U.S. Department of Health and Human Services (HHS)

Assistant Secretary for Preparedness and Response (ASPR)

Incident Response Framework

Version 2.1

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Forward

Per its statutory mission, the Department of Health and Human Services (HHS) Assistant Secretary for Preparedness and Response (ASPR) led the coordination of the federal public health and medical response to three devastating hurricanes impacting the States of Texas and Florida and the U.S. territories of Puerto Rico and the Virgin Islands in the latter half of 2017. This response involved extensive communication and coordination across a large number of ASPR offices and HHS Operating Divisions (OPDIVs) and Staff Divisions (STAFFDIVs); federal, state, local, territorial, and tribal (FSLTT) agencies; non-governmental organizations (NGOs); and private- sector partners. These vitally important communication, coordination, and resource support activities, and the information required to develop and maintain ongoing situational awareness and support decision maker needs at all levels of the response, were channeled through the Secretary's Operations Center (SOC) and ASPR's extended network of forward deployed HHS agency representatives, response teams, and other field response elements. HHS/ASPR continued to assist recovery efforts in the affected areas in the months after response operations concluded.

Extensive after action reporting and lessons learned activities conducted in the aftermath of the 2017 hurricane season identified the need for ASPR to develop and implement a single, overarching framework linking the principal components of its structure for incident response in a comprehensive and integrated way. After action findings also noted that the ASPR incident response structure should be designed to support priority needs identified and validated in the field in concert with locally based FSLTT agencies, NGOs, and private-sector partners, with headquarters-based elements performing in an incident support versus an incident management role.

This HHS/ASPR Incident Response Framework document is intended to address the after action findings discussed above in a broader, all-hazards context, while recognizing and maintaining approaches, procedures, and protocols that have proven effective over time. It also incorporates additional enhancements based on other previous and more recent 2018 incident response experiences, as well as updated guidance and best-practice approaches provided in the National Incident Management System (NIMS), Third Edition (October 2017).

I look forward to working with all of our ASPR staff and our many HHS and external partners in implementing this new Framework and achieving greater effectiveness and efficiencies as we carry out our important life-saving and protection mission in a dynamic and ever more complex all-hazards risk environment.

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1. Introduction

1.1. Background and Situational Overview

The mission of the Department of Health and Human Services (HHS) Assistant Secretary for Preparedness and Response (ASPR) is to save lives and protect Americans from 21st century health security threats. ASPR leads the nation's medical and public health preparedness for, response to, and recovery from disasters and public health emergencies. HHS is specifically designated as the lead federal agency for Emergency Support Function 8 (ESF-8) (Public Health and Medical Services) under the National Response Framework (NRF). HHS also provides support to various other ESFs, including ESF-6 (Mass Care, Emergency Assistance, Temporary Housing, and Human Services). Key tasks performed by ASPR and its many partners in support of the overall ASPR mission are identified in the various ESF, support, and incident-specific annexes to the NRF. Additionally, HHS serves as the Coordinating Agency for the Health and Social Services (H&SS) Recovery Support Function (RSF) under the National Disaster Recovery Framework (NDRF).[1]

1.2. Purpose

This HHS/ASPR Incident Response Framework (also referred to as the "Framework") describes the organizational structure, functional roles and responsibilities, and operational concepts that form part of the ASPR organization's overarching approach to incident response and special event preparedness. As such, this Framework forms the basis from which HHS/ASPR personnel (including both permanent and intermittent staff), augmentees, and agency representatives internal and external to HHS will execute their assigned missions at the headquarters and field levels across the life-cycle of an incident or special event. This Framework is also intended to inform the development of various standard operating procedures (SOPs), incident reporting templates, position descriptions, position task books (PTBs), qualification and training programs, etc., corresponding to and aligning with the various coordinating structures identified herein.

This Framework incorporates key concepts and requirements detailed in the National Incident Management System (NIMS); National Preparedness System (NPS) mission area frameworks, plans, and other related guidance; and various HHS-specific policies, plans, and procedures (See Section 1.4 below).

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[1] Note: HHS/APSR's organizational structure, coordination mechanisms, and supporting activities under the NDRF are discussed in detail in the Health and Social Services Recovery Support Function, Concept of Operations Plan, August, 2015. An updated version of this document is currently under development.

1.3. Scope and Applicability

1.3.1. *Scope*

The scope of this Framework encompasses natural disasters, deliberate and unintentional human-caused incidents, National Special Security Events (NSSEs) and other supported special events, and public health emergencies within the U.S. and its territories, as well as international incidents when HHS support is requested and authorized. This Framework is relevant to all aspects of the incident life-cycle, ranging from steady-state preparedness, to emergent threats, and, finally, to the response to and the initial recovery from realized events. Additionally, this Framework is applicable in the context of incidents involving Presidential declarations under the Stafford Act, public health emergencies declared by the HHS Secretary, and other incident responses that require federal public health and medical assistance and coordination.

The organizational structures, functions, and staffing described herein form part of a scalable, flexible, and adaptive approach that can be further tailored or refined based on incident size, scope, complexity, and other scenario-specific considerations. The structures, roles, and responsibilities described in this Framework can be implemented fully or partially based on the nature of a specific emergent threat or hazard; in anticipation of a pre-planned special event; or in response to an actual incident. This selective approach to Framework implementation allows for a scaled response, the delivery of specific, right-sized resources and capabilities needed, and the level of coordination appropriate to the situation.

1.3.2. *Applicability*

This Framework applies directly to all ASPR personnel (including both full- time and intermittent staff, as well as temporary employees), augmentees, internal and external liaisons and federal agency representatives, and contract support staff with primary or ancillary roles and responsibilities in incident response or special event preparedness. In addition, this Framework is intended to inform ASPR's many interagency and intergovernmental partners regarding specific guidelines for participation in ASPR headquarters-level incident support operations as well as incident management operations conducted in the field.

1.4. Authorities and Policies

The following represent key baseline authorities and policies underpinning this HHS/ASPR Incident Response Framework:

- *The Public Health Service Act (PHSA)*, as amended, including but not limited to, Sections 311, 319, 319F-2, 2801, 2811, and 2812 (42 U.S.C. 201 et seq. §§ 243, 247d, 247d-6b, 300hh, 300hh-10, and 300hh-11).

- *Robert T. Stafford Disaster Relief and Emergency Assistance Act*, as amended (42 U.S.C. 5121 et seq).

- *Post-Katrina Emergency Management Reform Act (PKEMRA) of 2006 (Public Law 109- 295)*, October 4, 2006.

- *Sandy Recovery Improvement Act of 2013 (SRIA)*, (Public Law 113-2).

- *National Health Security Strategy*, 2018.

- *Homeland Security Presidential Directive 5, "Domestic Incident Management" (HSPD-5)*, 2003.

- *Presidential Policy Directive 8 (PPD-8), "National Preparedness,"* March 30, 2011.

- PPD-25 (Classified).

- PPD-44 (Classified.)

- *National Preparedness Goal*, September 2011.

- *National Preparedness System*, November 2011.

- *National Incident Management System (NIMS) (third edition)*, October 2017.

- *National Response Framework (NRF) (third edition)*, June 2016.

- *National Disaster Recovery Framework (NDRF) (second edition)*, June 2016.

- *Federal Emergency Management Agency (FEMA), National Incident Support Plan*, February 2011.

- FEMA, *NIMS Intelligence/Investigations Function Guidance and Field Operations Guide*, October 2013.

- Emergency Management Accreditation Program (EMAP), *Emergency Management Standard*, 2016.

1.5. Framework Maintenance and Revision

The Immediate Office (IO) of the ASPR is designated as the Office of Primary Responsibility (OPR) for the ongoing management and revision of this Framework. A comprehensive review and update of this document will be accomplished on a biennial basis. Out-of-cycle reviews and updates also will be accomplished, as required, based on changes in HHS/ASPR's risk, policy, and/or operational environments, as well as on the basis of observations, findings, and lessons learned from ongoing training and exercise activities and real world incident responses.

2. Assumptions and Guiding Principles

2.1. Assumptions

Incidents that may require HHS/ASPR to coordinate federal public health and medical response resources may:

- Occur at any time with little or no warning in the context of either a general or a specific threat or hazard;

- Involve multiple, highly varied hazards or threats on a local, regional, national, or international scale;

- Involve single or multiple geographic impact areas with overlapping resource needs;

- Require provision of integrated federal expertise and protective action guidance from various agencies;

- Require significant information-sharing at the unclassified level across multiple government agencies and jurisdictional levels and between the public and private sectors;

- Require significant information-sharing at the classified level across multiple government agencies;

- Have significant international impact and/or require significant international information-sharing, resource coordination, and/or assistance;

- Result in numerous casualties; fatalities; displaced persons, including individuals with access, functional, and specialized medical needs; property loss; disruption of normal life-support systems, essential public services, and basic infrastructure; and/or significant damage to the environment;

- Impact critical infrastructures and related dependencies/interdependencies and supply chains across sectors, including key lifeline sectors such as Healthcare and Public Health, Food and Agriculture, Energy, Water/Wastewater, Communications/Information Technology, and Transportation;

- Exceed the capabilities of State, Local, Territorial, and Tribal (SLTT) government and private-sector partners;

- Attract a sizeable influx of independent, spontaneous volunteers and supplies, as well as offers of medical assistance from foreign governments in the form of emergency medical teams, supplies, and medicines;

- Require extremely short-notice federal resource coordination and response timelines;

- Require prolonged, sustained incident management operations and support activities; and/or

- Require that HHS/ASPR lead the federal response because the incident is primarily a biological and/or public health incident, such as if a public health emergency is declared for a non-Stafford Act incident or if the President designates HHS as the Lead Federal Agency (LFA) for the incident response.

2.2. Guiding Principles

The ASPR organization works collectively to save lives and help protect the Nation from 21st century threats. This goal is achieved through people, systems, processes, and capabilities that enable the ASPR to effectively and efficiently lead and manage federal public health and medical response and recovery operations. These efforts are guided by the following core principles:

All-Hazards Approach: The ASPR organization must be ready to execute public health and medical missions in response to a wide variety of man-made and naturally occurring threats and hazards. This includes catastrophic incidents that may severely impact vulnerable populations and cripple regional or national public health and healthcare systems and interconnected lifeline infrastructure systems.

NIMS and NRF Compatible: The ASPR organization's approach to emergent threats and incidents must be scalable, flexible, and adaptable. It must also be compatible with the NIMS, NRF, and other core aspects of the NPS. Alignment with these national standards and proven principles, in a way that is tailored to meet HHS mission needs, is essential to ensure that ASPR efforts are right-sized, fully integrated, and interoperable with those of various diverse FSLTT and non-governmental partners.

Unity of Command/Unity of Effort: The ASPR organization's incident response structure must be responsive to an orderly and disciplined line of authority from the HHS Secretary to the ASPR and down to designated incident managers in the field. This ensures that designated field leaders receive clear direction from the HHS Secretary and the ASPR, are properly empowered to do their jobs, and are not burdened by vague or convoluted authorities. An orderly line of authority promotes the fundamental principles of unity of command for ASPR resources and unity of effort across HHS and its broader stakeholder community.

Incident Support vs. Incident Management Responsibilities: Incidents are managed most efficiently and effectively at the organizational level closest to the impacted area using established concepts and procedures codified in NIMS/Incident Command System (ICS) doctrine. HHS and ASPR headquarters elements, including the Secretary's Operations Center (SOC), perform incident support activities and provide strategic situational awareness to the Department's senior leadership and other U.S. Government (USG) leadership, as directed.

Designated HHS/ASPR field elements, specifically the Federal Health Coordinating Officer (FHCO), Incident Management Teams (IMTs), and regional staffs, are responsible for localized management of the federal public health and medical response. This includes the command and control of HHS' deployed field capabilities and coordination with ASPR's many incident response partners in the field under the NRF. ASPR field elements and deployed response staff must be appropriately organized, trained, equipped, and empowered to perform their various incident management responsibilities.

Expanding Range of Public Health and Medical Missions and Other Support: The ASPR organization's all-hazards approach to the overall HHS mission demands preparation for a wider range of missions and incident scenarios, including those involving impacts to critical lifeline infrastructures and vulnerable populations, than those which have conditioned previous incident responses. Moving forward, ASPR will require an enhanced ability to work with diverse healthcare partners and government and non-governmental capability providers. Other HHS OPDIVs/STAFFDIVs and personnel that are not traditionally considered part of emergency response may be instrumental to ASPR's ability to perform these missions successfully.

Operational Readiness: The ASPR organization must constantly strive to enhance the operational readiness of its response teams, materiel, information systems, and personnel. The organization must have the ability to rapidly gain an accurate and precise understanding of the readiness of key response elements. Headquarters and field elements must be appropriately trained, qualified, and rehearsed to established readiness standards in order to meet demands of varying scope, complexity, and consequences. Teams also must be prepared to respond in highly stressful environments, with appropriate emphasis on post-deployment decompression and recovery.

Collaborative Culture: The ASPR organization must embrace a collaborative culture that promotes integration across all of ASPR, all of HHS, and with key interagency, intergovernmental, and private-sector partners. Future incidents are certain to require new, diverse, innovative, and enhanced capabilities to allow ASPR to help save lives and mitigate the health and medical impacts of complex, high-consequence events. Some incidents may be so large and complex that they require an "all-hands-on-deck" response from ASPR and many other parts of the Department. The organization's culture must acknowledge and respect the unique contributions that HHS and its FSLTT, NGO, and private-sector partners can make together to achieve the mission.

Accountability and Continuous Improvement: All ASPR personnel must be accountable for their actions and remain committed to organizational learning and continuous improvement.

Deficiencies in response capabilities and actions must be identified, and the requisite corrective actions must be implemented promptly and smartly. Directors and managers must cultivate an environment in which innovation and improvement are respected and encouraged.

3. Organizational Structure for Incident Response

3.1. Overarching Organizing Framework

The overarching HHS/ASPR organizing structure for incident response, based on concepts described in the NIMS/NRF, is depicted in Figure 1 below. Descriptions of each of the individual key components that comprise this overall structure are provided in the paragraphs that follow.
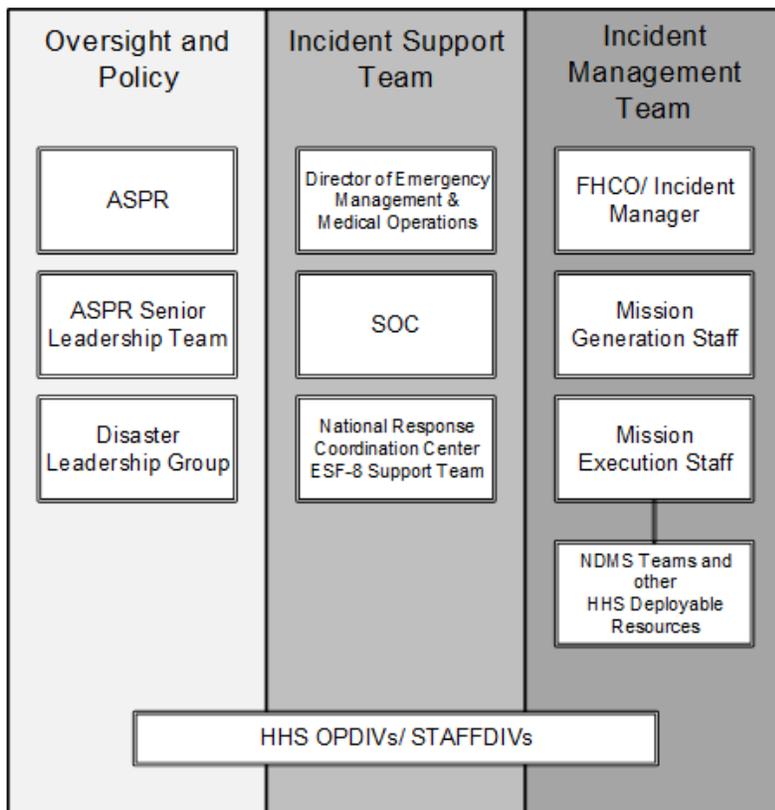
Figure 1 A depiction of the key components of the HHS/ASPR organizing structure for incident response, including Oversight and Policy, Incident Support, Incident Management, and HHS OPDIVS/STAFFDIVS.

As depicted in Figure 1, the key components of the HHS/ASPR Incident Response Framework are grouped under four major organizing categories: 1) Oversight and Policy; 2) Incident Support Team (IST); 3) Incident Management Team (IMT); and 4) HHS OPDIVs/STAFFDIVs.

3.2. Oversight and Policy

Overall oversight and policy direction related to this Framework are provided via the ASPR, ASPR Senior Leadership Team (SLT), and the Disaster Leadership Group (DLG) as discussed below.

3.2.1. *Assistant Secretary for Preparedness and Response*

Section 2811 of the PHSA, as amended, establishes the position of the ASPR, and, subject to the authority of the Secretary, assigns the following roles and responsibilities (among other duties) to the ASPR:

- Serve as the principal advisor to the Secretary on all matters related to federal public health and medical preparedness and response for public health emergencies;

- Register, credential, organize, train, equip, and have the authority to deploy federal public health and medical personnel under the authority of the Secretary, including the National Disaster Medical System (NDMS) and U.S. Public Health Service (USPHS) Commissioned Corps, and coordinate such personnel with the Medical Reserve Corps and the Emergency System for Advance Registration of Volunteer Health Professionals;

- Coordinate with relevant federal officials to ensure integration of federal preparedness and response activities for public health emergencies;

- Coordinate with SLTT public health officials, the Emergency Management Assistance Compact (EMAC), health care systems, and emergency medical service systems to ensure effective integration of federal public health and medical resources during a public health emergency;

- Promote improved emergency medical services direction, system integration, research, and uniformity of data collection, treatment protocols, and policies with regard to public health emergencies;

- Oversee advanced research, development, and procurement of qualified countermeasures, security countermeasures, and qualified pandemic or epidemic products;

- Provide integrated policy coordination and strategic direction with respect to all matters related to federal health and medical preparedness and execution and deployment of the federal response for public health emergencies and incidents covered under the NRF;

- Identify inefficiencies in medical and public health preparedness and response activities and actions necessary to overcome these obstacles;

- Align and coordinate medical and public health grants and cooperative agreements as applicable to preparedness and response activities authorized by the PHSA;

- Carry out drills and operational exercises in consultation with the Department of Homeland Security (DHS), the Department of Defense (DoD), and the Department of Veterans Affairs (VA), and other applicable federal departments and agencies, as necessary and appropriate, to identify, inform, and address gaps in and policies related to all-hazards medical and public health preparedness and response;

- In coordination with the Secretary of Veterans Affairs, Secretary of Homeland Security, General Services Administration, and other public and private entities, provide logistical

- support for medical and public health aspects of federal responses to public health emergencies; and

- Provide leadership in international programs, initiatives, and policies that deal with public health and medical emergency preparedness and response.

Section 2811 of the PHSA also assigns the ASPR the following functions:

- Lead responsibility within the Department for emergency preparedness and response policy coordination and strategic direction;

- Authority over and responsibility for:
  - the National Disaster Medical System (NDMS) pursuant to Section 2812 of the PHSA (42 U.S.C. 300hh–11);
  - the Hospital Preparedness Cooperative Agreement Program pursuant to Section 319C-2 of the PHSA (42 U.S.C. 247d–3b);
  - the Biomedical Advanced Research and Development Authority pursuant to Section 319L of the PHSA (42 U.S.C. 247d–7e);
  - the Medical Reserve Corps pursuant to Section 2813 of the PHSA (42 U.S.C. 300hh–15);
  - the Emergency System for Advance Registration of Volunteer Health Professionals pursuant to Section 319I of the PHSA (42 U.S.C. 247d–7b); and
  - administering grants and related authorities related to trauma care under Parts A through C of title XII of the PHSA (42 U.S.C. 300d to 300d-32).

- Responsibilities and authorities of the Secretary regarding the coordination of:
  - the Public Health Emergency Preparedness Cooperative Agreement Program pursuant to Section 319C-1 of the PHSA (42 U.S.C. 247d–3a);
  - the Strategic National Stockpile (SNS) pursuant to Section 319F-2 of the PHSA (42 U.S.C. 247d–6b); and
  - the Cities Readiness Initiative.

- Other duties as determined appropriate by the Secretary.

Further, the Secretary has delegated to the ASPR his authority under Section 2801 of the PHS Act to lead all Federal public health and medical response to public health emergencies and incidents covered by the NRF. As the federal coordinator for ESF-8 under the NRF, the ASPR's functional responsibilities include, but are not limited to: public health, medical surge support including patient movement, behavioral health services, and mass fatality management. A detailed listing and description of ESF-8 functional areas for which ASPR is responsible is provided in the ESF-8 Annex to the NRF, re-issued in July 2016. HHS/ASPR also has responsibilities to support other ESFs during Stafford Act and non-Stafford Act responses per the NRF.

The ASPR's priorities during incident response are focused on saving lives, stabilizing the impacted health and medical infrastructure, and providing for basic public health and medical needs in collaboration with appropriate intergovernmental and private-sector partners. These priorities are achieved via engaged partnership; tiered response; scalable, flexible, and adaptable operational capabilities; unity of effort; and readiness to act. The ASPR maintains overall responsibility and accountability for all HHS/ASPR incident support and incident management activities conducted to further these priorities and supporting tasks. The ASPR is responsible for providing initial and ongoing guidance regarding HHS/ASPR goals, objectives, and key strategies and activities in support of the overall incident response. He/she is also responsible for initiating and/or approving key pre-designations/designations (including designation of the FHCO and delineation of FHCO responsibilities specific to the incident at hand), delegations of authority, team activations, and other guidance as detailed in this Framework. The ASPR also serves as final review and approval authority for ASPR plans developed in support of designated special events.

3.2.2. ASPR SLT

The ASPR SLT serves a primary advisory body to the ASPR, collectively providing advice and recommendations regarding incident response courses of action and facilitating the implementation and monitoring of decisions taken by the ASPR or his/her designated representative(s).

Specific SLT roles and responsibilities include the following:

- Support the establishment and provision of initial and ongoing strategic guidance governing the overall HHS/ASPR incident response and/or special event planning and conduct;

- Develop situationally-based courses of action or provide input/recommendations based on courses of action proposed by other key components of the ASPR Incident Response Framework;

- Support the prioritization of requests for assistance within a resource constrained and/or multi-incident environment;

- Provide subject matter, functional area, and/or technical expertise relevant to course of action discussions; and

- Per individual position-based roles and responsibilities within the ASPR organization,

support the implementation of course of action recommendations approved by the ASPR or his/her designated representative, including resource support, as appropriate.

The SLT is comprised of the following principal members:

- Principal Deputy Assistant Secretary (PDAS)
- Deputy Assistant Secretary (DAS) for Incident Command and Control
- ASPR Chief of Staff
- Director, Biomedical Advanced Research and Development Authority (BARDA)
- Director of Emergency Management and Medical Operations (EMMO)
- Office of the General Counsel (OGC) Representative (whose role is to provide legal advice to the other members of the SLT as they carry out the roles and responsibilities listed above).

In addition to these principal members, additional individuals (i.e. the SOC Director, ASPR Division Directors, FHCO, technical subject matter experts, etc.) may be called upon by the ASPR or primary SLT members to participate in SLT meetings, physically or virtually, to provide specialized expertise/advice based upon the nature of the emergency at hand.

3.2.3. *DLG*

The DLG is a policy committee convened by the ASPR when anticipated incident or event conditions are expected to raise significant policy issues that require increased surveillance, coordination, and/or information sharing across HHS or throughout the USG. The DLG is primarily a forum for HHS senior leaders; however, some incidents/events may require expertise from other federal interagency partners or individual input from other external subject matter experts.

The DLG's purpose is to: 1) provide a forum for deliberation and decision-making by senior leaders within HHS; 2) address policy issues of national significance that impact or potentially impact the preparedness, response, and recovery of public health and/or medical systems in the U.S., U.S. territories, and Tribal Nations; and 3) serve as a forum for HHS leadership to make recommendations to the HHS Secretary. Depending on the nature of the event, the DLG may be convened once, or periodically over the course of an extended event as needed.

The DLG is not an operational response forum for HHS OPDIVs and STAFFDIVs; rather it is a forum to resolve policy issues and barriers to preparedness, response, recovery, and mitigation activities through careful examination of applicable laws and regulations, funding priorities, and actions of government. The DLG is activated at the discretion of the ASPR. A request to convene a DLG may be generated by the SOC Director or by the leadership of any HHS OPDIV or STAFFDIV. In addition to ongoing incidents or events, the DLG may also be activated when a Secretary's Critical Information Requirement (CIR) has been triggered and/or the situation has gained the attention of the White House, resulting in executive level meetings. Additional information regarding the DLG and relevant supporting protocols is provided in DLG SOP Number ASPR-OPP-3001.01.

3.3. Incident Support

"Incident Support" refers to the coordination of all resources (including personnel, equipment, supplies, information technology systems, etc.) that support incident response, recovery, logistics, and mitigation. Core focus areas include: the deployment of national-level assets; support of national objectives and programs applicable to the incident at hand; and support of incident management operations conducted in the field via specialized resources, expertise, and information.

Incident support activities involve coordinating the alert/notification, activation, mobilization, deployment, and de-mobilization of the resources required to support HHS field-level incident management activities and validated requirements originating from the field. Incident support also may include developing courses of action regarding the strategic prioritization and allocation of HHS assets/resources in the case of multiple incidents/events or emergent threats with competing resource demands. Incident support also involves facilitating multi-directional information sharing between headquarters and field elements of the response and developing and maintaining overall situational awareness and a common operating picture. This overall approach ensures that HHS/ASPR incident support efforts are properly focused on effectively and efficiently resourcing unmet needs, and building an integrated information picture that supports the decision making needs of key leaders at various levels of the response. HHS/ASPR incident support operations are facilitated via three principal coordination and information sharing components, collectively referred to as the "IST": 1) the Director of EMMO;

2) the SOC; and 2) the HHS/ASPR National Response Coordination Center (NRCC) ESF-8 Support Team (and/or Agency representatives posted to another national-level operations center(s)/coordination center(s) as required by the situation). Each of these components is discussed in the sections that follow.

