Department of Defense
INSTRUCTION

NUMBER 6200.03
March 5, 2010
Incorporating Change 2, Effective October 2, 2013

USD(P&R)

SUBJECT: Public Health Emergency Management within the Department of Defense

References: See Enclosure 1

1. PURPOSE. This Instruction:

a. Reissues DoD Directive (DoDD) 6200.3 (Reference (a)) as a DoD Instruction (DoDI) in accordance with the authority in DoDD 5124.02 (Reference (b)).

b. Establishes DoD guidance in accordance with applicable law, including References (c) through (k), ensures mission assurance and readiness by protecting installations, facilities, personnel, and other assets in managing the impact of public health emergencies caused by all-hazards incidents as defined in Reference (k).

c. Provides DoD management of public health emergencies by requiring integration with the Installation Emergency Management (IEM) Program in accordance with Reference (k).

d. Clarifies the public health emergency management roles and responsibilities of the Military Commander within the Commander's scope of authority.

e. Clarifies the roles and responsibilities of the Public Health Emergency Officer (PHEO).

f. Clarifies the public health emergency management roles and responsibilities of the Military Treatment Facility (MTF) Commander or Officer in Charge (OIC).

g. Establishes the roles and responsibilities for MTF emergency management and creates the position of MTF Emergency Manager (MEM).

h. Establishes DoD policy for Disaster Mental Health Response (DMHR) and the roles and responsibilities of DMHR teams.

i. Defines a public health emergency within the Department of Defense as an occurrence or imminent threat of an illness or health condition that:

(1) May be caused by any of the following:

(a) Biological incident, naturally occurring or intentionally introduced;

(b) The appearance of a novel, previously controlled, or eradicated infectious agent or biological toxin;

(c) Natural disaster;

(d) Chemical attack or accidental release;

(e) Radiological or nuclear attack or accident;

(f) High-yield explosive detonation; and/or

(g) Zoonotic disease.

(2) May pose a high probability of any of the following:

(a) A significant number of deaths in the affected population considering the severity and probability of the event;

(b) A significant number of serious or long-term disabilities in the affected population considering the severity and probability of the event;

(c) Widespread exposure to an infectious or toxic agent, including those of zoonotic origin, that poses a significant risk of substantial future harm to a large number of people in the affected population; and/or

(d) Health care needs that exceed available resources.

(3) And/or may require notification to the World Health Organization (WHO) as a potential Public Health Emergency of International Concern (PHEIC) pursuant to the International Health Regulations (Reference (l)).

j. Implements Federal human quarantine regulation (parts 70 and 71 of Reference (h)) and supersedes those portions of Army Regulation 40-12/Secretary of the Navy Instruction 6210.2A/Air Force Regulation 161-4 (Reference (m)), relevant to human quarantine.

2. APPLICABILITY

a. This Instruction applies to OSD, the Military Departments (including the Coast Guard at all times, including when it is a Service in the Department of Homeland Security (DHS) by agreement with that Department), the Office of the Chairman of the Joint Chiefs of Staff and the Joint Staff, the Combatant Commands, the Office of the Inspector General of the Department of

Defense, the Defense Agencies, the DoD Field Activities, and all other organizational entities in the Department of Defense (hereafter referred to collectively as "the DoD Components"). The term "Military Services," as used herein, refers to Active and Reserve Components of the Army, Navy, Air Force, and Marines Corps (including their Service Academies).

b. This Instruction applies to military personnel and those civilian personnel, dependents of military or civilian personnel, contractors, and other individuals who are visiting or are present on DoD installations. It applies to DoD facilities located in the United States (including territories and possessions) as well as those outside the United States.

c. In areas outside the United States, this Instruction applies to the extent it is consistent with local conditions, and the requirements of applicable treaties, agreements, and other arrangements with foreign governments and allied forces. Implementation of these provisions at non-U.S. installations and field activities shall require formal agreements with host-nation authorities as well as allied and coalition forces.

3. DEFINITIONS. See Glossary.

4. POLICY. It is DoD policy that:

a. DoD installations, property, and other assets, as well as personnel and other individuals working in, residing on, or visiting DoD installations and commands, shall be protected in accordance with applicable legal authorities including:

(1) Sections 113, 3013, 5013, and 8013 of Reference (c), which generally provides authority to conduct the affairs of the Department of Defense authorized by the Constitution and laws of the United States.

(2) Reference (d), which provides penalties for violating any lawful regulation or order for protecting or securing any property or places subject to the jurisdiction and administration, or in the custody, of the Department of Defense. This may include ingress or egress or otherwise providing for safeguarding the same against destruction, loss, or injury either by accident or by enemy or other subversive actions.

(3) Reference (e), which authorizes the regulation of entry onto DoD installations.

(4) Reference (f), which authorizes regulations for the custody, use, and preservation of Government property.

(5) Sections 243, 248, 249, and 264-272 of Reference (g) and parts 70 and 71 of Reference (h), which contain regulations for preventing the introduction, transmission, and spread of communicable diseases and/or other hazardous substances from foreign countries into the United States, and from one State or possession into another. These references also authorize the Director of the Centers for Disease Control and Prevention (CDC), through delegated

authority of the Secretary of the U.S. Department of Health and Human Services (HHS), to apprehend, detain, and conditionally release individuals with those communicable diseases listed in Executive Order 13295 (Reference (n)).

b. In accordance with DoD 6025.18-R (Reference (o)), protected health information shall be used and disclosed only as necessary to safeguard public health and safety.

c. DoD Components shall cooperate closely with the CDC regarding public health emergencies. The Director of the CDC is empowered by part 70 of Reference (h) to take further public health measures or combination of measures, beyond those outlined in part 70 of Reference (h), that the Director deems necessary regarding facilities owned by the Federal Government within the United States. The PHEO should maintain contact with the local CDC Quarantine Officer regarding these further public health measures that may include oral authorization for Military Commanders to quarantine individuals not within their scope of authority until a formal written order is issued by the CDC.

d. All public health emergencies shall be managed in accordance with Reference (k).

e. In accordance with sections 1856 and 1856a of Reference (g), the Heads of the DoD Components and Military Commanders responsible for providing fire protection and/or emergency services, including basic medical support, may enter into mutual aid agreements with any governmental entity or public or private corporation or association in the United States or in any foreign country that maintains facilities for fire protection and/or emergency services, including basic medical support, and that provides such protection, services, or support.

(1) Mutual aid agreements in accordance with sections 1856 and 1856a of Reference (g) may provide for reciprocal support in the form of personal services and equipment required for fire prevention, the protection of life and property from fire, firefighting, and emergency services, including basic medical support, basic and advanced life support, hazardous material containment and confinement, and special rescue events involving vehicular and water mishaps, and trench, building, and confined space extractions.

(2) A reciprocal agreement in accordance with paragraph 4.e. shall be for mutual aid in providing authorized emergency services for the specified area under the authority of the DoD Component or Military Commander involved and the area for which the other organization normally provides comparable emergency services.

