Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

HHS PUBLIC HEALTH AND MEDICAL SERVICES EMERGENCY SUPPORT PREPAREDNESS

Daniel R. Levinson
Inspector General

November 2012
OEI-04-11-00260

EXECUTIVE SUMMARY: HHS PUBLIC HEALTH AND MEDICAL SERVICES EMERGENCY SUPPORT PREPAREDNESS
OEI-04-11-00260

WHY WE DID THIS STUDY

In 2010, the Council of the Inspectors General on Integrity and Efficiency published *An IG's Guide for Assessing Federal Response Capabilities*, which recommended that Federal agencies assess their emergency preparedness. Within the Department of Health and Human Services (HHS), the Office of the Assistant Secretary for Preparedness and Response (ASPR) organizes HHS's resources and response as the Coordinator and Primary agency responsible for Emergency Support Function-8 (ESF-8), Public Health and Medical Services. HHS also has responsibilities as a Support agency for nine additional ESFs.

HOW WE DID THIS STUDY

We reviewed ASPR's and other Federal agencies' documentation and information request responses regarding HHS participation in ESF preparedness activities. We determined the total number of incidents to which HHS deployed resources in 2010 and 2011 and reported responses from ASPR and States regarding HHS's response to three selected incidents.

WHAT WE FOUND

HHS has participated in preparedness activities to fulfill its Coordinator, Primary, and Support agency ESF responsibilities. However, other ESF Coordinator and Primary agencies did not always report having a clear understanding of HHS's Support agency role and available resources during incident response. Further, HHS deployed resources for 28 incidents in 2010 and 2011 and demonstrated its ability to effectively fulfill its ESF-8 responsibilities for 3 incidents we reviewed in 2010 and 2011. However, States reported receiving multiple requests from HHS for the same information, which were burdensome during incident response.

WHAT WE RECOMMEND

We recommend that ASPR: (1) continue to increase communication with the ESF Coordinator and Primary agencies it serves as a Support agency, and (2) coordinate HHS requests from HHS Staff Divisions and Operating Divisions to reduce the burden on States during incident response. ASPR concurred with both recommendations.

TABLE OF CONTENTS

OBJECTIVES

1. To determine whether the Department of Health and Human Services (HHS) has prepared to provide public health and medical services to fulfill its emergency support responsibilities.
2. To report the total number of emergencies and disasters (i.e., incidents) to which HHS deployed resources in 2010 and 2011 and describe HHS's response to three selected incidents.

BACKGROUND

In 2010, the Council of the Inspectors General on Integrity and Efficiency (CIGIE), a group of Inspectors General (IG) from agencies across the Federal Government, created *An IG's Guide for Assessing Federal Response Capabilities* (*IG's Guide*).[1] The *IG's Guide* recommends that IGs assess their Federal agency's emergency preparedness capabilities.[2] It provides a framework for Offices of Inspectors General to conduct independent assessments of their department or agency's (agency) incident response capabilities. The *IG's Guide* is based on the National Response Framework (NRF), Emergency Support Functions, and the National Planning Scenarios.[3] Recent incidents such as Hurricane Sandy emphasize the need for Federal agencies to assess their emergency response capabilities.

NRF

When an incident occurs that exceeds or is expected to exceed State, territory, tribal, or local resources, these entities may request Federal assistance.[4] The Federal Government uses the NRF, which was developed through coordination of the Department of Homeland Security (DHS), to organize and coordinate its response and provide supplementary resources to affected areas. The NRF establishes a comprehensive, national,

[1] CIGIE comprises all Inspectors General whose offices are established under the Inspector General Act of 1978 (5 U.S.C. App.), those that are Presidentially appointed/Senate confirmed, and those that are appointed by agency heads (designated Federal entities). CIGIE, *Mission and Organization*. Accessed at http://www.ignet.gov/cigie1.html#mission on July 11, 2012.

[2] The *IG's Guide* includes researchable questions that agencies can use as a starting point to frame their assessments. However, all questions included in the *IG's Guide* may not be applicable to all agencies. CIGIE, *An IG's Guide for Assessing Federal Response Capabilities* (August 2010). Accessed at http://www.ignet.gov/randp/igguidefederalresponse0810.pdf on April 12, 2011.

[3] CIGIE, op. cit., pp. 7–8.

[4] States include U.S. districts and territories.

all-hazards approach to domestic incident responses.[5] An all-hazards approach focuses on general capability-based planning that can be applied to a variety of incidents.[6, 7] Federal agencies may also move resources close to an area or event where an incident may occur in anticipation of needs.[8] For example, HHS deployed medical personnel to East Coast States in anticipation of Hurricane Irene's landfall.

The NRF serves as a guide for organizing efforts of Federal, State, tribal, and local governments, as well as nonprofit and for-profit private-sector organizations (e.g., American Red Cross, private businesses). The NRF outlines each Federal agency's role during an incident and organizes agencies within 15 Emergency Support Functions (ESF).[9]

ESFs

The 15 ESFs within the NRF assign responsibilities to agencies.[10] Appendix A provides a listing of each ESF and identifies assigned responsibilities.

ESFs are activated by a declaration from the President or a Federal agency based on the needs resulting from an incident.[11] Once ESFs are activated, agencies with ESF responsibilities can provide requested resources to affected States, territories, tribes, and localities.[12] States, territories, tribes, and localities are not required to request or accept Federal resources during an incident response. If these entities request Federal resources, the ESF Coordinator and Primary agencies consider the requests and provide resources as they are available and necessary.

---

[5] DHS, *National Response Framework*, January 2008 (which superseded the National Response Plan, 2004), pp. 1, 28. Accessed at http://www.fema.gov/pdf/emergency/NRF/NRF-core.pdf on March 7, 2011.

[6] DHS, *National Preparedness Guidelines*, September 2007, p. 3. Accessed at http://www.fema.gov/pdf/emergency/NRF/NRF-core.pdf on June 21, 2011. DHS, *National Response Framework*, p. 31.

[7] DHS, *Presidential Policy Directive–8*. Accessed at http://www.dhs.gov/xabout/laws/gc_1215444247124.shtm on November 7, 2011. In March 2011, Presidential Policy Directive-8 (i.e., PPD-8) was released; it emphasizes integrated, risk-based preparedness planning for all agencies and organizations involved in incident response. The NRF is being revised as a result of PPD-8.

[8] DHS, *National Response Framework*, p. 11.

[9] DHS, *National Response Framework*, pp. 3–4.

[10] Ibid., p. 29. The ESFs can be found at http://www.fema.gov/emergency/*NRF*/#.

[11] Upon the advice of the Federal Emergency Management Agency (FEMA) Administrator, the President may declare a disaster. ESFs are activated on the basis of the needs caused by the incident. 42 U.S.C. §§ 5170, 5191. A Federal agency may also declare a disaster or emergency (e.g., the Secretary of HHS may declare a public health emergency) and activate ESFs to which the agency is assigned. *Public Health Service Act*, § 319 (42 U.S.C. § 247d); DHS, *National Response Framework*., p. 60.

[12] Ibid., pp. 24–26.

Each ESF divides Federal responsibilities among agencies on the basis of their capabilities. Federal agencies are designated as Coordinator, Primary, and/or Support agencies. Each ESF has one Coordinator agency, but may have one or more Primary agencies and multiple Support agencies and organizations.[13] For example, ESF responsibilities require that, as a Coordinator and Primary agency, HHS provide medical personnel when an incident occurs. As a Support agency, the Department of Agriculture may provide food safety and inspection services for the same incident. For-profit and nonprofit private-sector organizations, hereinafter referred to as organizations, may also provide assistance as Support organizations in an ESF response.

Throughout the preparedness, response, and recovery phases of an incident, the Coordinator agency is responsible for managing and organizing the resources provided by Primary and Support agencies and organizations.[14] Primary agencies provide specific resources identified in the ESF (e.g., medical personnel to an affected area) and collaborate with other Federal, State, territory, tribal, and local governments and organizations that have other available resources. Support agencies and organizations are assigned ESF responsibilities on the basis of their ability to provide supplementary resources to the Primary agency responsible for the ESF.[15]

Coordinator, Primary, and Support agencies and organizations engage in a variety of activities to prepare for an incident. Federal emergency preparedness guidance documents outline these five preparedness activities, which generally include:

- developing written incident response plans (e.g., scenario playbooks, field operations guides, strategies to obtain and deploy staff and equipment);
- participating in training and exercises;[16]
- purchasing equipment and procuring contracts to support incident response;

[13] The same agency within an ESF is often assigned to be both Coordinator and a Primary agency and leads ESF responses based on its capabilities. For example, HHS serves as a Coordinator and a Primary agency for ESF-8.

[14] DHS, *Emergency Support Function Annexes Introduction*, pp. iii–v.

[15] Ibid.

[16] Exercises include tabletop and live exercises. Tabletop exercises use HHS plans and representations of people and resources to simulate incident response. Live exercises also use HHS plans but involve personnel and volunteer participants to simulate incident response.

- coordinating internally as well as externally with other ESF agencies; and
- conducting situational and readiness assessments.[17, 18]

These activities are referred to as preparedness activities hereinafter.

HHS's ESF Responsibilities

HHS is the Coordinator and Primary agency for ESF-8, Public Health and Medical Services. As such, it manages the Federal response to an incident for activities in these areas. HHS also provides public health and medical services as a Support agency for nine additional ESFs (see Appendix A).

ESF-8 is the "mechanism for coordinated Federal assistance to supplement State, tribal, and local resources in response to a public health and medical disaster."[19] HHS conducts national situational and readiness assessments to prepare to respond to States' public health and medical needs when incidents occur. Further, HHS may provide ESF support to States, territories, tribes, and localities in the form of technical and situational and readiness assessment assistance, when requested. Within HHS, the Office of the Assistant Secretary for Preparedness and Response (ASPR) organizes HHS's preparedness resources and response activities.[20] Specifically, ASPR coordinates with HHS Staff Divisions (e.g., ASPR, Assistant Secretary for Health (ASH)) and Operating Divisions (e.g., Center for Disease Control and Prevention (CDC), Food and Drug Administration (FDA)) to ensure that HHS is prepared to provide public health and medical resources when incidents occur.[21]

---

[17] Information pertinent to this review was taken from the *IG's Guide* and consolidated into the five prepared activities. CIGIE, loc. cit.

[18] DHS, *Emergency Support Function Annexes Introduction*, pp. iii–v; DHS, *National Response Framework;* DHS, *National Preparedness Guidelines.*

[19] DHS, *ESF-8–Public Health and Medical Services Annex*, p. 1. Accessed at http://www.fema.gov/pdf/emergency/*NRF*/*NRF*–esf–08.pdf on May 13, 2011.

[20] HHS is made up of the Office of the Secretary, which is divided into 16 Staff Divisions, and 11 Operating Divisions. Operating and Staff Divisions perform tasks that include research, public health work, food and drug safety, grants funding, and health insurance. Staff Divisions provide direct support to the Secretary of HHS. For example, ASPR supports the Secretary's mission through its preparedness and response efforts. HHS, *HHS Operating and Staff Divisions*. Accessed at http://www.hhs.gov/about/ on May 15, 2012.

[21] ASPR, *Office of the Assistant Secretary for Preparedness and Response*. Accessed at http://www.phe.gov/about/aspr/Pages/default.aspx on May 11, 2011.

HHS's ESF-8 responsibilities include 17 core functional areas of public health and medical services (e.g., assessment of public health and medical needs, health surveillance, and medical care personnel).[22, 23] Appendix B contains detailed descriptions of the 17 core functional areas as they appear in the NRF.

HHS as the ESF-8 Coordinator and Primary Agency. HHS is charged with continually assessing and coordinating its resources and capabilities to ensure that it is prepared to fulfill its responsibility for the 17 core functional areas of public health and medical services.[24, 25] If HHS does not have the resources or capability to fulfill the 17 core functional areas, it can request assistance from designated Support agencies and organizations. Sixteen ESF Support agencies and organizations are tasked with providing supplementary resources to HHS, as needed.[26, 27]

HHS as an ESF Support Agency. When an incident occurs and HHS is not the Coordinator or Primary agency, it provides supplementary resources, as needed, for nine additional ESFs (see Appendix A). HHS provides public health and medical services as a Support agency similar to those that it provides as a Primary agency for ESF-8. For example, if ESF-10 (Oil and Hazardous Materials Response) is activated, the Environmental Protection Agency (EPA), as the ESF-10 Primary agency, can request that HHS provide supplementary medical personnel.[28, 29] Seven of the nine ESFs list which public health and medical services HHS must be prepared to provide as a Support agency.[30]

---

[22] DHS, *ESF-8 Annex*, pp. 4–8.

[23] ESF-8 includes a core functional area entitled Worker Safety and Health. The Department of Labor is the lead Federal agency for this core functional area, and HHS serves as a Support agency. Therefore, the Worker Safety and Health core functional area is not included in our list of HHS's 17 core functional areas of ESF-8.

[24] DHS, *Overview: ESF and Support Annexes Coordinating Federal Assistance In Support of the National Response Framework*. Accessed at http://www.fema.gov/pdf/emergency/*NRF*/*NRF*–overview.pdf on November 4, 2011.

[25] DHS, *ESF-8 Annex*, p. 9.

[26] Ibid., pp. iv, 10.