3.3.1. *Director of EMMO*

The Director of EMMO, as the first component of the IST, provides overall oversight of HHS/ASPR headquarters-level incident support activities during incident response and special events. Working in concert with the SOC Director, HHS ASPR Regional Administrator (RA) for the impacted region(s), and the designated field-level FHCO/Incident Manager (IM), the Director of EMMO performs a number of important functions in direct support of the ASPR, SLT, DLG, and the HHS senior leadership. Specific roles and responsibilities include the following:

- Maintain a strategic overview of incident response and special event planning and support activities;

- In close coordination with the SOC Director, ASPR RA for the impacted region(s), and designated FHCO/IM, oversee the coordination, alert/notification, activation, mobilization, deployment, and demobilization of HHS/ASPR resources assigned to support field-level incident management activities (*Note: operational authority over and control of these resources is vested in the FHCO/IM during the mission employment phase*);

- Facilitate effective integration, coordination, synchronization, and information sharing between the headquarters and field elements of the HHS/ASPR Incident Response Framework;

- In consultation with the SOC Director, ASPR RA for the impacted region(s), and designated FHCO/IM, oversee the Senior Leader Briefing (SLB) and course of action development processes in support of ASPR and HHS senior leader informational and decision making needs;

- In consultation with the SOC Director, ASPR RA for the impacted region(s), and designated FHCO/IM, provide resource prioritization and allocation recommendations to the ASPR and SLT in situations involving competing demands for limited resources;

- Monitor and provide ongoing feedback on the implementation of decisions made/direction given by the ASPR and/or the SLT; and

- Provide additional senior leader support as required.

The SOC Director reports to the Director of EMMO during an incident response and during the conduct of pre-planned special events. Although the Director of EMMO maintains no command and control authority over the FHCO/IM, both individuals work closely together to meet the needs of the incident at hand. The Director of EMMO may delegate authority to deputies via signed orders of succession for incidents that involve activation of HHS Continuity of Operations Plans.

3.3.2. *SOC*

3.3.2.1. *Mission*

The second component of the IST is the SOC. The SOC operates as the emergency operations center (EOC) for HHS Headquarters. Organized according to principles established in the NIMS, the mission of the SOC is to help protect the health, safety, and security of the nation by serving as the 24/7/365 focal point for public health and medical information collection, sharing, and analysis, as well as coordination of HHS preparedness, response, recovery, and mitigation operational resource requirements. The SOC's organizational structure is modular, flexible, and scalable based on the incident situation and corresponding mission requirements.

3.3.2.2. *Roles and Responsibilities*

The SOC maintains a "steady-state" 24-hour watch function to establish and maintain situational awareness of any actual or potential incident or emerging situation, nationally or internationally, which may require a coordinated federal disaster response, or may be of concern to the HHS senior leadership. Based on the situation and in accordance with applicable authorities, the SOC provides notifications including general situational awareness and updates; coordinates personnel actions (alerts, activations, mobilizations, and demobilizations); initiates and/or coordinates conference calls regarding specialized topic areas such as Biowatch, patient movement, and Strategic National Stockpile (SNS) requests; and coordinates and conducts regional and national conference calls as requested.

In the context of an emergent threat or an incident in progress, SOC staffing expands in concert

with the situation and corresponding mission requirements to provide appropriate information management, planning, and resource coordination/support in response to critical needs identified by the deployed IMT(s). In these situations, the SOC also establishes and maintains strategic situational awareness to inform and otherwise support HHS senior leader decision making needs. The scalability and flexibility inherent in the SOC's organizational structure allow it to address a single incident or multiple incidents and/or special events occurring simultaneously.

The SOC's overall roles and responsibilities include the following:

- *Monitoring and Detection*: Actively monitor various sources of data and information for the purpose of identifying and assessing threats and/or incidents, both domestically and internationally, which may require federal public health, medical, and/or human services support.

- *Alert and Notification*: Maintain ongoing situational awareness and provide the ASPR and ASPR organization (headquarters and field elements), HHS senior leadership, and HHS stakeholders with timely and reliable notification of threats and/or incidents that may require federal public health, medical, and/or human services support.

- *Senior Leader Decision Support*: Develop course of action recommendations and provide decision support to the ASPR, ASPR SLT, DLG, and other HHS senior leaders, as required;

- *Resource Support*: Participate in special events planning and coordinate incident-related resource support, including HHS/ASPR teams and equipment, to satisfy validated unmet needs identified by ASPR incident management field elements;

- *Resource Allocation and Prioritization*: In consultation with the ASPR RA for the impacted region(s), FHCO/IM, and other elements of the deployed IMT(s), provide resource prioritization recommendations for consideration by the ASPR, ASPR SLT, DLG, or the HHS senior leadership in those situations in which field needs surpass available resources and/or situations involving multiple overlapping incidents/special events with competing resource requirements;

- *Resource Notification, Activation, Mobilization, and Tracking*: Coordinate the alert/notification, activation, mobilization, deployment, and demobilization of resources and track Mission Assignments in alignment with validated needs identified by the field elements of the HHS/ASPR Incident Response Framework, including the following: FHCO/IM; ASPR RA(s) from the impacted region(s); Regional Emergency Coordinators (RECs); IMTs; NRCC, FEMA Regional Response Coordination Center (RRCC), Joint Field Office (JFO), SLTT, and other ESF-8 Support Teams/Liaisons (Note: the RRCC and SLTT ESF-8 Support Teams/ASPR Representatives are activated by ASPR RAs from the impacted region(s) in consultation with the designated FHCO; the mobilization, deployment, and employment of these resources is supported and monitored by the SOC); and members of the NDMS, USPHS Commissioned Corps, and other deployable HHS resources (teams and individuals). (Note: Until such time that the designated FHCO/IM determines that the IMT is sufficiently established and ready to assume operational control, the SOC coordinates with other ASPR headquarters elements to

support the management, administration, and operational control of deploying resources, including mobilization processing and daily accountability.)

- *Continuity of Operations and Government*: Support both Department level Continuity of Operations (COOP) and Continuity of Government (COG) through processes instituted in coordination with HHS, FEMA, and White House Military Affairs Office COOP/COG programs.

- *Communications*: Utilize a combination of communication devices, communications processes, and communication redundancies to allow for effective and efficient communications with SOC stakeholders.

- *Information Management*: Collect, receive, analyze, and disseminate information from multiple sources in real and near real-time to develop situational awareness; establish a common operating picture; facilitate multi-path information sharing with deployed field elements, headquarters elements, and external partners; and assist with HHS senior leader decision support.

- *International Health Regulations*: Serve as the operational component of the USG National Focal Point under the binding International Health Regulations (IHR) established in 2007.

3.3.2.3. *Tiered Activation*

The SOC maintains various flexible levels of activation to meet situational requirements, starting from a lower activation level (Level IV) comprised of 24-hour watch, monitoring, and routine reporting functions, along with select virtual or physical staffing across its core NIMS/ICS-based Command and General Staff sections, as required. Higher activation levels (Levels I-III) may include full augmentation from other ASPR offices, as well as representatives from other HHS OPDIVs, STAFFDIVs, and/or interagency partners. The SOC operates out of HHS headquarters, or from its designated COOP location, as directed.

The decision to activate SOC staff to a Level III posture is made by the SOC Director, in consultation with the Director of EMMO. The SOC Director makes an immediate Level III activation notification to the ASPR and ASPR SLT by telephone and/or electronic messaging. The decision to activate SOC staff to a Level II or Level I posture is made by the ASPR in consultation with the SLT and SOC Director. In the context of certain high consequence, no-notice events such as a catastrophic earthquake or an improvised nuclear device detonation, the SOC Director (or designee if the SOC Director is unavailable) will activate the SOC to a Level I posture immediately, while simultaneously notifying the ASPR and SLT via phone and electronic messaging. The SOC Director is responsible for maintaining up-to-date communications rosters including contact information for the ASPR, SLT members, key SOC staff, FHCO and IMT cadre members, and HHS regional staff.

The SOC Director, in consultation with the ASPR and the SLT, deactivates SOC staff augmentation as circumstances allow a return to a normal operations/steady state condition. Deactivation of staff beyond those personnel required to support steady state operations typically occurs when the incident or event no longer requires the support and coordination

functions provided by the augmented SOC staff or when those functions can be managed by individual organizations or by steady-state coordination mechanisms. The SOC Director may conduct deactivation of augmentation staff in a phased manner depending on mission needs. Individual SOC staff members complete resource demobilization and transfer any ongoing incident support/recovery activities to another responsible party before deactivating. After-action and lessons learned reviews are included as part of the staff deactivation process.

The SOC's tiered staff activation levels, along with corresponding activation criteria for each level, are described in Table 1 below. These activation levels and supporting criteria are aligned with NRCC activation levels established in FEMA's National Incident Support Plan. SOC activation and staff augmentation requirements are communicated via a formal OPORD process. SOC staffing rosters are maintained and updated by the SOC Director's steady-state staff.

Table 1 A notional depiction of SOC activation Levels, along with condition/criteria and staffing guidelines.

ACTIVATION LEVEL	CONDITION/CRITERIA	STAFFING GUIDELINES
Level I	• An incident of such magnitude that the available resources that were designed and put in place for the response are completely overwhelmed or disrupted at the local, regional, or national level. • Due to its severity, size, location, actual or potential impact on public health, welfare, and infrastructure, the incident requires an extraordinary level of direct federal assistance for response and recovery efforts. • Requires extensive coordination among FSLTT entities due to massive levels and breadth of damage, severe impact or multi-state scope. • Requires major involvement of HHS including full activation of SOC, OPDIV/STAFFDIV coordination, and deployment of IMT(s), Support Teams/Liaisons, and NDMS and other HHS deployable resources.	• SOC Director/Deputy Director • Full SOC activation including all Command Staff and General Staff Section Chiefs and supporting elements. • Activation and deployment of IMT(s), Support Teams/Liaisons, and NDMS and other select HHS resources based on mission requirements. • 24/7 staffing requirements likely at all levels of the HHS/ASPR incident response structure.

ACTIVATION LEVEL	CONDITION/CRITERIA	STAFFING GUIDELINES
Level II	• A disaster which, due to its severity, size, location, actual or potential impact on public health, welfare, and infrastructure requires a high level of direct federal assistance for response and recovery efforts. • Requires elevated coordination among FSLTT entities due to moderate levels and breadth of damage. • Requires significant involvement of HHS, including elevated SOC activation, OPDIV/STAFFDIV coordination, and possible deployment of IMT(s), Support Teams/Liaisons, and NDMS and other HHS deployable resources to support the requirements of the affected jurisdiction/area.	• SOC Director/Deputy Director • Robust SOC activation including Command Staff, all General Section Chiefs and select supporting elements. • Likely activation and deployment of IMT(s), Support Teams/Liaisons, NDMS, and/or other select HHS resources based on mission requirements. • 24/7 staffing requirements likely at select levels of the HHS/ASPR incident response structure.
Level III	• A disaster which, due to its severity, size, location, actual or potential impact on public health, welfare, and infrastructure requires a moderate level of direct federal assistance. • Typically, this primarily represents a recovery effort with minimal response requirements and existing federal regional resources will meet requests. • Requires coordination among involved FSLTT entities due to minor-to-average levels and breadth of damage. HHS OPDIV/STAFFDIV coordination and resource deployment may be limited based on situation impacts. • Typical posture for routine special events with extensive prior planning.	• SOC Director/Deputy Director, Select Command Staff and General Staff Section Chief representatives in SOC; all others activated virtually. • May require select deployment of IMT, Support Teams/Liaisons, NDMS and other resources based on mission requirements and/or special event plan specifications. • Extended hours staffing for select elements may be required.

ACTIVATION LEVEL	CONDITION/CRITERIA	STAFFING GUIDELINES
Level IV	• Steady state monitoring – no event or incident in progress.	• SOC Director, 24/7 watch staff, virtual connectivity with Command and General Staff elements as required.

In concert with a Level I-III activation, the SOC Director oversees the development, coordination, and issuance of a series of documents outlining key mission guidance, authorities, and initial operating requirements, including a SOC and IMT Activation Notification, an Operations Order (OPORD), supporting Task Orders (TOs), and activation and designation letters (under ASPR signature, as required). The OPORD defines the situation and the phase of the response (Preparedness, Response, or Recovery). The SOC and IMT Activation Notifications specify the operational period, specific positions activated, and the operational status of activated positions (on-site, virtual, or on-call). TOs specify key leadership roles for the incident as well as the specific teams/personnel and equipment being readied for activation, mobilization, and deployment. Prior to their formal publication, OPORDs and supporting TOs are forwarded to appropriate ASPR staff offices/sections and other OPDIVs/STAFFDIVs, as appropriate, for staffing coordination. If NDMS or USPHS resources are required to support mission needs, an activation letter is drafted by the SOC for signature by the ASPR.

3.3.2.4. *Organizing Structure*

The SOC's "steady state" structure for situational awareness, event reporting, and initial incident alert/activation is depicted in Figure 2 below.
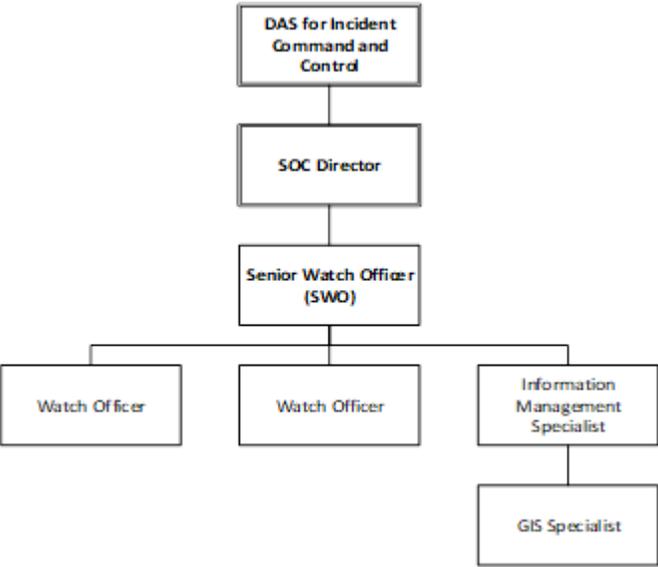
Figure 2 A depiction of the SOC's organizational structure for Level IV "steady-state" operations, including senior watch officer, watch officer, information management, and GIS specialist positions.

In the context of an emergent threat, incident, or pre-planned special event (Activation Levels I-III as described above), the SOC is aligned to the NIMS Incident Support Model structure for EOCs per Figure 3 below. In accordance with this model, jurisdictions/organizations that focus

their EOC's efforts on information, planning, and resource support may choose to separate the situational awareness function from the planning function and combine operations and logistics functions into a more functionally integrated incident support structure. This Incident Support Model most closely aligns with the primary roles and responsibilities of the SOC. This organizational structures puts the SOC Director in direct contact with those responsible for situational awareness/information management and streamlines resource sourcing, ordering, and tracking.

Based on NIMS guidelines, the SOC's organizational structure for Level I-III activation, including the SOC's Command and General Staff components, is flexible, scalable, and expandable to best meet the demands generated by a specific emergent threat, incident, or special event and corresponding mission requirements.

A representative organizational structure of the SOC for support of HHS/ASPR tiered-based incident response activities, including Command and General Staff elements, is depicted in Figure 3 below. An expanded version of this organization structure depicting branch and unit-level entities, along with branch and unit-specific descriptions, is provided in Annex A of this Framework.
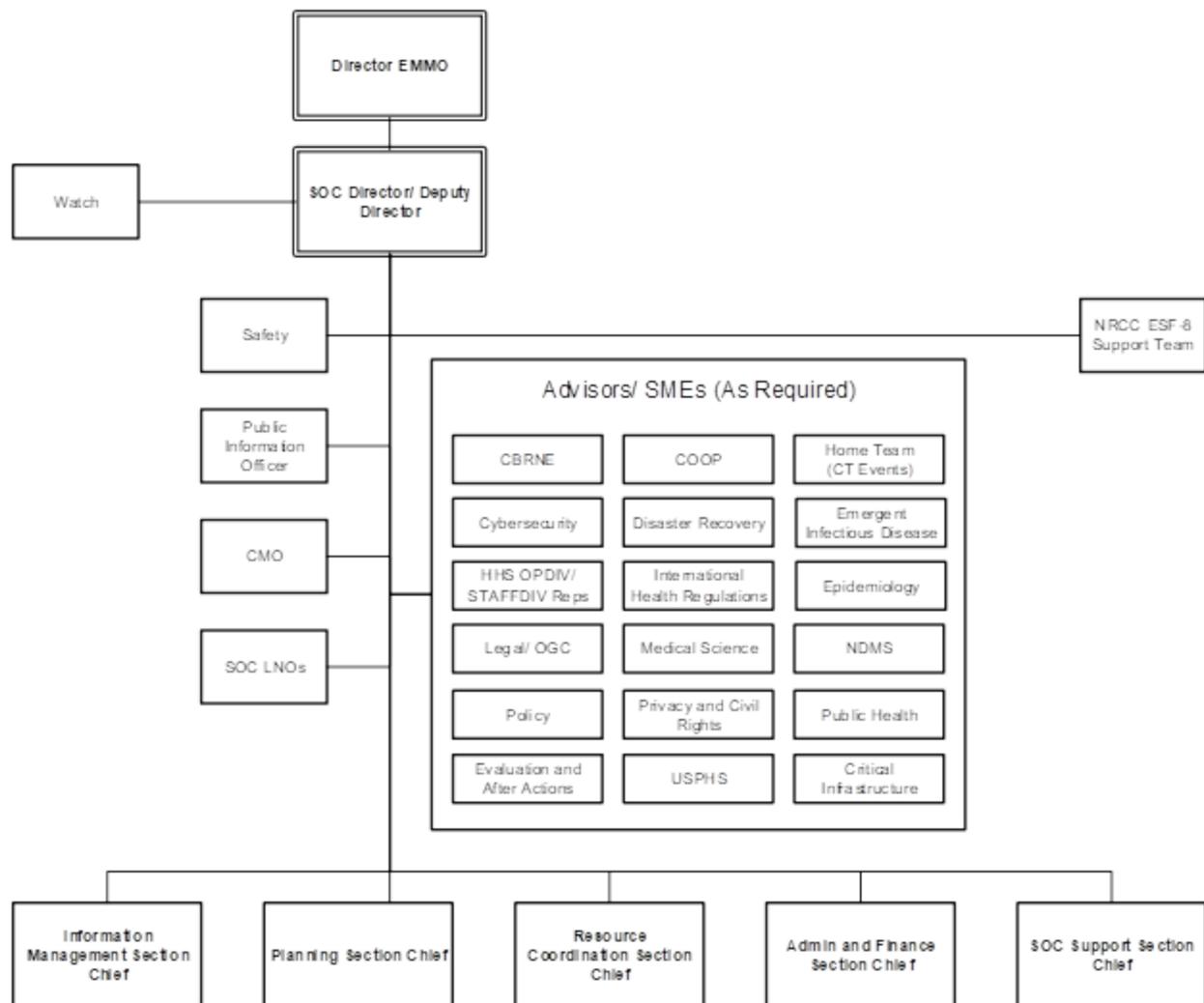
Figure 3 A depiction of the SOC's baseline organizational structure for Tier I-III activation, including relevant command and general staff elements based on ICS doctrine. This structure is flexible, scalable, and expandable to best meet the demands generated by the incident at hand.

Key SOC leadership and staff positions and their corresponding roles and responsibilities are described below.

SOC Director/Deputy Director. The SOC Director/Deputy Director oversee and direct the activity of the SOC across all levels of potential activation (Note: The Deputy Director position is staffed only for Level I-III events). The SOC Director reports to the DAS for Incident Command and Control under steady-state (Level IV) conditions. During an incident response (Levels I-III) or during the conduct of a pre-planned special event, the SOC Director operationally reports to the Director of EMMO and works to meet the needs of the FHCO/IM and otherwise support the ASPR SLT, ASPR, and other HHS senior leaders.

The SOC Director/Deputy Director coordinate and collaborate directly with the affected RA (s) and regional staff early and often during a response situation to define the size and scope of the SOC organization and determine physical versus virtual activation posture and staffing requirements based on the nature of the incident/event at hand. They also confirm information management, planning, and resource coordination priorities and mobilize resources to meet requirements generated and validated by the deployed IMT(s). Additionally, they work to establish effective headquarters level inter/intra-agency communication and coordination in order to facilitate successful incident support. Finally, the SOC Director/Deputy Director focus on maintaining strategic level situational awareness, providing situation updates, and assisting with decision support to HHS senior leaders. In the instance of multiple, overlapping incidents/events, the SOC Director/Deputy Director ensure that each incident/event is appropriately supported based on ASPR/SLT guidance and available resources and that approved resources are provided in an expeditious fashion.

Additional specific roles and responsibilities of the SOC Director/Deputy Director include the following:

- In close coordination with the Director of EMMO, ASPR RA for the impacted region(s), and designated FHCO/IM, support the coordination, alert/notification, activation, mobilization, deployment, and demobilization of HHS/ASPR resources assigned to support field-level incident management activities;

- Determine operational requirements for SOC Command Staff including on call, virtual, on-site, and operational hours;

- Establish SOC shift timeframes and approve the SOC operational schedule;

- Approve SOC Support and Incident Support Plans (ISPs);

- Approve SOC Contingency and Demobilization Plans;

- Approve the SOC Information Management Plan including the schedule of when information is collected and distributed, in coordination with the ASPR RA(s) for the impacted region and designated FHCO/IM;

- Assign, assess, and determine completion and close out of all SOC tasks; and

- With the concurrence of the Director of EMMO, approve the request for, and release of, Interagency Representatives supporting the SOC.

SOC Command Staff. The SOC Director/Deputy Director determine requirements and assign Command Staff as needed to support the overall SOC management function. The SOC's Command Staff includes the following baseline positions across Activation Levels I-III: Public Information Officer (PIO), Safety Officer, Chief Medical Officer (CMO), and a Liaison Officer(s) (LNO) who report directly to the SOC Director/Deputy Director. The SOC Director/Deputy Director may appoint/activate additional advisors and/or subject matter experts, as needed in the context of a specific incident scenario or activation level, representing any or all of the following subject matter expertise:

- Policy

- International Health Security/International Health Regulations (IHR)

- Legal/Office of the General Counsel

- Privacy and Civil Rights

- COOP

- Disaster Recovery

- NDMS

- USPHS Commissioned Corps

- HHS Home Team

- OPDIV/STAFFDIV Representatives

- Chemical, Biological, Radiological, Nuclear (CBRN)

- Epidemiology

- Emergent Infectious Diseases

- Medical Science

- Critical Infrastructure

- Cybersecurity

- Public Health

- Evaluation and After Action

- Agency Representatives

Advisors, subject matter experts, and Agency Representatives may represent organizations internal to ASPR (i.e., BARDA or the broader HHS community (i.e., the Centers for Disease Control and Prevention (CDC)), or they may represent external federal organizations such as DHS, DoD, VA, etc.

SOC General Staff. The SOC's General Staff consists of the Information Management, Planning, Resource Coordination, Finance/Administration, and SOC Support Section Chiefs. These individuals are responsible for the functional aspects of the incident support activities conducted within the SOC. The SOC Director/Deputy Director activate these section chiefs as needed. In turn, each Section Chief activates supporting staff as needed based on situational considerations and mission requirements.

Information Management Section. The SOC's Information Management Section is responsible for maintaining and providing strategic-level public health, medical, and human services response situational awareness; establishing and maintaining a common operating picture; developing an incident-specific Information Management Plan; collecting and analyzing validated FSLTT and private sector data as appropriate (including Hospital Preparedness Program (HPP) and healthcare coalition data) relevant to the response and established CIRs; responding to and tracking the status of requests for information (RFIs); developing consolidated incident situation reports (SITREPs), senior leader briefings (SLBs), and electronic/geospatial presentations of incident data; sharing appropriate information with field elements of the HHS/ASPR incident response structure; providing HHS senior leader decision support; and archiving incident-related data. This is accomplished by establishing a seamless and integrated information management structure and supporting processes throughout the HHS/ASPR incident response organization as well as appropriate information coordination at the strategic level with federal and international partners.

Planning Section. The Planning Section provides a range of planning services to address current operations requirements and to anticipate and develop strategies to address future operations needs and provide strategic direction for the Incident Support mission. Specifically, the Planning Section conducts mission and risk analysis, supports SOC-level course of action planning, and develops and maintains the SOC's Incident Support Plan (ISP), published daily, to communicate initial and ongoing incident support priorities, objectives, and strategies. From a current operations perspective, this section leads the SOC's daily incident support planning process, in close coordination with the IMT's Planning Section, to address requirements identified by the deployed IMT(s), as well as national level concerns generated by the incident, including impacts of the incident on HHS' national-level readiness. It also assists in recommending priorities in the context of multi-incident scenarios with competing demands, along with recommendations regarding associated resource allocation. The Planning Section also conducts future operations planning activities such as recovery transition, and planning for a range of potential contingencies that may occur concurrently during the execution of an incident response. It provides additional support as requested by deployed IMTs by leveraging the functional expertise residing in the SOC and throughout the Department, as appropriate. This involves collaborative planning including, but not limited to, public health, medical, and human services issues.

Finally, the Planning Section performs contextual analysis of incident information, conducts national-level adaptive planning[2] (such as that related to pre-staging of capabilities, resource reconstitution or alternative capabilities to meet needs identified or anticipated), and provides decision support tools to facilitate and enable senior leader decision making.[3]

At the direction of the SOC Director or the Director of EMMO, the Planning Section Chief may convene a task force or working group with representation across select elements of the SOC Command and General Staff to address complex issues requiring inputs from multiple entities represented within the SOC and to collaborate with entities external to the SOC, as appropriate. An example would be a "Private Sector Task Force/Working Group" convened to address multi-level and multi-issue dialogue and course of action development with key private sector partners. Another example is the planning coordination and collaboration that occurred during Hurricanes Irma and Maria in 2017, with the establishment of a "Dialysis Task Force/Working Group." This group was comprised of elements of the SOC Command and General Staff, including the Centers for Medicare & Medicaid Services Agency Representative, the End Stage Renal Disease (ESRD) Network, the Kidney Community Emergency Response (KCER) Coalition, and various Territorial health officials, convened to address dialysis issues and develop dialysis patient movement plans for the U.S. Virgin Islands.