(3) Each such agreement in accordance with this section shall include a waiver by each party of all claims against every other party for compensation for any loss, damage, personal injury, or death occurring in consequence of the performance of such agreement. Any such agreement may provide for the reimbursement of any party for all or any part of the cost incurred by such party in furnishing authorized services for or on behalf of any other party.

f. Military installations are authorized to serve as receipt, staging, and storage (RSS) sites for Strategic National Stockpile (SNS) assets and as closed points of dispensing (PODs) capable of dispensing State, local, tribal, and territorial (SLTT) SNS assets to their DoD population (as

defined in Military Department planning guidelines). Military installations are prohibited from serving as open PODs for SNS assets. Military installations located outside the United States and its territories do not have access to SNS assets and should refer to References (j) and (k) for further guidance.

g. In accordance with the authority of section 1074(c) of Reference (c) and DoDI 6025.23 (Reference (p)), and in relation to actual or potential public health emergencies, DoD laboratories that are members of, or participate in, the Laboratory Response Network (LRN) of the CDC are authorized to provide diagnostic services pertaining to laboratory specimens of non-DoD health care beneficiaries referred for analysis, consistent with designated LRN tests, other procedures, agreements, and the mission of the LRN. The authority to perform laboratory diagnostic services for non-DoD health care beneficiaries shall be used very sparingly and shall not result in a laboratory incurring significant incremental costs or limiting of its laboratory operations. Laboratory diagnostic services for non-DoD health care beneficiaries that would result in significant incremental costs will be conducted in accordance with DoDD 3025.18 (Reference (q)).

h. Public health emergencies can be declared by different entities:

(1) The Secretary of HHS has the authority to declare a national public health emergency pursuant to section 247d of Reference (g). When the Secretary of HHS declares a national public health emergency, the Department of Defense shall, to the extent practicable, act consistently with applicable provisions of that declaration.

(2) Also, where individual States (and in some instances local governments) have the authority to declare a public health emergency, DoD installations in that State or jurisdiction shall, to the extent practicable, act consistently with applicable provisions of those declarations.

(3) Military Commanders, in consultation with their PHEO, may declare a DoD public health emergency and implement relevant emergency health powers to achieve the greatest public health benefit while maintaining operational effectiveness.

i. Geographically proximate Military Commanders and their PHEOs shall coordinate and collaborate, to the maximum extent possible, in order to provide unified representation of the Department of Defense to SLTT, other Federal agencies' regional offices, and host-nation emergency management planners and public health authorities.

j. PHEO, alternate PHEO, and MEM appointees, as described in this Instruction, should be assigned positions that provide adequate time to fully perform all of the duties assigned due to the significant investment in time, training, and effort required to prepare for and respond to public health emergencies.

k. Every DoD installation will have access to a DMHR team and disaster mental health (DMH) services in the event of an all-hazards incident.

5. RESPONSIBILITIES. See Enclosure 2.

6. PROCEDURES. See Enclosure 3. Enclosure 4 discusses surge capabilities and procedures in public health emergencies. Enclosures 5 and 6 outline the requirements for notification of public health emergencies. Enclosure 7 contains the decision algorithm for determining a public health emergency.

7. RELEASABILITY. UNLIMITED. This Instruction is approved for public release and is available on the Internet from the DoD Issuances Website at http://www.dtic.mil/whs/directives.

8. EFFECTIVE DATE. ~~This Instruction is effective immediately.~~ *This Instruction:*

a. Is effective March 5, 2010.

b. Must be reissued, cancelled, or certified current within 5 years of its publication to be considered current in accordance with DoD Instruction 5025.01 (Reference (an)).

c. Will expire effective March 5, 2020 and be removed from the DoD Issuances Website if it hasn't been reissued or cancelled in accordance with Reference (an).

Gail H. McGinn
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Performing the Duties of the
Under Secretary of Defense for
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Enclosures
1. References
2. Responsibilities
3. Procedures
4. Surge Capabilities and Procedures for Health Care in Public Health Emergencies Within the Department of Defense
5. Quarantinable Disease and Other Public Health Emergency Notification Routing Procedures
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REFERENCES

(a) DoD Directive 6200.3, "Emergency Health Powers on Military Installations," May 12, 2003 (hereby canceled)
(b) DoD Directive 5124.02, "Under Secretary of Defense for Personnel and Readiness (USD(P&R))," June 23, 2008
(c) Sections 113, 142, 1074, 3013, 5013, and 8013 of title 10, United States Code
(d) Section 797 of title 50, United States Code
(e) Section 1382 of title 18, United States Code
(f) Section 301 of title 5, United States Code
(g) Sections 243, 247d, 248, 249, 264-272, 1856, and 1856a of title 42, United States Code
(h) Parts 70 and 71 of title 42, Code of Federal Regulations
(i) DoD Instruction 5200.08, "Security of DoD Installations and Resources and the DoD Physical Security Review Board (PSRB)," December 10, 2005
(j) DoD Instruction 3020.52, DoD Installation Chemical, Biological, Radiological, Nuclear, and High-Yield Explosive (CBRNE) Preparedness Standards, May 18, 2012
(k) DoD Instruction 6055.17, "DoD Installation Emergency Management (IEM) Program," January 13, 2009
(l) World Health Organization, "International Health Regulations," 2005
(m) Army Regulation 40-12, Secretary of the Navy Instruction 6210.2A, Air Force Regulation 161-4, "Quarantine Regulations of the Armed Forces," January 24, 1992
(n) Executive Order 13295, "Revised List of Quarantinable Communicable Diseases," as amended
(o) DoD 6025.18-R, "DoD Health Information Privacy Regulation," January 24, 2003
(p) DoD Instruction 6025.23, "Health Care Eligibility Under the Secretarial Designee Program and Related Special Authorities," September 16, 2011
(q) DoD Directive 3025.18, "Defense Support of Civil Authorities (DSCA)," December 29, 2010
(r) DoD Instruction 1322.24, "Medical Readiness Training," July 12, 2002
(s) DoD Directive 5111.13, "Assistant Secretary of Defense for Homeland Defense and Americas' Security Affairs (ASD(HD&ASA))," January 16, 2009
(t) DoD Directive 5111.10, "Assistant Secretary of Defense for Special Operations and Low-Intensity Conflict (ASD(SO/LIC))," March 22, 1995
(u) DoD Directive 5111.18, "Assistant Secretary of Defense for Global Strategic Affairs (ASD(GSA))," June 13, 2011
(v) DoD Directive 2060.02, "Department of Defense (DoD) Combating Weapons of Mass Destruction (WMD) Policy," April 19, 2007
(w) DoD Instruction 6440.03, "DoD Laboratory Network (DLN)," June 10, 2011
(x) DoD Instruction O-3020.43, "Emergency Management and Incident Command on the Pentagon Facilities," March 6, 2007
(y) DoD Directive 6400.4, "DoD Veterinary Services Program," August 22, 2003
(z) Chairman of the Joint Chiefs of Staff Manual 3150.05D, "Joint Reporting Structure Situation Monitoring Manual," January 31, 2011

(aa) DoD Directive 6490.02E, "Comprehensive Health Surveillance," Feburary 8, 2012
(ab) DoD Instruction 6200.02, "Application of Food and Drug Administration (FDA) Rules to Department of Defense Force Health Protection Programs," February 27, 2008
(ac) DoD Instruction 6205.4, "Immunization of Other Than U.S. Forces (OTUSF) for Biological Warfare Defense," April 14, 2000
(ad) DoD Instruction 1300.18, "Department of Defense (DoD) Personnel Casualty Matters, Policies, and Procedures," January 8, 2008
(ae) DoD Directive 3020.26, "Department of Defense Continuity Programs," January 9, 2009
(af) Department of Homeland Security Worldwide Joint Training and Scheduling Conference 07-1, "National Exercise Program (NEP)," March 8, 2007
(ag) National Institute of Mental Health (2002), "Mental Health and Mass Violence: Evidence-Based Early Psychological Interventions for Victims/Survivors of Mass Violence. A Workshop to Reach Consensus on Best Practices." National Institute of Health Publication No. 02-5138, Washington, D.C.: U.S. Government Printing Office
(ah) Department of Health and Human Services Publication No. ADM 90-537 (2000). Field Manual for Mental Health and Human Service Workers in Major Disasters. Washington, D.C.
(ai) Part 199.17 of title 32, United States Code
(aj) Agency for Healthcare Research and Quality, "Mass Medical Care with Scarce Resources: A Community Planning Guide," February 2007[1]
(ak) DoD Instruction 1100.21, "Voluntary Services in the Department of Defense," March 11, 2002
(al) DoD Instruction 5210.25, "Assignment of American National Red Cross and United Service Organizations, Inc., Employees to Duty with the Military Services," May 12, 1983
(am) Joint Publication 1-02, "Department of Defense Dictionary of Military and Associated Terms," current edition
(an) DoD Instruction 5025.01, "DoD Directives Program," September 26, 2012, as amended