[27] ASPR, *Response Coordination*. Accessed at http://www.phe.gov/Preparedness/responders/soc/Pages/coordination.aspx on June 22, 2011.

[28] ASPR, *Response Coordination*; DHS, *Emergency Support Function Annexes Introduction*, p. iv.

[29] DHS, *ESF-10 Oil and Hazardous Materials Response Annex*. Accessed at http://www.fema.gov/pdf/emergency/*NRF*/*NRF*–esf–10.pdf on August 24, 2011.

[30] DHS, *NRF Resource Center*. Accessed at http://www.fema.gov/emergency/*NRF*/# on August 24, 2011. The following ESFs list resources that HHS should be prepared to provide as a Support agency during an ESF response: ESF-3, - 6, - 7, - 9, -10, -11, and -14. ESF-5 and -15 call for general HHS public health and medical support.

National Planning Scenarios

DHS created the 15 National Planning Scenarios to illustrate the potential scope, magnitude, and complexity of a range of major events for which the nation should be prepared. The 15 National Planning Scenarios are one of four parts of the National Preparedness Guidelines.[31] DHS created the National Preparedness Guidelines to assist Federal, State, and local governments and organizations in coordinating incident preparedness and response. Agencies may also develop written plans to address incidents that may require unique plans and resources.[32]

Similar to the NRF, the 15 National Planning Scenarios provide guidance on preparedness efforts for a range of potential incidents.[33] The NRF provides general guidance regarding collaboration during incident response, and the scenarios provide guidance specifically regarding preparedness and response to incidents, such as a major hurricane. See Appendix C for a complete list of the 15 National Planning Scenarios.

METHODOLOGY

Scope

We determined whether HHS has prepared to fulfill its Coordinator and Primary agency ESF-8 responsibilities. We also determined whether HHS addressed the 15 National Planning Scenarios through its participation in preparedness activities. Further, we determined whether HHS participated in preparedness activities with other ESF Coordinator and Primary agencies for the nine additional ESFs it serves as a Support agency.

We also reported the total number of incidents to which HHS deployed resources in 2010 and 2011. We then took an indepth look at three selected incidents to which HHS responded.

We used the *IG's Guide* as a framework for our evaluation and addressed categories from the guide that pertained to HHS's responsibilities. We reviewed the following categories: participating in activities regarding the 15 National Planning Scenarios, developing written plans, participating in training and exercises, purchasing equipment and procuring contracts,

[31] The four parts that make up the National Preparedness Guidelines are: National Preparedness Vision, National Planning, Universal Task List, and Target Capabilities List. DHS, *National Preparedness Guidelines*, pp. iii, 31. Accessed at http://www.dhs.gov/files/publications/gc_1189788256647.shtm on June 25, 2012. DHS, *National Response Framework*, pp. 31, 73.

[32] ASPR, *Playbooks Introduction*. Accessed at http://www.phe.gov/Preparedness/planning/playbooks/rdd/Pages/default.aspx on April 20, 2012, p. 3.

[33] DHS, *National Preparedness Guidelines*, p. 31.

coordinating internally among HHS Staff and Operating Divisions and externally with other ESF agencies, and conducting situational and readiness assessments. We did not include categories from the *IG's Guide* regarding financial accountability and recovery operations.[34]

Data Collection and Analysis

HHS as a Coordinator and Primary Agency. We requested information and collected documentation (e.g., After-Action Reports describing events that occurred in the National Level Exercise and service contracts procured by HHS for development of an Internet application) from ASPR regarding participation in preparedness activities to fulfill HHS's Coordinator and Primary responsibilities for the 17 core functional areas of ESF-8. We also requested information and collected documentation from ASPR on HHS's participation in preparedness activities to respond to the 15 National Planning Scenarios. ASPR coordinated with other HHS Staff Divisions and Operating Divisions, as needed, to fulfill our request.

We analyzed HHS's responses and documentation to determine whether HHS participated in preparedness activities to fulfill the 17 core functional areas of ESF-8. If HHS had addressed a core functional area by participating in each of the five preparedness activities at least once (i.e., developing written incident response plans, participating in training and exercises, purchasing equipment and procuring contracts, coordinating internally and externally, and conducting situational and readiness assessments), we considered HHS as having prepared for that core functional area. We then report the number of core functional areas in which HHS had prepared. Further, we describe each of the five preparedness activities, how HHS engaged in them, and the core functional areas that correlated with them.

We also analyzed HHS's responses and documentation to determine whether HHS has participated in each of the five preparedness activities at least once to address the 15 National Planning Scenarios.

HHS as a Support Agency. We coordinated with ASPR to identify appropriate points of contact for the ESF Coordinator and Primary agencies for the nine additional ESFs. We requested and received information from these Coordinator and Primary agencies for all nine ESFs. We collected documentation from the ESF Coordinator or one or

[34] HHS OIG's Office of Audit Services conducts audits specifically addressing financial accountability. In September 2011, DHS introduced the National Disaster Recovery Framework in which HHS has specific recovery responsibilities separate from what is included in the *IG's Guide*. DHS, *National Disaster Recovery Framework.* Accessed at http://www.fema.gov/pdf/recoveryframework/ndrf.pdf on August 13, 2012.

more of the ESF's Primary agencies regarding HHS's involvement in planning and response activities as a Support agency.[35]

We analyzed responses and documentation from HHS and the information provided by other ESF Coordinator and Primary agencies to determine whether HHS has prepared to fulfill its Support agency responsibilities.

HHS's Support to States During 2010 and 2011 Incidents. We requested and received from ASPR the total number of incidents to which HHS deployed resources in 2010 and 2011. We also requested that ASPR identify selected incidents to which HHS deployed resources and to which it responded as an ESF-8 Coordinator and Primary agency in 2010 and 2011. Because some incidents require resources from only a portion of the 17 core functional areas, we asked that ASPR's list include the smallest number of incidents that collectively required resources from all 17 core functional areas. ASPR identified three incidents: Red River flooding in North Dakota in March 2010; a tornado in Joplin, Missouri, in May 2011; and Hurricane Irene along the East Coast in August 2011. ASPR identified
17 States that were affected by these incidents.[36] We then requested information from State officials about their requests for and receipt of HHS support during these incidents. All 17 States responded to our request.

We also analyzed State responses to open-ended questions about HHS's response during incidents, the resources HHS provided, and any successes or challenges the States experienced in working with HHS. We report whether States indicated that HHS provided them resources and present examples of the States' experiences working with HHS. We also requested information from ASPR regarding the ESF-8 resources provided by HHS to States affected by these incidents.

Limitations

We assessed HHS's preparedness activities based on self-reported data from Federal agencies and States. We did not independently verify HHS's reported preparedness activities. We did not determine HHS's capability to respond to an incident, or whether the reported response was sufficient.

---

[35] Each ESF may have more than one Coordinator and Primary agency. We requested information from all ESF Coordinator and Primary agencies for which HHS is a Support agency—a total of 18 points of contact. We received responses from at least one Coordinator or Primary agency for each ESF that HHS supports. We received multiple responses from agencies for some ESFs. The total number of responses was 13.

[36] The Red River flooding affected North Dakota. The Joplin tornado affected Missouri. States affected by Hurricane Irene were Connecticut, Delaware, the District of Columbia, Maryland, Massachusetts, New Jersey, New York, North Carolina, Pennsylvania, Puerto Rico, Rhode Island, South Carolina, U.S. Virgin Islands, Vermont, and Virginia.

Standards

This study was conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

FINDINGS

HHS has participated in preparedness activities to fulfill its Coordinator, Primary, and Support agency ESF responsibilities

The ESF framework within the NRF describes HHS's responsibility to fulfill the 17 core functional areas of ESF-8 as a Coordinator, Primary, and Support agency. HHS has led and supported other agencies in five preparedness activities that Federal guidance documents describe as important to being prepared to respond to an incident. These five preparedness activities are developing written plans; participating in training and exercises; purchasing equipment and procuring contracts to support incident response; coordinating internally among HHS as well as externally with other ESF agencies; and conducting situational and readiness assessments.

HHS has developed written incident response plans

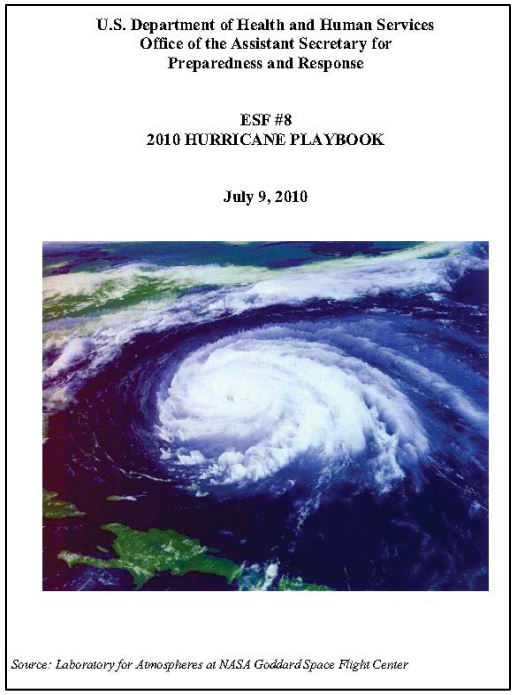

Photo provided by ASPR

The Hurricane Playbook describes HHS's public health and medical services written incident response plans.

HHS has created incident response plans for all 17 core functional areas of ESF-8. Further, HHS's National Planning Scenario playbooks and other written incident response plans address all the core functional areas.

Specifically, HHS has developed playbooks for 14 of the 15 National Planning Scenarios (see Appendix D). Although no playbook has been written for the cyber security National Planning Scenario, HHS included incident response plans for cyber security

in the 2010 Health Care and Public Health Sector Specific Plan and the 2010 Sector Annual Report.[37]

HHS has prepared other written incident response plans and technical and health care preparedness guidance documents that address topics including: the Hospital Preparedness Program, medical movement of evacuees, National Veterinary Response Teams, disaster behavioral health, and National Disaster Medical System (NDMS) (i.e., medical personnel). HHS has also published the National Health Security Strategy and Implementation Plan, which outline a national vision and actions regarding public health and medical preparedness, response, and recovery capabilities.

HHS has participated in incident response training and exercises

Photo provided by FEMA
Health care workers rush to decontaminate a simulated victim during an exercise at the Center for Domestic Preparedness in Anniston, Alabama. These students were attending the Hospital Emergency Response Training for Mass Casualty Incidents course.

HHS has participated in at least one training activity and exercise to ensure it is prepared to fulfill its responsibilities in all 17 core functional areas of ESF-8. Exercises in a realistic setting provide personnel opportunities to use training and hone skills they will need during incident response. For example, the U.S. Public Health Service (USPHS) has trained personnel to provide mass care (i.e., sheltering, feeding operations, emergency first aid, bulk distribution of emergency items, and collecting and providing information on victims to family members) to people affected by an incident. USPHS maintains teams of trained personnel that can address specific needs during a response.

[37] DHS and HHS, *2010 Sector CIKR Protection Annual Report for the Health Care and Public Health Sector*. Accessed at http://www.phe.gov/Preparedness/planning/cip/Documents/2010cikrannualreport.pdf on April 20, 2012; ASPR, *Health Care & Pubic Health Sector Specific Plan*. Accessed at http://www.phe.gov/Preparedness/planning/cip/Pages/ssp.aspx on April 20, 2012.

In 2010 and 2011, HHS reported that it conducted or participated in 60 live and tabletop exercises.[38] Three of the seven tabletop exercises that HHS conducted in 2011 focused on an anthrax dispersal scenario. These exercises did not require participants to simulate the incident response. Instead, using visual aids for illustration, participants were invited to discuss roles and responsibilities that would be needed during a response.

Additionally, 11 live anthrax dispersal scenario exercises in 2010 and 2011 included other Federal and State agencies and organizations. The exercises exposed gaps and demonstrated strengths in planning, training, and resources and allowed participants to examine policy and operational needs in responding to an aerosolized anthrax dispersal scenario.

HHS and other Federal, State, tribal, and local governments and organizations participated in the National Level Exercise, a live annual exercise in which participants simulated incidents in real time. The 2011 National Level Exercise focused on an earthquake scenario in which participants simulated an appropriate response. For example, personnel used tangible resources and set up evacuation and alternative water supply stations. Local responders communicated their needs to State and Federal agencies, which collaborated to provide resources for the response. In addition, HHS communicated with private-sector partners and shared situational awareness information that assisted in rapid local response. For example, HHS collaborated with organizations such as the American Red Cross to provide resources for medical surge response efforts.

Photo by SSG Brad Staggs

Missouri National Guard members participated in the 2011 National Level Exercise, which took place at Muscatatuck Urban Training Complex in Butlerville, Indiana.

[38] HHS conducted and participated in 27 live and 3 tabletop exercises in 2010 and 23 live and 7 tabletop exercises in 2011.