Resource Coordination Section. The SOC's Resource Coordination Section performs hybrid operations and logistics functions under the NIMS EOC structure. This includes the acquisition and provision of health and medical resources based on FHCO/IM-validated and prioritized Requests for Resources (RFRs) submitted through the RFR process to address unmet needs identified 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. This section also oversees the establishment and operation of the ASPR's Mobilization Center. Key mobilization and demobilization functions include: mission briefings/debriefings, personnel accountability, logistics, safety, medical oversight/assessment, occupational health functions such as respiratory protection program activities, and behavioral health support. Finally, the Resource Coordination Section oversees personnel demobilization once a handoff is conducted with the IMT.

Administration and Finance Section. The Administration and Finance Section is responsible for cataloguing and analyzing all incident costs, financial considerations, and administrative matters in support of federal public health and medical activities related to the incident

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[2] Adaptive Planning is a process that allows for the creation and revision of plans rapidly and systematically, as circumstances require. It accommodates changes aimed at improving the probability of success or mitigating risk. It is a collaborative endeavor that requires dialogue with senior leaders; concurrent plan development; and collaboration across the various levels of planning in the organization.

[3] ASPR Office of Strategy, Policy, Planning, and Requirements (SPPR) staff may be assigned to support the SOC Planning Section with the following: 1) Development of strategy; 2) Formulating strategic direction recommendations; 3) Developing recommendations for alternative capabilities to meet operational needs/requirements; 4) Conducting risk analysis; and 5) Collaborating on development of decision support tools.

response. This Section determines financial reporting time lines and appropriate formatting of reports, tracks all incident cost data, and develops operational period costs summary reports. It also provides guidance on fiscally responsible practices in support of mission planning and execution. Additional tasks performed include: timekeeping, financial accountability, compensation and claims, as appropriate, travel reimbursement claims, procurement, Mission Assignment funds management, and the coordination of various administrative support needs. Finally, the Administration and Finance Section ensures that all emergency admin/finance activities are accomplished within the parameters of existing statutes, regulations, and Department policies.

SOC Support Section. The SOC Support Section provides resource, facility, security, communications, and information technology support to ensure uninterrupted functioning of the SOC. In addition, the SOC Support Section coordinates SOC surge staff orientation, just-in-time training, and scheduling to ensure proper staffing across all Command and General Staff positions. The SOC Support Section provides support for all technology used during activation, assisting staff members with administrative- and human resources-related policies and procedures as well as maintaining the status of staff. This section ensures that all personnel conduct activities/operations in a safe and healthy environment; maintains physical security of the SOC facility, staff, and equipment; and assists SOC staff members with the properly handling, protection, and management of sensitive and classified information. Finally, the SOC Support Section publishes and updates the SOC daily operational tempo as needed and maintains the activation roster, contact information, and other pertinent information.

Other Representation. The SOC includes HHS/ASPR staff and representatives from federal interagency partner organizations as well as emergency coordinators from OPDIVs and STAFFDIVs across HHS. Agency Representatives serve as a central point of coordination and communication for their respective department, agency, office, or function. As such, they are required to be able to speak on behalf of their agency or office leadership. Additionally, Agency Representatives may perform in a "dual-hatted" role in that they may be assigned specific functional responsibilities within the SOC's NIMS/ICS-based organizational structure. Individuals serving in this capacity work to ensure that all information within their purview is verified and that all course of action recommendations are coordinated and communicated as appropriate.

3.3.3. *NRCC ESF-8 Support Team*

HHS/ASPR may deploy an individual representative or a Support Team to a federal coordination center to facilitate federal public health and medical coordination during incidents and special events. This occurs most frequently during responses to Stafford Act and non-Stafford Act emergencies under the NRF when an HHS/ASPR National ESF-8 Support Team deploys to the FEMA NRCC. The following section focuses on the role of the ESF-8 National Support Team at the NRCC as the third component of the IST.

3.3.3.1. *NRCC Mission*

The NRCC is a multiagency center that operates from FEMA headquarters to coordinate the overall federal support for major disasters and emergencies, including catastrophic incidents and emergency management program implementation. The NRCC is managed by FEMA and

may operate 24 hours a day/7 days a week in support of an incident response.

The National Response Coordination Staff (NRCS) is responsible for providing coordination, support, and situational awareness for internal and external stakeholders and resolving disaster response resource allocation and policy issues brought to the NRCC for resolution. NRCS members include representatives from across the federal interagency, to include ESF organizations. The NRCS has multiple branches of staff, to include the Resource Support Section, where ESF-8 is located organizationally.

3.3.3.2. *NRCC ESF-8 Support Team Mission*

The NRCC ESF-8 Support Team is requested by FEMA, is activated via the SOC, and reports to the SOC Director while activated. The Team is physically located in the NRCC during incident response and select special events, and serves as a direct link between the SOC, the NRRC/RRCC(s), other relevant ESFs under the NRF, and FEMA headquarters. The NRCC ESF-8 Support Team supports and enables various ESF-8 activities at the field, regional, and headquarters activities. Broadly speaking, ESF-8 is designed to facilitate assistance and information sharing in the following core areas:

- Assessment of public health/medical needs;

- Health surveillance;

- Medical surge;

- Health/medical/veterinary equipment and supplies;

- Patient movement;

- Patient care;

- Safety and security of drugs, biologics, and medical devices;

- Blood and tissues;

- Food safety and defense;

- Agriculture safety and security;

- All-hazards public health and medical consultation, technical assistance, and support;

- Behavioral healthcare;

- Public health and medical information;

- Vector control;

- Guidance on potable water/wastewater and solid waste disposal;

- Mass fatality management, victim identification, and mitigating health hazards from contaminated remains; and

- Veterinary medical support.

The NRCC ESF-8 Support Team is the final authority for reporting content of any and all ESF-

8/HHS statistics and information to be used for planning purposes or input into briefings and reports by the NRCC Situational Awareness Section. The NRCC ESF-8 Support Team also coordinates with its other ESF counterparts in the NRCC to provide expertise, guidance, and resource support as required. In the context of ESF-6, the NRCC ESF-8 Support Team provides expertise, guidance, and resource support on the public health, medical, and human services issues related to mass evacuations and sheltering of populations with various needs. Additional specific roles and responsibilities include:

- Advise FEMA senior leadership and federal Interagency partners on federal public health and medical issues and corresponding HHS ASPR core authorities and capabilities;

- Facilitate situational awareness and the exchange of operational information between the SOC, NRCC, RRCC, federal Initial Operating Facility (IOF)/JFO, and interagency partners (including other activated ESFs) to help promote a common operational picture and a unified response effort;

- Advise the SOC Director on matters related to NRCC and FEMA senior leader focus, priorities, and activities;

- Monitor the status of FEMA Resource Request Forms (RRFs), Mission Assignments, and resource deployment processes for requested HHS resources and capabilities in support of HHS regional and field staff managing federal ESF-8 incident activities;

- Collect information regarding public health and medical CIRs for the incident or event; and

- Participate in NRCC meetings, planning sessions, and other activities, as required.

The NRCC ESF-8 Support Team is activated by the SOC in concert with a NRCC activation directed by FEMA, and follows the staffing schedule set by the NRCC leadership. It is comprised of the following positions at a minimum: 1) Public Health and Medical Unit Lead (PHMUL); and Public Health and Medical Specialist (PHMS). Specific roles and responsibilities for these positions are identified in their respective PTBs. Additional information management resources and/or specialists/SMEs with specific ESF-8 functional area expertise may also be assigned to support the NRCC ESF-8 Support Team mission, as required.

3.4. Incident Management

"Incident Management" refers to the collection of activities executed by the field level of the HHS/ASPR Incident Response Framework. Responsibilities include the direct control and employment of resources; management of incident-level planning, coordination, communications; and the delivery of HHS assistance and resources throughout all phases of incident response or special events preparedness. Generally speaking, most types of incidents or events are managed most effectively and efficiently at the geographic and jurisdictional level closest to the incident as established in NIMS/ICS doctrine and the federal support processes described in the NRF. This concept is equally relevant in the context of incidents and special events with significant public health and medical components and corresponding information sharing and resource coordination needs. (Note: an exception to this general rule would be in the instance of a nation-wide public health emergency such as an emerging infectious disease

outbreak in which multiple regions or the entire country may be considered an "incident site," whereby a national level area command would most likely come into play. Similarly, incidents with impacts at a regional level affecting multiple states may create the need to establish a regional area command encompassing multiple IMTs.) In situations which call for the activation of an IOF/JFO under the NRF to organize and provide federal resource coordination in support of impacted communities' needs, HHS field elements collocate with or operate in close proximity to the IOF/JFO, whenever possible, and work closely with FEMA; other federal ESF partners; SLTT public health agencies; NGOs; and private-sector partners to address incident response requirements and related support.

3.4.1. *Escalating Response*

ASPR regional staff, under the direction of an ASPR RA, have the day-to-day responsibility for developing and maintaining robust relationships with FSLTT officials and private sector healthcare representatives and laying the groundwork for an effective federal response to incidents with public health and medical requirements. Regional staff also often provide technical advice and specific subject matter expertise consultation as needed.

ASPR regional offices typically lead the federal ESF-8 response and coordinate with FSLTT partners in the context of a variety of regional incidents and special events which are generally smaller in size, scope, and complexity, via the ASPR RA, Regional Emergency Coordinators (RECs), and other assigned staff.[4] Regional offices report information to and maintain communication with the SOC to share situational awareness and provide regional context for incidents/events which fall below the threshold of FHCO and IMT activation. Staffing/resourcing decisions for these smaller-scale incidents/events are made in conjunction with the Director of EMMO.

For larger-scale incidents/events, ASPR regional offices are responsible for establishing and maintaining situational awareness, conducting stakeholder coordination, and leading the initial federal public health and medical response until a FHCO is appointed and an appropriate transition occurs. ASPR regional staff will continue to provide significant context and insight to the FHCO throughout the incident response given their regional relationships and knowledge. Regional staff also are typically appointed to key response positions (FHCO, Deputy FHCOs, Chief of Staff, Agency Representatives, etc.) in various incident response coordination locations as described in this Framework.

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[4] The regional ASPR offices, typically responsible for smaller-scale incidents/events or the initial period of a larger-scale response, consist of full-time ASPR staff including: RECs, Hospital Preparedness Program Field Project Officers (HPP FPOs), and Medical Reserve Coordinators (MRCs). Each of the eleven regions, including the National Capital Region (NRC), is led by an ASPR RA. Additionally, the ASPR regional offices receive in-region support from the HHS OPDIVS and STAFFDIVS, normally through the Regional Advisory Committee (RAC), and other USPHS Commissioned Corps officers organized into Regional Incident Support Teams (RISTs). More complete information regarding ASPR regional staff elements, capabilities, roles and responsibilities, and response protocols/procedures is provided in Annex C of this Framework, ASPR Regional Response Annex: Immediate Actions through Escalated Response.

3.4.2. *IMT*

The cornerstone of HHS/ASPR's approach to localized incident management for larger-scale incidents/events under NIMS/ICS doctrine is the IMT. IMTs are comprised of a combination of the following: 1) experienced and specially trained emergency management professionals; 2) ESF-8 public health and medical planners and providers; and 3) regionally based staff who are able to deploy on short notice to support all-hazard incident response activities or who are activated in support of pre-planned special events, as directed by the ASPR or his/her designated representative. Collectively, IMT members have expertise in the core NIMS/ICS-based functions (Operations, Logistics, Plans, and Administration and Finance) and corresponding command and general staff positions; experience with specialized public health and medical assessment, planning, and resource delivery; specific area knowledge (including knowledge of state and local medical and public health response plans and capabilities/capability gaps); and professional relationships corresponding to the HHS region(s) to which many IMT members are assigned.

3.4.2.1. *Mission*

The mission of the IMT is to work with FSLTT, NGO, and private-sector partners to identify the prioritized needs of the communities affected by human-caused or naturally occurring emergencies, identify and coordinate resources to meet those needs, and effectively and efficiently manage HHS/ASPR deployed field resources and capabilities to ensure successful completion of assigned missions. The IMT is organized according to general ICS principles as tailored to meet unique HHS/ASPR mission requirements, with a team-member composition and subject matter expertise that are scalable and adjustable to meet the needs of specific threats, incidents, or special events.

3.4.2.2. *Readiness*

IMT program management leadership and regional office staff coordinate closely on a steady-state basis to ensure that potential IMT members are trained, qualified, and ready to deploy (including fitness testing where applicable, safety training, vaccinations, etc.) based on ASPR Incident Response Qualification System guidance. (Note: see Section 5 below)

3.4.2.3. *Activation*

The decision to activate and deploy an IMT, including an appropriately mission-tailored Advance Team, is made by the ASPR, in consultation with the designated FHCO, HHS/ASPR RA for the impacted region(s), and the ASPR SLT. This decision is formally codified via the SOC's OPORD/TO process. An IMT activation/deployment decision is based on one or more of the criteria identified below:

- In support of direction by the President or Secretary of Health and Human Services;

- Stafford Act situations involving the activation of a federal JFO/IFO, and/or other federal coordination nodes such as a FEMA RRCC; Non-Stafford Act situations involving extensive coordination with FSLTT partners at a regional or local level;

- Situations involving a Public Health Emergency declaration such as in the case of an emergent infectious disease with a highly distributed geographic footprint;

- Situations involving the deployment of HHS resources to the impacted area;

- Support to select, pre-designated special events, including NSSEs; and/or

- As otherwise determined by the ASPR.

An out-of-region IMT may be designated/activated to lead local federal public health and medical response activities in the context of a catastrophic no-notice event in which the impacted HHS ASPR regional staff and/or pre-designated IMT is incapacitated and unable to respond or communicate (e.g., earthquake, catastrophic hurricane, Weapon of Mass Destruction (WMD) incident, etc.). An IMT Advance Team may be activated and deployed prior to the onset of a noticed event (i.e. a hurricane or major flood event, etc.) if there is sufficient time and warning to permit a comprehensive situational assessment by the ASPR and SLT, in coordination with the impacted ASPR RA and designated FHCO/IM.

3.4.2.4. *Organizing Structure/Roles and Responsibilities*

The IMT structure is built out in two distinct components: 1) a scalable Advance Team consisting of initial emergency management leadership, public health and medical needs assessment and planning capabilities, and regional stakeholder network and region-specific subject matter expertise; and 2) follow-on Command and General staff elements and deployable operational capabilities based on a flexible NIMS/ICS structure tailored to meet field-level mission requirements.

A representative, scalable organizing structure for the IMT Advance Team for a complex Level 1 event, including a notional initial Advance Team staffing complement, is depicted in Table 2 below. *The FHCO/IM and Deputies, in consultation with the Director of EMMO, SLT, and the ASPR RA for the impacted region(s), will determine the exact size, composition, staffing source, and geographic positioning of the IMT Advance Team based on relevant situational/operational analysis of mission requirements, as well as the nature of available facilities and the projected geographic footprint of the IMT*. Regional Office staff for the region(s) impacted by the incident will play a significant role in staffing the IMT Advance Team. The FHCO/IM also may be able to leverage FEMA-led Incident Management Assistance Team (IMAT) capabilities (if activated) to address additional key support needs and functions beyond the capabilities provided by this initial IMT Advance Team staffing complement until follow-on staffing support is activated, mobilized, and deployed.[5] The IMT advance element also includes a representative assigned to the FEMA IMAT (if activated and requested) for initial situational assessment, planning, and coordination purposes. The staffing for this HHS ASPR representative to the FEMA IMAT will be

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[5] IMATs are regionally-based response teams that provide a rapidly deployable, forward federal presence to conduct the initial interface with Regional and SLTT partners, usually at the State EOC. The decision to deploy an IMAT rests with the FEMA Administrator and the affected FEMA Regional Administrator(s). IMATS are staffed with subject matter experts who are able to quickly assess the situation, determine the level of required federal support immediately required, establish an initial organized federal presence within the affected SLTT jurisdiction, and assume coordination of the initial federal response. IMATs do not include all federal personnel required to manage the federal response over the long term; rather they provide a core nucleus of personnel that can help rapidly assess the situation, develop an organizational structure to meet immediate operational needs, determine requirements, and identify and order follow-on resources.

situation-specific, but generally will be sourced from an appropriate ASPR regional staff element with regional knowledge and established professional relationships.

Table 2 A notional depiction of scalable IMT Advance Team staffing for a Level 1 activation. Final staffing levels and sources will be determined based on the nature of the incident/event, mission requirements, and initial logistics considerations.

IMT Advance Team Position	Number of Positions to be Filled
FHCO/IM	1
Chief of Staff/Executive Officer (as needed)	1
Deputy FHCO/IM for Mission Generation (D/FHCO-MG)	1
Deputy FHCO/IM for Mission Execution (D/FHCO-ME)	1
Representative to FEMA IMAT	1 Staffed by Regional staff based on situational context; this position may be "dual-hatted" with another advanced IMT Advance Team position
IOF/JFO ESF-8 Core Staff	1-3 Includes Public Health and Medical Unit Lead and Specialist (Staffed by regional staff/intermittent) and Information Management Specialist (staffed by HQ ASPR Incident Management Division staff)
IOF/JFO ESF-8 Mission Specialists	1 TBD based on mission requirements
ESF-8 Representative(s) to RRCC	1 Number of staff TBD based on incident; staffed by Regional staff
ESF-8 Representative(s) to SLTT EOC(s)/Public Health Agency(ies)	Number of staff TBD based on incident; staffed by Regional staff
IMT Operations Section Chief	1 Staffing TBD
IMT Logistics Section Chief	1 Staffing TBD
IMT Plans Section Chief	1 Staffing TBD
IMT Information Management Section Chief	1 Staffing TBD in coordination with HQ ASPR Information Management Division
IMT Admin and Finance Section Chief	1 Staffing TBD

IMT Advance Team Position	Number of Positions to be Filled
IMT Chief Medical Officer	1 Staffed by Regional/ intermittent staff
IMT Public Information Officer	1 Staffed by HQ ASPR staff
IMT IT/Communications Officer	1 Staffed by HQ ASPR IT Division or intermittent staff
IMT Security	1 Staffed by intermittent staff
IMT Safety	1 Staffed by intermittent staff

The IMT Advance Team is responsible for supporting initial incident assessment and resource coordination requirements with ASPR regional staff, FEMA, and the affected SLTT community(ies). The Advance Team is designed to be rapidly deployable with the ability to operate under austere conditions within its assigned area of operations. Once in place, its initial responsibilities include:

- Establish the initial HHS/ASPR forward deployed presence in *accordance with this Framework*;

- Conduct an overall situational assessment and develop an initial strategic approach to HHS/ASPR field level incident management;

- Establish communication channels and conduct liaison with the FEMA IMAT, RRCC ESF-8 Support Team, HHS SOC, Regional Advisory Committee(s) (RACs), and SLTT EOCs/public health agencies;

- Conduct focused information collection activities, in collaboration with ASPR regional staff, based on HHS/ASPR CIRs;

- Conduct/support an initial public health and medical and healthcare system needs assessment in coordination with SLTT and private sector authorities to determine initial priority requirements based on unmet needs; Coordinate and conduct initial planning and Mission Assignment processing with the FEMA IMAT and other federal agency field representatives; SLTT health officials; NGOs; and private-sector partners;

- Establish the initial ESF-8 presence in the Federal IOF/JFO (when activated);

- Identify the need for and positioning additional ESF-8 Agency Representatives with the supported SLTT EOCs and/or public health agencies, as required;

- Conduct outreach with public health and medical leadership and other authorities within the impacted communities, as appropriate;

- Manage the situational awareness picture from the field until the IMT is fully operational via coordination with ESF-8 Support Elements assigned to the RRCC and

State EOCs/public health agencies;

- Coordinate staging areas with the FEMA IMAT and Defense Coordinating Element to find suitable locations for ambulances, teams, and other ESF-8 response resources; and

- Determine IMT follow-on staffing, equipment, and other logistical support requirements.

Once established, the IMT Advance Team assumes command and operational control of follow-on HHS/ASPR teams and equipment designated to support incident operations and other collateral responsibilities. The term "command and operational control" is used to signify that the IMT has authority over and assumes the responsibility for all field-based coordination with FEMA and other intergovernmental and private-sector partners, setting incident objectives, tasking HHS/ASPR and other assigned resources in the forward deployed area of operations, and developing field-level plans.

The typical organizing structure that may be necessary to support a full-scale Level I IMT activation in the field is depicted in Figure 4 below. Again, this structure may vary to some degree from incident to incident based on the specifics of the scenario at hand. An expanded version of this organizational structure depicting branch/unit-level entities and corresponding functional responsibility descriptions is provided in Annex B.

In an ideal situation, all elements of the deployed IMT are grouped together and are collocated with or are located in close proximity to the designated FEMA IOF/JFO. In certain situations, the two Deputy FHCOs and their staffs may have to operate from separate locations. In this circumstance, the FHCO/IM and Deputies will tailor the NIMS/ICS-based Command and General Staff aspects of the IMT in a way that best meets mission generation and mission execution needs.
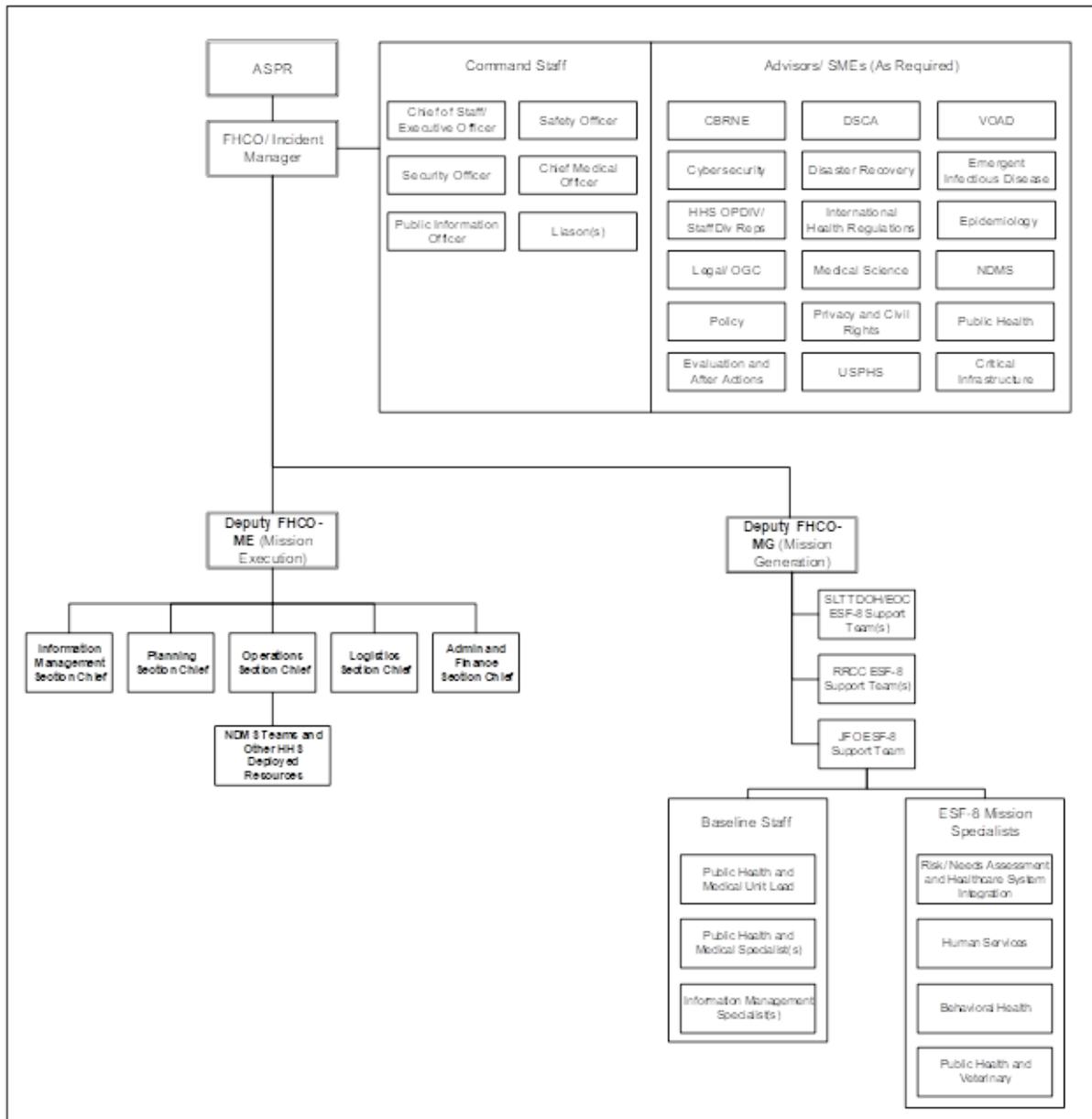
Figure 4 A depiction of the representative IMT staffing organization for a Level I activation, including relevant command and general staff elements based on ICS doctrine.

Key IMT leadership and staff positions and their corresponding roles and responsibilities are described below.

