL	N	U	N	H	N	L	VL	L	VL	VL	L	N
HSS: Injuries/ illnesses: greatest for single incident	L	H	L	VL	L	M-H	H	VL	N	U	N		N	L	VL	L	L	L	VL	U
HSS: Well-being reduction				M-H	H		M-H	M-H	L-M	M-H	L	H	L	M	M	M	L-M	L	N-L	M-H
Econ: Cost: average annual				L	M		M	M	M		L	H	M	M	M	M	L	L	M	M
Econ: Cost: greatest for single incident	L	H	M	L	H	M	H	M	M	H	L		H	H	M	H	M	M	M	H
Econ: Lifeline/ infrastructure effects: Single incident	L	H	M	L	L-M	M	N	N	N	H	N	N	H	H	H	H	H	M	L	H
Environmental: Greatest damage	L	M	M	L	L-H	L	N	L-M	M-H	L	N	N	H	M	M	H	M	H	L	L-M
Gov: Greatest disruption	L	M	L	N	L-M	M	M-H	N	N	M	N	N	N	L	N	L	M	L	N	
Risk: Incident frequency	VL	VL	VL	H		VL	L	L	M	M-H	M		H	H	H	H	VL	VL	H	L
Risk: Incident unpredictability	H	H	H	M-H	M-H	H	L	L	L	H	L-M	L	L	H	L	L	H	L	L	H
Risk: Estimate imprecision				H	M		L	M	L	H	L		L	H	L	L	L	L	M	H

E-1-B. Cause – probability of each cause given an incident occurring

Key: L: low, M: medium, H: high, Inh: inherent

Cause	***Chemical attack or accident***	***Nuclear attack***	***Radiological attack or NPP accident***	***Small arms or explosive attack***	Attack on critical infrastructure	***Biological weapon attack***	***Pandemic*** [a]	Foreign animal disease outbreak	Agricultural plant disease outbreak	***Cyber incident in critical infrastructure networks*** [b]	Mass migration (surge in illegal immigration)	Drug crisis (surge in illicit drug use or abuse) [c]	Drought	***Earthquake***	Flooding	***Hurricane***	Tsunami	Volcano	Wildfire	Space weather
Natural							H	H	H				Inh	Inh	Inh	Inh	Inh	Inh	M	Inh
Intentional-state											H	Inh								
Intentional-terrorist	M	M	M		M	M				H										
Intentional-criminal	H	H	H	H	H	H				H										
Accidental				H						H									M	
Natural	H		H							L									M	

E-1-C. Geographical scope

Key: L: local, R: regional, N: national, I: international

Parameter	***Chemical attack or accident***	***Nuclear attack***	***Radiological attack or NPP accident***	***Small arms or explosive attack***	Attack on critical infrastructure	***Biological weapon attack***	***Pandemic*** [a]	Foreign animal disease outbreak	Agricultural plant disease outbreak	***Cyber incident in critical infrastructure networks*** [b]	Mass migration (surge in illegal immigration)	Drug crisis (surge in illicit drug use or abuse) [c]	Drought	***Earthquake***	Flooding	***Hurricane***	Tsunami	Volcano	Wildfire	Space weather
Geographical scope	L	L-R	L-R	L	L-N	L-I	N-I	R-N	R-N	L-I	R-N	N-I	R	R	L-R	R	L-R	L	L-R	R-N

E-1-D. Notice

Key: y: year(s), m: month(s), w: week(s), d: day(s), h: hour(s), 0: none

Parameter	***Chemical attack or accident***	***Nuclear attack***	***Radiological attack or NPP accident***	***Small arms or explosive attack***	Attack on critical infrastructure	***Biological weapon attack***	***Pandemic*** [a]	Foreign animal disease outbreak	Agricultural plant disease outbreak	***Cyber incident in critical infrastructure networks*** [b]	Mass migration (surge in illegal immigration)	Drug crisis (surge in illicit drug use or abuse) [c]	Drought	***Earthquake***	Flooding	***Hurricane***	Tsunami	Volcano	Wildfire	Space weather
Notice	0-h	0-h	0-h	0-h	0-h	0-h	d-w	d-w	d-w	0-h	d-w	d-w	d-w	0-h	h-d	d-w	h-d	h-d	h-d	0-h

E-1-E. Time course

Key: h: hour(s), d: day(s), w: week(s), m: month(s), y: year(s)

Time course	***Chemical attack or accident***	***Nuclear attack***	***Radiological attack or NPP accident***	***Small arms or explosive attack***	Attack on critical infrastructure	***Biological weapon attack***	***Pandemic*** [a]	Foreign animal disease outbreak	Agricultural plant disease outbreak	***Cyber incident in critical infrastructure networks*** [b]	Mass migration (surge in illegal immigration)	Drug crisis (surge in illicit drug use or abuse) [c]	Drought	***Earthquake***	Flooding	***Hurricane***	Tsunami	Volcano	Wildfire	Space weather
Time course response	d-w	w-m	w-m	d-w	w-m	m-y	m-y	w-m	w-m	w-m	w-m	m-y	w-m	w-m	w-m	w-m	w-m	d-w	d-w	d-w
Time course recovery	w-m	m-y	m-y	w-m	w-m	m-y	m-y	w-m	w-m	w-m	w-m	m-y	w-m	m-y	m-y	m-y	m-y	w-m	m-y	w-m

2-1-F. Illness/injury types

Key: f: few, s: some, m: many, vm: very many, 2º: secondary illness or injury (caused indirectly)

Illness/injury type	***Chemical attack or accident***	***Nuclear attack***	***Radiological attack or NPP accident***	***Small arms or explosive attack***	Attack on critical infrastructure	***Biological weapon attack***	***Pandemic*** [a]	Foreign animal disease outbreak	Agricultural plant disease outbreak	***Cyber incident in critical infrastructure networks*** [b]	Mass migration (surge in illegal immigration)	Drug crisis (surge in illicit drug use or abuse) [c]	Drought	***Earthquake***	Flooding	***Hurricane***	Tsunami	Volcano	Wildfire	Space weather
Mechanical trauma		vm		s	2º-f					2º-f				vm		s	m	m		
Thermal burn		s-m																m	m	
Chemical/toxin trauma	m-vm																			
Radiologic illness/injury		vm	m																	
Biological infection		2º-s	2º-s											2º-s	2º-s	2º-s				
• Aerial transmission						m	m													
• Non-aerial direct transmission						m	s													
• Insect vector							s													
• Animal (non-insect) vector								s												
Behavioral health effect	s-m	s-vm	s-m	s-m	s-m	s-m	m			m			s-m	s-m	s-m	s-m	s-m	s-m	s-m	
Physiological											2º-m		s	s						
Drug use/abuse/overdose												vm								

3. References

Willis HH, Tighe M, Lauland A, Ecola L, Shelton SR, Smith ML, Rivers JG, Leuschner KJ, Marsh T, and Gerstein DM, 2018. Homeland Security National Risk Characterization: Risk Assessment Methodology. URL: https://www.rand.org/pubs/research_reports/RR2140.html. Accessed 14 September 2022.

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