HHS has purchased equipment and procured contracts to support incident response

HHS has purchased at least one piece of equipment and procured contracts to fulfill its responsibilities in each of the 17 core functional areas of ESF-8. Such equipment and contracts cover a wide range of areas. For example, HHS has purchased equipment and procured contracts to assemble and maintain Disaster Medical Assistance Team (DMAT) caches. Items needed for the caches include pharmaceuticals, ventilators, defibrillators, communications equipment, and electronic medical record software. Service contracts have been procured for the equipment in caches. Caches are prepackaged for rapid deployment and are also strategically stored around the country so that they are readily available when an incident response is required.[39]

HHS also has procured contracts for services to ensure it is able to fulfill its ESF-8 responsibilities. For example, in 2011, HHS contracted with a vendor to develop an Internet-based application to help track medical care personnel. The application makes public health and medical volunteer credential information available to health care facilities when incidents occur. It allows States' credential information to be linked, creating a single network for use nationwide.

Photo provided by ASPR
A member of a DMAT sets up an NDMS cache with equipment and supplies needed to provide medical care.

Further, HHS contracted with a vendor to conduct a national survey of medical equipment and supplies. This survey determined the number of ventilators in acute care hospitals that could be used in mass casualty scenarios, such as a pandemic.

[39] HHS has purchased equipment for caches in the following areas: Basic IT/Telecom Kit, Critical Care, Disaster Medical Assistance Team, Disaster Portable Morgue Unit, Electronic Medical Record Kit, Family Assistance Center Team, Federal Medical Station, Incident Response Coordination Team, International Surgical Response Team, Mobile Medical Kit, National Medical Response Team, National Special Security Event, National Veterinary Response Team, and Personnel Support Kit.

HHS has coordinated its incident response efforts internally and externally

During 2010 and 2011, HHS provided internal and external coordination to fulfill its responsibilities in all 17 core functional areas of ESF-8. HHS regularly coordinates internally with its Staff Divisions and Operating Divisions to ensure it is ready to respond when incidents occur. For example, the Office of the Surgeon General's Office of Force and Readiness and Deployment coordinates with USPHS teams regarding ESF-8 response. USPHS has seven types of teams and the Office of the Surgeon General's Office of Force and Readiness and Deployment frequently conducts meetings to update written incident response plans, training, and exercises regarding ESF-8 response responsibilities.[40]

HHS also coordinates externally with other Federal, State, tribal, and local governments and organizations and participates in preparedness activities with them to ensure resources are provided through a coordinated response. For example, in 2011, HHS coordinated with other Federal agencies, State, and local governments, and organizations to establish procedures for joint delivery of veterinary services in preparation for an incident response through the Pets Multi-Agency Coordination System (Pets-MACS). Through its participation in Pets-MACS, HHS coordinates with other agencies, governments, and organizations to deploy National Veterinary Response Teams to treat animals in need.

Photo provided by FEMA

Ambulances departed from Stewart Air Force Base to evacuate patients from New York hospitals after Hurricane Irene in August 2011 under the Federal National Ambulance Contract.

In many instances, HHS must coordinate internally and externally to cover the same responsibility. For example, in 2011, HHS coordinated with FEMA to develop the National Federal Ambulance Contract, which was developed to provide patient evacuation using private-sector ground and air ambulance services. Coordination internally within HHS and with

[40] The seven types of teams are Services Access, Rapid Deployment Force, Applied Public Health, Mental Health, Capitol Area Providers, National Incident Response, and Regional Incident Response.

FEMA, and externally with private-sector ambulance service businesses, was necessary to develop this contract.

HHS regularly conducts situational and readiness assessments to respond to an incident quickly

The HHS Secretary's Operation Center (SOC) operates 24 hours a day, every day of the year, and maintains real-time situational and readiness assessments. Through these assessments, HHS monitors potential and actual incidents requiring public health and medical resources within all 17 core functional areas of ESF-8.

To provide comprehensive assessments, the SOC conducts situational and readiness assessments before, during, and after an incident.

Photo provided by ASPR

HHS's Emergency Management Group staffs the SOC and maintains communication with Federal, State, territorial, tribal, and local governments, and other organizations.[41] The Emergency Management Group provides real-time information to assist HHS Staff Divisions and Operating Divisions as they consider deploying resources before and during an incident. Examples of regular SOC situational and readiness assessment activities include:

- identifying emerging threats through public health data for special topics (e.g., West Nile virus, influenza activity). When threats are identified, SOC personnel provide relevant information to HHS, other government agencies, and leaders of organizations;
- tracking field reports received from Regional Emergency Coordinators (REC), HHS Operating Divisions, and other ESF-8 agencies that support State, territorial, tribal, and local incident response;

[41] The Emergency Management Group consists of liaisons from HHS Staff Divisions and Operating Divisions and other Federal agencies.

- conducting conference and video calls to facilitate coordination and information sharing between HHS and deployed field personnel, such as the RECs, NDMS, and USPHS; and
- preparing and coordinating situational assessments regarding HHS resources available for deployment in advance of and during prominent national events (e.g., Presidential inauguration, Super Bowl).

HHS has participated in preparedness activities to fulfill its Support agency ESF responsibilities

HHS has participated in preparedness activities for all nine of the additional ESFs it is required to support.[42] Coordinator and Primary agencies from eight of the nine ESFs said that, as a Support agency, HHS is prepared to fulfill its responsibilities. One ESF-3 agency, DOD-U.S. Army Corps of Engineers, said that it has not communicated with HHS regarding its Support agency role.

Many of the preparedness activities in which HHS has participated as a Coordinator and Primary agency are the same as those HHS provides in its Support agency role. For example, HHS participated in the 2011 National Level Exercise as an ESF-8 Coordinator and Primary agency and as a Support agency for nine additional ESFs.

HHS also participated in exercises with Coordinator and Primary agencies for five of the nine ESFs for which it is a Support agency.[43] For example, HHS participated as an ESF-7 Support agency in quarterly meetings of the Disaster Management Strategic working group with FEMA and the Government Services Administration. HHS also provided public health and medical services resources requested by these agencies. HHS provided many of the same core public health and medical services in each instance, with the distinction being who was responsible for leading the ESF response.

Coordinator and Primary Agencies Did Not Always Report Having a Clear Understanding of HHS's Support Agency Role and HHS's Available Resources.

Two of the eight ESF Coordinator and Primary agencies that reported HHS participation in preparedness activities as a Support agency indicated

[42] Support agency preparedness activities include developing written incident response plans, conducting training and exercises, purchasing equipment and procuring contracts, and conducting situational and readiness assessments. Internal and external coordination are not considered Support agency preparedness activities in this report.

[43] ESF-5, -6, -7, -10, and -15 reported that HHS participated in exercises.

that increased HHS communication regarding planning activities and available resources would improve its Support capabilities. The ESF-9 agency (FEMA-Urban Search and Rescue) stated that better communication of strategic information and preparedness planning and activities would improve HHS's performance as a Support agency. The ESF-6 agency (FEMA-Individual Assistance Division) stated that improved communication about resources that HHS is able to provide could improve incident response. For example, during an ESF-6 incident response, HHS can provide medical personnel as an ESF-6 Support agency. FEMA stated that it would be helpful for HHS to communicate, as soon as possible during an incident response, the number of available HHS-authorized medical facilities and medical personnel. Using this information, FEMA would be better able to determine whether additional facilities and medical personnel were needed.

HHS deployed resources to 28 incidents in 2010 and 2011 and demonstrated its ability to effectively fulfill its ESF responsibilities for 3 selected incidents we reviewed in 2010 and 2011

HHS deployed resources to 15 incidents in 2010 and to 13 in 2011. The incidents varied from mudslides in Kentucky to humanitarian missions in Hawaii after the 2011 earthquake and tsunami (see Appendix F). HHS also provided resources for 20 prominent national events in 2010 and 2011.[44] These events ranged from the State of the Union address to the Cherry Blossom Festival. In preparing to provide public health and medical services, HHS may position resources prior to incidents and events.

Of the 28 incidents, we reviewed 3 that affected 17 States. During these 3 incidents, HHS demonstrated its ability to effectively fulfill all 17 core functional areas of its ESF-8 responsibilities. The incidents were:

- Red River flooding in North Dakota in March 2010;
- Tornado in Joplin, Missouri, in May 2011; and
- Hurricane Irene along the East Coast in August 2011.

Public health emergencies were declared for all three incidents. For each, ASPR conducted situational and readiness assessments to determine what public health and medical services States might need. Through its Emergency Management Group, ASPR monitored the incident from the SOC. ASPR disseminated relevant information to HHS Staff Divisions

[44] HHS provided resources for 13 events in 2010 and for 7 in 2011.

and Operating Divisions and coordinated with them to provide requested HHS resources.

HHS Operating Divisions outside of the Office of the Secretary also conducted situational and readiness assessments to ensure that resources were prepared for deployment in all three incidents. For example, CDC monitored State health department reports regarding vector control (i.e., eradicating mammals, birds, or insects that transmit diseases such as West Nile virus) and prepared to provide resources, such as products to eradicate insects, if needed. The Substance Abuse and Mental Health Services Administration (SAMHSA) assessed potential impact to behavioral health systems (i.e., networks of behavioral health services providers) and coordinated with stakeholders, assessed needs, and provided technical assistance to all three affected populations. SAMHSA and support organizations also distributed behavioral health materials. SAMHSA deployed behavioral health specialists and provided grants to restore behavioral health facilities and support services.

The Administration for Children and Families (ACF) and FDA also participated in HHS's response efforts. ACF assessed the impact the incidents had on services such as access to food and emergency housing. FDA deployed food safety consultants to conduct risk assessments of food service and manufacturing facilities and of agricultural animals used for human consumption.

For all three incidents, NDMS medical personnel were activated (i.e., instructed by the HHS Secretary to provide medical services) and hospital bed availability was continually assessed through the Hospital Preparedness Program's Hospital Available Beds for Emergencies and Disasters system. This system reports available hospital beds in real time at the local and regional level. HHS also provided reports detailing available blood resources and types to NDMS and other medical personnel for all three selected incidents.

Finally, after each of the three incidents, ASPR coordinated with all affected States to determine whether supplementary HHS resources were needed. Appendix E is a detailed list of ESF-8 resources provided to States by HHS during its response to three selected incidents in 2010 and 2011.

Red River flooding in North Dakota

On March 21, 2010, the Red River crested at 36.99 feet—19 feet above flood level. Floodwaters destroyed homes, covered roadways, and closed bridges. In an attempt to protect the city of Fargo from the floodwaters, Federal, State, and local governments and organizations coordinated

efforts to stack 700,000 sandbags around the city. At least 10 people were reportedly rescued from floodwaters.[45]

During the flood response, HHS provided North Dakota with resources in 12 of the 17 core functional areas of ESF-8.[46] (The State did not request resources for the other five core functional areas.) Throughout the response, HHS RECs monitored North Dakota's requests for public health and medical equipment and technical assistance, and provided requested resources.

HHS deployed ESF-8 personnel to the North Dakota Emergency Operations Center to provide technical support. Specifically, an HHS Incident Response Coordination Team (IRCT) was deployed to assess flood damage. The IRCT interacted with State and local emergency response personnel to determine what additional ESF-8 resources HHS could provide to support the State response.

Photo provided by FEMA
Burlington, North Dakota, was inundated during the Red River flood in March 2010.

In addition to the IRCT, DMATs were identified to assist in shelter operations, as needed. Health and medical caches containing mobile medical kits and prescription drugs were deployed to support response personnel.

An HHS public affairs officer coordinated with State representatives to assess public health and medical communication needs. To provide further support, CDC posted information on its Web site to keep the public informed about the flooding.

[45] CNN, *FEMA Chief to Survey Red River flooding*. Accessed at http://www.cnn.com/2010/US/weather/03/22/severe.weather/index.html?iref=allsearch on June 22, 2012.

[46] Core functional area resources not needed during the Red River flooding response were Patient Evacuation; Agricultural Safety and Security; Vector Control; Mass Fatality Management, Victim Identification, and Decontaminating Remains; and Veterinary Medical Support.

State representatives reported that HHS's response was "efficient and effective," and that all resources provided by HHS were sufficient, helpful, and appropriate.

Tornado in Joplin, Missouri

On May 23, 2011, a "monster tornado" struck Joplin, killing 116 people and injuring another 400.[47] Measuring over a half-mile wide, the tornado destroyed an estimated 2,000 homes, schools, and businesses. One hundred eighty patients at St. John's Regional Medical Center attempted to find shelter as the roof was ripped off by the tornado. Weather officials reported that the tornado was the single deadliest twister in the United States since 1947 and one of the nine deadliest in recorded history.[48]

Photo provided by FEMA

Damage to the front entrance of St. John's Regional Medical Center in Joplin, Mo., after a deadly F-5 tornado struck.

HHS provided Missouri with resources in 16 of the 17 core functional areas of ESF-8. (The State did not request resources for the other core functional area.[49]) HHS ESF-8 personnel deployed to Joplin assessed damage to the medical infrastructure, including hospitals and long-term-care facilities. An HHS IRCT and the Emergency Management Group collaborated with FEMA and State and local officials to determine the State's need for Federal resources to repair the health care infrastructure.

DMATs also assisted with patient care and emergency services. A Medical Strike Team was deployed to assess the impact on public health

---

[47] Reuters, *Tornado devastates Joplin, Missouri, 116 dead*. Accessed at http://www.reuters.com/article/2011/05/23/us–usa–weather–tornadoes–idUSTRE74M08L20110523 on June 22, 2012.

[48] Ibid.