FHCO/IM. The FHCO/IM is designated by and reports to the ASPR, and serves as the lead representative of the ASPR in the field. The FHCO/IM operationally commands and controls all HHS/ASPR deployed personnel resources and capabilities, including NDMS and USPHS Commissioned Corps members assigned to support the incident response or pre-designated special event, and facilitates federal public health and medical support via ESF-8 and other relevant ESFs to the established ICS Unified Command structure overseeing incident response operations or special events preparedness. The FHCO ensures that incident management and

special events preparedness efforts are maximized through effective and efficient coordination. The FHCO/IM also serves as a primary point of contact and situational awareness locally for the ASPR and the ASPR SLT. The FHCO/IM generally collocates with the FEMA IOF/JFO once established. (*Note 1: In those situations in which a designated FHCO is not immediately available, has to travel to assume his or her duties, or is not immediately required due to the scope of the incident/event, the ASPR may designate another individual such as the HHS ASPR RA or a member of the REC cadre to serve as the acting FHCO/IM on an interim basis. In any case, effective and efficient IMT mobilization and deployment will require close coordination between the designated FHCO and regionally-based ASPR leadership, including the RA and REC cadre). (Note 2: More than one FHCO/IM may be designated and more than one IMT deployed if an incident impacts more than one HHS region or multiple states/territories within a region. In this case, an area command structure as discussed in the NIMS also may be activated at the discretion of the ASPR to provide overarching, multi-regional/multi-state command, control, and coordination of HHS resources).*

Specific FHCO/IM roles and responsibilities include the following:

- Represent the ASPR as the lead federal official for all public health and medical incident management activities and special events preparedness at the field level;

- Establish and oversee the HHS/ASPR forward deployed, NIMS/ICS-based IMT structure and operational teams; federal public health and medical support structure; and field-level ESF-8 Support Teams/Agency Representatives;

- In coordination with the ASPR, SLT, and Director of EMMO, provide initial and ongoing strategic guidance and direction for HHS/ASPR IM activities and special events preparedness at the field level;

- Approve the consolidated Incident Action Plan (IAP) governing IM activities for each operational period;

- Establish procedures for joint decision making and documentation with respect to IM and special event preparedness field activities;

- Serve as a primary, although not exclusive, point of contact for federal public health and medical interface with SLTT elected/appointed officials, NGOs, the private sector, and the media[6];

- Coordinate directly with the FCO and participate as a member of the Unified Command Group (UCG) within the federal IOF/JFO (when activated);

- Ensure overall coordination of mission generation and mission execution functions to include federal public health and medical incident management, needs assessment, and resource allocation and coordination activities in support of validated needs;

- Ensure the seamless integration of federal ESF-8 related activities in support of and in

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[6] Additional interface may be conducted by ASPR leadership and staff, including the RA, RECs, and others, based on mission needs as well as pre-existing relationships and regional knowledge.

coordination with appropriate SLTT entities and NGOs;

- Serve as ultimate validation authority for field-level federal ESF-8 related Requests for Resources (RFRs), Mission Assignments, and other resource support requests in concert with SLTT requirements;

- Provide leadership, guidance, support, and direction to the Deputy FHCOs/IMs for Mission Generation and Mission Execution, respectively, to identify, validate, prioritize, and execute Mission Assignments;

- Lead IMT Advance Team and special events preparedness coordination activities;

- Ensure the timely provision of localized incident information and situational awareness to the ASPR, ASPR SLT, Director of EMMO, and the SOC Director;

- Establish procedures for capturing lessons learned and best practices resulting from IM activities;

- In conjunction with the impacted ASPR RA(s), establish procedures for coordinating with and providing bi-directional information flow between the deployed IMT and RAC members; [7]and

- Ensure overall readiness for deployment and participate in ongoing steady-state preparedness efforts in their assigned geographic area of operations.

The FHCO is assisted by two deputy FHCOs as discussed in the paragraphs that follow. The FHCO and Deputy FHCOs will coordinate frequently with one another to maintain situational awareness of evolving situations/missions, resource capabilities/shortfalls, and the operational footprint of the IMT and deployed response assets and teams.

Deputy FHCO/Deputy IM for Mission Generation (D/FHCO-MG). Acting under guidance provided by the FHCO/IM, the D/FHCO-MG oversees the public health and medical assessment and needs generation, validation, prioritization, and Mission Assignment processes in close collaboration with the FEMA FCO, federal ESF leads, and other intergovernmental partners, including SLTT public health and medical authorities, private sector officials, and NGOs, as appropriate. The D/FHCO-MG generally collocates with the FEMA IOF/JFO once established. (Note: Depending on the geographic scope of the incident, the FHCO may elect to designate more than one D/FHCO-MG to provide dedicated support for each impacted State or Territorial partner in a wide area incident).

Specific roles and responsibilities of the D/FHCO-MG include the following:

- Oversee the establishment and ongoing activities of the ESF-8 function within the IOF/JFO;

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[7] Each HHS Regional office has an established RAC, comprised of leadership from each of the HHS regional components, which is responsible for regional-level planning and communication. This group is poised to provide additional situational awareness during a response. During a response, the RAC Lead will coordinate and provide bi- directional information flow between the IMT and RAC members.

- Provide support to and coordination with other ESFs within the IOF/JFO and participate in other JFO activities, as required;

- Oversee the overall synchronization, coordination, and integration, as appropriate, of the various ESF-8 Support Teams/ASPR Representatives (including the JFO, RRCC, and SLTT DOH/EOC ESF-8 Support Teams, when activated) established to support incident management activities;

- Establish and maintain a common operating picture with FSLTT partners and provide significant information input to the IMT Plans/Information Management Sections on a frequent and ongoing basis;

- Support the conduct of rapid and ongoing situational and needs assessments and the identification, validation, and prioritization of unmet public health and medical and healthcare system needs;

- Work with FSLTT and other partners to develop and adjust strategic direction as required;

- Identify and coordinate resource support via the FEMA Mission Assignment process in close collaboration with the SOC Staff, FEMA IOF/JFO staff, NRCC/RRCC staff, and the DFHCO-ME and staff;

- Work with the D/FHCO-ME staff to support IAP development;

- Communicate regularly with the DFHCO-ME to ensure mission needs are met in a timely manner and adjust as necessary;

- Coordinate with the RAC for the impacted region(s) on an as-needed basis to keep the ESF 8 regional partners informed and to solicit technical advice/resource support as needed;

- Determine follow-on ESF-8 Support Team staffing, equipment, and other logistical support requirements; and

- Provide additional support to the FHCO/IM as directed.

Deputy FHCO/Deputy IM for Mission Execution (D/FHCO-ME). Acting under guidance provided by the FHCO/IM, the D/FHCO-ME oversees the establishment and day-to-day operation of the IMT's NIMS/ICS-based General Staff and deployed specialized response teams. He/she is responsible for ensuring the successful completion of all tasks assigned to the IMT General Staff and deployed teams and that all deployed personnel adhere to established mission parameters. He/she also ensures that deployed IMT staff and ASPR operational teams have the necessary equipment and personnel to accomplish the mission, and provides for the ongoing care, safety, sustenance, and logistics support of deployed personnel. The D/FHCO-ME and assigned staff may be collocated with the FEMA IOF/JFO, once established, or operate from a location used as a staging area for deployed teams or another location, as determined by mission needs. The ultimate decision on where to locate will be reached via coordination between the FHCO/IM, D/FHCO-ME, and the Director of EMMO.

Specific roles and responsibilities of the D/FHCO-ME include the following:

- Based on overall guidance provided by the FHCO/IM, oversee the establishment and sustained operation of the deployed IMT NIMS/ICS-based General Staff organizational structure in consideration of incident-specific impacts and support requirements;

- Maintain ongoing situational awareness and provide situational reports and other key information to the ASPR, ASPR SLT, and Director of EMMO via the SOC;

- Support the D/FHCO-MG and participate in the public health and medical planning needs assessment process in coordination with other IMT elements, federal agency field representatives, SLTT health officials, NGOs, and private-sector partners;

- Oversee development of the consolidated IAP governing all IMT activities for each operational period;

- Assist in the coordination of public health and medical resource support to address unmet needs in close collaboration with the D/FHCO-MG and the SOC Director;

- As directed by the FHCO/IM, provide day-to-day operational oversight and coordination of HHS/ASPR deployed teams and capabilities;

- Communicate and collaborate with the DFHCO-MG regarding the utilization of field assets;

- Maintain accountability of IMT staff and ASPR teams at all times;

- Determine and source IMT follow-on staffing, equipment, and other logistical support requirements;

- Oversee IMT demobilization upon the conclusion of response activities; and

- Provide additional support to the FHCO/IM as directed.

IMT Command Staff. The FHCO/IM and Deputy FHCOs jointly identify and assign Command Staff, physically or virtually, as needed, to support the command function. The Command Staff reports to the FHCO/IM via the Chief of Staff (CoS) (or directly to the FHCO if a CoS is not assigned), and supports both the mission generation and mission execution functions of the deployed IMT, as required. The baseline Command Staff will typically include a CoS/Executive Officer (as needed), PIO, Safety Officer, Security Officer, CMO, and a Liaison Officer(s).

Additional Command Staff advisor or technical specialist positions may be established as needed, either physically or virtually, based on the incident at hand including, but not limited to, the following advisory and/or subject matter expertise:

- Policy

- International Health Security/IHR

- Legal/Office of the General Counsel

- Privacy and Civil Rights

- Medical Science

- Public Health

- Disaster Recovery

- NDMS

- USPHS

- Voluntary Organizations Active in Disaster (VOAD) (as appropriate)

- DoD (Defense Support to Civil Authorities expert)

- CBRN

- Epidemiology

- Emergent Infectious Diseases

- Critical Infrastructure

- Cybersecurity

- Evaluation and After Action

- Agency Representatives

In the event the IMT is split between two or more physical operating locations, the FHCO, in consultation with the Deputy FHCOs and CoS, will determine the optimum physical location for the baseline Command Staff and additional specialists/technical advisors.

In addition to the positions identified above, it may be necessary to draw upon Agency Representatives from other HHS OPDIVs/STAFFDIVs or from HHS' federal interagency partners to ensure the proper capability is on hand to address specific issues. In this context, these representatives are SMEs who serve as action officers on specific matters within their areas of expertise. In addition, they provide situational awareness updates to the IMT leadership and ESF-8 Support Teams assigned to the JFO and SLTT EOCs and public health agencies within their assigned focus areas. For example, it may be necessary for the Centers for Medicare & Medicaid Services (CMS), Food and Drug Administration (FDA), or the CDC to deploy representatives to address their specific agencies' activities as they pertain to the response.

Requirements for OPDIV or STAFFDIV support will be determined by the specific public health and medical circumstances of the federal response.

IMT General Staff. The General Staff consists of the Information Management, Operations, Planning, Logistics, and Finance/Administration Section Chiefs. These individuals are responsible for supporting the various functional aspects of the overall IM structure. The FHCO/IM activates these section chiefs as needed based on consideration of a variety of situational and operational factors. The General Staff reports to the D/FHCO-ME on a day-to-day basis while deployed.

Information Management Section Chief. The Information Management Section Chief directs information management activities within the IMT. The IMT's Information Management Section is responsible for providing field-level public health, medical, and human services response

situational awareness and a common operating picture; developing a field-level, incident-specific Information Management Plan; collecting and analyzing FSLTT and private sector information (including HPP and healthcare coalition data) relevant to the response and established CIRs; responding to and tracking the status of RFIs at the field level; developing consolidated situation reports (SITREPs) and providing information for input into the IAP and HHS SLBs; and providing decision support to the FHCO/IM and deputies, IMT General Staff Sections, and other elements of the HHS/ASPR field-level incident response structure. These responsibilities are accomplished by establishing a seamless and integrated deployed information management structure and supporting processes and ensuring close collaboration with HHS's field level response partners and with the SOC's Information Management Section.

Planning Section Chief. The Planning Section Chief is responsible for directing planning and related support activities within the IMT. The Planning Section, supported by the Information Management Section, is responsible for developing and maintaining the overall daily IAP, which is intended to establish and communicate initial and ongoing incident management priorities, objectives, and strategies in support of validated SLTT requirements. The Planning Section also conducts resource coordination planning, current operations and future operations planning (such as recovery and demobilization), and adaptive planning activities. Finally, the Planning Section performs contextual interpretation of incident information and supports senior leader decision making at the field level.

Operations Section Chief. The Operations Section Chief is responsible for overseeing the conduct of various tactical activities to achieve the incident objectives established by the FHCO/IM and deputies and codified via the IAP development process. Operations Section activities typically focus on saving lives, reducing the immediate hazard, protecting property and the environment, establishing situational control, and restoring normal operations. The Operations Section is organized based on the nature and scope of the incident; the jurisdictions and organizations involved; and the priorities, objectives, and strategies developed to guide the incident response. Key functions of Operations Section personnel include the following: 1) direct the management of tactical activities on the FHCO/IM's behalf; 2) develop and implement strategies and tactics to achieve incident objectives; 3) support IAP development for each operational period; 4) oversee, maintain accountability, and monitor the employment of HHS resources and teams; and 5) maintain the pulse on the effectiveness of HHS resource and team employment as well as the health and welfare of team members.

Logistics Section Chief. The Logistics Section Chief is responsible for directing the Logistics Section of the IMT. The Logistics Section supports all IMT-level logistics functions under the NIMS/ICS structure. This includes coordinating with the SOC in the acquisition and provision of health and medical resources based on unmet needs identified by the ASPR incident management field structure, and identifying and filling shortfalls or gaps in the ASPR field organization's ability to support operational requirements and unmet resource needs. The Logistics Section also coordinates with the SOC regarding the operation of the HHS/ASPR Mobilization Center and the logistics needs of deploying teams and personnel.

Administration and Finance Section Chief. The Administration and Finance Section Chief is responsible for directing the Administration and Finance activities of the IMT. Administration

and Finance Section responsibilities include: developing and maintaining financial documentation related to the incident response; executing and overseeing acquisition actions and relevant vendor contracts at the field level, including emergency purchases; tracking and analyzing incident-related costs; and reconciling operational records with financial documents. The Administration and Finance Section ensures that all emergency finance and acquisition activities are accomplished within the parameters of existing statutes, regulations, and Department policies.

3.4.2.5. *IMT Staffing*

Key leadership positions within the IMT, particularly those corresponding to the IMT Advance Team, are staffed largely by a core cadre of ASPR regional office and select headquarters personnel with a mix of emergency management and public health and medical planning expertise, along with regional familiarity and professional relationship networks. Additional staff is provided via intermittent employees, subject to the policies and conditions of employment outlined by NDMS. Additional staff may also be assigned from other government full-time equivalent (FTE) personnel and from the USPHS. Personnel from other sources are subject to the personnel and administrative policies of their employer. For complex, larger-scale or multiple or overlapping disasters, public health emergencies, incidents, longer deployments, or special events, it may be necessary to seek supplemental personnel resources from other internal (e.g., HHS OPDIVs/STAFFDIVs) and/or external federal partners (e.g., VA, DoD, U.S. Coast Guard, etc.) to staff IMT positions. Achieving efficiencies in IMT staff operations requires the in-advance cross-training of IMT personnel to allow individuals to perform more than one function where and when appropriate. This allows the FHCO/IM and his/her deputies to build out the team as the mission dictates, and to appropriately rotate members during extended operations or in the event of illness.

3.4.3. *Mission Generation: SLTT ESF-8 Support Teams/Representatives*

The IMT leadership typically is supported by a Support Team or a Representative (s) assigned to various SLTT EOCs, SLTT public health agencies, and other coordination nodes activated to support SLTT public health and medical situational awareness, needs assessments, planning, resource coordination, and related information requirements based on the nature of the emergency at hand.[8] These individuals are typically activated, deployed, and initially staffed by the ASPR RA for the impacted region in consultation with the designated FHCO/IM. Once in place, they report initially to the RA and then the D/FHCO-MG (once activated and in place) and work to provide a direct link between the IMT, JFO and RRCC ESF-8 Support Teams, and impacted SLTT partners and/or resource providers. The SLTT ESF-8 Support Team/Representative positions are normally staffed by the affected regional ASPR staff who maintain familiarity with SLTT stakeholders, programs, plans and capability gaps, etc. The roles and responsibilities performed by these individuals are largely intergovernmental affairs centric requiring well-honed interpersonal and subject matter expertise. They often interface with governors, state cabinet secretaries, state health officers, state emergency management directors, and state public health preparedness directors. SLTT ESF-8 Support Teams/Representatives provide technical advice and coordination throughout the incident response or special event. Additional specialists/SMEs may also be assigned to support the SLTT ESF-8 Support Team mission, as required, as the response progresses.

Specific roles and responsibilities of deployed SLTT ESF-8 Support Teams/Representatives include the following:

- Advise the SLTT organization to which they are assigned on matters related to the federal public health and medical response and corresponding HHS/ASPR core authorities and capabilities;

- Facilitate situational awareness and the exchange of operational information to help promote a common operational picture and a unified response effort;

- Assist SLTT officials with the drafting of requests through the EMAC and/or the federal Mission Assignment process; Advise the ASPR RA, FHCO/IM, IMT leadership, and SOC

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[8] SLTT public health agencies may activate their own EOCs to support their response missions or elect to conduct coordination as part of a multi-agency SLTT EOC. They may also elect to send a representative to a multi-agency SLTT EOC while activating their own EOC to facilitate their own unique incident response requirements. HHS ASPR Regional staff will be postured to support any of these options based upon the situation.

leadership on matters related to SLTT focus, priorities, and activities;

- Provide support to and coordinate with representatives of other ESFs operating within the SLTT EOC or other EOC to which they are assigned;

- Maintain ongoing coordination with the SOC and IMT, as required;

- Support the conduct of a public health and medical risk and needs assessment (including factors related to at-risk populations) and planning activities in coordination with other IMT elements, federal Interagency field representatives, SLTT health officials, and private-sector partners;

- Collect information regarding public health and medical CIRs for the incident or event; and

- Provide additional support to the SLTT agency to which assigned as required.

3.4.4. *Mission Generation: RRCC ESF-8 Support Team*

HHS/ASPR may deploy an ESF-8 Regional Support Team to a federal regional coordination center to facilitate federal public health and medical operations during incidents and special events. This occurs most frequently during responses to Stafford Act and non-Stafford Act emergencies under the NRF when an ESF-8 Support Team deploys to a FEMA RRCC. The following section focuses on the role of HHS/ASPR Regional ESF-8 Support Teams assigned to RRCCs.

The RRCC is a standing multiagency center that FEMA operates in nine of its ten regional offices (excluding FEMA Region IX which defaults to a JFO activation). The RRCC serves as the primary situational awareness and coordination center for support to FEMA's incident management activities at the UCG level in the field. In the context of an emergent threat or incident, the FEMA RA or designee activates the RRCC staff, which may include FEMA personnel, relevant ESFs (including ESF-8), and other personnel (including nongovernmental organizations and private sector representatives when appropriate) to provide needed resources and policy guidance to support an incident and coordinate with the NRCC. The RRCC staff coordinates federal regional response and support efforts, conducts planning, deploys regional-level entities, collects and disseminates incident information, and maintains connectivity with State EOCs and fusion centers, and other FSLTT operations and coordination centers.

For Stafford Act events, prior to the FCO assuming control of federal incident management responsibilities, the RRCC:

- Activates all RRCC staff positions needed, including ESF coordinators;

- Coordinates within the EOC in the affected state(s) to identify capabilities and anticipate shortfalls to determine initial response and support requirements;

- Processes RFRs for Resources and Mission Assignments in support of the initial response;

- Implements processes for gathering, collating, analyzing, and disseminating incident information to all appropriate parties;

- Provides the NRCC with information necessary to make critical national-level incident management decisions;

- Acquires other federal agencies' resources through the use of Mission Assignments and interagency agreements;

- Establishes mobilization centers and staging areas as needed;

- Deploys Regional IMATs and incident staff; and

- Requests the deployment of a National IMAT(s) or additional Regional IMATs from other Regions when needed.

When the FEMA FCO is in place and the federal JFO becomes operational, the RRCC:

- Maintains situational awareness of the incident to support the FEMA Regional Administrator's incident management oversight role; and

- Develops and implements Regional Support Plans to source and address identified resource shortfalls.

An ESF-8 Support Team is activated and assigned to the FEMA RRCC(s) during incident response and select special events. Team members provide a direct link with the RA, SOC, NRCC ESF-8 Support Team, and the HHS/ASPR IMT. RRCC ESF-8 Support Team/Representative positions are normally staffed by the affected ASPR regional office staff who maintain familiarity with regional stakeholders, programs, plans and capability gaps, etc. The RRCC ESF-8 Support Team is designed to facilitate assistance and information sharing in the core areas described in Section 3.3.2.2 above.

The RRCC ESF-8 Support Team is the final authority for reporting content of any and all HHS/ESF-8 statistics and information to be used for planning purposes or put into briefings and reports by the RRCC Situational Awareness Section. Additional specific roles and responsibilities include:

- Advise FEMA regional leadership and federal Interagency partners on federal public health and medical matters and corresponding HHS ASPR core authorities and capabilities;

- Facilitate situational awareness and the exchange of operational information between the SOC, NRCC, RRCC, IOF/JFO, IMT, and interagency and private-sector partners to help promote a common operational picture and a unified response effort;

- Advise the FHCO/IM and the SOC Director on matters related to RRCC focus, priorities, and activities;

- Provide technical assistance to SLTT public health agencies in developing scopes of work and processing Mission Assignment requests;

- Facilitate and monitor the status of the Mission Assignment and resource deployment processes regarding requested HHS and or ESF-8 assets and capabilities;

- Collect information regarding public health and medical CIRs for the incident or event;

and

- Participate in RRCC meetings, planning sessions, and other activities, as required.

In concert with a RRCC staff activation directed by FEMA, the RRCC ESF-8 Support Team is activated and deployed by the HHS ASPR RA for the impacted region, in consultation with the designated FHCO/IM, and is staffed by the HHS/ASPR REC cadre for the impacted region. Once activated, the RRCC ESF-8 Support Team reports initially to the RA, and then to the designated FHCO for the incident via the D/FHCO-MG (if a FHCO has been designated for the incident/event). The RRCC ESF-8 Support Team follows the staffing schedule set by the FEMA RRCC leadership.

The RRCC ESF-8 Support Team is comprised, at a minimum, of the following positions: 1) Public Health and Medical Unit Lead; and 2) Public Health and Medical Specialist. Specific roles and responsibilities for these positions are identified in their respective PTBs. Additional specialists/SMEs may also be assigned to support the RRCC ESF-8 Support Team mission, as required. The FHCO coordinates with the SOC to obtain additional RRCC Support Team staffing and other augmentation required beyond that available at the regional level.

3.4.5. *Mission Generation: JFO ESF-8 Support Team*

The FHCO/IM may request the deployment of a Support Team to a Federal JFO or other incident management hub to facilitate federal public health and medical needs assessment, coordination, and information sharing during larger-scale incidents and special events. This occurs most frequently during responses to Stafford Act and non-Stafford Act emergencies under the NRF when an HHS/ASPR ESF-8 Support Team deploys to a Federal JFO. The following section focuses on the role of the HHS/ASPR ESF-8 Support Team assigned to a JFO.

The JFO is a temporary, federal multi-agency coordination center, established locally to facilitate field level response coordination and other activities. It provides a central location for coordination of federal, SLTT, nongovernmental, and private-sector organizations involved in field-level incident management activities. The importance of adequately staffing the JFO cannot be overstated, as the JFO provides the forum to engage the interagency at the field level and develop long-term solutions to the most pressing incident impacts.

The JFO is the center of gravity for all federal field-level information and resource coordination related to an incident/event. It develops a common operating picture by tapping into activities of all engaged FSLTT, private sector, and NGO partners involved in the response. HHS is both a supplier and a user of the field level information that is developed in and/or collected by the JFO to support incident response planning and resource coordination.

The FHCO/IM is supported by a dedicated staff assigned to the IOF/JFO to support various activities related to the public health and medical response in the field. Activated by the FHCO/IM and reporting to the D/FHCO-MG, this ESF-8 Support Team provides a direct link between the IMT; FEMA JFO staff; other ESFs activated and operating from the JFO; ESF-8 NRCC and RRCC Support Teams; and activated SLTT EOCs and public health agency EOCs (where additional ESF-8 federal representatives are positioned). This Support Team is designed to facilitate planning, information sharing, and resource coordination in the core ESF-8 functional

areas described above.

The JFO ESF-8 Support Team is the final authority for reporting content of any and all federal public health and medical statistics and information to be used for planning purposes or put into briefings and reports by the JFO. Additional specific roles and responsibilities include:

- Advise the FEMA JFO leadership and federal Interagency partners on matters related to the federal public health and medical response and corresponding HHS ASPR core authorities and capabilities;

- Facilitate situational awareness and the management and exchange of operational information to help promote a common operational picture and a unified response effort;

- Advise the FHCO/IM and IMT leadership on matters related to JFO focus, priorities, and activities;

- Provide support to and coordinate with other ESFs within the IOF/JFO and participating in JFO activities, as required;

- Maintain ongoing coordination with HHS/ASPR Support Teams/representatives posted to the FEMA NRCC/RRCC(s), SLTT EOCs, SLTT public health agencies, and other coordination nodes;

- Support public health and medical and healthcare system risk and needs assessments (including factors regarding at risk populations) and planning activities in coordination with other IMT elements, federal agency field representatives, SLTT health officials and emergency managers, NGOs, and private-sector partners;

- Identify and coordinate prioritized resource support via the FEMA Mission Assignment process in close collaboration with the FEMA IOF/JFO staff, NRCC/RCCC staff, and the Deputy FHCOs for MG/ME and staff;

- Provide technical assistance to SLTT public health agencies in developing scopes of work and processing Mission Assignment requests;

- Draft, develop, submit, and track Mission Assignments related to public health and medical requirements;

- Facilitate and monitor the status of the Mission Assignment and resource deployment processes regarding requested HHS resources and capabilities;

- Collect information regarding public health and medical CIRs for the incident or event; and

- Provide additional support to the FHCO/IM as directed.

JFO ESF-8 Support Team Staffing. The JFO ESF-8 Support Team is comprised of a baseline staff and additional ESF-8 mission specialists/SMEs who are activated based on the scenario at hand. The baseline staff includes individuals with appropriate training and experience regarding JFO ESF-8 operations and the FEMA Mission Assignment process and related coordination and

documentation requirements, as well as information management requirements specific to the JFO ESF-8 Support Team. Mission area specialists/SMEs are assigned to the JFO ESF-8 Support Team, as required, to support risk analysis, needs assessment, strategic and operational planning, and resource coordination and delivery in the following areas:

- Public Health and Veterinary, maintaining a focus on potential emergent infectious diseases and veterinary issues;

- Risk Assessment and Healthcare and Healthcare Systems Integration, maintaining a focus on: 1) patient triage, referral, movement, and case management; 2) integration of public and private healthcare programs and capabilities; and 3) assessment of and reporting on the status of medical and health facilities, resources, operating capability and unmet needs;

- Human Services, maintaining a focus on: 1) identifying and facilitating resources to meet critical support needs for at-risk populations; 2) integrating public and private resources and capabilities and identifying "wrap-around" needs; and 3) implementing an effective case management system; and

- Behavioral Health, maintaining a focus on: 1) force health protection; 2) impacted populations; and 3) integrated public-private assistance and support.

3.4.6. *Mission Execution: NDMS Teams and Other Deployable Capabilities*

NDMS. The NDMS is a federally coordinated healthcare system and partnership comprising HHS, DHS, DoD, and the VA, working in collaboration with states and other appropriate public or private entities. Its purpose is to support SLTT authorities in the wake of disasters and public health emergencies by supplementing health and medical systems and response capabilities.