[1] www.ahrq.gov/research/mce/

ENCLOSURE 2

RESPONSIBILITIES

1. UNDER SECRETARY OF DEFENSE FOR PERSONNEL AND READINESS (USD(P&R)). The USD(P&R) shall provide criteria, guidance, and instruction to incorporate public health emergency management requirements into appropriate DoD policy, program, and budget documents.

2. ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS (ASD(HA)). The ASD(HA) under the authority, direction, and control of the USD(P&R), shall:

a. Oversee the policy, program planning and execution, and allocation and use of public health and medical resources for activities within the Department of Defense related to public health emergencies. These activities are coordinated with other applicable officials such as the Assistant Secretary of Defense for Nuclear and Chemical and Biological Defense Programs (ASD(NCB)), Assistant Secretary of Defense for Reserve Affairs, Assistant Secretary of Defense for Homeland Defense and Americas' Security Affairs (ASD(HD&ASA)), Assistant Secretary of Defense for Global Strategic Affairs (ASD(GSA)), and Assistant Secretary of Defense for Special Operations and Low Intensity Conflict (ASD(SO/LIC)).

b. Serve as the principal medical and public health advisor to the Secretary of Defense.

c. Issue any necessary DoD medical and public health (including mental health) guidance to implement this Instruction.

d. Collaborate with Federal and other applicable entities to implement this Instruction.

e. Develop additional policy and guidance regarding human quarantine and isolation within the Department of Defense as appropriate. The ASD(HA) shall consult with the Joint Staff Surgeon; the Surgeons General of the Army, Navy, and Air Force, and the Director, Coast Guard Health, Safety, and Work-Life; the ASD(HD&ASA); appropriate joint force commanders; the HHS Assistant Secretary for Preparedness and Response; the Surgeon General of the Public Health Service; and the Director of the CDC regarding such policy and guidance.

f. Ensure that standardized public health and medical training and education requirements associated with implementation of this Instruction are met in accordance with DoDI 1322.24 (Reference (r)).

g. Ensure ~~TRICARE Management Activity (TMA)~~ *Defense Health Agency (DHA)* coordinates public health emergency management with the Surgeons General of the Army, Navy, and Air Force; appropriate joint force commanders; and the Director, Coast Guard Health, Safety, and Work-Life.

h. Issue any necessary guidance regarding the protection of humans from environmental health threats.

i. Grant exceptions to this Instruction consistent with law.

3. UNDER SECRETARY OF DEFENSE FOR ACQUISITION, TECHNOLOGY, AND LOGISTICS (USD(AT&L)). The USD(AT&L) shall provide criteria, guidance, and instruction to incorporate public health emergency management requirements into relevant IEM Program elements.

4. DEPUTY UNDER SECRETARY OF DEFENSE FOR INSTALLATIONS AND ENVIRONMENT (DUSD(I&E)). The DUSD(I&E), under the authority, direction, and control of the USD(AT&L), shall advocate for resources and support planning, programming, and budgeting processes to meet public health emergency management requirements of the DoD IEM Program.

5. ASD(NCB). The ASD(NCB), under the authority, direction, and control of the USD(AT&L), shall:

a. Serve as the Principal Staff Assistant and advisor to the Secretary of Defense, the Deputy Secretary of Defense, and the USD(AT&L) for activities that combat current and emerging weapons of mass destruction (WMD) threats, including all matters related to research, development, and acquisition (RDA) of chemical, biological, radiological, and nuclear (CBRN) defense materiel pursuant to section 142 of Reference (c).

b. Execute Chemical and Biological Defense Program (CBDP) oversight activities, related acquisition policy guidance, and interagency and international coordination.

c. Provide oversight of Planning, Programming, Budgeting, and Execution processes and funds allocation for CBDP defense-wide accounts.

d. Review, evaluate, integrate, prioritize, and provide guidance to DoD organizations to support CBDP investment planning.

e. Ensure CBDP activities in support of combating WMD missions are aligned with national and DoD guidance.

f. Develop policies and guidance in support of CBDP RDA activities.

6. UNDER SECRETARY OF DEFENSE FOR POLICY (USD(P)). The USD(P) shall coordinate Defense Support for Civil Authorities (DSCA) policy with other Federal departments and agencies, State agencies, and the DoD Components, as appropriate pursuant to Reference (q) and establish DoD policy governing DSCA.

7. ASD(HD&ASA). The ASD(HD&ASA), under the authority, direction, and control of the Under Secretary of Defense for Policy, shall coordinate the development of DoD requirements related to homeland security, homeland defense, defense support of civil authorities, and continuity of operations missions, to include the national biodefense and the domestic nuclear detection architectures, with appropriate OSD and interagency organizations, including the DUSD(I&E). The ASD(HD&ASA) shall serve as the DoD Domestic Crisis Manager as set forth in DoDD 5111.13 (Reference (s)).

8. ASD(SO/LIC). The ASD(SO/LIC), in accordance with DoDD 5111.10 (Reference (t)), oversees humanitarian assistance, disaster relief, and global health (HA/DR/GH) policy, program planning and execution, and allocation and use of resources for activities that DoD conducts related to HA/DR/GH, including international public health emergencies.

9. ASD(GSA). The ASD(GSA), in accordance with DoDD 5111.18 (Reference (u)) and DoDD 2060.02 (Reference (v)), is the principal advisor to the Secretary of Defense responsible for the development and implementation oversight of countering weapons of mass destruction policy, to include Foreign Consequence Management policy. In accordance with DoDI 6440.03 (Reference (w)), the ASD(GSA) provides DoD global security guidance and expertise related to DoD laboratories, programs, and activities.

10. DIRECTOR OF ADMINISTRATION AND MANAGEMENT (DA&M). The DA&M shall oversee the preparation of emergency plans on the Pentagon facilities in accordance with DoDI 3020.43 (Reference (x)) and consistent with Reference (k).

11. DoD CHIEF INFORMATION OFFICER (DoD CIO). The DoD CIO shall oversee and provide direction for the development, fielding, operations, and maintenance of command, control, and communications systems used in response to public health emergencies. This includes, but is not limited to, collaboration and situational assessment of potential and confirmed public health emergencies, coordination of medical response to potential and confirmed public health emergencies, and organizations' continuity of operations and continuity of Government plans in the event of a public health emergency.

12. HEADS OF THE DoD COMPONENTS. In addition to the specific responsibilities assigned

by this Instruction, the Heads of the DoD Components shall implement this Instruction and any implementing guidance of the ASD(HA).