[49] Patient Evacuation core functional area resources were not needed during the Joplin tornado response.

and respond to chemical, biological, and radiological dispersals.[50] RECs collaborated with a hospital to set up a mobile medical unit. Health and medical caches containing prescription drugs and mortuary equipment and supplies were also deployed to Joplin. HHS personnel conducted family interviews to assist with victim identification.

SAMHSA deployed behavioral health specialists who provided psychological first aid and crisis counseling training to responders in Joplin. SAMHSA coordinated with the American Red Cross, which also provided mental health services to Joplin residents, as needed. SAMHSA also managed the transport of patients, service providers, and drugs requiring additional security, such as methadone, during the response.

ACF collaborated with ESF-6 personnel (e.g., DHS, FEMA), the Missouri State Division of Family Services, and the Child Care Development Fund to provide technical assistance and consultation to affected Joplin residents. FDA inspected and provided surveillance of retail food establishments and food manufacturing facilities. CDC assessed vaccine need and availability and animal control, and assessed needs for vector control resources. CDC worked with EPA to provide vector control resources to eradicate mosquitoes in Joplin. CDC also worked with Joplin's health department to inform the affected population about the need to boil water before use.

Public health emergency information was disseminated to the public through ASPR's Web site. CMS published information regarding Medicare, Medicaid, and the Children's Health Insurance Plan benefits during an incident response. SAMHSA also provided stress management information on its Web site.

State representatives reported that all requested resources were sufficient, helpful, and appropriate. They stated that HHS provided technical support and "guidance in some very challenging circumstances."

Hurricane Irene along the East Coast

On August 22, 2011, Hurricane Irene struck Puerto Rico. The storm downed trees, flooded streets, and left over a million people without electricity. Hurricane advisories were issued for most States along the

[50] A Medical Strike Team is prepared to assist with medical management and respond to the public health consequences of chemical, biological, and radiological incidents that result from accidental or deliberate acts. The team is designed to supplement the local hazardous materials and medical response to weapons of mass destruction by offering specialized equipment and knowledge, as well as additional fire and emergency personnel, physicians, and nurses.

East Coast as Irene left Puerto Rico.[51] On August 26, the hurricane struck the East Coast and left millions of people without electricity for several days and, in some cases, several weeks. Homes, businesses, and crops were damaged or destroyed by high winds and heavy rains. The storm killed 45 people.[52]

Fifteen States on the East Coast were affected by Hurricane Irene.[53] HHS reported that it provided affected States with resources in 16 of the 17 core functional areas of ESF-8. (States did not request resources for the remaining core functional area.[54]) HHS began its response by deploying IRCTs, DMATs, Logistical Response Assistance Teams, and Rapid Deployable Force teams to affected States. Communications equipment was deployed to assist IRCTs in assessing States' needs and the resources HHS could provide. Caches containing medical equipment had been strategically positioned along the East Coast to prepare them for rapid deployment during incident response. The Federal National Ambulance Contract was activated in New York to assist with patient evacuation from hospitals and other health care facilities.

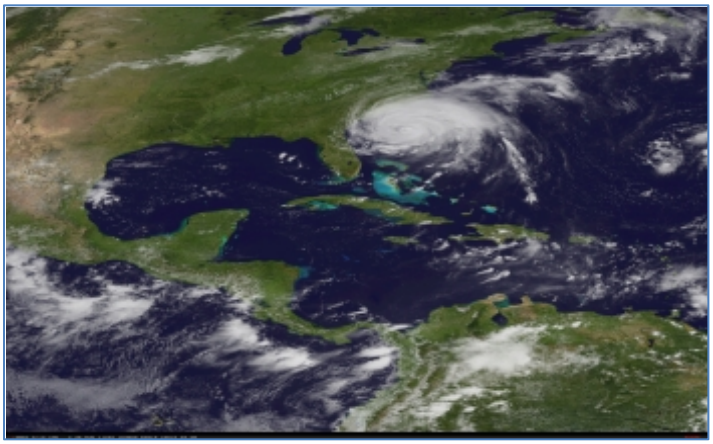

Photo provided by National Oceanic Atmospheric Administration
Hurricane Irene as it strikes the East Coast in August 2011.

CDC assessed the need for vector control resources and conducted epidemiology conference calls with affected States. CDC provided the Virginia Department of Health with technical assistance regarding vector control. The Health Resources and Services Administration assessed the

[51] CBS News, *Hurricane Irene Slams Puerto Rico, Eyes U.S.* Accessed at http://www.cbsnews.com/2100–201_162–20095323.html on June 22, 2012.

[52] Associated Press, *Hurricane Irene's Impact, State by State*. Accessed at http://www.nj.com/news/index.ssf/2011/08/hurricane_irenes_impact_state.html on June 22, 2012.

[53] The 15 States were Connecticut, the District of Columbia, Delaware, Massachusetts, Maryland, North Carolina, New Jersey, New York, Pennsylvania, Puerto Rico, Rhode Island, South Carolina, Vermont, Virginia, and the U.S. Virgin Islands.

[54] Safety and Security of Drugs, Biologics, and Medical Devices core functional area resources were not needed during the Hurricane Irene response.

impact of Hurricane Irene on service providers and their ability to deliver community-based services to patients. HHS provided critical infrastructure support to the American Red Cross in Baltimore to ensure that blood supplies were secure.

Public health information regarding well water contamination was disseminated to the public through ASPR's Web site. CDC also updated hurricane information on its Web site.

Representatives from 10 of the 15 States reported that they received HHS resources, and that the resources provided were appropriate, based on their requests. Of the 10 States that reported receiving resources, 9 indicated that HHS resources were helpful. One State reported a neutral response about the resources it received.[55]

States Reported That Multiple Requests From HHS for the Same Information Were Burdensome During Incident Response.

Five of the fifteen respondents reported that the same information was requested multiple times by different HHS Staff Divisions and Operating Divisions.[56] States reported that it appeared HHS personnel did not communicate information among Staff Divisions and Operating Divisions and that each division made separate requests. States indicated that these multiple requests were burdensome.

One State said that although it had established a regular, recurring reporting system during the Hurricane Irene response, HHS requested information that the State had already provided or intended to provide in the next reporting cycle.[57]

[55] The 10 States that received resources were Connecticut, Maryland, New Jersey, New York, North Carolina, Pennsylvania, Puerto Rico, Rhode Island, Vermont, and Virginia. The five States that did not receive resources were the District of Columbia, Delaware, Massachusetts, South Carolina, and the U.S. Virgin Islands. The only State that reported a neutral response about HHS resources received was Maryland.

[56] The five States that reported receiving multiple requests for the same information were Maryland, New York, North Carolina, Rhode Island, and Virginia.

[57] Virginia.

CONCLUSION AND RECOMMENDATIONS

In 2010, CIGIE published the *IG's Guide,* which recommended that IGs assess their Federal agency's emergency preparedness capabilities. Recent incidents such as the Sandy super storm emphasize the need for Federal agencies to assess their emergency response capabilities. HHS is charged with serving as the Coordinator and Primary agency for ESF-8 Public Health and Medical Services. Within HHS, ASPR organizes HHS resources and response as the Coordinator and Primary agency for ESF-8. HHS also serves as the Support agency for nine additional ESFs.

HHS has taken action in all five preparedness activities we reviewed to fulfill its ESF responsibilities as a Coordinator, Primary, and Support agency. However, HHS can improve communication of its Support agency role, responsibilities, and the resources it can provide during incident response.

Further, HHS responded to 28 incidents in 2010 and 2011 and demonstrated its ability to respond to 3 incidents we reviewed that affected 17 States. Twelve of the seventeen States affected by these three incidents reported requesting HHS resources and stated that the resources they received were appropriate, based on their requests. However, internal communication with Staff Divisions and Operating Divisions could be increased to reduce duplicative information requests to States.

We recommend that HHS:

Continue to Increase Communication with ESF Coordinator and Primary Agencies It Serves as a Support Agency

The NRF states that ESF Support agencies must be prepared to provide resources and participate in preparedness activities to support the ESF Coordinator and Primary agency's mission. HHS should continue to work toward increasing its communication with the Coordinator and Primary agencies for the nine additional ESFs for which HHS serves as a Support agency. Specifically, HHS should increase communication regarding its Support agency role and the resources it can provide during incident response.

Coordinate Requests for Information From HHS Staff Divisions and Operating Divisions To Reduce the Burden on States During an Incident Response

Five of the fifteen States affected by Hurricane Irene indicated that HHS Staff Divisions and Operating Divisions made several requests for the same information. States found this burdensome and reported that the repeated requests slowed their incident response. HHS should coordinate

all requests for information during an incident response to ensure that States are not being unnecessarily burdened. For example, HHS could establish one point of contact per response area to communicate with State and local governments during the incident response. This point of contact could, in turn, disseminate information to HHS Staff Divisions and Operating Divisions.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

ASPR concurred with our recommendations and provided information regarding its efforts to fulfill its emergency support responsibilities. Specifically, ASPR will continue to include all appropriate Coordinator and Primary agencies in any planning endeavors as well as routine collaboration with partner agencies.

Regarding our second recommendation, ASPR will continue to improve information collection from States concerning multiple agency requests during incident response. Although ASPR makes every effort to ensure that requests to States are well-coordinated and minimally burdensome, it recognizes that during a response communication breakdowns may occur at the Federal and State levels. ASPR acknowledges this challenge and places a high priority on building and enhancing communications with all of its partners and stakeholders.

We support ASPR's efforts to address and continue to make progress in these areas. For the full text of ASPR's comments, see Appendix G.

APPENDIX A

Emergency Support Functions

The *National Response Framework* assigns 15 Emergency Support Functions (ESF) to various Federal agencies. Each ESF divides Federal responsibilities among Coordinator (C), Primary (P), and Support (S) agencies and organizations. The chart below indicates which Federal agencies and organizations are assigned responsibilities within each ESF. The highlighted column and row indicate the Department of Health and Human Services' ESF-8 responsibilities.

Table A-1 Selected Federal Agencies With Coordinator, Primary, and Support Roles for Emergency Support Functions

Agencies and Organizations	#1 Transportation	#2 Communications	#3 Public Works and Engineering	#4 Firefighting	#5 Emergency Management	#6 Mass Care, Emer. Assist., Housing, and Human Svs.	#7 Logistics Management and Resource Support	#8 Public Health and Medical Services	#9 Search and Rescue	#10 Oil and Hazardous Materials Response	#11 Agriculture and Natural Resources	#12 Energy	#13 Public Safety and Security	#14 Long-Term Community Recovery	#15 External Affairs
American Council on Historic Preservation											S				
American Red Cross			S		S	S		S			S			S	
Corporation for National & Community Service			S		S									S	
Department of Homeland Security (DHS)	S	C/P/S	P/S	S	C/P/S	C/P/S	C/P/S	S	C/P/S	P/S	S	S	S	C/P	C/P
Department of Commerce	S	S	S	S	S		S	S	S	S	S	S	S	S	S
Department of Defense	S	S	C/P/S	S	S	S	S	S	P/S	S	S	S	S	S	S
Department of Energy	S		S		S		S	S		S	S	C/P	S	S	S

continued on next page

Table A-1 Selected Federal Agencies With Coordinator, Primary, and Support Roles for Emergency Support Functions, Continued

Agencies and Organizations	#1 Transportation	#2 Communications	#3 Public Works and Engineering	#4 Firefighting	#5 Emergency Management	#6 Mass Care, Emer. Assist., Housing, and Human Svs.	#7 Logistics Management and Resource Support	#8 Public Health and Medical Services	#9 Search and Rescue	#10 Oil and Hazardous Materials Response	#11 Agriculture and Natural Resources	#12 Energy	#13 Public Safety and Security	#14 Long-Term Community Recovery	#15 External Affairs
Department of the Interior	S	S	S	S	S	S	S	S	P	S	P/S	S	S	S	S
Department of Justice	S				S	S		S	S	S	S		C/P		S
Department of Labor			S		S	S	S	S	S	S	S	S		S	S
Department of State	S		S	S	S			S		S	S	S			S
Department of Transportation	C/P		S		S	S	S	S		S	S	S		S	S
Delta Regional Authority														S	
Department of Education					S										S
Environmental Protection Agency			S	S	S			S		C/P	S	S	S	S	S
Federal Communications Commission		S			S										S
General Services Administration	S	S	S		S	S	C/P	S		S	S				S
Heritage Emergency National Task Force											S				
Department of Health and Human Services			S		S	S	S	C/P	S	S	S			S	S

continued on next page

Table A-1 Selected Federal Agencies With Coordinator, Primary, and Support Roles for Emergency Support Functions, Continued															
Agencies and Organizations	#1 Transportation	#2 Communications	#3 Public Works and Engineering	#4 Firefighting	#5 Emergency Management	#6 Mass Care, Emer. Assist., Housing, and Human Svs.	#7 Logistics Management and Resource Support	#8 Public Health and Medical Services	#9 Search and Rescue	#10 Oil and Hazardous Materials Response	#11 Agriculture and Natural Resources	#12 Energy	#13 Public Safety and Security	#14 Long-Term Community Recovery	#15 External Affairs
Department of Housing and Urban Development					S	S								P	S
National Archives and Records Administration											S				
National Aeronautics and Space Administration					S		S		S				S		S
Nuclear Regulatory Commission			S		S					S		S			S
National Voluntary Organizations Active in Disaster						S								S	
Office of Personnel Management					S		S								S
Small Business Administration					S	S								P	S
Social Security Administration						S							S		S

continued on next page

Table A-1 Selected Federal Agencies With Coordinator, Primary, and Support Roles for Emergency Support Functions, Continued															
Agencies and Organizations	#1 Transportation	#2 Communications	#3 Public Works and Engineering	#4 Firefighting	#5 Emergency Management	#6 Mass Care, Emer. Assist., Housing, and Human Svs.	#7 Logistics Management and Resource Support	#8 Public Health and Medical Services	#9 Search and Rescue	#10 Oil and Hazardous Materials Response	#11 Agriculture and Natural Resources	#12 Energy	#13 Public Safety and Security	#14 Long-Term Community Recovery	#15 External Affairs
Department of the Treasury					S	S							S	S	S
Tennessee Valley Authority			S		S							S			S
Agency for International Development								S	S						S
Department of Agriculture	S	S	S	C/P	S	S	S	S		S	C/P/S	S		P	S
Postal Service	S				S	S		S			S		S		S
Veterans Administration			S		S	S	S	S					S		S

Source: DHS, *National Response Framework*. Accessed at http:// www.fema.gov/pdf/emergency/NRF/NRF-core.pdf on March 7, 2011. DHS, *ESF-8–Public Health and Medical Services Annex*. Accessed at http://www.fema.gov/pdf/emergency/*NRF*/*NRF*–esf–08.pdf on May 13, 2011.