HHS/ASPR employs the NDMS to provide patient care, patient movement, and definitive care, as well as veterinary services and fatality management support when requested by SLTT authorities or other federal agencies. Examples of common missions supported by the NDMS include: augmenting a hospital in a disaster area to decompress an overtaxed emergency department; providing veterinary services to federal working animals during NSSEs, such as the Presidential Inauguration; or supporting the National Transportation Safety Board and affected localities with fatality management services following major transportation disasters. Although NDMS is primarily a domestic disaster response capability, NDMS teams and personnel have also responded to disasters internationally, such as in Iraq and Haiti following devastating earthquakes.

NDMS has three major components:

- Emergency medical response by medical teams made up of Intermittent Federal Employees (IFEs) (civilians who are hired as federal employees with intermittent schedules and can be activated when necessary to participate in Federal NDMS duties), equipment, and supplies deployed to a disaster area when requested by SLTT authorities or to a location determined by the Secretary to be at risk of a public health emergency;

- Movement of ill and injured patients from a disaster area to areas unaffected by the incident; and

- Definitive care of patients at hospitals in areas unaffected by the incident.

Over 5,000 NDMS civilian medical personnel (IFEs) are organized into a number of types of teams, each designed to provide specific medical capabilities supporting the federal public health and medical mission during incident response and in preparation for special events:

- **Disaster Medical Assistance Team (DMAT)**. Provides medical care during a disaster or other incident.

- **Disaster Mortuary Operational Response Team (DMORT)**. Provides forensic analysis of human remains in order to identify victims following a disaster or major transportation incident.

- **Victim Identification Center (VIC)**. Conducts interviews with family members to gather ante mortem information, including DNA samples, to assist in identifying human remains.

- **National Veterinary Response Team (NVRT)**. Provides veterinary services in a disaster area, or assessment and consultation regarding the need for veterinary services following major disasters or public health emergencies.

- **Federal Coordinating Centers (FCCs)**. Receive, triage, stage, track, and transport inpatients affected by a disaster or national emergency to a participating NDMS medical facility capable of providing the required definitive care.

- **Trauma Critical Care Team (TCCT)**. A specialized team of medical professionals trained, and equipped to establish a fully capable field surgical facility anywhere in the world.

NDMS personnel can also be mobilized via the SOC on a team or on an individual basis to support specialized staffing needs identified by the SOC Director and/or FHCO/IM across the key nodes of the HHS/ASPR Incident Response Framework, consistent with the statutory purposes for which NDMS IFEs can be activated. Specific protocols regarding NDMS alert/notification, activation, mobilization, processing for deployment, and demobilization are provided in a separate SOP maintained on the HHS/ASPR Emergency Management (EM) Portal. Once in place at the final deployment location, NDMS teams and personnel are directed by the D/FHCO-ME via the IMT Operations Section Chief based on incident objectives established by the IMT leadership. The Operations Section Chief relies on the internal command structure of the deployed teams to ensure efficient and effective operations at the team level. The Operations Section Chief or designee conduct daily coordination calls or visits with deployed teams whenever possible.

USPHS. The USPHS maintains a variety of response teams and capabilities that are designed to provide resources and assistance to SLTT health authorities throughout the U.S. These capabilities were created in 2006 as part of the NRF's ESF-8 public health and medical resources provisions. USPHS response teams may be deployed in response to an ESF-8 or non-ESF-8 public health emergency.

A brief description of the various USPHS response teams is provided below:

- **Rapid Deployment Forces (RDFs)**. RDFs provide the following: 1) mass care (primary care, mental health, and public health services for sheltered populations); 2) point of distribution operation (mass prophylaxis and vaccination); 3) medical surge; 4) isolation and quarantine; 5) pre-hospital triage and treatment; 6) community outreach and assessment; 7) humanitarian assistance; 8) on-site incident management; 9) medical supplies management and distribution; 10) public health needs assessment and epidemiological investigations; 11) worker health and safety; and 12) animal health emergency support.

- **Applied Public Health Teams (APHTs)**. APHTs provide the following: 1) epidemiology/surveillance; 2) preventive (medical) services delivery (e.g., disease prevention, vaccinations, laboratory information, health information); and 3) environmental public health (air, water, waste, vectors, food, safety, shelter, etc.).

- **Mental Health Teams (MHTs)**. MHTs provide the following: 1) incident assessment and personnel assessment (diagnosis and treatment); 2) screening for suicide risk, acute and chronic stress reactions, substance abuse, and mental health disorders; 3) supporting development of behavioral health training programs for impacted populations; 4) specialized counseling; and 5) psychological first aid, crisis intervention and time-limited counseling for serious mental illness and/or substance abuse.

- **Services Access Teams (SATs)**. SATs provide the following: 1) needs assessment; 2) plan development/cultural sensitivity; 3) advocating/connecting; 4) clinical care coordination; 5) continuity/transition management; 6) psycho-social management; 7) re-integration; and 8) confidentiality assurance.

- **National Incident Support Teams (NISTs)**. NISTs provide the following: 1) continual event needs assessment; 2) support and direction for incoming response resources; 3) coordination of deployed field resources; 4) liaison with SLTT officials; 5) on-site incident management; 6) response personnel health and safety; and 7) demobilization support.

- **Regional Incident Support Teams (RISTs)**. RISTs provide the following: 1) rapid event needs assessment; 2) support and direction for incoming response resources; 3) liaison with SLTT officials; 4) on-site incident management; and 5) response resource health and safety.

- **Capital Area Provider Teams (CAPTs)**. CAPTs provide the following: 1) first responder and primary care; 2) basic and advanced life support; 3) pre-hospital triage and treatment; 4) point of distribution operation (mass prophylaxis and vaccination); 5) medical surge; 6) on-site incident management; and 7) response resource health and safety.

4. HHS OPDIVs/STAFFDIVs

HHS OPDIVs and STAFFDIVs perform a variety of roles and responsibilities with direct relevance to emergency operations, and may be called upon to provide critical health, medical, and

human services in response to incidents and special events, often under their own individual statutory authorities. OPDIVs/STAFFDIVs, including the CMS, CDC, and FDA, have regional representatives in place throughout the country who routinely coordinate a variety of plans and activities with FSLTT officials. OPDIVs/STAFFDIVs also have the authority and ability to deploy additional personnel to conduct the work of their agency in response or recovery operations. When needed, OPDIVs and STAFFDIVs may be called upon to provide a representative(s) to the headquarters and/or field components of the HHS/ASPR Incident Response Framework to facilitate coordination and provide technical assistance/subject matter expertise as needed. For example, it may be necessary to deploy representatives from CMS, FDA, or CDC to the SOC or deployed IMT to address their agency-specific activities as they pertain to the response.

5. Incident Response Staff Training

All personnel supporting headquarters or field incident response activities must be properly trained and qualified to perform their roles and responsibilities as discussed in this HHS/ASPR Incident Response Framework. This requirement applies to ASPR staff as well as to augmentation staff (HHS OPDIVs/STAFFDIVs, USPHS, NDMS, etc.) and individuals representing external federal agencies. Individual training and qualification requirements include a variety of ICS courses offered by FEMA, as well as position-specific courses tailored to the specific duties and responsibilities to which an individual staff member, augmentee, or external agency representative may be assigned. Additionally, PTBs and Job Action Sheets (JAS) have been developed for each function/position to assist in defining and sequencing position-based tasks and activities. The PTBs/JAS provide a roadmap of training elements, performance tasks, and skills verification that are required for each function/position. Completion of the relevant PTB is a critical aspect of the qualification process to fill a SOC, IMT, or Agency Representative position. An HHS/ASPR Incident Response Qualification System, which is a performance-based qualification system, outlines the process necessary to become fully qualified in a specific function/position. In-advance training at the individual position level is supplemented by "just-in-time" training provided to SOC, IMT, and Agency Representative staff in conjunction with an incident or special event activation.

A second aspect of incident response staff training involves collective training and drill/exercise activities to ensure that individuals, sections, and teams supporting each component within the HHS/ASPR Incident Response Framework are skilled in their shared competencies, processes, and mission requirements. Hence, collective training and exercise activities focus on section-level (i.e. SOC and IMT General Staff sections) and overall "team" preparedness (i.e. SOC, IMTs, Support Teams/Representatives). In the case of staff typically assigned to positions on IMTs and ESF-8 Support Teams on a regional basis, an additional focus will be provided on the nuances of that particular region. This collective approach is performance oriented and provides a realistic environment for all elements of the HHS/ASPR Incident Response Framework to learn, test, and evaluate their capability to manage and coordinate assigned public health, medical, and human services response missions. Finally, when possible, IMT-level training and exercise activities training will be conducted in conjunction with scheduled NDMS/DMAT training to enhance the realism of the training/exercise environment.

Incident response staff training and exercise activities should leverage ongoing training and exercise programs and specific events planned, organized, and conducted by FEMA (i.e.

National Level Exercises and Regional Level Exercises), Federal ESF partners, and SLTT entities (i.e. regional, state, and local exercises). The ASPR Exercise, Evaluation, and After Action Division works in conjunction with SOC, IMT, and ESF-8 Support Team training cadres/points of contact to develop and coordinate such activities in coordination with appropriate external stakeholders.

6. Supplemental Incident Response Processes and Procedures

Detailed processes and procedures corresponding to various key elements discussed in this HHS/ASPR Incident Response Framework will be developed and warehoused in the Procedural Document Library located on the HHS/ASPR Emergency Management (EM) Portal. This documentation is intended to provide specific information regarding: processes/procedures for identifying, alerting, and activating key command, control, and coordination nodes; interaction between the SOC and deployed field elements; Mission Assignment life-cycle management; interaction between the IMT and deployed Support Teams/Representatives; etc.

At the onset of a specific incident or pre-planned special event, the SOC will create a link on the HHS/ASPR EM Portal specific to that incident/event. Examples of products typically posted to this incident-specific site include: OPORDs, TOs, RFIs, RFRs, Mission Assignment documentation, modeling products, health and safety guidance, situation reports, event storyboards, etc. The EM Portal also contains information regarding the day-to-day accountability of all SOC incident support staff. The incident-specific site is the main conduit for virtual collaboration for that incident for the SOC and deployed IMTs.

APPENDIX 1: Acronyms

ADA	Americans with Disabilities Act
APHT	Applied Public Health Team
ASPA	Assistant Secretary for Public Affairs
ASPR	Assistant Secretary for Preparedness and Response
BARDA	Biomedical Advanced Research and Development Authority
CAPT	Capital Area Provider Team
CBRN	Chemical, Biological, Radiological, and Nuclear
CDC	Centers for Disease Control and Prevention
CFR	Code of Federal Regulations
CIP	Critical Infrastructure Protection
CIR	Critical Information Requirement
CMO	Chief Medical Officer
CMS	Centers for Medicare and Medicaid Services
COMSEC	Communications Security
CONOPS	Concept of Operations
COOP	Continuity of Operations
CUI	Controlled Unclassified Information
CVI	Chemical Vulnerability Information
DAS	Deputy Assistant Secretary
D/FHCO-ME	Deputy FHCO for Mission Execution
D/FHCO-MG	Deputy FHCO for Mission Generation
DHS	Department of Homeland Security
DLG	Disaster Leadership Group
DMAT	Disaster Medical Assistance Team
DMORT	Disaster Mortuary Operational Response Team
DOD	Department of Defense
DOH	Department of Health
DSCA	Defense Support to Civil Authorities
EOC	Emergency Operations Center
EM	Emergency Management
EMAC	Emergency Management Assistance Compact
EMAP	Emergency Management Accreditation Program
EPAP	Emergency Prescription Assistance Program
EMMO	Emergency Management and Medical Operations
ESF	Emergency Support Function
ESRD	End Stage Renal Disease
FCC	Federal Coordinating Center
FCO	Federal Coordinating Officer
FDA	Food and Drug Administration

FEMA	Federal Emergency Management Agency
FHCO	Federal Health Coordinating Officer
FPO	Field Project Officer
FSLTT	Federal, State, Local, Territorial, Tribal
HHS	Health and Human Services
HPP	Hospital Preparedness Program
HSPD	Homeland Security Presidential Directive
HSIN	Homeland Security Information Network
H&SS	Health and Social Services
IAP	Incident Action Plan
ICS	Incident Command System
IFE	Intermittent Federal Employee
IHR	International Health Regulations
IM	Incident Manager
IMAT	Incident Management Assistance Team
IMT	Incident Management Team
INFOSEC	Information Security
IOF	Initial Operating Facility
ISP	Incident Support Plan
IST	Incident Support Team
IT	Information Technology
JAS	Job Action Sheet
JFO	Joint Field Office
JTTF	Joint Terrorism Task Force
KCER	Kidney Community Emergency Response
LES	Law Enforcement Sensitive
LNO	Liaison Officer
LRAT	Logistics Response Assistance Teams
MCT	Movement Control Team
MC-UL	Mobilization Center Unit Leader
MHT	Mental Health Team
NDMS	National Disaster Medical System
NDRF	National Disaster Recovery Framework
NGO	Nongovernmental Organization
NIMS	National Incident Management System
NIST	National Incident Support Team
NOC	National Operations Center
NPS	National Preparedness System
NRCC	National Response Coordination Center
NRCS	National Response Coordination Staff
NRF	National Response Framework

NSSE	National Special Security Event
NVRT	National Veterinary Response Team
OCIO	Office of the Chief Information Officer
OGC	Office of the General Counsel
ONS	Office of National Security
OPDIV	Operating Division
OPORD	Operations Order
OPR	Office of Primary Responsibility
OPSEC	Operational Security
PCII	Protected Critical Infrastructure Information
PDAS	Principal Deputy Assistant Secretary
PHSA	Public Health Service Act
PHMUL	Public Health and Medical Unit Lead
PHMS	Public Health and Medical Specialist
PKEMRA	Post-Katrina Emergency Management Reform Act
PPD	Presidential Policy Directive
PTB	Position Task Book
RDF	Rapid Deployment Force
RAC	Regional Advisory Committee
REC	Regional Emergency Coordinator
REDDOG	Readiness and Deployment Operations Group
RFR	Request for Resources
RFR-UL	Request for Resources Unit Leader
RFR-TM	Request for Resources Tracking Manager
RIST	Regional Incident Support Team
RM	Resource Manager
RP-UL	Responder Personnel Unit Leader
RRF	Resource Request Form
RRCC	Regional Response Coordination Center
RSF	Recovery Support Function
RTM	Resource Tracking Manager
SAC	Services Access Team
SIOC	Strategic Information and Operations Center
SITREP	Situation Report
SLB	Senior Leadership Brief
SLT	Senior Leadership Team
SLTT	State, Local, Territorial, and Tribal
SME	Subject Matter Expert
SNS	Strategic National Stockpile
SOC	Secretary's Operations Center
SOP	Standard Operating Procedure

SPPR	Strategy, Policy, Planning, and Requirements
SRIA	Sandy Recovery Improvement Act
STAFFDIV	Staff Division
STAM	Staging Area Manager
STLD	Strike Team Leader
SWO	Senior Watch Officer
TCCT	Trauma Critical Care Team
TFLD	Task Force Leader
TO	Task Order
TOM	Task Order Manager
TTM	Travel Team Manager
TUL	Transportation Unit Leader
UCG	Unified Coordination Group
USG	U.S. Government
USPHS	United States Public Health Service
VA	Veterans Affairs
VIC	Victim Identification Center
VOAD	Voluntary Organizations Active in Disaster
VTC	Video Teleconference
WHO	World Health Organization

ANNEX A: SOC Organizational Structure and Staffing for Level I Activation
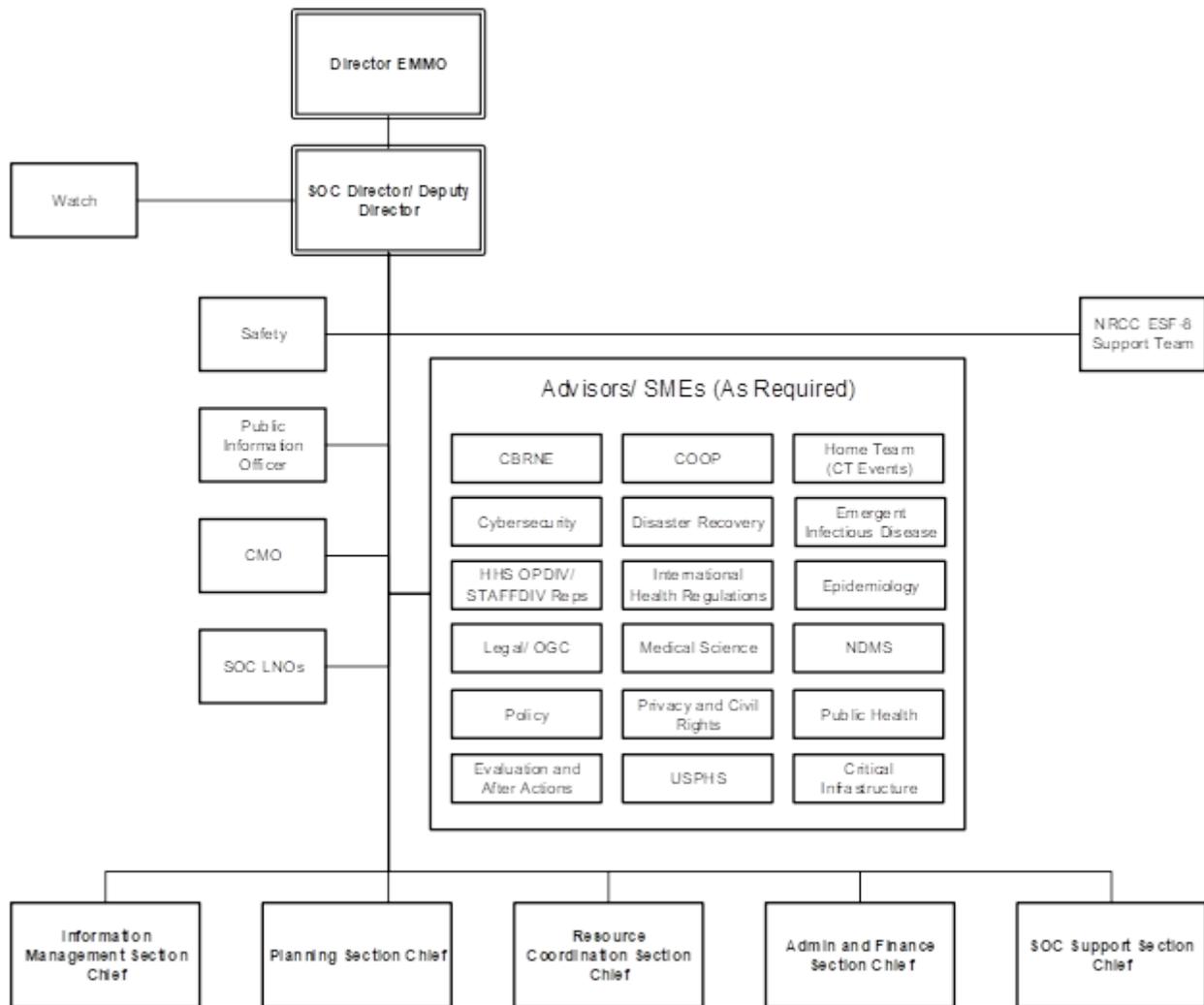
Figure 5 A depiction of the representative SOC staffing organization for a Level I activation, including relevant command and general staff elements based on ICS doctrine.

SOC Command Staff Positions

Baseline Positions (SOC Activation Levels 1-3):

Public Information Officer (PIO): Provides advice and counsel on all aspects of communication with the public, media, and/or with other agencies or organizations leading up to, during, and immediately after an incident or public health emergency response. The PIO identifies strategies for two-way communication between the organization and target audiences. The PIO also develops messaging and communication products consistent with HHS Assistant Secretary for Public Affairs (ASPA) guidance and further based on crisis and emergency risk communication principles to address the public health and medical concerns of internal and external audiences. The PIO coordinates with HHS/ASPA, Information Management, HHS

OPDIVs/STAFFDIVs, and other federal agencies. The PIO works with HHS OPDIVs/STAFFDIVs to identify deployable PIOs to support the IMT and coordinates with deployed PIOs.

Safety Officer: Monitors headquarters-level incident support operations and advises the SOC Director and the ASPR and SLT on matters related to the health and safety of the incident support staff. The Safety Officer is also responsible for establishing the systems and procedures necessary to assess, communicate, and mitigate hazardous conditions, including developing and maintaining the Incident Safety Plan, coordinating multi-agency safety efforts, and implementing measures to promote the safety of incident support staff. The Safety Officer also helps stop and/or prevent unsafe acts during incident support operations.

Chief Medical Officer: Serves as chief medical advisor to the SOC. The CMO coordinates directly with the IMT CMO to assist with medical guidance for ESF #8 health care professionals, serves as a SME on medical issues, contributes to medical surveillance analysis, and provides input into issues concerning quality of medical care and responder health and safety. In addition, the CMO advises on the appropriate medical capability and capacity to support the incident from a strategic perspective, particularly as it relates to team and health care provider capabilities and medical issues pertaining to patient movement.

Liaison(s): Assists in coordination with agencies external to ASPR not represented in the SOC.

Advisors/SMEs (Designated at the discretion of the SOC Director in coordination with the Director of EMMO):

Policy Advisor: Responsible for identifying emergent and potential policy issues and raising them to the SOC Director/EMMO Director for resolution in coordination with appropriate stakeholders. If issues cannot be resolved at the SOC Director/EMMO Director level, the Policy Advisor develops coordinated course of action recommendations for consideration by the ASPR SLT or the DLG, and ultimate decision by the ASPR and/or HHS senior leadership.

International Health Security/IHR Advisor: Responsible for ensuring that all course of action recommendations developed and/or actions taken by the SOC Director/EMMO Director and activated staff components are consistent with international partnerships, agreements, and regulations (including the IHR) to which USG and HHS are bound as international law, in consultation with the Office of the General Counsel as needed. The International Health Security/IHR Advisor recommends the implementation of policies and procedures for responding to requests or requesting public health and medical assistance from international entities; oversees the response to international RFIs; advises on communication with the WHO Health Emergency Programme and other international partners as required under the IHR and other international agreements; and serves as a liaison with the HHS Office of Global Affairs, the Department of State, and other entities involved in the international aspects of a response, etc.

Legal Advisor: Provides legal advice on course of action recommendations developed and/or actions taken by the SOC Director/EMMO Director and activated staff components, when requested. The Legal Advisor recommends alternatives/waivers/exceptions as required to accomplish the HHS/ASPR mission by maintaining awareness of the situation and applying sound legal judgment as appropriate.

Privacy and Civil Rights Advisor: Confirms that course of action recommendations developed and/or actions taken by the SOC Director/EMMO Director and activated staff components comply with applicable privacy and civil rights statutes, Executive Orders and Presidential Directives, and Department policy, in consultation with the Office of the General Counsel as needed.

Science Advisor: Provides evidence-based information to support public health and medical-related decision making needs.

Public Health Advisor: Responsible for maintaining ongoing communication and coordination with CDC operations staff in the context of an emergent infectious disease or other incident with potential or actual public health impacts. The Public Health Advisor is responsible for notifying the SOC Director/EMMO Director of any issues raised by CDC operations as an emergent public health threat or incident.

Disaster Recovery Advisor: Responsible for monitoring, providing advice, and assisting in the development of coordinated course of action recommendations regarding all issues that have a potential or demonstrated impact on community recovery as a part of, or in the aftermath of, response operations.

NDMS Representative: Provides subject matter expertise on the capabilities of the various NDMS Teams by individual team category and supports course of action development regarding NDMS utilization. The NDMS Representative may also assist in tracking and monitoring the status of activated teams and individuals in concert with the SOC's Resource Coordination Section.

USPHS Representative: Provides subject matter expertise on the capabilities of the various USPHS Teams by individual team category and supports course of action development regarding USPHS Team utilization. The USPHS Representative may also assist in tracking and monitoring the status of activated teams and individuals in concert with the SOC's Resource Coordination Section.

VOAD Representative: Collaborates with ASPR by providing subject matter expertise on the capabilities and operations of the various VOADs engaged in the incident response as appropriate. Maintains ongoing communications and coordination with VOADs engaged in activities related to HHS incident response operations and collaborates with the SOC Director/EMMO Director on any potential/ongoing mutual issues or concerns.

DOD Representative: Provides subject matter expertise on DoD's Defense Support to Civil Authorities capabilities, operations, and Mission Assignment/resource deployment and employment processes. The DoD Representative also maintains ongoing communications and coordination with DoD headquarters to maintain awareness of and/or support coordination regarding DoD resources tasked to provide support to or operate in coordination with HHS and its deployed resources/teams.

HHS Home Team Representative: Provides a linkage to the Home Team, a team comprised of HHS headquarters-based personnel serving as the focal point for the Department during pre-incident exigent terrorist-related threats. Further information on the HHS Home Team is provided in a classified annex to this Framework.

CBRN Advisor(s): Provides advice and course of action recommendations regarding all aspects of a CBRN-related incident throughout the incident's life cycle including, but not limited to: agent characterization; human, infrastructure, and environmental effects; HHS responder protection guidance; etc.

Epidemiologist: Provides advice and course of action recommendations regarding all aspects of an incident involving an emergent infectious disease or other public health emergency throughout the incident's life cycle including, but not limited to, disease characterization; potential method/pathway for contagion; human and environmental effects; HHS responder protection guidance; medical countermeasures and other mitigation measures; etc.

Emergent Infectious Disease Advisor: Provides advice and course of action recommendations regarding all aspects of an incident involving an emergent infectious disease or other public health emergency throughout the incident's life cycle including, but not limited to, disease characterization; potential method/pathway for contagion; human and environmental effects; HHS responder protection guidance; medical countermeasures and other mitigation measures; etc.

Critical Infrastructure Advisor: Provides information and decision support to both government senior leadership and private sector partners regarding the operating status and critical needs of the Healthcare and Public Health (HPH) Sector during incident response, with a focus on critical facilities and interconnected supporting infrastructure. The Critical Infrastructure Advisor participates in frequent partnership calls between government and private sector partners during an incident response to establish and maintain situational awareness of HPH Sector operational impacts (including those felt well beyond the localized incident footprint such as regional or national level supply chain impacts), priority restoration and recovery activities, and unmet needs and ongoing concerns. Through established partnership connections and information sharing, the Advisor provides analysis of private sector and critical infrastructure concerns and issues, as well as strategic input on resource prioritization as needed.