13. SECRETARIES OF THE MILITARY DEPARTMENTS. The Secretaries of the Military Departments, in addition to the responsibilities listed in section 12 of this enclosure, shall:

a. Ensure commanders develop and maintain collaborative relationships with SLTT authorities, other Federal agencies' regional offices, and host-nation authorities to meet mutual aid and support requirements of public health emergencies and formally document such agreements.

b. Develop and maintain intra- and inter-Service collaborative networks of installation and/or command PHEOs. Consistent with the IEM Program, these networks shall coordinate locally and regionally with other Federal agencies and the Geographic Combatant Commands in order to provide unified representation of the Department of Defense to SLTT authorities, other Federal agencies' regional offices, and host-nation emergency planners and public health authorities.

c. Develop budget estimates and submit program objective memorandum requirements that cover program establishment; equipment; tactics, techniques and procedures; training; exercises; assessments; and sustaining activities to make it possible to execute the responsibilities prescribed in this Instruction.

d. Coordinate with the ~~TMA~~ *DHA* regarding public health emergency management.

e. Ensure that required public health emergency management resources and capabilities are identified and developed (e.g., mass notification and recall, command and control elements).

f. Provide written approval and authorization to military installations to serve as RSS sites and closed PODs for SNS assets as appropriate and inform the appropriate Geographic Combatant Commander. Maintain comprehensive and up-to-date lists of installations that have signed agreements with SLTT SNS coordinators to serve as RSS sites and closed PODs. When appropriate, encourage Military Commanders to participate in the CDC's Cities Readiness Initiative and other applicable SLTT public health planning by serving as closed PODs capable of dispensing SLTT SNS medical materiel to their DoD population as defined by Military Department planning guidelines.

14. SECRETARY OF THE ARMY. The Secretary of the Army, in addition to the responsibilities listed in sections 12 and 13 of this enclosure, shall act as the DoD Executive Agent for DoD Veterinary Services in accordance with DoDD 6400.4 (Reference (y)).

15. GEOGRAPHIC COMBATANT COMMANDERS. The Geographic Combatant Commanders, in addition to the responsibilities listed in section 12 of this enclosure, shall:

a. Appoint a PHEO and alternate PHEO at their Headquarters level to ensure effective integration of all public health emergency management activities.

b. Designate an individual at levels of their organizational structure (local, regional, and theater) to facilitate coordinated planning among PHEOs and MEMs (within their area of operations) with SLTT governments and other Federal agencies' regional offices within the United States and host nations regarding public health emergency management.

c. In collaboration with the appropriate chief of mission, engage each host nation regarding respective roles for reporting and notification of PHEICs as required by Reference (l).

16. CHIEF, NATIONAL GUARD BUREAU (NGB). The Chief, NGB, shall direct Commanders of Army National Guard (ARNG) and Air National Guard (ANG) units not collocated on an active duty military installation to communicate identified health threats to the DoD Installation PHEO in their catchment area in coordination with the Secretaries of the Army and Air Force and in consultation with the National Guard Adjutants General of the States.

ENCLOSURE 3

PROCEDURES

1. GENERAL

a. Public health emergencies can appear and progress rapidly, leading to widespread health, social, and economic consequences. Military Commanders must be prepared to make timely decisions to protect lives, property, and infrastructure and enable DoD installations and/or military commands to sustain mission-critical operations and essential services. Military Commanders should expect a level of uncertainty during the decision-making process, especially during early stages of a public health emergency. Efforts that strengthen lines of communication with civilian decision makers at the community level will greatly enhance the response's effectiveness.

b. Circumstances suggesting a public health emergency, as defined by WHO, CDC, and the Department of Defense, shall be immediately reported through appropriate Service, Geographic Combatant Commander, and DoD channels in accordance with Enclosure 5 of this Instruction. Every DoD Component identified in Enclosure 5 shall ensure each of the Component's specified reporting relationships is established and operational. Upon approval for release by the ASD(HA), the National Military Command Center (NMCC)/Global Situational Awareness Facility (GSAF) shall notify any circumstance suggesting a PHEIC to the HHS Secretary's Operation Center (SOC), which serves as the U.S. Government's National Focal Point for Reference (l). Circumstances suggesting a public health emergency from other sources should be reported using the process described in Chairman of the Joint Chiefs of Staff Manual 3150.05D (Reference (z)). Pursuant to Reference (l), the HHS SOC shall inform WHO within 24 hours of assessment of public health information, of all events that may constitute a PHEIC within the United States. Pursuant to Reference (l), the HHS SOC shall inform WHO, as far as practical, within 24 hours of receipt of evidence of an international public health risk outside the United States.

c. The PHEO shall ascertain the existence of cases suggesting a public health emergency, ensure that sources of infection and/or contamination are investigated, recommend implementation of proper control measures, and define the distribution of the illness or health condition. As directed by the Military Commander, appropriate actions may include:

(1) Identifying all individuals or groups affected by the communicable disease or other imminent threat to health.

(2) Counseling and interviewing such individuals or groups, as appropriate, to assist in positively identifying exposed individuals or groups and developing information relating to the source and spread of the communicable disease or other imminent threat to health.

(3) Advising the Military Commander on examining, closing, evacuating, or decontaminating any facility or decontaminating or destroying any material contributing to the public health emergency.

(4) Sharing information developed during activities in accordance with paragraph 1.c. of this enclosure, including personally identifiable health information in accordance with Reference (o), with Federal, State, or local officials responsible for public health and public safety to the extent necessary to protect public health and safety.

(5) Notifying, directly or through applicable DoD channels, appropriate law enforcement authorities concerning information indicating a possible terrorist incident or other crime. Without compromising efforts to preserve life and minimize risk to health, the PHEO should seek to support law enforcement efforts to prevent terrorist acts, ameliorate their effects, and to apprehend and prosecute their perpetrators.

d. In accordance with Enclosure 5, a declaration of a public health emergency within the Department of Defense shall be immediately reported by the Military Commander through the chain of command to the Secretary of Defense. The declaration of a public health emergency within the Department of Defense shall also be reported by the PHEO through the technical chain of command to:

(1) The respective Surgeons General of the Army, the Navy, or the Air Force or, if the commander is under the command of a Combatant Commander, to the senior medical officer of the Joint Staff.

(2) The ASD(HA).

(3) The Armed Forces Health Surveillance Center (AFHSC), which serves as the authoritative DoD agency for comprehensive medical surveillance and reporting of rates of diseases and injuries among DoD Service members and beneficiaries in accordance with DoDD 6490.02E (Reference (aa)).

(4) The CDC; State and local public health agencies; and, if applicable, host-nation authorities.

e. Public health emergency declarations within the Department of Defense shall terminate automatically in 30 days, unless renewed and re-reported, or may be terminated sooner by the Military Commander who made the declaration, any senior commander in the chain of command, the Secretary of the Military Department concerned, or the Secretary of Defense.

f. For zoonotic diseases, PHEO activities/procedures will be conducted in coordination with other public health and veterinary providers.

g. In coordinating with the Coast Guard, DoD Components should note that the Coast Guard has designated the Director, Coast Guard Health, Safety, and Work-Life (or designee) to serve as the PHEO and MEM for the United States Coast Guard.