APPENDIX B

Seventeen Core Functional Areas of Emergency Support Function-8

Emergency Support Function-8 (ESF-8) describes Federal public health and medical services that can be provided to assist States, tribes, and localities when an incident occurs. The Department of Health and Human Services (HHS), in conjunction with Federal Support agencies and organizations, fulfills the responsibilities within ESF-8. The 17 core functional areas of ESF-8, as quoted in the National Response Framework are:[58, 59]

1. *Assessment of Public Health/Medical Needs*. HHS, in collaboration with the Department of Homeland Security (DHS), mobilizes and deploys ESF-8 personnel to support national or regional teams to assess public health and medical needs, including the needs of at-risk population groups, such as language assistance services for limited English-proficient individuals and accommodations and services for individuals with disabilities. This function includes the assessment of the health care system/facility infrastructure.

2. *Health Surveillance*. HHS, in coordination with supporting departments and agencies, enhances existing surveillance systems to monitor the health of the general and medical needs population; carries out field studies and investigations; monitors injury and disease patterns and potential disease outbreaks, blood and blood product bio-vigilance, and blood supply levels; and provides technical assistance and consultations on disease and injury prevention and precautions.

3. *Medical Care Personnel*. Immediate medical response capabilities are provided by assets internal to HHS (e.g., U.S. Public Health Service Commissioned Corps (PHSCC), National Disaster Medical System (NDMS), and Federal Civil Service employees) and from ESF-8 supporting organizations.

   ESF-8 may request Department of Defense (DOD) support for casualty clearing and staging, patient treatment, and support services such as surveillance and laboratory diagnostics.

---

[58] DHS, *ESF-8–Public Health and Medical Services Annex*. Accessed at http://www.fema.gov/pdf/emergency/*NRF*/*NRF*–esf–08.pdf on May 13, 2011.

[59] ESF-8 includes a core functional area entitled Worker Safety and Health. The Department of Labor is the lead Federal agency for this core functional area, with HHS serving as a Support agency. Therefore the Worker Safety and Health core functional area is not included in our list of HHS's 17 core functional areas of ESF-8.

ESF-8 may seek individual clinical public health and medical care specialists from the Department of Veterans Affairs (VA) to assist State, tribal, and local public health and medical personnel.

ESF-8 may engage civilian volunteers, such as Medical Reserve Corps (MRC), to assist State, tribal, and local public health and medical personnel.

4. *Health/Medical/Veterinary Equipment and Supplies*. In addition to deploying assets from the Strategic National Stockpile (SNS), ESF-8 may request DOD or the VA to provide medical equipment, durable medical equipment, and supplies, including medical, diagnostic, and radiation-detecting devices, pharmaceuticals, and biologic products in support of immediate medical response operations and for restocking health care facilities in an area affected by a major disaster or emergency. When a veterinary response is required, assets may be requested from the National Veterinary Stockpile (NVS), which is managed by the Department of Agriculture (USDA) Animal and Plant Health Inspection Service (APHIS).

5. *Patient Evacuation*. ESF-8 is responsible for transporting seriously ill (i.e., seriously ill describes persons whose illness or injury is of such severity that there is cause for immediate concern, but there is not imminent danger to life) or injured patients, and medical needs populations from casualty collection points in the impacted area to designated reception facilities. ESF-8 coordinates the Federal response in support of emergency triage and pre-hospital treatment, patient tracking, and distribution. This effort is coordinated with Federal, State, tribal, and local emergency medical services officials.

   ESF-8 may request DOD, VA, and DHS/Federal Emergency Management Agency (FEMA), via the national ambulance contract, to provide support for evacuating seriously ill or injured patients. Support may include providing transportation assets, operating and staffing NDMS Federal Coordination Centers, and processing and tracking patient movements from collection points to their final destination reception facilities.

   DOD is the only recognized Federal partner responsible for regulating and tracking patients transported on DOD assets to appropriate treatment facilities (e.g., NDMS hospitals).

6. *Patient Care*. ESF-8 may task HHS components to engage civil service personnel, the PHSCC, the regional offices, and States to engage civilian volunteers and request the VA and DOD to provide available personnel to support pre-hospital triage and treatment, inpatient hospital care,

outpatient services, pharmacy services, and dental care to victims who are seriously ill, injured, or suffer from chronic illnesses who need evacuation assistance, regardless of location.

ESF-8 may assist with isolation and quarantine measures and with point of distribution operations (mass prophylaxis and vaccination). Health care providers and support staff will ensure appropriate patient confidentiality is maintained, including Health Insurance Portability and Accountability Act privacy and security standards, where applicable.

7. *Safety and Security of Drugs, Biologics, and Medical Devices*. ESF-8 may task HHS components to ensure the safety and efficacy of and advise industry on security measures for regulating human and veterinary drugs, biologics (including blood and vaccines), medical devices (including radiation emitting and screening devices), and other HHS-regulated products.

8. *Blood, Organs, and Blood Tissues*. ESF-8 may task HHS components and request assistance from other ESF-8 partner organizations to monitor and ensure the safety, availability, and logistical requirements of blood, organs, and tissues. This includes the ability of the existing supply chain resources to meet the manufacturing, testing, storage, and distribution of these products.

9. *Food Safety and Security*. ESF-8, in cooperation with ESF-11, may task HHS components and request assistance from other ESF-8 partner organizations to ensure the safety and security of federally regulated foods. (Note: HHS, through the Food and Drug Administration (FDA), has statutory authority for all domestic and imported food except meat, poultry, and egg products, which are under the authority of the USDA Food Safety and Inspection Service. The Environmental Protection Agency (EPA) establishes tolerance levels for pesticide residues.)

10. *Agriculture Safety and Security*. ESF-8, in coordination with ESF-11, may task HHS components to ensure the health, safety, and security of food-producing animals, animal feed, and therapeutics. (Note: HHS, through the FDA, has statutory authority for animal feed and for the approval of animal drugs intended for both therapeutic and non-therapeutic use in food animals as well as companion animals.)

11. *All-Hazards Public Health and Medical Consultation, Technical Assistance, and Support*. ESF-8 may task HHS components and regional offices and request assistance from other ESF-8 partner organizations in assessing public health, medical, and veterinary medical effects resulting from all hazards. Such tasks may include assessing exposures on the general population and on high-risk population groups; conducting field

investigations, including collection and analysis of relevant samples; providing advice on protective actions related to direct human and animal exposures, and on indirect exposure through contaminated food, drugs, water supply, and other media; and providing technical assistance and consultation on medical treatment, screening, and decontamination of injured or contaminated individuals. While State, tribal, and local officials retain primary responsibility for victim screening and decontamination operations, ESF-8 can deploy the National Medical Response Teams (NMRT) to assist with victim decontamination.

12. *Behavioral Health Care*. ESF-8 may task HHS components and request assistance from other ESF-8 partner organizations in assessing mental health and substance abuse needs, including emotional, psychological, psychological first aid, behavioral, or cognitive limitations requiring assistance or supervision; providing disaster mental health training materials for workers; providing liaison with assessment, training, and program development activities undertaken by Federal, State, tribal, or local mental health and substance abuse officials; and providing additional consultation as needed.

13. *Public Health and Medical Information*. ESF-8 provides public health, disease, and injury prevention information that can be transmitted to members of the general public who are located in or near areas affected in languages and formats that are understandable to individuals with limited English proficiency and individuals with disabilities.

14. *Vector Control*. ESF-8 may task HHS components and request assistance from other ESF-8 partner organizations, as appropriate, in assessing the threat of vector-borne diseases; conducting field investigations, including the collection and laboratory analysis of relevant samples; providing vector control equipment and supplies; providing technical assistance and consultation on protective actions regarding vector-borne diseases; and providing technical assistance and consultation on medical treatment of victims of vector-borne diseases.

15. *Public Health Aspects of Potable Water/Wastewater and Solid Waste*. ESF-8 may task HHS components and request assistance from other ESF-8 organizations to assist in assessing potable water, wastewater, solid waste disposal, and other environmental health issues related to public health in establishments holding, preparing, and/or serving food, drugs, or medical devices at retail and medical facilities, as well as examining and responding to public health effects from contaminated water; conducting field investigations, including collection and laboratory analysis of relevant samples; providing equipment and supplies as needed; and providing technical assistance and consultation.

16. *Mass Fatality Management*. ESF-8, when requested by State, tribal, or local officials, in coordination with its partner organizations, will assist the jurisdictional medico-legal authority and law enforcement agencies in the tracking and documenting of human remains and associated personal effects; reducing the hazard presented by chemically, biologically, or radiologically contaminated human remains (when indicated and possible); establishing temporary morgue facilities; determining the cause and manner of death; collecting ante mortem data in a compassionate and culturally competent fashion from authorized individuals; performing postmortem data collection and documentation; identifying human remains using scientific means (e.g., dental, pathology, anthropology, fingerprints, and, as indicated, DNA samples); and preparing, processing, and returning human remains and personal effects to the authorized person(s) when possible; and providing technical assistance and consultation on fatality management and mortuary affairs. In the event that caskets are displaced, ESF-8 assists in identifying the human remains, recasketing, and reburial in public cemeteries.

    ESF-8 may task HHS components and request assistance from other ESF-8 partner organizations, as appropriate, to provide support to families of victims during the victim identification mortuary process.

17. *Veterinary Medical Support*. ESF-8 will provide veterinary assistance to ESF-11. Support will include the amelioration of zoonotic disease and caring for research animals where ESF-11 does not have the requisite expertise to render appropriate assistance.

    ESF-8 will assist ESF-11 as required to protect the health of livestock and companion and service animals by ensuring the safety of the manufacture and distribution of foods and drugs given to animals used for human food production. ESF-8 supports DHS/FEMA together with ESF-6 – Mass Care, Emergency Assistance, Housing, and Human Services, ESF-9 – Search and Rescue, and ESF-11 to ensure an integrated response to provide for the safety and well-being of household pets and service and companion animals.

APPENDIX C

National Planning Scenarios

Fifteen National Planning Scenarios describe specific incidents that may occur, ranging from hurricanes and influenza pandemics to biological attacks. Agencies with Emergency Support Function responsibilities can use the 15 National Planning Scenarios as a guide to developing preparedness plans and participating in activities for these specific incidents that may require unique plans and resources beyond all-hazards plans. The 15 National Planning Scenarios are: [60]

1. Biological Attack—Aerosolized Anthrax
2. Biological Attack—Botulinum Food Contamination
3. Biological Attack—Pandemic Influenza
4. Biological Attack—Pneumonic Plague
5. Biological Attack—Foreign Animal Disease
6. Chemical Attack—Blister Agent
7. Chemical Attack—Chlorine Tank Explosion
8. Chemical Attack—Toxic Industrial Chemicals
9. Chemical Attack—Nerve Agent
10. Cyber Attack—Cyber Security
11. Explosives Attack—Bombing Using Improvised Explosive Devices
12. Explosives Attack—Improvised Nuclear Device
13. Natural Disaster—Major Earthquake
14. Natural Disaster—Major Hurricane
15. Radiological Attack—Radiological Dispersal Devices and Radiological Explosive Devices

[60] Federal Emergency Management Agency, *National Preparedness Guidelines,* pp. 4–5. Accessed at http://www.fema.gov/pdf/emergency/*NRF*/National_Preparedness_Guidelines.pdf on June 21, 2011.

APPENDIX D

The National Planning Scenario Playbooks and Emergency Support Function-8

The 15 National Planning Scenario (NPS) playbooks contain written guidance that addresses Federal agencies' responsibilities when an incident (i.e., emergency or disaster) occurs. The Department of Health and Human Services (HHS) is assigned public health and medical services responsibilities for Emergency Support Function #8 (ESF-8). Within ESF-8 are 17 core functional areas for which HHS is responsible when an incident occurs. The chart below indicates which of the 17 core functional areas are addressed in the HHS's 14 NPS playbooks.