Cybersecurity Advisor: Provides advice and counsel on all aspects of an emergent cyber threat or incident across the spectrum of prevention, protection, response, recovery, and mitigation. The Cybersecurity Advisor also maintains ongoing communications and coordination with the HHS Health Cyber Communications and Coordination Center and the DHS National Cyber and Communications Coordination and Integration Center.

Exercise, Evaluation, and After Action Representative: Collects data concerning emerging issues, potential corrective actions, and lessons learned during SOC Level I-III activations in concert with the SOC Director/Deputy Director and activated Section Chiefs. The Exercise, Evaluation, and After Action Representative also facilitates SOC section-specific and overall hot-wash meetings as requested, either during operations or as sections stand down. This representative

also assists in development of the incident after-action report and improvement plan, as needed.

Agency Representatives: Provide advice on matters related to their agency or organization pertinent to the incident response. Agency Representatives also monitor and support the desk for their respective agency or organization during SOC Level I-III activations and provide accurate and timely information regarding HHS's plan of action and other activities relevant to their agency or organization. They participate in SOC planning sessions, briefings, and other activities as required.

SOC General Staff Branch/Unit Level Staffing Organization

Information Management Section
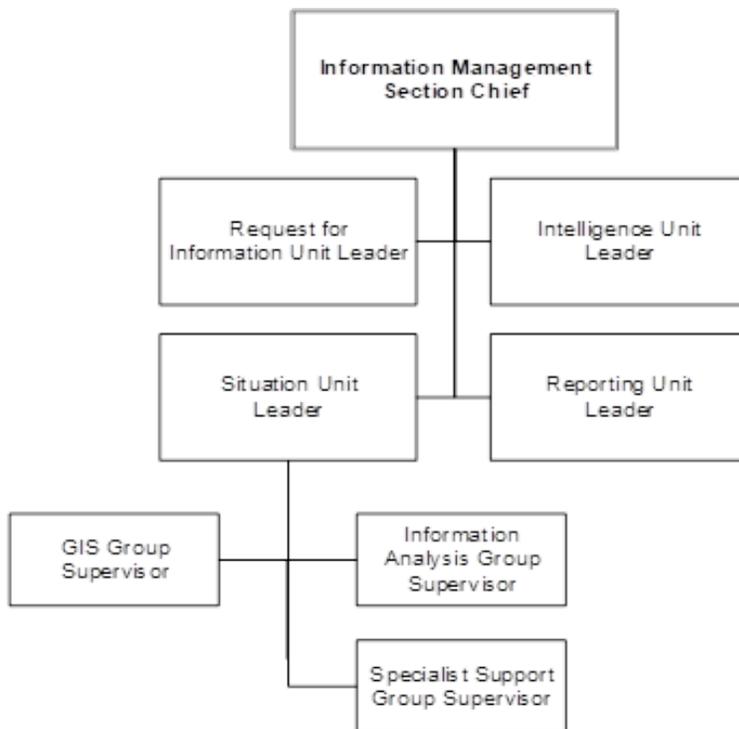
Figure 6 A depiction of the SOC Information Management Section staffing organization.

The SOC's Information Management Section is responsible for maintaining and providing strategic-level public health, medical, and human services response situational awareness; establishing and maintaining a common operating picture; developing an incident-specific Information Management Plan; collecting and analyzing FSLTT and private sector data, as

appropriate (including HPP[9] and healthcare coalition data), relevant to the response and established CIRs; responding to and tracking the status of RFIs; developing consolidated incident situation reports, SLBs, and electronic/geospatial presentations of incident data; informing development of the ISP; sharing appropriate information with field elements of the HHS/ASPR incident response structure; providing HHS Senior Leader decision support; and archiving incident-related data. This is accomplished by establishing a seamless and integrated information management structure and supporting processes throughout the HHS/ASPR incident response organization as well as appropriate information coordination at the strategic level with federal and international partners.

The Information Management Section is comprised of the following primary elements: RFI Tracker, Situation Unit, Information Analysis Group, GIS Group, Specialist Support Group, Reporting Unit, and the Intelligence Unit (incident dependent). These elements are described in further detail below.

RFI Tracker. Responsible for tracking and addressing all RFIs that come through the SOC. This includes managing the full RFI process, assigning RFIs to the appropriate party for adjudication at the national level, providing responses to the initial requestor, and archiving RFI responses once complete. This position coordinates closely with the NRCC ESF-8 Support Team and other deployed ASPR support teams and representatives.

Situation Unit. Responsible for analyzing incident information and assessing potential incident impacts to inform the SOC's decision support and information management products. The SOC Situation Unit coordinates closely with the IMT Situation Unit. This unit is comprised of three groups: the Information Analysis Group, GIS Group, and Specialist Support Group. The Information Analysis Group analyzes and reviews incident information to determine actual or potential impacts on response operations and develops comprehensive products to inform the SLB, Storyboard, and SOC leadership decision processes as well as development of the ISP. This includes incident analysis, incident-specific modeling and simulation, and monitoring of social media. The GIS Group is responsible for spatial information collection and analysis and the development of mapping products, both static and dynamic, for strategic decision support and situational awareness. This unit helps to establish the Common Operating Picture for the response. The Specialist Support Group is responsible for monitoring impacts to public health and medical systems and supported communities and developing strategic courses of action to address issues identified. The SOC Specialist Support Group includes subject matter experts who provide specialized, scenario-based technical expertise and information to support SOC leadership and senior leader decision-making processes.

Reporting Unit. Responsible for participating in conference calls/meetings, monitoring SOC email inboxes, and coordinating with other SOC Information Management units/groups to

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[9] HPP staff may be called upon to provide assistance to the Information Management Section in any or all of the following areas: 1) Collecting and monitoring CIRs; 2) Providing situational awareness on the status of healthcare delivery systems; 3) Responding to RFIs on healthcare system capabilities, capacities, and operational status; 4) Synthesis and reporting of information; and 5) Providing analysis and making recommendations for future operations.

collect a wide variety of incident information. The Reporting Unit synthesizes that information to develop the daily SLB, Storyboards, and other decision support products as requested.

Additionally, this unit implements standardization and archiving of all Information Management documentation and records.

Intelligence Unit. The receipt, assessment, and management of incident-related intelligence information (including Classified, Law Enforcement Sensitive (LES), Protected Critical Infrastructure Information (PCII), Chemical Vulnerability Information (CVI), and/or Controlled Unclassified Information (CUI) information) is a vital aspect of ICS and ASPR operations. When activated, the Intelligence Unit, in coordination with the HHS Office of National Security (ONS), is responsible for the following functions: (1) Gathering, processing, assessing, securing, and appropriately disseminating finished intelligence products related to the threat/incident; (2) Providing situational awareness of an evolving threat/incident to various internal and external audiences and informing senior leader decision making based on classified or sensitive information; (3) Informing and supporting operational planning and life safety operations, including the safety and security of all ASPR/ESF-8 response facilities/nodes, personnel, equipment, and information/information systems; 4) In coordination with ASPR regional offices, providing interface with appropriate FSLTT intelligence centers and information sharing entities (i.e. state or major urban area fusion centers, Joint Terrorism Task Forces (JTTFs), and other analytic and investigative entities as applicable); and 5) Maintaining access to information sharing tools and portals (i.e. such as the Homeland Security Information Network (HSIN) and other information sharing systems).

The Intelligence Unit ensures relevant intelligence information is integrated into ASPR planning and mission execution, as appropriate, using information protection protocols based on category of information and other guidance, across all levels of the ASPR Incident Response Framework and externally with appropriately cleared response and Healthcare and Public Health Sector partners. The Intelligence Unit also works closely with the Physical Security Manager, IT Systems Security Specialist, and Communications Specialist at the SOC and IMT levels, respectively, to provide up-to-date threat information and to inform operations security (OPSEC), information security (INFOSEC), and communications (COMSEC) postures and risk management strategies, as needed. The Intelligence Unit confers with the SOC and IMT Command/General Staffs to ensure the confidentiality and security of intelligence activities are not compromised in the conduct of authorized information sharing activities.

The size and composition of the Intelligence Unit is determined based on the specifics of the threat environment and corresponding mission needs. In larger, more complex incidents and special events, the Intelligence Unit will establish a more expanded footprint to facilitate coordination with the interagency intelligence/investigations function outlined in the NIMS: Intelligence/Investigations Function Guidance and Field Operations Guide. The Intelligence Unit also may position appropriately cleared ASPR Agency Representatives to serve in a liaison capacity with federal intelligence, law enforcement, homeland security, and/or investigative operations centers including, but not limited to, the FBI's Strategic Information and Operations Center (SIOC) or Joint Operations Center (JOC), DHS National Operations Center (NOC), or the USCG National Response Center.
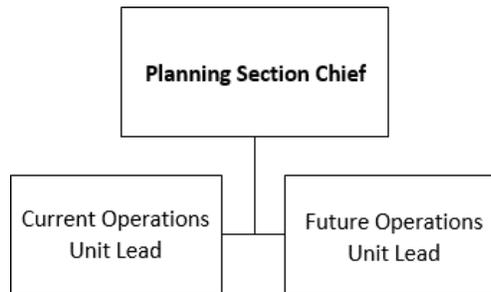
Planning Section

Figure 7 A depiction of the SOC Planning Section staffing organization, including both current operations and future operations planning functions.

The SOC's Planning Section is organized to conduct current operations planning and future operations planning. Using time horizons to delineate responsibilities, the Planning Section normally focuses current operations planning on activities occurring inside of 24-hours or within a designated operational period, and focuses future operations planning on issues and activities taking place between 24 and 96 hours and beyond. This planning horizon division enables the Planning Section to conduct current operations planning to address immediate and near-term issues and activities associated with ongoing operations. This includes leading the SOC's daily incident support planning process, in close coordination with the IMT's Planning Section, to address requirements identified by the deployed IMT(s), as well as national level requirements generated by the incident including estimations of impacts of the incident on national readiness. Future operations planning allows for planning to address the next phase of operations, with a specific focus on opportunities or challenges that could require a revision or a different operational approach to the current operation, and to anticipate spontaneous contingencies encompassing additional emergent threats or incidents that could occur during the current incident response.[10]

Current operations planning processes and products executed and produced by the Planning Section require coordination with various elements of the SOC Command and General Staff and with the deployed IMT's Planning Section. Likewise, future operations planning processes and products normally require significant coordination and collaboration with various elements of the SOC Command and General Staff (including advisors, SMEs, and other representatives from the cadre of Agency representatives and some entities external to the SOC). Future operations planning also may involve extensive interaction with elements of the deployed IMT.

The Planning Section is comprised of two primary units: the Current Operations Planning Unit and the Future Operations Planning Unit. These units are described in further detail below.

Current Operations Planning Unit. Focuses on the present situation and addresses current and short-term requirements for resources and programmatic decisions. The Current Operations

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[10] ASPR SPPR staff may be assigned to support the SOC Planning Section with the following: 1) Identifying policy issues that could impact incident response efforts; 2) Conducting policy analysis and coordination; 3) Developing strategic and operational policy recommendations; 4) Tracking policy issues during incident responses; and 5) Collaborating on the development of decision support products."

Planning Unit is responsible for the development of the daily SOC ISP.[11] To develop the ISP, this Unit, in collaboration with the IMT Planning Section, coordinates a SOC-wide effort each day (or on an operational period basis) to: (1) jointly develop a common understanding of incident support objectives, requirements, and constraints as well as leadership priorities and other national-level considerations; (2) integrate all stakeholders' capabilities and expertise in addressing incident support objectives, requirements, constraints, leadership priorities, and other national-level considerations; (3) propose SOC-level incident support objectives and tasks for the next day (or operational period); (4) track and update the status of the objectives and tasks from the previous ISP; and (5) identify and include information on other pertinent activities provided by the various SOC staff elements. Current Operations Planning Unit staff coordinates the team's work in resolving issues and detailing those solutions and other pertinent information in the ISP.

Future Operations Planning Unit. Anticipates future requirements and issues from a national perspective. In so doing, Unit staff considers: (1) the long-term impact of all incidents that the SOC is currently supporting and the resource requirements or policy issues associated with these incidents; and, (2) the potential for additional incidents and the cascading effect of new requirements and issues on national resource supplies and national programs.

In the course of supporting incident response activities, Planning Section staff routinely address specifically identified or anticipated problems and develop ad-hoc Functional Plans/Adaptive Plans to deal with these problems, many of which may be program or policy-specific. The Current and Future Operations Planning Units may be required to collaborate to support Functional/Adaptive Planning efforts. A Functional Plan typically includes five sections: Situation; Mission; Execution; Administration, Resources, and Funding; and Oversight, Coordinating Instructions, and Communications.

Resource Coordination Section

The SOC's Resource Coordination Section performs hybrid operations and logistics functions under the NIMS EOC structure. This includes the acquisition and provision of health and medical resources via the RFR process to address unmet needs identified/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. This section also oversees the establishment and

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[11] The ISP provides a snapshot of the SOC's objectives and activities for the day or other defined operational period. For leadership, it provides a to-do list of what must get accomplished that day. It also helps to ensure national-level efforts address incident objectives and the priorities of leadership at all levels. The ISP's iterative development process helps to drive the SOC's daily operational tempo. Characteristics of the ISP include the following: 1) It is primarily intended to inform the SOC staff; 2) It is a tool that shows the "who, what, when and where" of SOC activities in support of incident requirements; 3) It describes specific, measurable, achievable, realistic, and time- bound objectives and leadership priorities for the SOC staff; and 4) It describes significant constraints and includes functional plans that address constraints and support of established objectives and priorities.

operation of the ASPR Mobilization Center. Key mobilization functions include: mission briefings/debriefings, personnel accountability, logistics, safety, security, medical oversight/assessment, occupational health functions such as respiratory protection program activities, and behavioral health support. Finally, the Resource Coordination Section oversees all aspects of personnel demobilization once a handoff is conducted with the IMT.

The Resource Coordination Section is comprised of the following primary elements: 1) Request for Resources Unit Leader (RFR-UL); 2) RFR Tracking Manager (RFR-TM); 3) Task Order Manager (TOM); 4) Resource Management Unit Leader (RM-UL); 5) Resource Tracking Manager (RTM); 6) Responder Personnel Unit Leader (RP-UL); 7) Transportation Unit Leader (TUL); 8) Travel Team Manager (TTM); 9) ESF-8 NRCC Movement Control Team (MCT) Representative; and 10) Mobilization Center Unit Leader (MC-UL). These elements are described in further detail below.
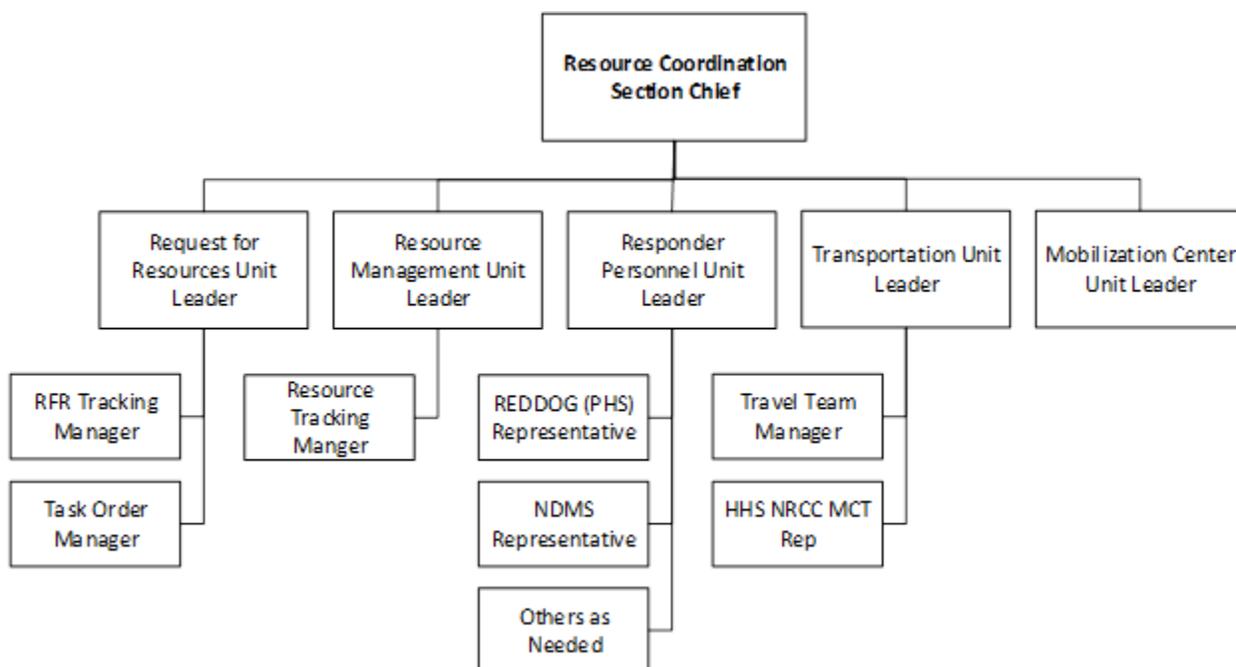

Figure 8 A depiction of the SOC Resource Coordination Section staffing organization.

Request for Resources Unit Leader. The RFR-UL oversees the receipt, review, recording, and processing of all FHCO-approved RFRs that come into the SOC via the EM Portal System or by e-mail from the IMT. The process overseen by the RFR-UL confirms and sorts each request approved by the FHCO and submitted by the IMT, in coordination with appropriate IMT personnel and based on urgency of need assigned by the FHCO. The RFR-UL further clarifies/refines the request if not complete enough to address in a TO. Requests are subsequently forwarded to the TOM for action. Issues impacting the ability to process a priority request are immediately brought to the attention of the SOC Director/EMMO Director. The

RFR-UL may have multiple RFR-TMs under their supervision during a "major response," or may process the requests directly during a smaller-scale response.

RFR Tracking Manager. An RFR-TM is assigned to the RFR-UL and performs tasks associated

with the receipt, review, recording, and processing of all RFRs that come into the SOC via the EM Portal System or by e-mail. The process overseen by the RFR-TM ensures that RFR forms are completed, processed, and prioritized (based on FHCO-designated urgency) through the system for resourcing. This process may include several additional support personnel based on the size, scope, and complexity of the response.

Task Order Manager. The TOM oversees the development, review, recording, processing, and distribution of all TOs and any required amendments based on completed RFRs received from the RFR-UL in the SOC via the EM Portal System or by email. The process overseen by the TOM directs the resource provider to execute an action or provide a service, personnel, or equipment against a specific request at a specific time and place. This position requires awareness of and the ability to identify the various points of contacts for different types of RFRs.

Resource Management Unit Leader. The RM-UL is responsible to the Resource Coordination Section Chief for the synchronizing of all resource providers. This position is key to ASPR's ability to get the right people and equipment to the right place at the right time, while ensuring all responders are properly supported during a deployment and all services (travel, lodging, rental cars, etc.) are reserved and in place, as required. This position requires a full knowledge of where resources come from and the multiple internal and external capabilities that support timely and efficient resource provision. During smaller-scale responses, the RM-UL function may be performed by the Resource Coordination Section Chief.

Resource Tracking Manager. The RTM reports to the RM-UL and is responsible for providing 100 percent visibility on all resources requested for a specific response. Using a myriad of reports and data provided by the IMT, email traffic, and available databases, the RTM shares the necessary data with the IM Section and GIS specialists to enable publication of "Force and Equipment Laydown" documentation. This product is intended to keep senior ASPR leaders informed of what resources are in the field, which are in transit, what equipment remains available, and which personnel are on alert (i.e. a complete 360 degree view of ASPR resources).

Responder Personnel Unit Leader (RP-UL). The RP-UL is responsible for initiating the resourcing process for any responder as directed via a TO. Working with various organizations that provide personnel resources (i.e. NDMS, Logistics Response Assistance Teams (LRATs), Readiness and Deployment Operations Group (REDDOG), Agency Representatives, etc.), the RP-UL oversees the preparation of deployment rosters, ensures the accuracy of profile information in the Responder Management System (RMS), and activates and sends the roster to the TTM for action. The RP-UL also maintains a log of all TOs related to personnel requirements, assigns roster numbers used to fill each request, and tracks the fill status of any roster generated against a TO. The RP-UL answers all roster and personnel inquiries and provides updates on data regarding deployed/rostered personnel when requested by the Resource Coordination Section Chief. The RP-UL works closely with personnel resource providers to find personnel to fill "reload" requests.

The RP-UL also is responsible for tracking personnel status from point of departure to the intended deployed location, and again from demobilization to return to Home of Record. In the

case of personnel deployed and working under the direction of the IMT, the RP-UL works with the IMT Plans Section to maintain awareness of their status. As personnel demobilize from a response, the RP-UL updates RMS to reflect the actual demobilization dates and provides daily reporting on the status of all in transit personnel.

Transportation Unit Leader. The TUL is broadly responsible for coordinating transportation of personnel, equipment, and supplies, as well as lodging and other miscellaneous services under their purview in support of IMT and deployed responder requirements. The TUL leverages the ASPR Logistics Division Transportation Branch to accomplish the many actions associated with responder deployments, and represents the Transportation Branch Chief as part of the activated SOC staff. The TUL ensures the provision of important travel information from the very beginning of a response to the very end, and works with the RM-UL and RP-UL to track the movement of and account for responders and freight in support of assigned missions.

Travel Team Manager. The TTM is responsible for coordinating any and all deployed personnel transportation, lodging, and or miscellaneous services under their purview (rental cars, conference space at deployment location, buses, etc.).

HHS ESF-8 NRCC Movement Control Team Representative. The ESF-8 NRCC MCT Representative coordinates the transportation of all HHS response resources at the FEMA NRCC Movement Coordination Center. Within the NRCC MCT, this individual works with FEMA and DoD MCT personnel to coordinate and prioritize movement of HHS Resource into and out of the response area. This is often accomplished using FEMA contracting authority and/or DoD assets.

Mobilization Center Unit Leader. The MC-UL is responsible for executing the essential tasks associated with responder preparation in the early stages of any deployment as directed by the FHCO and the DFHCO-ME. The specific tasks conducted during mobilization will vary based on the FHCO's determination of time to conduct the associated tasks, location of deployment, urgency of need for health services, and other mission-related considerations. (Note: Refer to the ASPR Mobilization Center Standard Operating Procedure Manual for a list of required and essential tasks). The MC-UL ensures that required tasks are performed with minimal impacts to the timeliness and efficiency of personnel and team deployment. On the back end of any deployment, the MC-UL is responsible for providing demobilization services commensurate with the response and as further described in supplemental demobilization guidance.
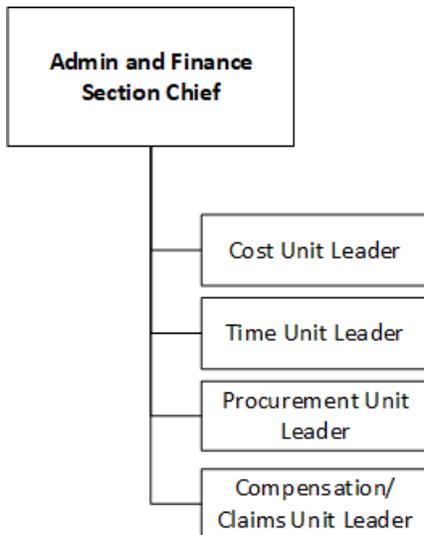
Administration and Finance Section

Figure 9 A depiction of the SOC Admin and Finance Section staffing organization.

The SOC's Administration and Finance Section is responsible for cataloguing and analyzing all incident costs, financial considerations, and administrative matters in support of federal public health and medical activities related to the incident response. This Section determines financial reporting time lines and appropriate formatting of reports, tracks all incident cost data, and develops operational period cost summary reports. It also provides guidance on fiscally responsible practices in support of mission planning and execution. Additional tasks performed include: timekeeping, financial accountability, compensation and claims, as appropriate, travel reimbursement claims, procurement, Mission Assignment funds management, and the coordination of various administrative support needs. Finally, the Administration and Finance Section ensures that all emergency finance and administrative activities are accomplished within the parameters of existing statutes, regulations, and Department policies.

The Administration and Finance Section is comprised of four primary functional units: 1) Time Unit; 2) Compensation/Claims Unit; 3) Cost Unit; and the 4) Procurement Unit. These units are described in further detail below.

Time Unit. The Time Unit is responsible for recording time for personnel and equipment. This unit provides HHS policy and ITAS system guidance to ensure that appropriate time and attendance procedures are followed. The unit also records time for personnel and equipment in accordance with specific agency requirements and prepares payroll reports as required.

Compensation/Claims Unit. The Compensation/Claims Unit is responsible for financial matters pertaining to incidents in which a federal or temporary federal employee sustains any level of injury during the course of duty. The unit facilitates timely, accurate processing of worker compensation and claims and ensures that compensation forms and logs are in compliance with the receiving agency's requirements and policies. The unit maintains files on injuries and illnesses associated with the incident, obtains written witness statements, and documents investigations and agency follow-up activities. The unit also provides written authority for

individuals requiring medical treatment and ensures that an Authority for Treatment Release Statement accompanies all individuals seeking treatment.

Cost Unit. The Cost Unit is responsible for collecting all cost data, performing cost effectiveness analyses, and preparing cost saving recommendations. Cost information related to an incident, includes, but is not limited to, applicable costs for personnel, equipment, vehicles, supplies, claims, contracts, lodging, rentals, etc. The unit establishes procedures for cost and expenditure reporting and ensures that a system is in place that is in compliance with HHS financial reporting and accounting policies. The unit prepares estimates of future incident costs/trends and ensures estimated costs are updated with actual costs as they become available. The Cost Unit conducts close coordination with the Procurement Unit to ensure that all cost records and reports are accurately prepared and cumulative incident cost records are maintained.