2. RESTRICTION OF MOVEMENT AND OTHER EMERGENCY HEALTH POWERS

a. Quarantine and isolation are types of restriction of movement that can in certain circumstances be imposed by a Military Commander for individuals within the scope of the authority of the Commander. These restrictions should be considered in coordination with the local CDC Quarantine Officer as outlined in paragraph 4.c. in the front matter of this Instruction. Among other authorities, the Director of the CDC may, in accordance with part 70 of Reference (h), take public health measures that the Director deems necessary with respect to facilities owned or operated by the Federal Government.

b. The needs of persons or groups of persons quarantined or isolated shall be addressed in a systematic and competent fashion. Places of quarantine shall be maintained in a safe and hygienic manner, designed to minimize transmission of infection and/or contamination or other harm to persons subject to quarantine. Adequate food, clothing, medical care, and other necessities shall be provided.

c. A person or groups of persons subject to quarantine or isolation shall obey the rules and orders established by the Military Commander in consultation with the PHEO, shall not go beyond the quarantine premises, and shall not put himself or herself in contact with any person not subject to quarantine, except as authorized by the Military Commander.

d. No person or groups of persons may, without authorization, enter quarantine or isolation premises. A person who, by reason of unauthorized entry, poses a danger to public health becomes subject to quarantine.

e. Quarantine or isolation shall be accomplished through the least restrictive means available, consistent with protection of public health. Quarantine or isolation of any person or groups of persons shall be terminated when no longer necessary to protect public health.

f. The PHEO shall, as soon as practicable, ensure that every individual or group subject to quarantine is provided written notice of the reason for the quarantine and plan of examination, testing, and/or treatment designed to resolve the reason for the quarantine. The PHEO shall provide an opportunity to present information supporting an exemption or release from quarantine to any person or groups of persons subject to quarantine who contest the reason for quarantine. The Military Commander or designee (who has not been previously involved in any medical determination concerning the person or groups of persons) shall review such information. The reviewing official shall exercise independent judgment and promptly render a written decision on the need for quarantine for the person or groups of persons.

g. Security and enforcement measures should be implemented appropriate to the circumstances.

h. Military personnel may be ordered to submit to diagnostic or medical treatment, subject to any applicable Food and Drug Administration rules in accordance with DoDI 6200.02 (Reference (ab)). Persons other than military personnel may be required as a condition of exemption or release from restriction of movement to submit to vaccination or treatment diagnostics as necessary to prevent transmitting a communicable disease and enhance public

health and safety. The submission to vaccination or treatment diagnostics may be a requirement to return to work or gain access to a DoD installation or facility. Qualified personnel shall perform vaccination and treatment, consistent with appropriate medical standards, including appropriate exemption criteria. DoDI 6205.4 (Reference (ac)) does not apply to vaccinations under this paragraph.

i. After appropriate consultation with chain of command and local public health authorities and the coroner's office, the PHEO shall recommend measures for reasonable and necessary testing and safe disposition of human remains in order to prevent contamination and dissemination of the hazard, ensuring proper labeling, identification, and records regarding the circumstances of the death and disposition. The CDC, the Central Joint Mortuary Affairs Office, and the Office of the Armed Forces Medical Examiner will provide guidance regarding the testing and safe disposition of human remains in accordance with DoDI 1300.18 (Reference (ad)).

j. Individuals and groups subject to quarantine shall be advised that violators may be charged with a crime pursuant to law (including References (d), (e) or (h)) and subject to punishment of a fine or imprisonment for not more than 1 year, or both. In the case of military personnel, these potential sanctions are in addition to applicable military law authorities, to the extent allowed by law. Those individuals or groups not subject to military law and who refuse to obey or otherwise violate an order under this Instruction may be detained by the Military Commander until appropriate civil authorities can respond. The Military Commander shall coordinate with civil authorities to ensure the response is appropriate for the public health emergency.

3. LIMITATIONS OUTSIDE THE UNITED STATES

a. Host-nation ownership and control of installations outside the United States may prevent Military Commanders from unilaterally implementing many of the provisions of this Instruction. Ultimately, U.S. authorities and control at locations outside the United States are subject to the sovereignty of the host nation, except as otherwise defined in applicable international agreements, such as status-of-forces agreements, defense cooperation agreements, and base rights agreements. Coordination with Department of State (DOS) should be sought as appropriate.

b. A Military Commander's authority over personnel outside the United States is also limited. That authority extends generally only to U.S. Service members, civilian employees of the U.S. Government, U.S. DoD contractor employees (when specified by agreements), and the dependents of these categories of personnel.

c. With regard to emergency health powers, a Military Commander's authority may be limited in scope as it pertains to host-nation personnel. Installations outside the United States shall review their respective host-nation agreement and incorporate, by supplement to this Instruction, the authority local commanders possess as it pertains to host-nation personnel.

d. Many of the authorities cited in this Instruction are inapplicable or cannot be implemented in an environment outside the United States without the cooperation of host-nation authorities, except to the extent as may be specified by governing international agreements.

4. COMMAND RESPONSIBILITIES

a. Military Commanders. The Military Commanders shall:

(1) Ensure without further delegation that all units and tenant organizations comply with requirements of this Instruction.

(2) Appoint a PHEO and an alternate PHEO as defined in paragraph 4.b. of this enclosure.

(a) For DoD installations and/or military commands with widely geographically dispersed responsibilities, Commanders may designate a PHEO appropriate with the level of organizational structure when an appropriate asset, as defined by the Service military medical department, does not exist. Direct communication between the Military Commander and the PHEO will enhance preparedness for and response to public health emergencies.

(b) In joint basing and tenant organization situations, the Installation commander will appoint the PHEO. On those installations where a joint medical center is a tenant, the commander of the joint medical center shall make a qualified individual available to serve as PHEO for the host installation. In some locations, it may be appropriate to appoint a PHEO from one of the other tenant organizations, especially where a highly specialized skill set exists in another organization. The alternate PHEO may be selected from a Service different to that of the PHEO. Joint basing and tenant organization agreements should reflect the requirement to provide a single coordinated response to any public health emergency. When the appointment of an appropriate PHEO is not forthcoming or causes local difficulties, the Service Headquarters PHEOs should be consulted for adjudication; however, the final appointment decision rests with the Installation commander.

(3) Ensure that the PHEO and alternate PHEO have adequate support and resources to accomplish their mission.

(4) Ensure that force health protection measures and public health emergency management are integrated into existing DoD installation and/or military command continuity, emergency preparedness, and response plans and agreements (References (j), (k), and DoDD 3020.26 (ae)). Ensure appropriate public health and medical representation in the Installation Emergency Management Working Group (IEMWG) in accordance with Reference (k). These plans shall be exercised regularly and integrated into existing exercise programs including the National Exercise Program (Reference (af)).

(5) Coordinate planning, preparedness, and response to public health emergencies with SLTT government, other Federal agencies' regional offices, and title 32 authorities.

(6) Negotiate agreements with SLTT SNS coordinators to serve as RSS sites and closed PODs and plan bridging strategies for medical countermeasures and other medical materiel to cover DoD populations (as defined by Military Department planning guidelines) for up to 48 hours before resupply and assistance from the SNS is received.

(7) In response to a suspected or confirmed public health emergency and in consultation with his or her PHEO, declare a DoD public health emergency within the scope of the Commander's authority and implement relevant emergency health powers to achieve the greatest public health benefit while maintaining operational effectiveness. These powers are listed in subparagraphs 4.a.(7)(a) through 4.a.(7)(i). To the extent necessary for protecting or securing DoD property or places and associated military personnel, such powers may also include persons other than military personnel who are present on a DoD installation or other areas under DoD control, including Reserve Component (RC) installations not collocated with active duty installations. Emergency health powers may include:

(a) Collecting specimens and performing tests on any property or on any animal or disease vector, living or deceased, as reasonable and necessary for emergency response.

(b) Closing, directing the evacuation of, or decontaminating any asset or facility that endangers public health; decontaminating or destroying any material that endangers public health; or asserting control over any animal or disease, living or deceased, vector that endangers public health.