Table D-1 The 17 Core Functional Areas of ESF-8 and the 15 NPS Playbooks

Core Functional Areas	#1 Aerosolized Anthrax	#2 Botulinum Food Contamination	#3 Pandemic Influenza	#4 Pneumonic Plague	#5 Foreign Animal Disease	#6 Blister Agent	#7 Chlorine Tank Explosion	#8 Toxic Industrial Chemical	#9 Nerve Agent	#10 Cyber Security*	#11 Improvised Explosive Device	#12 Improvised Nuclear Device	#13 Major Earthquake	#14 Major Hurricane	#15 Radiological Dispersal Device and Radiological Explosive Device
Assessment of public health and medical needs	x	x	x	x	x	x	x	x	x		x	x	x	x	x
Health surveillance	x	x	x	x	x	x	x	x	x		x	x	x	x	x
Medical care personnel	x	x	x	x	x	x	x	x	x		x	x	x	x	x
Health/medical/veterinary equipment and supplies	x	x	x	x	x	x	x	x	x		x	x	x	x	x
Patient evacuation	x	x	x	x	x	x	x	x	x		x	x	x	x	x
Patient care	x	x	x	x	x	x	x	x	x		x	x	x	x	x
Safety and security of drugs, biologics, and medical devices	x	x	x	x	x	x	x	x	x		x	x	x	x	x
Blood and blood products	x	x		x	x	x	x	x	x		x	x	x	x	x
Food safety and security	x	x	x	x	x	x	x	x	x		x	x	x	x	x
Agriculture safety and security	x	x	x	x	x	x	x	x	x		x	x	x	x	x

continued on next page

Table D-1 The 17 Core Functional Areas of ESF-8 and the 15 NPS Playbooks, Continued															
Core Functional Areas	#1 Aerosolized Anthrax	#2 Botulinum Food Contamination	#3 Pandemic Influenza	#4 Pneumonic Plague	#5 Foreign Animal Disease	#6 Blister Agent	#7 Chlorine Tank Explosion	#8 Toxic Industrial Chemical	#9 Nerve Agent	#10 Cyber Security*	#11 Improvised Explosive Device	#12 Improvised Nuclear Device	#13 Major Earthquake	#14 Major Hurricane	#15 Radiological Dispersal Device and Radiological Explosive Device
All-hazard public health and medical consultation, technical assistance, and support	x	x	x	x	x	x	x	x	x		x	x	x	x	x
Behavioral health care	x	x	x	x	x	x	x	x	x		x	x	x	x	x
Public health and medical information	x	x	x	x	x	x	x	x	x		x	x	x	x	x
Vector control	x		x	x		x	x		x		x	x	x	x	x
Potable water/wastewater and solid waste disposal	x	x	x	x	x	x	x	x	x		x	x	x	x	x
Mass fatality management, victim identification, and decontamination of remains	x	x	x	x	x	x	x	x	x		x	x	x	x	x
Veterinary medical support	x	x	x	x	x	x	x	x	x		x	x		x	x

* No NPS playbook has been written for cyber security. Gray-shaded boxes indicate that planning for the listed core functional area was not found in the playbooks. However, HHS has written incident response plans to address these areas. Source: Federal Emergency Medical Agency, *ESF-8-Public Health and Medical Services Annex*. Accessed at http://www.fema.gov/pdf/emergency/nrf/nrf-esf-08.pdf, on May 15, 2011. DHS, *National Preparedness Guidelines,* September 2007, p. 3. Accessed at http://www.fema.gov/pdf/emergency/*NRF*/National_Preparedness_Guidelines.pdf on June 21, 2011.

APPENDIX E

Department of Health and Human Services Response to Three Selected Incidents in 2010 and 2011

The Department of Health and Human Services (HHS) provides resources to States when an incident (i.e., emergency or disaster) occurs. HHS is assigned public health and medical services responsibilities as the lead for the Emergency Support Function 8 (ESF-8), Public Health and Medical Services. Within ESF-8 are 17 core functional areas for which HHS is responsible. The chart below describes three selected incidents—Red River flooding in North Dakota, March 2010; a tornado in Joplin, Missouri, May 2011; and Hurricane Irene along the East Coast, August 2011—and the resources HHS provided, or was prepared to provide, to these States during incident response.

Table E-1 HHS Resources Provided to Affected States in 2010 and 2011

Core Functional Area	Incident	State(s)	HHS Resource(s) Provided		
			Objective	Strategy	Response
1. Assessment of Public Health/Medical Needs	Red River flooding	North Dakota	To evaluate the need for public health and medical support	Assess public health and medical infrastructure threatened by flooding	• ESF-8 personnel deployed to North Dakota Emergency Operations Center (EOC) and assessed potential damage from flooding • National Disaster Medical System (NDMS) activated • Incident Response Coordination Team (IRCT)/Logistics Response Assessment Team (LRAT) deployed • Administration for Children and Families (ACF) assessed impact to human services • Centers for Disease Control (CDC) monitored reports from state health departments, assessed need for technical assistance on vector control (i.e., eradicating mammals, birds, or insects that transmit diseases such as West Nile virus) • Food and Drug Administration (FDA) conducted risk assessments • Substance Abuse and Mental Health Services Administration (SAMHSA) assessed impact to behavioral health systems

continued on next page

Table E-1 HHS Resources Provided to Affected States in 2010 and 2011, Continued					
Core Functional Area	Incident	State(s)	HHS Resource(s) Provided		
			Objective	Strategy	Response
	Joplin tornado	Missouri	Ensure the integrity of the public health and medical infrastructure	Assess potential damage to health care and long-term-care facilities and other infrastructure that may have resulted from damage because of winds, flooding, etc.	• NDMS activated • ESF-8 Lead/Regional Emergency Coordinator (REC) to MO—Conducted assessments of medical infrastructure damage to hospitals and long-term-care facilities • CDC monitored reports from State health departments, provided technical assistance on vector control • Regional Incident Support Team (RIST)/IRCT deployed • ACF assessed impact to human services • At-Risk Behavioral Health Coordination (ABC)/ ACF monitored child care support to ESF-6 • SAMHSA assessed impact on behavioral health systems
	Hurricane Irene	CT, DC, DE, MA, MD, NC, NJ, NY, PA, PR, RI, SC, VT, VA, USVI	Ensure the integrity of the public health and medical infrastructure	Support Local Public Health Agency	• NDMS activated • ACF assessed impact to human services • CDC monitored reports from State health departments, technical assistance on vector control • FDA conducted risk assessments • SAMHSA assessed impact on behavioral health systems
2. Health Surveillance	Red River flooding	North Dakota	Maintain situational awareness	Monitor public health surveillance reports and systems	• Hospital Preparedness Program (HPP)/ Hospital Available Beds for Emergencies and Disasters (HAvBed) bed status reports reviewed
	Joplin tornado	Missouri	Maintain situational awareness	Monitor public health surveillance reports and systems; report on anomalies	• HPP/HAvBed bed status reports reviewed
	Hurricane Irene	CT, DC, DE, MA, MD, NC, NJ, NY, PA, PR, RI, SC, VT, VA, USVI	Evaluate the need to provide public health and medical support	CDC Epidemiology team (CDC EPI) responds under its own authorities, conducts interviews, and records abstract reviews	• HPP/HAvBED bed status reports reviewed

continued on next page

Table E-1 HHS Resources Provided to Affected States in 2010 and 2011, Continued					
Core Functional Area	Incident	State(s)	HHS Resource(s) Provided		
			Objective	Strategy	Response
3. Medical Care Personnel	Red River flooding	North Dakota	Evaluate the need to provide public health and medical support	Evaluate the need for NDMS support and identify Medical Strike Team (MST) and IRCT on the basis of capability	• Six on-call Disaster Medical Assistance Team (DMAT) identified to support potential emergency decompression and shelter operations; plus 2 24-person teams identified, if needed • One IRCT deployed
			Evaluate the need to provide public health and medical support	Prepare safety briefing for alerted teams	• Health and Safety Plan (HASP) used
			Evaluate the need to provide public health and medical support	Be prepared to provide mental health and stress management technical assistance	• ABC coordinated behavioral health stakeholders to identify needs/materials and provide technical assistance
	Joplin tornado	Missouri	Provide life-saving medical capability	Monitor public health surveillance reports and systems; report on anomalies	• Two standard DMATs determined whether the State was unable to handle health care infrastructure damage; each team had capability to perform emergency decompression, as required
			Provide force protection for deployed personnel	Provide necessary communication equipment, training, Personnel Protective Equipment, and medical countermeasures, if required	• MST deployed for force protection • Behavioral health specialist deployed to support responders • HASP used
	Hurricane Irene	CT, DC, DE, MA, MD, NC, NJ, NY, PA, PR, RI, SC, VT, VA, USVI	Evaluate the need to provide public health and medical support and ensure the integrity of the health and medical infrastructure	Evaluate the need for public health and medical resources in support of the State	• Three IRCT deployed • Five DMAT deployed to support States • One LRAT deployed • One Rapid Deployable Force (RDF) deployed • HASP used

continued on next page

Table E-1 HHS Resources Provided to Affected States in 2010 and 2011, Continued

Core Functional Area	Incident	State(s)	HHS Resource(s) Provided		
			Objective	Strategy	Response
4. Health/Medical/ Veterinary Equipment and Supplies	Red River flooding	North Dakota	Provide life-saving medical capability	Augment local health care with medical personnel or logistical support to minimize patient care shortfalls	• One IRCT cache deployed • One DMAT cache deployed • Two Federal Medical Station caches deployed • Seven MST team kits deployed • Three Lab caches deployed • Seven Pharmacy caches deployed • Seven Electronic Medical Record kits deployed • Seventeen IT/Telecom kits deployed • Three Medical Mobile Kits (MMK) deployed
	Joplin tornado	Missouri	Provide life-saving medical capability	Augment local health care with medical personnel or logistical support to minimize patient care shortfalls	• Two IRCT caches deployed • One Deployable Portable Morgue Unit (DPMU) deployed • One DMPU Family Assistance Center Team (FACT) cache deployed • Two Electronic Medical Record kits deployed • Three MMKs deployed • Two IT/Telecom kits deployed
	Hurricane Irene	CT, DC, DE, MA, MD, NC, NJ, NY, PA, PR, RI, SC, VT, VA, USVI	Provide life-saving medical capability	Augment local health care with medical personnel or logistical support to minimize patient care shortfalls	• One IRCT cache deployed • Two DMAT caches deployed • Two Pharmacy caches deployed • Two Lab caches deployed • Five MMKs deployed • Twelve Electronic Medical Record kits deployed • Thirteen IT/Telecom kits deployed
5. Patient Evacuation	Red River flooding	North Dakota	Evaluate the need to provide public health and medical support	Assess the need for patient movement	• No State requests or HHS actions
	Joplin tornado	Missouri	Provide life-saving medical capability	Support patient movement either by Federal Emergency Medical Agency (FEMA) ambulance contract or NDMS evacuation	• No State requests or HHS actions
	Hurricane Irene	CT, DC, DE, MA, MD, NC, NJ, NY, PA, PR, RI, SC, VT, VA, USVI	None noted	None noted	• National Ambulance Contract activated in NY

continued on next page

Table E-1 HHS Resources Provided to Affected States in 2010 and 2011, Continued					
Core Functional Area	Incident	State(s)	HHS Resource(s) Provided		
			Objective	Strategy	Response
6. Patient Care	Red River flooding	North Dakota	Evaluate the need to provide public health and medical support	None noted	• Public Health Emergency (PHE) declared by the Secretary of HHS • CMS 1135 waiver requests[61]
	Joplin tornado	Missouri	Provide life-saving medical capability	Provide medical support teams with strike team kits and logistic support	• PHE declared by the Secretary of HHS • CMS 1135 waiver requests • Four DMAT alerted for emergency decompression/augmentation
			Provide life-saving medical capability	Augment local health care with medical personnel or logistic support to minimize patient care shortfalls	• No State requests or HHS actions
	Hurricane Irene	CT, DC, DE, MA, MD, NC, NJ, NY, PA, PR, RI, SC, VT, VA, USVI	None noted	None noted	• PHE declared by the Secretary of HHS • CMS 1135 waiver requests • Five DMAT shelter support teams deployed • Three IRCT deployed to affected regions
7. Safety and Security of Drugs, Biologics, and Medical Devices	Red River flooding	North Dakota	Evaluate the need to provide public health and medical support	Initiate actions to deploy and deliver appropriate Strategic National Stockpile (SNS) material to a Federal Mobilization Center or other designated reception location, if requested	• REC monitored potential Durable Medical Equipment (DME) requests

continued on next page

[61] When a public health emergency is declared, the Centers for Medicare & Medicaid Services (CMS) is permitted to temporarily waive or modify Medicare, Medicaid, and the Children's Health Insurance Program benefit requirements to assist in incident response efforts. This is commonly referred to as the 1135 waiver request and is submitted by affected States. ASPR, *Public Health Emergency Declarations Q&A*. Accessed at http://www.phe.gov/Preparedness/legal/Pages/phe-qa.aspx on May 31, 2012.