Procurement Unit. The Procurement Unit is responsible for all matters related to the origination and management of procurement contracts, including leases, service contracts/rentals, equipment, and fiscal agreements. This includes processing contracts (dependent upon specific contract authority) to acquire resources needed to support the SOC. The unit establishes procedures to process procurement requests and ensures compliance with HHS property management requirements for the financial accounting of all new personal property purchases. The unit ensures procurement items meet delivery schedules and that invoices are entered into accountability records. Finally, the unit maintains a log to track the flow of contracted goods and services throughout the response.
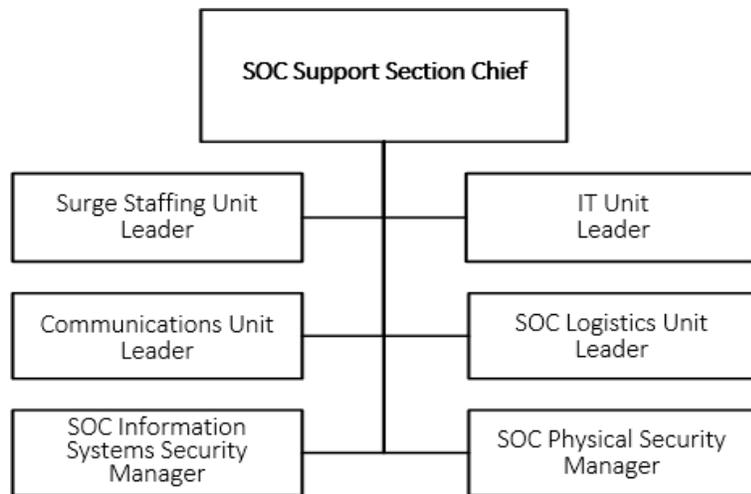
SOC Support Section

Figure 10 A depiction of the SOC Support Section staffing organization.

The SOC Support Section provides resource, facility, security, communications, and information technology support to ensure uninterrupted functioning of the SOC. In addition, the SOC Support Section coordinates SOC surge staff orientation, just-in-time training, and scheduling to ensure proper staffing across all Command and General Staff positions. The SOC Support Section provides support for all technology used during activation, and assists staff members with administrative- and human resources-related policies and procedures as well as maintaining the status of staff. This section ensures that all personnel conduct

activities/operations in a safe and healthy environment, maintains physical security, and assists staff members with the proper handling, protection, and management of sensitive and classified information and communications. Finally, the SOC Support Section publishes and updates the SOC daily operational tempo as needed and maintains the activation roster, contact information, and other pertinent information.

The SOC Support Section is comprised of the following primary elements: 1) SOC Information Technology Unit; 2) SOC Surge Staffing Unit; 3) SOC Logistics Unit; 4) SOC Communications Unit; and 5) SOC Physical Security Manager. These elements are described in further detail below.

SOC Information Technology Unit. Provides IT support for SOC staff members, including resolution of computer, printing, and other technological problems. The IT Unit also establishes and manages all video teleconferences (VTCs). In addition, the IT Unit provides administration of the SOC knowledge management system, including creating new work areas and applications and managing access.

SOC IT Systems Security Specialist. Responsible for the anticipation, identification, and assessment of potential threats to information and information systems used in conjunction with SOC operations. In coordination with ASPR IT staff and the HHS Office of the Chief Information Officer (OCIO), this individual develops and implements INFOSEC procedures and conducts coordination to protect SOC information and information systems from identified threats, including those potentially impacting operations in the field. This individual reports any security issues encountered to the SOC Support Section Chief, ASPR Chief Information Security Officer, and SOC Cybersecurity Advisor (if activated). The SOC IT Systems Security Specialist ensures activated staff are provided with up-to-date INFOSEC briefings and understand and comply with safeguards needed to protect information and information systems throughout the response. This individual coordinates closely with the Mobilization Center Unit Leader within the SOC's Resource Coordination Section to ensure all required INFOSEC considerations are addressed as part of the mobilization process for deploying personnel.

SOC Surge Staffing Unit. Coordinates SOC Command and General Staff recall and provides instruction on where and when activated personnel are to report. The Surge Staffing Unit reviews activation and demobilization requests to assist the various individual SOC Sections in determining and making recommendations for staffing levels. The Surge Staffing Unit also coordinates the registration, orientation, just-in-time training, scheduling, and supervision of surge staff volunteering to assist during the incident. Finally, the Surge Staffing Unit provides travel policies, regulations, documents, forms, and procedures and facilitates emergency lodging agreements when needed.

SOC Logistics Unit. Provides facilities, facility services, equipment, parking, and supplies for the SOC. In addition, the Logistics Unit ensures that environmental conditions are properly maintained, including power, heating, air conditioning, and lighting.

SOC Communications Unit. Organizes and coordinates internal and external communications and ensures equipment availability to support all such communications. In addition, the Unit manages all aspects of SOC conference calls and briefings. This includes, but is not limited to: scheduling, invitations, conference call management, and updating/printing briefing materials

discussed during conference calls.

SOC Communications Security Specialist. Responsible for the anticipation, identification, and assessment of potential threats to communications systems used in conjunction with SOC operations. In coordination with ASPR IT staff and the HHS OCIO, this individual develops and implements COMSEC procedures and conducts coordination to protect SOC communications systems from identified threats, including those potentially impacting operations in the field. This individual reports any security issues encountered to the SOC Support Section Chief, ASPR Chief Information Security Officer, and SOC Cybersecurity Advisor (if activated). The SOC Communications Security Specialist ensures activated staff are provided with up-to-date COMSEC briefings and understand and comply with safeguards needed to protect communications systems throughout the response. This individual coordinates closely with the Mobilization Center Unit Leader within the SOC's Resource Coordination Section to ensure all required COMSEC considerations are addressed as part of the mobilization process for deploying personnel.

SOC Physical Security Manager. Responsible for the anticipation, identification, and assessment of potential physical threats to the SOC facility, personnel, and government equipment and supplies. In coordination with HHS/ONS, this individual also develops and implements physical security procedures, and conducts coordination to protect persons and property from identified threats. The SOC Physical Security Manager ensures activated staff are provided with up-to-date security and counterintelligence (CI) briefings and understand and comply with safeguards needed to protect personnel and property from physical injury/damage or loss throughout the response. This individual coordinates closely with the Mobilization Center Unit Leader within the SOC's Resource Coordination Section to ensure all required OPSEC considerations are addressed as part of the mobilization process for deploying personnel. Finally, this individual coordinates closely with the SOC Safety Officer to ensure threats to occupational health and safety are addressed appropriately.

ANNEX B: IMT Organizational Structure and Staffing for Level I Activation

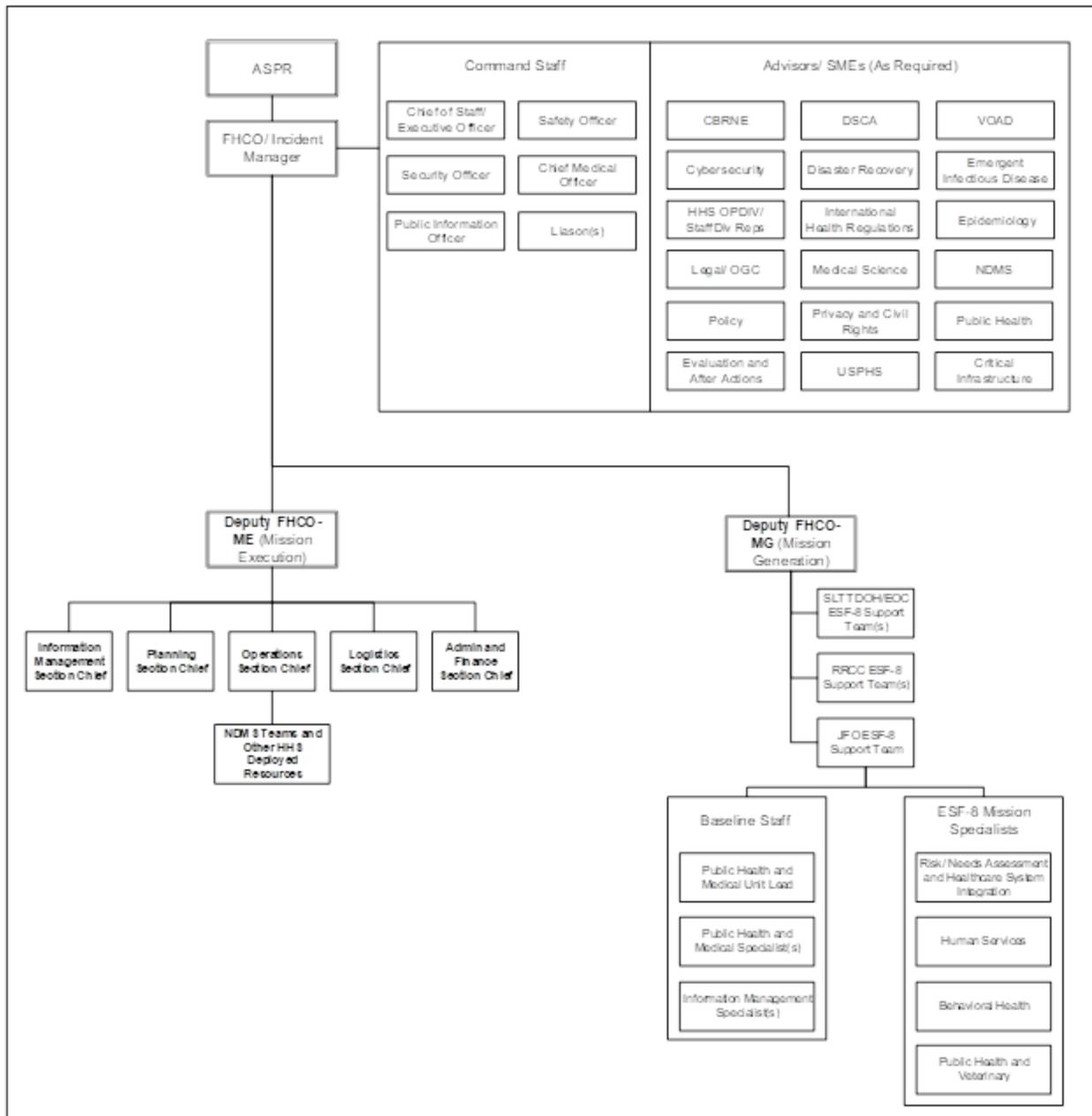Figure 11 A depiction of the representative IMT staffing organization for a Level I activation, including relevant command and general staff elements based on ICS doctrine.

IMT Command Staff Positions

Baseline Positions (IMT Activation Levels 1-3):

Chief of Staff (CoS)/Executive Officer (XO) (as needed): Ensures that staff work produced by the IMT Command and General Staff conforms to FHCO/IM guidance, mission support

requirements, and established timelines. The CoS/XO ensures that the D/FHCO-ME staff integrates and coordinates their administrative and operational activities internally and externally with all levels of involved organizations and agencies. In general, this includes making sure that staff engage in the timely sharing of emerging policy, critical strategic and tactical decisions, and critical information. In particular, the CoS/XO makes certain that all staff sections participate in and provide functional expertise in establishing and maintaining situational awareness and a common operating picture and enforces common reporting formats and product submission timelines. Finally, the CoS/XO establishes and manages the daily operational rhythm of the IMT and represents the FHCO/IM at interagency meetings and planning sessions as directed.

Public Information Officer (PIO): Provides advice and counsel on all aspects of communication with the public, media, and/or with other agencies or organizations leading up to, during, and immediately after an incident or public health emergency. The PIO identifies strategies for two-way communication between the organization and target audiences, coordinates messaging, and develops communication products based on crisis and emergency risk communication principles to address the public health and medical concerns of internal and external audiences. The PIO uses all appropriate communications methods – ranging from traditional media, social media and web content to visual communications products and printed materials – to support federal public health and medical response efforts and provide meaningful, accurate, and timely information on which target audiences can take action. Response messaging and activities are consistent with HHS/ASPA guidance and are coordinated with ASPR, the SOC PIO, and other relevant federal, SLTT and private entities, including with a federal joint information center if established. The PIO collaborates with Information Management and other sources to gather information relevant to message development and communications activities.

Safety Officer: Responsible for the anticipation, identification, and assessment of hazardous and unsafe conditions affecting the IMT, and develops measures to reduce risks and ensure personnel safety and accountability. The Safety Officer monitors and helps ensure the health needs of IMT personnel and deployed teams are met in conjunction with other deployed medical officers and the Medical Unit Leader. The Safety Officer can exercise emergency authority to stop or prevent unsafe acts/conditions, when judged to present an imminent danger. (Note: Imminent Danger is defined as a condition which may cause death, serious physical harm, or exposure to a toxic substance which can cause substantial impairment in physical or mental efficiency). The Safety Officer is also responsible for establishing the procedures necessary to assess, communicate, and mitigate hazardous environmental conditions, including developing and maintaining the Incident Safety Plan, coordinating multiagency safety efforts, and implementing measures to promote the safety of incident management staff.

Physical Security Officer: Responsible for the anticipation, identification, and assessment of potential physical threats to the IMT facilities, personnel, and government equipment and supplies. This individual liaises/coordinates with appropriate federal entities, including ESF-13 agencies, and local security/law enforcement personnel and develops and implements physical security procedures and conducts coordination to protect persons and property from identified threats across the IMT's deployment footprint. The Physical Security Officer also ensures that

deployed IMT staff and field teams are provided with up-to-date physical security, insider threat, and defensive CI briefings and understand and comply with safeguards needed to protect personnel and property from physical injury/damage or loss. This individual also provides security information for inclusion in safety/security bulletins and other messaging or guidance to IMT staff and deployed teams. In the absence of an activated Intelligence Unit, the Physical Security Officer facilitates and coordinates the flow of classified and sensitive information with local partners and HHS headquarters.

Chief Medical Officer: Serves as chief medical advisor to the FHCO/IM. The CMO provides medical guidance for ESF-8 health care professionals, serves as a SME for medical issues, contributes to medical surveillance analysis, and provides oversight for all issues concerning the quality of medical care and responder health and safety within the IMT and deployed teams. In addition, the CMO advises on the appropriate medical capability and capacity to support the incident, particularly as it relates to team and health care provider capabilities and medical issues pertaining to patient movement. The CMO provides oversight regarding the delivery of healthcare services by ESF-8 healthcare professionals and establishes response guidelines and SOPs when needed for all ESF-8 public health and medical operations. The CMO reviews deployment health and fitness standards for all ESF-8 missions associated with the incident, including exclusions to deployment and reasonable accommodations of disabilities.

Liaison(s): Assists in coordination with agencies/organizations external to ASPR not represented on the IMT Command Staff to support the needs of the IMT.

Additional Advisors/SMEs (Designated at the discretion of the FHCO):

Policy Advisor: Responsible for identifying actual and potential policy issues and raising them to the FHCO for resolution in coordination with appropriate stakeholders. If issues cannot be resolved at the FHCO level, the Policy Advisor develops coordinated course of action recommendations for the FHCO to forward for consideration by the ASPR SLT or the DLG, and ultimate decision by the ASPR and/or HHS senior leadership.

International Health Security/IHR Advisor: Confirms that all course of action recommendations developed and/or actions taken by the FHCO and activated IMT staff components are consistent with International Health Regulations to which HHS is bound, in consultation with the Office of the General Counsel as needed. The International Health Security/IHR Advisor recommends alternatives/waivers/exceptions as required to accomplish the HHS/ASPR mission by maintaining awareness of the situation and applying sound judgment as appropriate.

Legal Advisor: Provides legal advice on course of action recommendations developed and/or actions taken by the FHCO and activated IMT staff components, when requested. The Legal Advisor recommends alternatives/waivers/exceptions as required to accomplish the HHS/ASPR mission by maintaining awareness of the situation and applying sound legal judgment as appropriate.

Privacy and Civil Rights Advisor: Confirms that course of action recommendations developed and/or actions taken by the FHCO and activated IMT staff components comply with applicable privacy and civil rights statutes, Executive Orders and Presidential Directives, and Department policy, in consultation with the Office of the General Counsel as needed.

Science Advisor: Provides evidence-based information to support public health and medical-related decision making needs.

Public Health Advisor: Responsible for maintaining ongoing communication and coordination with CDC operations staff in the context of an emergent infectious disease or other incident with potential or actual public health impacts. The Public Health Advisor is responsible for notifying the FHCO of any issues raised by CDC operations regarding an emergent public health threat or incident.

Disaster Recovery Advisor: Responsible for monitoring, providing advice, and assisting in the development of coordinated course of action recommendations regarding all issues that have a potential or demonstrated impact on community recovery as a part of, or in the aftermath of, response operations.

NDMS Representative: Provides subject matter expertise on the capabilities of the various NDMS Teams by individual team category and supports course of action development regarding NDMS utilization. The NDMS Representative may also assist in tracking and monitoring the status of activated teams and individuals in concert with the SOC's Resource Coordination Section and the IMT's Operations and Logistics Sections.

USPHS Representative: Provides subject matter expertise on the capabilities of the various USPHS Teams by individual team category and supports course of action development regarding USPHS Team utilization. The USPHS Representative may also assist in tracking and monitoring the status of activated teams and individuals in concert with the SOC's Resource Coordination Section and the IMT's Operations and Logistics Sections.

VOAD Representative: Provides subject matter expertise on the capabilities and operations of the various VOADs engaged in the incident response as appropriate. Maintains ongoing communications and coordination with VOADs engaged in activities related to HHS incident response operations and collaborates with the FHCO on any potential/ongoing mutual issues or concerns.

DoD Representative: Provides subject matter expertise on DoD's DSCA capabilities, operations, and Mission Assignment/resource deployment and employment processes. The DOD Representative also maintains ongoing communications and coordination with DoD DSCA elements in the JFO to maintain awareness of and/or support coordination regarding DoD resources tasked to provide support to or operate in coordination with HHS and its deployed resources/teams.

CBRN Advisor(s): Provides advice and course of action recommendations regarding all aspects of a CBRN-related incident throughout the incident's life cycle including, but not limited to, agent characterization; human, infrastructure, and environmental effects; HHS responder protection guidance; etc.

Epidemiologist: Provides advice and course of action recommendations regarding all aspects of an incident involving an emergent infectious disease or other public health emergency throughout the incident's life cycle including, but not limited to: disease characterization;

potential method/pathway for contagion; human and environmental effects; HHS responder protection guidance; medical countermeasures and other mitigation measures; etc.

Emergent Infectious Disease Advisor: Provides advice and course of action recommendations regarding all aspects of an emergent infectious disease or other public health emergency throughout the incident's life cycle including, but not limited to: disease characterization; potential method/pathway for contagion; human and environmental effects; HHS responder protection guidance; medical countermeasures and other mitigation measures; etc.

Critical Infrastructure Advisor: Provides information and decision support to the IMT leadership and private sector regarding the operating status and critical needs of the HPH Sector during incident response, with a focus on critical facilities and interconnected supporting infrastructure in the impacted area. The Critical Infrastructure Advisor participates in frequent partnership calls between government and private sector partners during an incident response to establish and maintain situational awareness of local HPH Sector operational impacts, priority restoration and recovery activities, and unmet needs and ongoing concerns. Through established partnership connections and information sharing, the Advisor provides analysis of private sector and critical infrastructure concerns and issues, as well as strategic input on resource prioritization as

Cybersecurity Advisor: Provides advice and counsel on all aspects of an emergent cyber threat or cyber incident across the spectrum of prevention, protection, response, recovery, and mitigation. The Cybersecurity Advisor also maintains ongoing communications and coordination with the HHS Health Cyber Communications and Coordination Center and the DHS National Cyber and Communications Coordination and Integration Center.

Exercise, Evaluation and After Action Representative: Collects data concerning emerging issues, potential corrective actions, and lessons learned during IMT activations in concert with each activated section of the IMT. This representative also facilitates IMT section-specific and overall hot-wash meetings as requested, either during operations or as sections stand down. This representative also assists in development of the incident after-action report and improvement plan, as required.

Agency Representatives: Provide advice on matters related to their agency or organization pertinent to the incident response. Agency representatives also monitor and support the desk for their respective agency or organization during IMT Level I-III activations and provide accurate and timely information regarding HHS's plan of action and other activities relevant to their agency or organization. They also participate in IMT planning sessions, briefings, and other activities as required.

IMT General Staff Branch/Unit Level Staffing Organization
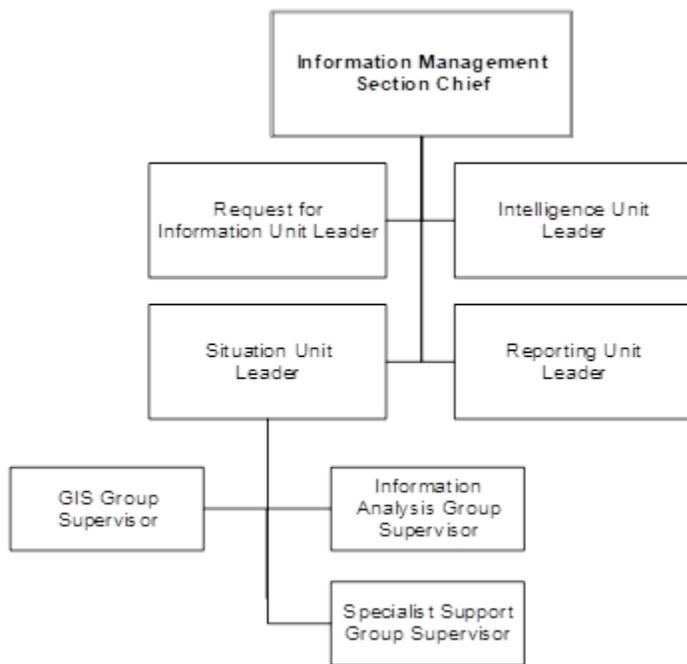
Information Management Section

Figure 12 A depiction of the IMT Information Management Section staffing organization.

The Information Management Section is responsible for directing information management activities within the IMT. This includes: 1) providing field-level public health, medical, veterinary, and human services response and recovery situational awareness and a common operating picture; 2) developing a field-level, incident-specific Information Management Plan; collecting and analyzing FSLTT and private sector data as appropriate (including HPP[12] and healthcare coalition data) relevant to the response and established CIRs; 4) responding to and tracking the status of RFIs at the field level; 5) developing consolidated SITREPs and providing information for input into the IMT IAP and HHS SLBs; and 6) providing decision support to the FHCO/IM and Deputies, IMT General Staff Sections, and other elements of the HHS/ASPR field-level incident response structure. These responsibilities are accomplished by establishing a seamless and integrated deployed information management structure and supporting processes and ensuring close collaboration with HHS's field level response partners, the SOC's

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[12] HPP FPO cadre members may be assigned to the Information Management Section staff to support the following activities: 1) Collecting and monitoring CIRs; 2) Providing situational awareness on the status of healthcare delivery systems; 3) Responding to RFIs on healthcare system capabilities, capacities, and operational status; 4) Synthesis and reporting of information; and 5) Providing analysis and making recommendations for future operations.

Information Management Section, and the Information Management Specialist(s) assigned to the JFO ESF-8 Support Team.

The Information Management Section is comprised of the following primary elements: RFI Tracker, Situation Unit, Information Analysis Group, Specialist Support Group, Reporting Unit, and Intelligence Unit. These elements are described in further detail below.

RFI Tracker. Responsible for tracking and addressing all RFIs that come through the IMT. This includes managing the full RFI process, assigning RFIs to the appropriate party for adjudication at the field level, providing responses to the initial requestor, and archiving RFI responses once complete. This position coordinates closely with the JFO ESF-8 Support Element and other deployed ASPR support teams and liaisons.

Situation Unit. Responsible for analyzing field-level incident information and assessing potential incident impacts to inform the IMT's decision support and information management products. In close collaboration with the IMT Plans Section, this unit also collects, assesses, and provides information for use in development of the IAP. Similarly, the IMT Situation Unit coordinates closely with the SOC Situation Unit.

The IMT Situation Unit is comprised of three groups: the Information Analysis Group, the GIS Group, and the Specialist Support Group. The *Information Analysis Group* analyzes and reviews incident information to determine actual or potential impacts on field-level response operations and develops comprehensive products to inform the IMT leadership. This includes incident analysis, incident-specific modeling and simulation in collaboration with the SOC, and monitoring of social media. This group also tracks critical public health and medical data such as special medical population needs and patient movement. The *GIS Group* is responsible for spatial information collection and analysis and the development of mapping products, both static and dynamic, at the tactical and operational level for decision support and situational awareness. This unit helps to establish the Common Operating Picture for the response. The *Specialist Support Group* is responsible for monitoring and informing recommendations to address impacts to public health and medical systems and affected communities at the local level. The Specialist Support Group also includes subject matter experts who provide specialized, scenario-based technical expertise and information to support IMT leadership decision processes. This group may also include Field Observers to gather information on the incident and/or response.

Reporting Unit. Responsible for participating in conference calls/meetings, monitoring IMT email inboxes, and coordinating with other IMT Information Management units/groups and other IMT sections to collect critical incident information. The Reporting Unit synthesizes information to develop and distribute reports and briefings such as the IMT SITREP, and support the development of reports/briefings produced by the SOC. Additionally, this unit implements standardization and archiving of all IMT Information Management documentation and records.

Intelligence Unit. When activated, serves as a forward extension of the SOC's Information Management Section Intelligence Unit. Its size and composition are determined based on the specifics of the threat environment and corresponding mission needs.

The IMT Intelligence Unit, in coordination with the SOC Intelligence Unit, is responsible for the following functions: (1) Assisting in gathering, processing, assessing, securing, and appropriately disseminating finished intelligence products related to the incident; (2) Contributing locally-derived situational awareness of an evolving threat or incident and informing IMT senior leader decision making based on classified/sensitive information; (3) Informing and supporting IMT operational planning and life safety operations, including the safety and security of IMT response facilities/nodes, personnel, equipment, and information/information systems; 4) Providing local interface with FSLTT intelligence centers, information sharing entities, and security/law enforcement officials; and 5) Maintaining access to information sharing tools/portals.

The IMT Intelligence Unit also works closely with the IMT Physical Security Officer, IT Systems Security Specialist, and Communications Specialist to provide up-to-date threat information and to inform IMT OPSEC, INFOSEC, and COMSEC postures and risk management strategies, as needed. The Intelligence Unit coordinates with the IMT Command and General Staffs to ensure that the confidentiality and security of intelligence/investigations activities are not compromised in the conduct of authorized information sharing activities.
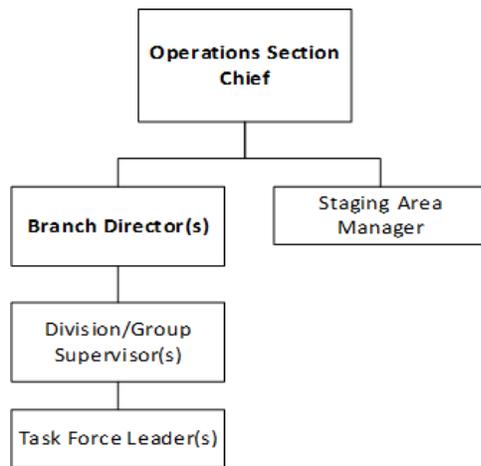
Operations Section

Figure 13 A depiction of the IMT Operations Section staffing organization.