(c) Using facilities, materials, and services for purposes of communications, transportation, occupancy, fuel, food, clothing, health care, and other purposes, and controlling or restricting the distribution of commodities as reasonable and necessary for emergency response.

(d) Controlling evacuation routes on, and ingress and egress to and from, the affected DoD installation and/or military command.

(e) Taking measures to safely contain and dispose of infectious waste as may be reasonable and necessary for emergency response.

(f) Taking measures reasonable and necessary, pursuant to applicable law, to obtain needed health care supplies, and controlling use and distribution of such supplies.

(g) Directing U.S. military personnel to submit to a medical examination and/or testing as necessary for diagnosis or treatment. Persons other than military personnel may be required as a condition of exemption or release from restrictions of movement to submit to a physical examination and/or testing as necessary to diagnose the person and prevent the transmission of a communicable disease and enhance public health and safety. Qualified personnel shall perform examinations and testing.

(h) Restricting movement to prevent the introduction, transmission, and spread of communicable diseases and/or any other hazardous substances that pose a threat to public health

and safety. In the case of military personnel, restrictions of movement, including isolation, or any other measure necessary to prevent or limit transmitting a communicable disease and enhance public safety may be implemented. In the case of persons other than military personnel, restrictions of movement may include isolation or limiting ingress and egress to, from, or on a DoD installation and/or military command.

(i) Isolating individuals or groups to prevent the introduction, transmission, and spread of a communicable disease and/or any other hazardous substances that pose a threat to public health and safety. Isolation measures may be implemented in health care facilities, living quarters, or other buildings on a DoD installation and/or military command. Isolation measures do not lessen the responsibilities of the Military Health System (MHS) to provide medical care to infected and/or affected persons to the standard of care feasible given resources available (see Enclosure 4 for further information).

(8) Ensure that risk and crisis communications are executed by the public affairs officer in coordination with all appropriate DoD installation and/or military command stakeholders.

(9) Ensure appropriate syndromic surveillance is being conducted to assess threats to public health through the use of the Electronic Surveillance System for Early Notification of Community-based Epidemics (ESSENCE) or other established surveillance systems.

(10) Outside the United States, exercise those emergency health powers granted in accordance with applicable international agreement, or otherwise within his or her inherent authority, in coordination with host-nation authorities. At installations outside the U.S., such action must be coordinated with host-nation authorities to meet the intent of this provision. The PHEO shall function as the Military Commander's primary public health advisor during an emergency regardless of host-nation actions.

(11) In carrying out activities under this Instruction, cooperate with authorized law enforcement and other agencies investigating or responding to an actual or potential terrorist act, crime, or other relevant public health emergency. This includes reasonable steps to preserve potential evidence of criminal activity.

(12) Ensure DMH services are available through a DMHR team in response to an all-hazards incident by:

(a) Appointing a licensed mental health provider as the DMHR team lead, who is trained in disaster mental health services, and who has overall responsibility for DMHR team training and service implementation.

(b) Integrating DMH preparedness and response with other DoD installation and military command emergency response plans.

(c) Entering into agreements, as needed, with other installations, Reserve units, National Guard units, and/or civilian providers for DoD installations to ensure access to a DMHR team when the personnel and resources necessary to form a DMHR team are not present on a DoD installation.

(d) On installations where an MTF exists, the installation commander may delegate the appropriate responsibilities in subparagraphs 4.a.(12)(a) to 4.a.(12)(c) of this enclosure to the MTF commander.

b. PHEOs and alternate PHEOs. The PHEOs and alternate PHEOs shall:

(1) Be either a uniformed services officer or DoD civilian employee who is a member of a Military Service medical department. The PHEO must be a clinician (as defined by the Services in their respective implementing instructions). The alternate PHEO is not required to be a clinician.

(2) Have:

(a) Experience and training in functions essential to effective public health emergency management (e.g., National Incident Management System (NIMS), National Response Framework (NRF)).

(b) A Master of Public Health degree (or equivalent degree) or 4 years of experience in public health, preventive medicine, and/or environmental health.

(c) An active national security clearance at the SECRET level or above.

(3) Provide Military Commanders with guidance and recommendations on preparing for, declaring, responding to, mitigating, and recovering from public health emergencies. PHEO responsibilities fall into 10 major categories and include:

(a) Collaborating closely with the installation emergency manager and the MEM in preparing for, declaring, responding to, and recovering from a public health emergency;

(b) Maintaining situational awareness of public health and medical threats;

(c) Providing advice to the Military Commander regarding the declaration of a public health emergency and the implementation of emergency health powers in accordance with relevant public health laws, regulations, and policies;

(d) Ensuring appropriate epidemiological investigations are conducted;

(e) Recommending appropriate diagnosis, treatment, and prophylaxis of affected individuals or groups and populations in consultation with appropriate clinical staff;

(f) Supporting Military Commanders in the integration of public health and medical preparedness with other DoD installation and/or military command emergency response planning and exercises;

(g) Supporting preparedness for public health and medical surge capacity in collaboration with the MEM as appropriate;

(h) Assisting in public affairs risk communications;

(i) Advising the Military Commander on public health aspects of workplace and return to work issues; and

(j) Coordinating with civilian SLTT, other Federal agency regional offices, title 32 forces, and host-nation agencies and organizations in all responsibilities listed in paragraphs 4.b.(3)(a) through 4.b.(3)(i) of this enclosure.

c. MTF Commanders or OICs. The MTF Commanders or OICs shall:

(1) Establish a Reference (k)-compliant, comprehensive emergency management program that integrates all aspects of public health and medical planning (e.g., mass medical care, medical logistics, and countermeasure acquisition and distribution).

(2) Designate, in writing, a MEM in accordance with this Instruction.

(3) Ensure that the MEM has adequate support and resources to accomplish the mission.

(4) Authorize licensed but non-credentialed health care providers, including non-DoD civilian health care providers offering assistance, to provide care within their facilities when necessary to respond to emergency requirements. Non-DoD civilian health care providers will maintain their licensure through their respective States.

(5) Direct every health care provider or medical examiner with respect to any diagnosed illness or health condition; every pharmacist with respect to prescription rates, types, or trends; and every laboratorian with respect to presumptive or confirmed laboratory diagnostic results to promptly report to the appropriate PHEO any circumstance suggesting a public health emergency. This is in addition to reports required by otherwise applicable surveillance systems, including non-DoD systems.

(6) Ensure each MTF identifies and designates all key response personnel (e.g., first responders/receivers) and coordinates to ensure appropriate access to the installation and perform assigned job functions.

(7) Ensure that MTF emergency management is integrated into existing emergency preparedness and response plans and agreements (References (j) and (k)). These plans shall be coordinated with both medical and non-medical stakeholders, including installation (or joint base), SLTT governments, other Federal agencies' regional offices, title 32 forces, and host-nation authorities (as applicable). These plans shall be exercised regularly.

(8) On DoD installations in the United States, ensure two trained ESSENCE users (one of whom may be the PHEO) are actively monitoring ESSENCE, which is the syndromic surveillance tool for the Department of Defense. For the NGB, ESSENCE shall be monitored centrally with applicable information pushed out to ARNG and ANG units as needed.

d. MEMs. The MEMs shall:

(1) Be either a uniformed service member or DoD civilian employee who is a member of a Military Service medical department.

(2) Have:

(a) Qualifications that include experience and training in functions essential to effective public health and medical emergency management (e.g., NIMS, NRF).