Table E-1 HHS Resources Provided to Affected States in 2010 and 2011, Continued					
Core Functional Area	Incident	State(s)	HHS Resource(s) Provided		
			Objective	Strategy	Response
	Joplin tornado	Missouri	Ensure the integrity of the public health and medical infrastructure	Assess risk to the public health and medical assets, including safety of human, biologics, veterinary drugs, and medical devices	• SAMHSA monitored methadone movement and security
	Hurricane Irene	CT, DC, DE, MA, MD, NC, NJ, NY, PA, PR, RI, SC, VT, VA, USVI	None noted	None noted	• No State requests or HHS actions
8. Blood, Organs, and Blood Tissues	Red River flooding	North Dakota	None noted	None noted	• Blood supply reports for area provided to State
	Joplin tornado	Missouri	Provide life-saving medical capability	Assess blood and blood product availability and mitigate shortages	• Blood supply reports for area provided to State
	Hurricane Irene	CT, DC, DE, MA, MD, NC, NJ, NY, PA, PR, RI, SC, VT, VA, USVI	None noted	None noted	• Blood supply reports for area provided to States
9. Food Safety and Security	Red River flooding	North Dakota	Assess integrity of public health infrastructure	Perform assessments of needs for vector control, food and water safety, and sanitation. Support State requests for assistance	• REC monitored State actions and requests
	Joplin tornado	Missouri	Provide life-saving medical capability	Assess blood and blood product availability and mitigate shortages	• Blood supply reports for area provided to State
	Hurricane Irene	CT, DC, DE, MA, MD, NC, NJ, NY, PA, PR, RI, SC, VT, VA, USVI	None noted	None noted	• Blood supply reports for area provided to States

continued on next page

Table E-1 HHS Resources Provided to Affected States in 2010 and 2011, Continued					
Core Functional Area	Incident	State(s)	HHS Resource(s) Provided		
			Objective	Strategy	Response
10. Agriculture Safety and Security	Red River flooding	North Dakota	None noted	None noted	• No State requests or HHS actions
	Joplin tornado	Missouri	Ensure the integrity of the public health and medical infrastructure	Provide technical assistance for protection of animal life in coordination with ESF-11	• CDC assessed vaccine and animal control efforts
	Hurricane Irene	CT, DC, DE, MA, MD, NC, NJ, NY, PA, PR, RI, SC, VT, VA, USVI	None noted	None noted	• FDA food safety consultants deployed • Technical assistance provided to ESF-11
11. All-Hazards Public Health and Medical Consultation, Technical Assistance, and Support	Red River flooding	North Dakota	None noted	None noted	• REC monitored State actions and requests • PHS subject matter expert (SME) deployed
	Joplin tornado	Missouri	Provide force protection for deployed personnel	Provide necessary communication equipment, training, personnel protective equipment (PPE), and medical countermeasures, if required	• REC assisted hospital in setup of mobile medical unit • ACF collaborated with ESF-6 and MO Division of Family Services, Child Care and Development Fund • CDC vaccine and animal control efforts assessed • DMORT needs assessed • FACT engaged • SAMHSA psychological first aid training provided • SAMHSA crisis counseling training provided
	Hurricane Irene	CT, DC, DE, MA, MD, NC, NJ, NY, PA, PR, RI, SC, VT, VA, USVI	Provide technical assistance	Technical assistance provided	• Monitored State health departments, water supplies, and technical assistance for vector control • CDC EPI conducted conference calls with States • Health Resources and Services Administration (HRSA) contacted grantees and partners to determine impact to community-based services delivery • HHS Critical Infrastructure support to American Red Cross Blood HQ in Baltimore • SAMHSA provided behavioral health technical assistance

continued on next page

Table E-1 HHS Resources Provided to Affected States in 2010 and 2011, Continued					
Core Functional Area	Incident	State(s)	HHS Resource(s) Provided		
			Objective	Strategy	Response
12. Behavioral Health Care	Red River flooding	North Dakota	Monitor transition to recovery	Be prepared to provide mental health and stress management technical assistance	• REC monitored State actions and requests • ABC coordinated behavioral health stakeholders to identify needs/materials and provided technical assistance • SAMHSA provided technical assistance, crisis counseling program grants, and monitored impact on behavioral health systems
			Monitor transition to recovery	Plan for recovery operations, including mental health support	• ABC coordinated behavioral health stakeholders to ensure that behavioral health was included in recovery efforts
	Joplin tornado	Missouri	Monitor transition to recovery	Plan for recovery operations including, mental health support	• Deployed behavioral health specialist to DPMU • ABC coordinated behavioral health stakeholders to ensure that behavioral health was included in recovery efforts
			Ensure the integrity of the public health and medical infrastructure	Provide behavioral health and stress management technical assistance	• SAMHSA assessed and monitored the relocation of methadone, patients, and service providers • SAMHSA provided crisis counseling program and SAMHSA emergency response grants (SERG) • SAMHSA provided technical assistance and consulted with State regarding behavioral health programs • American Red Cross provided disaster mental health services • SAMHSA administered crisis counseling program and SERG grants • SAMHSA provided communication materials for State and local dissemination and ABC technical assistance to HHS recovery personnel
			Maintain situational awareness	Monitor potential behavioral health concerns of affected populations	• ABC coordinated behavioral health stakeholders and ensured recovery needs were addressed and emergent needs were identified • SAMHSA communicated with local, regional, and State stakeholders
	Hurricane Irene	CT, DC, DE, MA, MD, NC, NJ, NY, PA, PR, RI, SC, VT, VA, USVI	None noted	None noted	• SAMHSA and ABC monitored and coordinated • SAMHSA grant funding info passed to VA DOH • SAMHSA provided crisis counseling grants • SAMHSA provided communication materials for statewide and local dissemination

continued on next page

Table E–1 HHS Resources Provided to Affected States in 2010 and 2011, Continued					
Core Functional Area	Incident	State(s)	HHS Resource(s) Provided		
			Objective	Strategy	Response
13. Public Health and Medical Information	Red River flooding	North Dakota	Assess the integrity of the public health infrastructure	Provide subject matter expertise on risk communication for the public regarding health concerns after flooding	• REC monitored State actions and requests • CDC assisted in posting public messages on Web site • Public affairs officer (PAO) contacted State officials • SAMHSA provided communication materials for State and local dissemination
	Joplin tornado	Missouri	Ensure the integrity of the public health and medical infrastructure	Coordinate public messaging with local health officials	• Public health emergency information published on the Assistant Secretary for Preparedness and Response's Web site • SAMHSA published stress management information on Web site • CMS provided information to beneficiaries regarding Children's Health Insurance Program (CHIP) and other CMS services on Web site and printed materials • SAMHSA provided communication materials for State and local dissemination
	Hurricane Irene	CT, DC, DE, MA, MD, NC, NJ, NY, PA, PR, RI, SC, VT, VA, USVI	Assess the integrity of the public health infrastructure	Coordinate potential requests or public messaging	• PAO worked with States on public messaging regarding well water contamination • CDC updated information about hurricanes on disaster Web sites • SAMHSA provided communication materials for State and local dissemination

continued on next page

Table E-1 HHS Resources Provided to Affected States in 2010 and 2011, Continued					
Core Functional Area	Incident	State(s)	HHS Resource(s) Provided		
			Objective	Strategy	Response
14. Vector Control (i.e., eradicating mammals, birds, or insects that transmit diseases, such as West Nile virus)	Red River flooding	North Dakota	Assess the integrity of the public health infrastructure	Perform assessments of needs for vector control, food and water safety, and sanitation; support State requests for assistance	• No State requests or HHS actions
	Joplin tornado	Missouri	Ensure the integrity of the public health and medical infrastructure	Provide vector control and surveillance of food safety	• CDC vector control efforts and fogging operations assessed
	Hurricane Irene	CT, DC, DE, MA, MD, NC, NJ, NY, PA, PR, RI, SC, VT, VA, USVI	Ensure the integrity of the public health and medical infrastructure	Conduct vector control survey and provide recommendations for long-term control and followup activities	• REC monitored Virginia Department of Health request for technical assistance for vector control
15. Public Health Aspects of Potable Water/Wastewater and Solid Waste	Red River flooding	North Dakota	Assess the integrity of the public health infrastructure	Perform assessments of needs for vector control, food and water safety and sanitation. Support State requests for assistance	• CDC/FDA monitored State and local requests for assistance
	Joplin tornado	Missouri	Ensure the integrity of the public health and medical infrastructure	Provide technical assistance for potable water/wastewater assessment	• CDC/FDA monitored State and local requests for assistance • CDC worked with local health department advisory assistance regarding handwashing and boil-water order • REC monitored needs regarding biowaste handling
	Hurricane Irene	CT, DC, DE, MA, MD, NC, NJ, NY, PA, PR, RI, SC, VT, VA, USVI	None noted	None noted	• CDC/FDA monitored State and local requests for assistance

continued on next page

Table E-1 HHS Resources Provided to Affected States in 2010 and 2011, Continued					
Core Functional Area	Incident	State(s)	HHS Resource(s) Provided		
			Objective	Strategy	Response
16. Veterinary Medical Support	Red River flooding	North Dakota	None noted	None noted	• No State requests or HHS actions
	Joplin tornado	Missouri	Ensure the integrity of the public health and medical infrastructure	Provide technical assistance for protection of animal life in coordination with ESF-11	• Discussed potential for veterinary support on ESF-8 national calls
	Hurricane Irene	CT, DC, DE, MA, MD, NC, NJ, NY, PA, PR, RI, SC, VT, VA, USVI	None noted	None noted	• Discussed potential for veterinary support on ESF-8 national calls
17. Mass Fatality Management, Victim Identification, and Decontaminating Remains	Red River flooding	North Dakota	None noted	None noted	• No State requests or HHS actions
	Joplin tornado	Missouri	Ensure the integrity of the public health and medical infrastructure	Provide fatality management capability	• DMORT support requested and sent to MO; processed over 120 remains
			Ensure the integrity of the public health and medical infrastructure	Provide victim identification and mortuary services	• FACT conducted family interviews and collection of data to support victim identification
	Hurricane Irene	CT, DC, DE, MA, MD, NC, NJ, NY, PA, PR, RI, SC, VT, VA, USVI	Ensure the integrity of the public health and medical infrastructure	Provide fatality management capability	• Provided two fatality management SME to VT and advised State on recovery of remains
			Ensure the integrity of the public health and medical infrastructure	Support the local coroner, provide identification of human remains	• Provided two fatality management SME to VT and advised State on recovery of remains
			Ensure the integrity of the public health and medical infrastructure	Provide victim identification and mortuary services	• Provided two fatality management SME to VT and advised State on recovery of remains

Source: The Office of the Assistant Secretary for Preparedness and Response (ASPR)

APPENDIX F

Table F-1 2010 and 2011 Incidents to Which the Department of Health and Human Services Deployed Resources*

2010 Incidents	2011 Incidents
Biomedical Advanced Research and Development Authority H1N1 Vaccine Support Mission	2011 Hawaii Humanitarian Mission 1
H1N1 Outbreak (On-Call)	Earthquake and Tsunami Response
Haiti Earthquake	Japan Earthquake/Tsunami Nuclear Accident
Vaccination Team Support	Pennsylvania Severe Winter Storms
Chile Earthquake	North Dakota Red River Flooding
North Dakota Red River Flooding	South Dakota Flooding
New England Flooding	Alabama Severe Storms, Tornadoes, and Straight-Line Winds
Tennessee Severe Storms, Flooding, and Straight-Line Winds	New York State Flooding
Tropical Storm and Hurricane Alex	Federal Emergency Management Agency (FEMA) Region II Flooding (Multiple States)[62]
Hurricane Earl	Hurricane Irene/Tropical Storm Lee
Louisiana BP Oil Spill	New England Severe Weather
2010 Hawaii Humanitarian Mission 1	Tropical Storm Maria
Rocky Boy Indian Reservation Montana Flooding	Missouri Severe Storms, Tornadoes, and Flooding
Kentucky Severe Storms, Flooding, and Mudslides	
2010 Hawaii Humanitarian Mission 2	
Total = 15	**Total = 13**

* Incidents include emergencies and disasters. Resources may be provided for international incidents.
Source: The Office of the Assistant Secretary for Preparedness and Response.

[62] FEMA provides resources to affected areas in States, territories, and tribes and divides its service area into regions. Region II is composed of New York, New Jersey, Puerto Rico, and the U.S. Virgin Islands. FEMA, *Region II*. Accessed at http://www.fema.gov/about/regions/regionii/ on June 22, 2012.

APPENDIX G

Agency Comments

DEPARTMENT OF HEALTH & HUMAN SERVICES Office of the Secretary

Assistant Secretary for Preparedness & Response
Washington, D.C. 20201

OCT 23 2012

TO: Daniel R. Levinson
Inspector General
Department of Health and Human Services

FROM: Assistant Secretary for Preparedness and Response

SUBJECT: Office of Inspector General's Draft Report: "HHS Public Health and Medical Services Emergency Support Preparedness" (OEI-04-11-00260)

The office of the Assistant Secretary for Preparedness and Response (ASPR) appreciates the opportunity to review and comment on the Office of Inspector General's draft report: "HHS Public Health and Medical Services Emergency Support Preparedness" (OEI-04-11-00260). Thank you for your review of this important issue.