The Operations Section is responsible for overseeing the conduct of various tactical activities to achieve the incident objectives established by the FHCO/IM and deputies and codified via the IAP development process. Operations Section activities typically focus on saving lives, reducing the immediate hazard, protecting property and the environment, establishing situational control, and restoring normal operations. The Operations Section is organized based on the nature and scope of the incident; the jurisdictions and organizations involved; and the priorities, objectives, and strategies developed to guide the incident response. Key functions of Operations Section staff include the following: 1) direct the management of tactical activities on the FHCO/IM's behalf; 2) develop and implement strategies and tactics to achieve incident

objectives; 3) support the Planning Section in IAP development for each operational period; 4) oversee, maintain accountability, and monitor the employment of HHS resources and teams; and 5) maintain the pulse on the effectiveness of HHS resource and team employment as well as the health and welfare of team members.

The Operations Section is comprised of the following primary elements: Geographic or Functional Branch(es), as required (i.e. Patient Movement Branch), Divisions/Groups, Task Force Leader(s)/Strike Team Leader(s), as required, and Staging Area Manager. These elements are described in further detail below.

Branches: Responsible for supervision of a functional or geographical branch of the Operations Section. Types of groups/branches that may exist in an ESF-8 response include, but are not limited to: Public Health Branch, Special Medical Needs Sheltering Branch, Mental Health Branch, Patient Movement Branch, Veterinary Branch, Human Services Branch, etc.

Patient Movement Branch (Functional Branch example): Responsible for coordination of all HHS response resources assigned to the IMT that enable ESF-8 patient movement. This branch is generally staffed to support engaged resources during large-scale responses. Significant preparation and thorough understanding of NDMS patient movement CONOPS, applicable laws, ESF-8 response resources employed for patient movement, and federal interagency partner capabilities, including DoD and VA, are required.

Divisions/Groups: Represent functional or geographic divisions/groups of the Operations Section. Groups/Divisions communicate with task force leaders and convey the operational objectives/tactics defined by the Operations Section Chief. They also oversee the coordination of ESF-8 assets and personnel. Functional responsibilities performed by Divisions/Groups also encompass all facility based, organized medical or veterinary health interventions required to meet the needs of the affected population. (Note: "Facilities" could include alternate treatment sites, including definitive care capabilities established on site to screen and medically release victims. "Facilities" could also include hospitals, nursing homes, clinics, alternative care sites, and in-home care activities supported during a public health emergency). Divisions/Groups also coordinate and communicate to ensure the operational functions, sub-functions, and processes determined by the Operations Section Chief are implemented.

Staging Area Manager (STAM): Responsible for managing all activities within a Staging Area. The STAM maintains work records on assigned personnel, and relays other important information to supervisory personnel. The STAM also coordinates with the Mobilization Team when mobilization and staging activities are conducted in the same location.

Task Force Leader (TFLD)/Strike Team Leader (STLD): Reports to a Division, Group, or On Scene Commander and is responsible for overseeing tactical activities assigned to the Task Force or Strike Team. This individual(s) reports work progress and status of resources, maintain work records on assigned personnel, and relay other important information to supervisory personnel. A TFLD supervises a group of resources with common communications that is assembled for a specific mission. A STLD supervises a specified combination of the same kind and type of resources with common communications. The TFLD and STCR positions are most often staffed by deployed response team personnel.
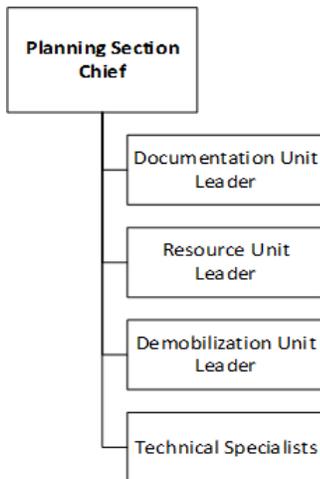
Planning Section

Figure 14 A depiction of the IMT Planning Section staffing organization.

The Planning Section is responsible for directing current operations planning and related support activities within the IMT. This section is responsible for developing and maintaining the overall daily IAP, which is intended to establish and communicate initial and ongoing incident management priorities, objectives, and strategies in support of validated SLTT requirements.

The section also conducts resource coordination planning, future operations planning (such as recovery and demobilization), and functional and adaptive planning activities. Finally, the Planning Section performs contextual interpretation of field-level incident information and supports senior leader decision making at the field level, and works with the Planning Section in the SOC on long term and adaptive planning issues and other efforts related to the response.

The Planning Section is comprised of the following primary elements: Resource Unit, Documentation Unit, Demobilization Unit, and Technical Specialists. These elements are described in further detail below.

Resource Unit: Responsible for processing federal public health and medical resource status information. This unit prepares and maintains displays, charts, and lists that reflect the current status of all IMT and other HHS resources assigned to the incident. It also implements an action tracking system to reflect current location/status of all resources assigned, available, or out-of-service.

Documentation Unit: Responsible for maintaining accurate and complete documentation of IMT planning activities. This unit maintains accurate and complete incident planning files and data for legal, analytical, and historical purposes. It also compiles, develops, reproduces, and distributes the IAP and other current and future operations planning products, including long-term and adaptive plans, and maintains the files and records that are developed as part of the IAP and planning function.

Demobilization Unit: Responsible for development and implementation of the Demobilization Plan for the IMT and federal public health and medical response teams. Preparation of the Demobilization Plan begins early in the incident via the creation of rosters of personnel and

resources and update of data as check-in proceeds.

Technical Specialists: May be employed for certain types of incidents or events where specialized knowledge and expertise are required to accomplish the mission. Technical Specialists may function within the Planning Section or be assigned wherever their services are required.
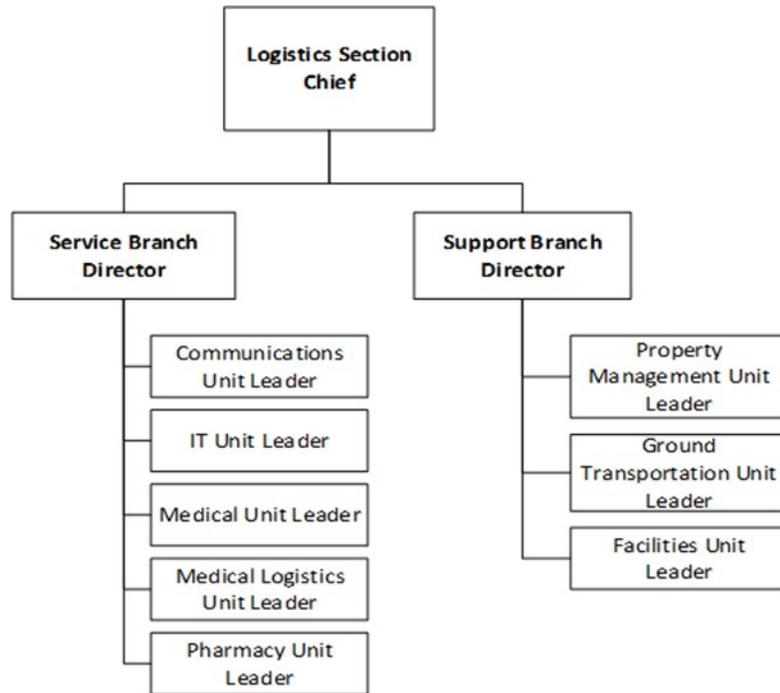
Logistics Section

Figure 15 A depiction of the IMT Logistics Section staffing organization.

The Logistics Section provides facilities, services, equipment, and supplies to the IMT and other federal public health and medical response resources. The Logistics Section also coordinates with the SOC's Resource Coordination Unit regarding the logistics needs of deploying teams and personnel.

The Logistics Section is comprised of the following primary elements: Services Branch, Communications Unit, IT Unit, Medical Unit, Medical Logistics Unit, Pharmacy Unit, Property Management Unit, Support Branch, Ground Transportation Unit, and Facilities Unit. These elements are described in further detail below.

Services Branch: Responsible for managing and coordinating the activities of the operations of the Communications, Information Technology, Medical, Medical Logistics, and Pharmacy Units. The Services Branch works with the Support Branch to develop transportation plans and requirements and conduct planning for delivery and set up of logistical, medical, and IT related supplies and equipment. The Services Branch is also responsible for providing personnel relocation updates to the Facilities Unit and cache/equipment movement updates to the

Property Management Unit for tracking purposes, and identifying any unmet needs to the Property Management Unit for generation of a RFR.

Communications Unit: Responsible for providing communication equipment and services support to the IMT and federal public health and medical response teams in accordance with assigned missions. The Communications Unit assists the Logistics Section Chief in determining the current status of deployed communications infrastructure, and determining communication requirements for deploying teams. The unit also identifies system shortfalls and gaps in coverage and corrective actions and provides input for the completion of the Logistics portion of the Unit Log (ICS 214) for the operational period. The unit also develops and maintains an up-to-date IMT Communications Plan (ICS205/205A). The Communications Unit deploys the follow communications elements as required: BGSN Satellite Data Unit, Iridium Satellite Phone, G2 Satellite, and VSAT.

Communications Specialist: Responsible for managing IMT communications system support during incident operations. The Communications Specialist assesses overall communication technology needs and participates in the development and implementation of the overall communications/systems plan, including appropriate COMSEC procedures. This individual also conducts coordination to protect IMT communications systems from identified threats, in coordination with the IMT Physical Security Officer, IMT IT Systems Security Specialist, and appropriate FSLTT partners. The Communications Specialist obtains frequencies, installs, operates, and maintains communication technology systems during incident operations, and coordinates communications requirements with other appropriate entities.

IT Unit: Responsible for providing IT equipment and services support to the IMT and federal public health and medical response teams in accordance with assigned missions. The IT Unit assists the Logistics Section Chief in determining the current status of deployed IT infrastructure, and determining IT and IT-related security requirements for IMT staff and deploying teams. The IT Unit is responsible for the establishment of effective communications through the acquisition, set up, and maintenance of computer/network resources provided within the IMT caches. The unit also identifies system shortfalls and gaps in IT system/asset coverage and corrective actions and provides input for the completion of the Logistics portion of the Unit Log (ICS 214) for the operational period. Finally, the IT Unit maintains full accountability of IT devices and property distributed to the teams and reports any discrepancies to the Property Management Unit Lead.

IT Specialist: Responsible for managing IT support during incident operations. The IT Specialist assesses overall IT needs and participates in the development of the overall IT architecture supporting field response activities. The Specialist obtains installs, operates, and maintains IT systems during incident operations, and coordinates IT requirements with other appropriate entities.

IT Systems Security Specialist: Responsible for the anticipation, identification, and assessment of potential threats to information and information systems used in conjunction with IMT operations. This individual develops and implements INFOSEC procedures and conducts coordination to protect IMT information and information systems from identified threats. The IT Systems Security Specialist ensures activated staff are provided with up-to-date INFOSEC

briefings and understand and comply with safeguards needed to protect information and information systems throughout the response. This individual also provides necessary INFOSEC information for inclusion in security bulletins and other messaging or guidance to IMT staff and deployed teams. This individual coordinates with the SOC IT Systems Security Manager and other federal deployed IT Systems Security representatives (i.e. DHS, FEMA, etc.) to ensure/maintain system integrity and security.

Medical Unit: Provides health and medical services for incident personnel, including pre-hospital and acute medical care, mental health care, occupational health support, and transportation of ill or injured incident responder personnel. In coordination with the CMO and the Safety Officer, the Medical Unit assists in controlling the transmission of disease among incident personnel. In coordination with the CMO, this unit also develops a Medical Plan that provides specific information on medical assistance capabilities at incident locations, off-site medical assistance facilities, and procedures for handling medical emergencies involving incident personnel. Finally, this unit assists the Finance/Administration Section with the administrative needs related to injury compensation, including obtaining written authorizations, billing forms, witness statements, administrative medical documents, and reimbursement as needed. (Note: based on mission analysis and other appropriate considerations, the FHCO and DFHCO-ME may elect to assign the functions of the Medical Unit as described in this paragraph to the CMO, obviating the need for a separate Medical Unit under the IMT Logistics Section).

Medical Logistics Unit: Responsible for the receipt, storage, relocation, and deployment of medical logistics assets. The Medical Logistics Unit provides inventory, report receipt, and cache information to Property Management Unit, and coordinates with the Transportation Unit if caches require repositioning. This units also coordinates release of assets to other elements within the IMT as directed by the Logistics Section Chief. Finally, this unit prepares equipment for shipment as determined by MMB, and transports and/or uploads materials to caches to commercial carrier/organic vehicles.

Pharmacy Unit: Responsible for managing the pharmaceutical program, including the transfer and accountability of pharmaceuticals and related documentation requirements, in support of assigned missions and in accordance with Federal laws and regulations. The Pharmacy Unit provides pharmaceuticals distribution information to the Property Management Unit. Finally, the Pharmacy Unit collaborates in the establishment and management of the Emergency Prescription Assistance Program (EPAP).

Support Branch: Responsible for development and implementation of logistics plans in support of the IAP. The Support Branch supervises the operations of the Property Management, Ground Transportation, and Facilities Units. This branch also reviews, tracks, and monitors logistics-focused RFRs and maintains asset accountability on behalf of the Logistics Section Chief.

Property Management Unit: Responsible for ordering, receiving, warehousing, maintaining, distributing, and inventorying equipment and supplies, including medical supplies, for the IMT and deployed federal public health and medical response teams. In coordination with the Services Branch, the Property Management Unit tracks incoming and outgoing property in accordance with established policies and procedures, and assists in projecting future resource

needs. This unit ensures proper documentation is completed for all property and all shipments leaving or entering the control of the IMT, and prepares and maintains records of HHS 22, Request for Property Action (HHS-22); HHS 439, Property Hand Receipt (HHS-439); and HHS 342, Report of Survey (HHS-342). The Property Management Unit also prepares and maintains records for all RFRs supported. Finally, this unit prepares and implements a packing and shipping plan for demobilization.

Ground Transportation Unit: Responsible for providing ground transportation for IMT and deployed team supplies, equipment, and personnel in support of assigned missions. The Ground Transportation Unit coordinates the supply of fuel for incident mobile equipment, develops and implements the Incident Traffic Plan, and coordinates with the Medical Logistics Unit for any requests for transportation of materials and personnel. This unit maintains a complete inventory of all transportation assets assigned to the IMT (e.g. organic trucks, commercial carriers, rental vehicles, material handling equipment). This unit also provides information to the Property Management Unit and the Resources Unit on the location and status of vehicles assigned to the Ground Transportation Unit, and maintains copies of all rental agreements and other transportation asset contracts on all vehicles under IMT control to include renewal dates.

Facilities Unit: Responsible for providing facilities and housing management for the IMT and deployed teams. Facilities Unit staff establish, maintain, and demobilize all facilities used in support of incident operations. The Facilities Unit collects information on the leasing of conference rooms, storage areas, and other required space. This unit also develops and maintains a tracking mechanism for hotel room assignments and contracted work/storage space as well as future needs, and ensures that all rooms are utilized or returned to hotel control after the demobilization of personnel. Finally, the Facilities Unit coordinates with the IMT Administration and Finance Section on the travel schedules for incoming and outgoing teams and personnel.

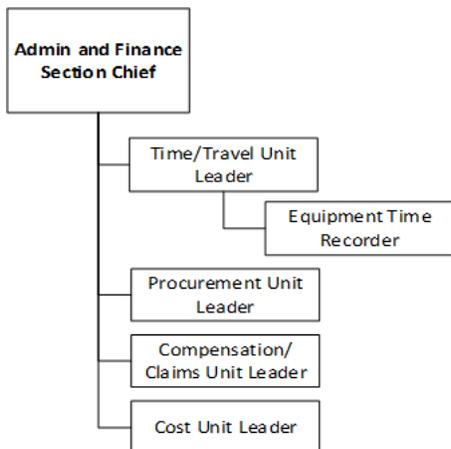**Administration and Finance Section**

Figure 16 A depiction of the IMT Admin and Finance staffing organization

The Administration and Finance Section is responsible for the following activities: 1) developing and maintaining financial documentation related to the incident response; 2) executing and overseeing acquisition actions and relevant vendor contracts at the field level, including emergency purchases; 3) tracking and analyzing incident-related costs; and 4) reconciling operational records with financial documents. The Administration and Finance Section ensures that all emergency finance and acquisition activities are accomplished within the parameters of existing statutes, regulations, and Department policies. Additional tasks include: timekeeping, financial accountability, compensation and claims, as appropriate, travel reimbursement claims, procurement, Mission Assignment funds management and the coordination of administrative support needs.

The Administration and Finance Section is comprised of the following primary elements: Time/Travel Unit, Equipment Time Recorder, Compensation/Claims Unit, Cost Unit, and Procurement Unit. These elements are described in further detail below.

Time/Travel Unit: Responsible for recording time for personnel and equipment, facilitating travel of response personnel, and ensuring accurate preparation of travel vouchers, in accordance with Federal Travel Regulations (or Joint Federal Travel Regulations for uniformed services members). The Time/Travel Unit provides HHS policy and ITAS system guidance to ensure that correct time and attendance procedures are followed. The unit records time for personnel and equipment in accordance with specific agency requirements, and prepares payroll reports at the end of each pay period for all deployed NDMS personnel. It also works with ASPR Travel to ensure timely coordination of incoming personnel and travel information, and provides Federal Travel Regulation guidelines and ensures that correct travel reimbursement procedures are followed. Finally, the Time/Travel Unit conducts coordination with the Planning Section's Resource Unit, as required.

Equipment Time Recorder: Reports to the Time/Travel Unit Leader and is responsible for overseeing the recording of time for all contracted, leased, or rented equipment assigned to an incident or event. This includes establishing procedures for equipment time reporting, determining reporting time lines, and maintaining a database for time recording and analysis. This individual conducts close coordination with the Property Management Unit, Resource Unit, Ground Transportation Unit, and Facilities Unit, as required.

Compensation/Claims Unit: Responsible for financial matters pertaining to incidents in which a federal or temporary federal employee sustains any level of injury during the course of duty.

The Compensation/Claims Unit facilitates timely, accurate processing of worker compensation and claims, and ensures that compensation forms and logs are in compliance with the receiving agency's requirements and policies. The unit files on injuries and illnesses associated with the incident, obtains written witness statements, and documents investigations and agency follow-up activities. The unit also provides written authority for individuals requiring medical treatment and ensures that an Authority for Treatment Release Statement accompanies all individuals seeking treatment. Since Medical Unit staff may also perform some of these tasks, the Medical and the Compensation and Claims Units coordinate closely with one another.

Cost Unit: Responsible for collection of all cost data, performing cost effectiveness analyses,

and preparing cost saving recommendations. The Cost Unit collects all cost information related to the incident, including, but not limited to, applicable costs for personnel, equipment, vehicles, supplies, claims, contracts, lodging, rentals, etc. The unit establishes procedures for cost and expenditure reporting and ensures that a system is in place that is in compliance with HHS financial reporting and accounting policies. The Cost Unit also prepares estimates of future incident costs/trends and makes sure estimated costs are updated with actual costs as they become available. Finally, the Cost Unit conducts close coordination with the Procurement Unit to ensure that all cost records and reports are accurately prepared and cumulative incident cost records are maintained.

Procurement Unit: Responsible for financial matters related to the origination and management of procurement contracts. The Procurement Unit administers all financial matters pertaining to vendor contracts, leases, service contracts/rentals, equipment, and fiscal agreements. This includes processing contracts (dependent upon specific contract authority) to acquire resources needed to support IMT and deployed team activities. The unit also establishes procedures to process procurement requests and ensures compliance with HHS property management requirements for the financial accounting of all new personal property purchases. Finally, the Procurement Unit ensures procurement items meet delivery schedules, invoices are entered into accountability records and maintains a log to track the flow of goods and services.

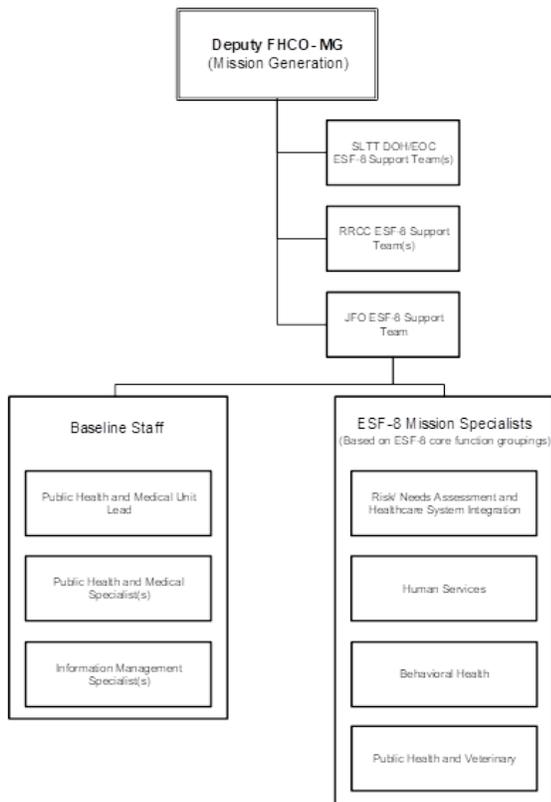## Deputy FHCO-MG Task Organization

Figure 17 A depiction of the Deputy FHCO-MG task organization for Level 1 activation, including deployed nodes and baseline staff and ESF-8 mission specialist positions.

Introduction

The Deputy FHCO-MG is responsible for the overall synchronization, coordination, and integration, as appropriate, of the various ESF-8 Support Teams/ASPR Representatives (including the JFO, RRCC, and SLTT DOH/EOC ESF-8 Support Teams, when activated) positioned to support a variety of requirements at the incident management level of the HHS/ASPR Incident Response Framework.

JFO ESF-8 Support Team Organization

The JFO ESF-8 Support Team is comprised of a baseline staff and additional ESF-8 mission specialists/SMEs who are activated based on mission requirements corresponding to the scenario at hand. The baseline staff includes individuals with appropriate training and experience regarding the FEMA Mission Assignment process and related coordination and documentation requirements, as well as information management requirements specific to the JFO ESF-8 Support Team. ESF-8 mission specialists/SMEs are assigned to the JFO ESF-8 Support Team as required based on specific mission needs to support a variety of risk analysis, needs assessment, strategic and operational planning, and resource coordination activities. Staff positions corresponding to the roles and responsibilities of the baseline staff and ESF-8 mission specialists/SMEs are described below:

Baseline Staff

Public Health and Medical Unit Lead: Serves as overall lead for the ESF-8 desk function in the JFO and as the point of entry for all ESF-8 coordination requirements, information requests, RFRs, etc. This includes responsibility for tracking and cataloguing the status of such coordination and requests.

Public Health and Medical Specialist(s): Responsible for supporting all aspects of the JFO ESF-8 Mission Assignment development, validation, tracking, and reporting process in concert with FEMA staff and other FSLTT agencies at the JFO. The Public Health and Medical Specialist(s) also interacts and coordinates with the SOC and ESF-8 Support Teams/Representatives assigned to the NRCC, RRCC, JFO, and SLTT EOCs/public health agencies.

Information Management Specialist(s): Responsible for supporting the information management needs of the Deputy FHCO/IM-MG and other staff assigned to the JFO ESF-8 Support Team in close coordination with the IMT Information Management Section.

ESF-8 Mission Specialists

Risk Assessor/Healthcare Systems Integration Specialist(s): maintains a focus on: 1) patient triage, referral, movement, and case management; 2) integration of public and private healthcare programs and capabilities; and 3) assessing and reporting on the status of public

health and medical and healthcare system facilities, resources, and operating capability and unmet needs.[13]

Public Health and Veterinary Specialist(s): maintains a focus on potential emergent infectious diseases and emergent animal health issues.

Human Services Specialist(s): maintains a focus on: 1) identifying and facilitating resources to meet critical support needs for at-risk populations; 2) integrating public and private resources and capabilities and identifying "wrap-around" needs; and 3) implementing an effective case management system.

Behavioral Health Specialist(s): maintains a focus on: 1) force health protection; 2) impacted populations; and 3) integrated public-private assistance and support.

RRCC ESF-8 Support Team and SLTT DOH & EOC ESF-8 Support Team Organization

Based on a variety of factors including, but not limited to, scope and complexity of the incident, anticipated mission requirements, and available facility space, the staff organization of the RRCC and SLTT DOH and EOC ESF-8 Support Team(s) may range from a single representative to a robust JFO ESF-8 Support Team-like construct featuring a baseline staff and ESF-8 mission specialists/SMEs.

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[13] An HPP FPO typically is assigned as a Healthcare System Assessor (Regional Medical Assessor) to conduct, in coordination with the FHCO/IM, IMT Advance Element Lead, or Region, rapid and ongoing assessments of the affected healthcare system/facility and provide real-time actionable recommendations to the FHCO on current healthcare system needs, operational capabilities and capacities, and potential shortfalls or limitations. As noted above, HPP FPOs also may be required to work with other elements of the JFO ESF-8 staff to support the following activities: 1) Collecting and monitoring CIRs; 2) Providing situational awareness on the status of healthcare delivery systems; 3) Responding to RFIs on healthcare system capabilities, capacities, and operational status; 4) Synthesis and reporting of information; and 5) Providing analysis and making recommendations for future operations.

ANNEX C: ASPR Regional Response: Guidance for Immediate Actions through Escalated Response (Provided separately)

ANNEX D: SOC and IMT Information Management (Provided separately)

ANNEX E: SOC and IMT Planning (Provided separately)

**ANNEX F: SOC and IMT Resource Coordination/Logistics & Operations
(Provided separately)**

ANNEX G: SOC and IMT Administration and Finance (Provided separately)

ANNEX H: Special Events Planning and Collaboration (Provided separately)