(b) An active national security clearance at the SECRET level or above.

(3) Coordinate planning and preparedness, and assist in the execution of all-hazards emergency management activities on behalf of the MTF commander or OIC. MEM responsibilities fall into five major categories and include:

(a) Acting as primary point of contact with the Installation Emergency Manager and serving as the MTF lead for military/civilian coordination as it relates to emergency management.

(b) Ensuring that threat information, vulnerability assessments, and all mitigating actions are considered in executing MTF emergency management activities as defined in Reference (l).

(c) Ensuring MTF emergency management plans are comprehensive, integrated, and compliant with Reference (k).

(d) Supporting MTF commanders or OICs in the coordination and integration of emergency management-related training and exercises.

(e) Serving as the primary advocate to ensure that appropriate resource needs are identified to execute mission requirements.

e. Veterinary Support Personnel. Veterinary support personnel shall:

(1) Coordinate and integrate veterinary public health and veterinary medical planning (e.g., veterinary mass medical care, veterinary medical logistics, and veterinary countermeasure acquisition and distribution).

(2) Direct increased surveillance, risk communications, food safety and security, training, laboratory diagnostics, field operations support that could include eradication of disease, identification of affected animals, animal quarantine implementation, euthanasia, carcass disposal, cleaning and disinfection, biosecurity, strategic vaccination and/or treatments for animals, wildlife management and vector control, and provide subject matter expertise for DoD installations and/or military commands.

(3) Report to the appropriate PHEO any circumstance suggesting a public health emergency. This is in addition to reports required by otherwise applicable surveillance systems, including non-DoD systems.

f. DMHR Teams. DMHR teams shall:

(1) Be comprised of a multidisciplinary team, to include, at a minimum, individuals in each of the following areas:

(a) Mental health (e.g., a psychiatrist, psychologist, social worker, psychiatric nurse practitioner, a mental health technician, and/or licensed provider who is trained in acute mental health intervention).

(b) Spiritual support (e.g., a chaplain and chaplain's assistant).

(c) Family support (e.g., a community readiness consultant).

(2) Have a licensed mental health provider serving as the DMHR team leader.

(3) Have the following responsibilities:

(a) Coordinate with family assistance centers on the installation and other agencies as appropriate to arrange DMH services to family and community members impacted by an all-hazards incident.

(b) Establish standard operating procedures (SOP) in accordance with the National Institute of Health Publication (Reference (ag)) that will include, at a minimum:

1. The composition and role of the team.

2. A listing of the available, locally trained resources with contact information.

3. A description of local conditions and any identified high-risk groups.

4. A response plan for team activation.

5. Plans for conducting DMH needs assessments and surveillance.

6. Required initial/periodic training.

(c) Establish a plan for maintaining individual DMHR team member psychological health in accordance with Department of Health and Human Services Publication (Reference (ah)) and integrating the plan within the DMHR SOP.

(d) Provide DMH services to include prevention, outreach, screening, triage, psychological first aid, education, and specialty referral(s) to individuals and groups who have

had or may have had exposure to an all-hazards incident. These services are not medical services, and therefore do not involve medical or mental health record documentation.

(e) Train annually as part of the overall installation IEM exercises in accordance with Reference (k).

(f) Train at least quarterly as a DMHR team, using evidence-based practices if available, to develop and maintain the competencies necessary to provide DMH services. Training will cover, at a minimum, prevention, outreach, screening, triage, psychological first aid, education, and referral services for individuals and groups who have had or may have had exposure to an all-hazards incident. Training will also cover command consultation and ethical issues during disasters.

(g) Identify and train primary and alternate DMHR team members for each role to ensure continuous access to DMH services.

(h) Coordinate efforts with the PHEO and integrate efforts of the DMHR team into the overall public health emergency preparedness and response.

5. PHEO PROCEDURES. The PHEO shall:

a. Ensure collaboration and serve as a clearinghouse for health-related information during a public health emergency. The PHEO shall work closely with other medical and non-medical personnel; SLTT governments; other Federal agencies' regional offices; title 32 forces; and host-nation authorities (as applicable) to identify, confirm, and control a public health emergency that may affect the DoD installation and/or military command.

b. In the United States, coordinate through the medical chain of command and the local CDC Quarantine Officer in relation to CDC actions in accordance with CDC quarantine authorities. These CDC authorities are provided in Reference (h). Outside the United States, coordination shall be with DOS and appropriate host-nation public health officials.

c. Provide accurate and relevant information to enable timely notification to affected individuals of a public health emergency, its termination, steps individuals should take to protect themselves, and actions taken to control or mitigate the emergency. All of this shall be performed in coordination with the installation and/or military command's public affairs office and if applicable, a joint information center.

d. Maintain close contact and coordination with SLTT governments, other Federal agencies' regional offices, title 32 forces, and host-nation authorities concerning all actions taken under this Instruction. Outside the United States, a PHEO shall coordinate with appropriate host-nation officials and, if applicable, other allied forces public health officials. Consistent with the protection of DoD installations, facilities, assets, and personnel, a PHEO shall facilitate the assumption of public health emergency responsibilities by civilian agencies with jurisdiction in

relation to persons other than military personnel and property not owned by the Department of Defense.

e. Use the definition of a public health emergency in paragraph 1.i. in the front matter of this Instruction and should use the Public Health Emergency Decision Algorithm (see Enclosure 7 of this Instruction) to assist in determining whether or not a public health emergency exists.

f. Maintain close contact and coordination with military veterinary authorities concerning all actions taken under this Instruction.

g. Maintain close contact and coordination with local ESSENCE monitors and their Service Public Health Centers.

h. In the United States, assist the Military Commander, the Installation Emergency Manager, and others in executing agreements with SLTT SNS coordinators regarding the receipt, distribution, and dispensing of SNS assets.

i. In the case of restricted movement of individuals or groups not within the scope of authority of the Military Commander in the United States, coordinate through the chain of command and the local CDC Quarantine Officer in relation to CDC actions in accordance with quarantine authorities provided in Reference (h). Outside the United States, coordination shall be sought with DOS and appropriate host-nation public health officials.

6. MEM PROCEDURES. The MEM shall

a. Be the central point of contact for MTF emergency planning and for coordinating public health and medical support to installation, local, or regional emergency response requirements.

b. Coordinate closely with functional subject matter experts through the MTF and installation emergency preparedness committees or working groups, the PHEO(s), and the IEMWG to ensure plans are adequate, supportable, coordinated, and synchronized.

ENCLOSURE 4

SURGE CAPABILITIES AND PROCEDURES FOR HEALTH CARE IN PUBLIC HEALTH EMERGENCIES WITHIN THE DEPARTMENT OF DEFENSE

1. GENERAL

a. Public health emergencies of national significance such as pandemic influenza are likely to result in surge requirements that overwhelm the response capacity, capability, and resources of both medical facilities and health care providers. Under these conditions, situational standards of care shall be adopted, and difficult decisions regarding the allocation of limited resources shall be required. All levels of command and health care providers shall incorporate these principles in developing their public health emergency response plans and in determining the allocation of limited medical resources.

b. The MHS shall adopt the following framework for the delivery of medical care during public health emergencies and shall incorporate it into all aspects of planning for these emergencies. This may include provision of care to non-DoD beneficiaries when directed by the President or Secretary of Defense.

c. The provisions of this enclosure are intended to establish a standard of care appropriate to the circumstances of the public health emergency and different from the standard of care ordinarily applicable to the MHS, absent a declaration of public health emergency.