As requested, the following are ASPR's final management decisions regarding the recommendations contained in this report. As stated in the draft, the objectives of this review were to 1) determine whether the Department of Health and Human Services (HHS) has prepared to provide public health and medical services to fulfill its emergency support responsibilities, and 2) to report the total number of emergencies and disasters (i.e., incidents) that HHS deployed resources to in 2010 and 2011 and describe HHS' response to three selected incidents.

OIG Recommendation #1: Continue to Increase Communication with ESF Coordinator and Primary Agencies It Serves as a Support Agency The NRF states that ESF Support agencies must be prepared to provide resources and participate in preparedness activities to support the ESF Coordinator and Primary agency's mission. HHS should continue to work toward increasing its communication with the Coordinator and Primary agencies for the nine additional ESFs for which HHS serves as a Support agency. Specifically, HHS should increase communication regarding its Support agency role and the resources it can provide during incident response.

ASPR Response:

ASPR concurs with this recommendation. Clear communication regarding roles and responsibilities and the availability of key resources are critical components of all preparedness and response activities. ASPR places a high priority on timely, effective, and efficient communications with all stakeholders and partners to ensure that the common goals of preparing for, responding to, and recovering from all-hazards events and incidents are achieved. We recognize that more can always be accomplished in this area; however, we feel that we are certainly moving in the right direction and will seek to engage further and wider as we move forward with the intent to be all inclusive in our approach to how we do business.

ASPR communicates regularly with our Emergency Support Function (ESF) partners through a variety of formal and informal mechanisms. For example, ASPR participates in the monthly Emergency Support Function Senior Leaders' Group (ESFLG). ESFLG is the senior federal level coordinating body responsible for resolving operational and preparedness issues related to interagency response and recovery activities at the national level.

In response to this recommendation, ASPR will continue to include all appropriate ESF partners in any planning endeavors as well as routine collaboration with partner agencies. Examples of the benefits of these engagements include collaboration on ASPR planning documents and playbooks and the incorporation of their input into HHS guidance documents. The ASPR standard practice has always been to involve the appropriate partners to collaborate in the development of "deliberate" plans as well as both current and prospective planning efforts both prior to, as well as during an incident.

Recently, ASPR has partnered with ESF #6 (Mass Care, Emergency Assistance, Housing and Human Services) representatives to engage and enhance efforts on behalf of the combined federal services to better prepare and provide appropriate care to sheltered populations, especially those in need of special measures. Most notably, in conjunction with ESF #6 (FEMA) and the American Red Cross, ASPR has developed an *Initial Intake and Assessment Tool* to facilitate triage for functional support at Red Cross and federal medical shelters. This tool will enable better accuracy and appropriate assignment of personnel to the location where the greatest need for their skill set exists: at general, special needs, or medical special needs shelters.

ASPR played a key role in the development and leadership of the Senior Leaders Council for Patient Movement, a cross-agency coalition of executive leaders that serves to identify and resolve policy and operational issues in advance of, and during the actual movement of, patients during large scale disaster responses. Topic points for this leadership group include, but are not limited to, collaboration between the various participating agencies, the development of the first interagency document on the "Movement of Medical" evacuees, and the development of rules and guidance for definitive care as well as the establishment of an agreement between civilian participating hospitals and the National Disaster Medical System (NDMS), which will also help resolve some of the previously identified complexities of moving patients during disasters.

Our Secretary's Operation Center (SOC) provides and maintains tiered points of contact for both internal and external partners so that immediate notifications and alerts can be made with efficiency and accuracy both prior to and during an incident. In keeping with its primary coordination role, ASPR recently expanded its scope by enhancing the number of liaisons to the Federal Emergency Management Agency (FEMA) National Response Coordination Center. These liaisons are both planners and operations specialists that serve to represent ASPR's primary mission responsibilities and goals into the larger national plan development. In addition, the operations component facilitates the immediate incorporation of information both inbound and outbound between the various operations centers functioning during a response and the SOC for HHS/ASPR situational awareness and response planning. This engagement will serve to further enhance the information flow with other ESF representatives reducing the need for queries from HHS agencies as well as ESF partners. Enhancing outbound situational awareness will keep greater numbers of interested parties informed.

ASPR will continue to invite not only the ESF #8 partners into the operations center during an incident, but enhance their participation through the inclusion of "non-traditional" liaisons that assist in private-public initiatives as well. This venue will allow the SOC to better engage both the federal family of support agencies, as well as select and appropriate state, local, and private partners. The ESF #8, federal, state, local, and private partners will also work directly with the Regional Emergency Coordinators (RECs) assigned throughout the ten FEMA regions. The RECs serve many roles and are the forward leaning arm of ASPR. Some key assignments and responsibilities focus on the areas of preparedness, response and recovery as well as a growing emphasis on building and sustaining resilient communities. In large part, at present, this initiative includes connecting and building coalitions from a state and regional perspective. Recent examples include the close work in preparation and execution of both the Republican and Democratic National Conventions.

Additional relevant examples of recent targeted engagement, which we will continue to develop and expand in response to this recommendation, include:

- Working with ESF #1 (Transportation) for additional transportation options for the strategic movement of patients to try and decrease the burden on the Department of Defense.
- Working with ESF #3 (Public Works and Engineering) in overall planning considerations should any of the various dams fail in the United States.
- Working with ESF #6 (Mass Care, Emergency Assistance, Housing and Human Services) in ensuring, should disaster case management be required, that it would be fully coordinated and available.
- During the recent Hurricane Isaac, HHS coordinated closely with ESF #13 to ensure the proper force protection of our teams as they moved forward into the disaster areas in Louisiana.
- Ongoing initiative in Region 1 where ASPR, through the Regional Coordinators, have engaged with the Regional Federal Emergency Management Agency staff to collaborate on hospital baseline assessments, hospital/medical resilience, and sheltering needs and concerns.

OIG Recommendation #2: Coordinate Requests for Information From HHS Staff Divisions and Operating Divisions To Reduce the Burden on States During an Incident Response Five of the fifteen states affected by Hurricane Irene indicated that HHS Staff Divisions and Operating Divisions made several requests for the same information. States found this burdensome and reported that the repeated requests slowed their incident response. HHS should coordinate all requests for information during an incident response to ensure that states are not being unnecessarily burdened. For example, HHS could establish one point of contact per response area to communicate with state and local governments during the incident response. This point of contact could, in turn, disseminate information to HHS Staff Divisions and Operating Divisions once collected from states.

ASPR Response:

ASPR concurs with this recommendation. Although ASPR makes every effort to ensure that requests to states are well-coordinated and minimally burdensome, we recognize that during an active response there may be breakdowns in communications at both the federal and state levels. ASPR acknowledges this challenge and we place a high priority on building and enhancing communications with all of our partners and stakeholders.

While the Pandemic and All-Hazards Preparedness Act (PAHPA) provides for the ASPR to serve as the focal point for public health and medical response within HHS, we have found that some challenges still exist. There is a real difference between normal daily operations and the routine administration of programs and the engagement that occurs immediately prior to or during a response to a disaster. Traditional roles and pathways of communication change with the evolving disaster and these pathways get overburdened when stressed. In these cases, it is imperative that all outbound queries get focused and filtered by the SOC, as has been identified and planned for with ASPR being assigned the responsibility for coordination on behalf of HHS. However, it is challenging during the global rush to provide assistance to control communications.

Some actions we have already taken toward this end include published policies and procedures to ensure that communications and requests to the states are coordinated through ASPR's RECs, including a detailed information management (situational awareness) plan. The RECs serve as a single point of contact for each of the ten regions and work with the SOC and headquarters staff to coordinate requests to, from, and with the states. These procedures were also developed to ensure the Operating and Staff Divisions coordinate through ASPR and the SOC (thus keeping coordination internal to HHS) and not directly with the states.

One of the areas that ASPR will focus on in the future and in response to this recommendation is the sharing of information and findings of many after action reports that have consistently found that multiple calls from multiple agencies to the same recipient at the state or local level does not help, but instead becomes a major hindrance. ASPR will seek to establish training services to stress that point. In addition, ASPR will work harder to push information that has been gathered to HHS partner divisions and agencies, and look to include enhanced situational awareness across the board with other operations centers.

ASPR is currently engaged in a number of innovative projects to address the collection and dissemination of information from states in an effort to enhance speed and competency as well as reduce the administrative burden often encountered, and we plan to expand and enhance these activities in response to OIG's report. One example of such innovation is a joint pilot program with the Department of Energy (DOE) to install frequency disturbance recorders in select critical facilities throughout the nation. These frequency disturbance recorders provide information on the target facility, specifically: 1) if the facility is on "regular" power, 2) if the facility is "off" power, or 3) if the facility is "off power" if it is on generator. This initiative is the first of its kind pilot for this sector that engages with DOE on an electronic notification system that feeds immediately information back to the monitoring agency. ASPR has also been in conversations with other partners to develop notification plans that will provide real-time remote situational awareness to reduce multiple phone calls to the same facility(ies).

During an influenza pandemic or any other public health emergency, the demand for healthcare and public health resources can quickly exceed any individual health care facility's ability to surge. As noted in the 2009 H1N1 Retrospective, there is a need for better national-level monitoring of health care system disruption and stress. Stress may be observed as increased demand for patient care services (e.g., triage, assessment, treatment, admission, and discharge), shortage and difficulty obtaining medical supplies, pharmaceuticals, personal protective equipment and/or adequate ancillary ventilator supplies, just to mention some of the most obvious. Stress may also be indicated through the activation of a facilities' disaster plan/emergency operations protocol or the implementation of surge strategies to meet a rising demand (e.g., expanding bed capacity within existing spaces, early discharges, cancelling elective surgeries, augmentation of personnel or reduction in staff-to-patient ratios, use of alternative care sites, requesting mutual aid).

As a result of the concerns of medical stress, one of the key priorities identified in the 2009 *H1N1 Improvement Plan* was to develop a system that can provide information about stress on the health care system and real time visibility on the availability of community health care resources. Such visibility requires large amounts of information that can only be primarily obtained by the states. In response, ASPR is seeking to define and harness critical components for health care systems. ASPR is assessing current health care system data that is routinely compiled by other agencies as part of their ongoing engagement with state and local health care components. The goal is to isolate and utilize existing and "routine" data to assist in the determination of a state or coalition's ability to counter real-time health care system stress. ASPR, through this ongoing initiative, is seeking to clearly define a logic model based on acquiring and assessing indirect and innovative indicators for health care system stress. This product will seek to utilize a tiered approach and will pursue four questions: who are the decision makers, what decisions do these leaders need to make at their tier, what data or information is needed to make good decisions, and how will leaders seek to assess that their health care system is stressed. This initiative should assist in answering one of the most common questions asked to states and other partners during a disaster and focus our requests for information.

Another way that ASPR is already working to reduce the reporting and information-gathering burden on states throughout the preparedness and response cycle is through the alignment of our grant programs, specifically the Hospital Preparedness Program (HPP) and Public Health Emergency Preparedness Program (PHEP), which is administered by the Centers for Disease Control and Prevention (CDC). Since 2010, ASPR, CDC, and our interagency partners have been working together to better align the funding programs that provide resources for public health and medical preparedness. Beginning this year, HPP and PHEP are utilizing a combined funding opportunity announcement and funding application, which reduces the administrative burden on states. In addition, alignment of these grant programs will promote cross-sector collaboration and help states and communities better prepare for and respond to disasters and emergencies. We will continue to work with CDC and our interagency partners to explore the possibility of expanding this model to other federal grant programs.

Finally, in order to fully implement this recommendation, ASPR will continue to communicate to all of the HHS Staff Divisions and Operating Divisions during our monthly Emergency Coordinator meetings that ASPR is the coordination lead during events and incidents and thus

the single point of contact with the states. Further, we will add an item to the agenda for our incident coordination calls, reminding HHS Staff Divisions and Operating Divisions of the need for a coordinated approach to information exchange with our state partners. Finally, we will stress to the Staff Divisions and Operating Divisions that questions can be forwarded to the SOC and the SOC can engage states, and then push summary reports out internally ASPR is identifying pre-existing federal reports and information sources to establish protected sharing capabilities with all our ESF partners prior to an incident response. These collaborations have improved situational awareness and planning efforts while similarly reducing the number of requests from the federal level to the states. These measures should alleviate multiple requests for information and help to ensure that states are not unnecessarily overburdened.

Thank you for carrying out your study and providing us with a report highlighting how HHS has prepared to provide public health and medical services to fulfill its emergency support responsibilities, and has carried out those responsibilities in selected responses. We appreciate the opportunity to review your report and respond to your recommendations. Please direct any questions to Jessica Tytel by telephone at 202.205.4369, or by e-mail at Jessica.Tytel@hhs.gov.

/S/

Nicole Lurie, MD, MSPH
Assistant Secretary for Preparedness and Response

ACKNOWLEDGMENTS

This report was prepared under the direction of Dwayne Grant, Regional Inspector General for Evaluation and Inspections in the Atlanta regional office, and Jaime Durley, Deputy Regional Inspector General.

Sarah McLaulin served as the team leader for this study. Other Office of Evaluation and Inspections staff from the Atlanta regional office who conducted the study include Hannah Spell. Central office staff who provided support include Kevin Farber, Debra Roush, and Talisha Searcy.

Office of Inspector General

http://oig.hhs.gov

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.