2. PRIORITIZING DELIVERY OF MEDICAL CARE AND AUTHORIZING SITUATIONAL STANDARDS OF CARE DURING PUBLIC HEALTH EMERGENCIES INVOLVING MASS CASUALTIES

a. The MHS direct care system has two primary objectives. The first is to support the national security mission and the second is to provide care for TRICARE Prime- and TRICARE Plus-enrolled beneficiaries with MTF primary care managers. Other objectives of the direct care system have lesser priority. It is DoD policy that MTF Commanders shall fulfill both of these primary objectives. Under emergency conditions, the allocation of resources may not be based solely on medical necessity or risk, but also may be based on operational or other national security requirements, as directed by the President or Secretary of Defense. Some uniformed personnel, for example, may receive a higher level of care due to operational requirements, independent of their immediate medical risk. This does not obviate the responsibility to continue to care for beneficiaries enrolled with MTF primary care managers. These beneficiaries have an understandable expectation of continued access to their primary care. Such expectation, however, does not create an entitlement.

b. Commanders of MTFs are directed to make public health emergency plans to meet surge requirements related to the two primary missions. Commanders shall make arrangements to ensure that the minimum level of care provided to all enrolled beneficiaries is, at the very least,

comparable to local community standards in the context of the public health emergency. Such arrangements may include special work schedules; increased use of RC members, intermittent employees, re-employed annuitants, contractor personnel, and volunteers; and coordination with the TRICARE managed care support contactor. Planning to ensure for the smooth transition of care for MTF-enrolled patients by non-DoD providers, to the extent that is necessary, must be accomplished well in advance of emergency conditions and the agreed-upon arrangements clearly communicated to all enrolled beneficiaries. Determination of critical personnel, rather than blanket policies affecting all Service members in an area of responsibility, will help meet the two seemingly conflicting objectives affecting mission requirements and beneficiary care. This will require a critical analysis at local levels of what represents a critical role. To fully manage expectations and appropriately educate the beneficiary population on the emergency response plan relating to access to care, it is imperative that risk communication messages and products include instructions pertaining to where to receive care in the event of a public health emergency.

c. As in any mass casualty event, when the number of casualties exceeds the available capability to rapidly treat and/or evacuate, the adoption of situational community standards of care shall be required. In non-deployed settings, the standard of care, at the very least, should be comparable to local civilian community standards. In many settings, the standard of care may exceed that of the local civilian community. In deployed settings, the situational standard of care will not necessarily mirror that of the host nation, but will be based on available assets and requirements consistent with preexisting DoD medical triage practice.

d. During a declared public health emergency, to the extent necessary to deal with mass casualties and without unnecessarily compromising the quality of care, the MTF Commander may authorize situational standards of care, including but not limited to:

(1) The scope of practice of health care practitioners and supporting technical staff (e.g., medical technicians, hospital corpsmen) may be expanded beyond the scope for which the practitioner is ordinarily privileged or authorized to perform, consistent with the judgment of the Commander and the training, experience, and capability of the practitioners involved.

(2) Standard operating procedures or standard clinical guidelines for specialty referrals, confirmatory clinical testing, use of equipment, provider-to-patient ratios, and similar matters may be suspended.

(3) Standard procedures for documentation regarding health care options, discussions, and decisions may be altered.

(4) Establishment of alternate or supplemental care sites that do not meet normal facilities standards.

(5) Expanded use of telemedicine.

e. When all available resources are insufficient to meet the health care needs of beneficiaries in a public health emergency, the MHS shall use the limited resources to achieve the greatest good for the greatest number. Under these circumstances, “good” is defined as lives

saved and suffering alleviated. In an environment of insufficient resources, MTF commanders shall not require expenditure of resources if treatment likely would prove futile or if a disproportionate amount of assets would be expended for one individual at the cost of many other lives that otherwise could be saved. MTF commanders are to ensure the most competent medical authority is available, at the lowest level of command possible, to make medical judgments of this nature.

f. Decisions involving triage for care and the allocation of medical supplies must take into account the values of personal rights and fairness to all. Critical mission requirements may require allocation of resources based on operational rather than medical risk. MTFs shall provide care to their enrolled populations as noted in paragraphs 2.a and 2.b of this enclosure. Other eligible beneficiaries are expected to seek care at the facilities where they routinely receive primary care. MTF commanders must communicate regularly and clearly on the resource limitations that exist at their facilities to maximize the communities' effective response to a public health emergency. Access to MTF care shall comply with the beneficiary group priority list at part 199.17 of title 32, U.S.C. (Reference (ai)). However, availability of care is always subject to mission requirements directed by the President or Secretary of Defense as authorized by Federal law.

g. Commanders and health care providers throughout the Department of Defense need to engage in ongoing planning and decision making consistent with this general policy and responsive to changing local conditions. They must effectively communicate those decisions to each other and the community before emergencies, as well as during emergencies when conditions change. Conditions affecting decisions include, but are not limited to, availability of health care providers and resources such as pharmaceuticals, ventilators, and hospital beds, all in the context of evolving disease characteristics on target and at-risk populations. A decision made in one area may not be appropriate for another due to conditions such as population demographics, susceptibility, capacity, and resources. A discussion of planning challenges, including ethical issues, is in the Agency for Healthcare Research and Quality document (Reference (aj)).

3. USE OF VOLUNTEERS TO SUPPLEMENT HEALTH CARE PERSONNEL

a. Upon a declaration of public health emergency, the MTF commander may supplement the available staff of health care personnel with the use of volunteers.

b. The policies and procedures of DoDI 1100.21 (Reference (ak)) and DoDI 5210.25 (Reference (al)) shall apply to the use of volunteers under this section, except that:

(1) For purposes of credentialing and privileging, the MTF commander may accept information and documentation provided through the Emergency Systems for the Advance Registration of Volunteer Health Personnel (a program managed by HHS) or such other documentation the commander determines reliable.

(2) There is no requirement for a criminal background check. However, volunteers without a criminal background check require close clinical supervision when they are caring for patients under the age of 18.

c. Volunteers under this section are considered employees of the Department of Defense to the extent provided in Reference (ak).

d. For purposes of licensure requirements, a current, valid license in a State (or other Federal jurisdiction) is required. There is no requirement that the license be unrestricted, such as a license restricted to Federal Government practice, so long as the restriction does not indicate a lack of qualifications to provide the services covered by the volunteer agreement. There is no requirement for a license from the specific State (or other Federal jurisdiction) where the DoD installation or treatment facility (including a temporary facility treating DoD personnel and health care beneficiaries and under DoD control) is located.

e. DoD public health emergency privileges may be initiated only when the hospital's emergency management plan has been activated and the hospital is unable to handle the immediate patient needs. These privileges allow non-staff practitioners to come to the aid of the hospital at the time of a public health emergency. The Commander may grant these privileges, but there should be a policy and procedure in place concerning these privileges, which should address all current accreditation requirements. All public health emergency privileges shall immediately terminate once the emergency management plan is no longer activated; however, the hospital may choose to terminate these privileges prior to that time.

ENCLOSURE 5

QUARANTINABLE DISEASE AND OTHER PUBLIC HEALTH EMERGENCY NOTIFICATION ROUTING PROCEDURES

These information flow charts are meant to depict a comprehensive notification routing for quarantinable diseases and other public health emergencies. This process identifies the primary notification sources and entities receiving notification. Many additional agencies and components may receive the notification as "information addees." There will be circumstances where it may be necessary to deviate from this outlined process. Dotted lines with arrows indicate informal communication channels. Figure 2 is an expansion of the right side of Figure 1 for Command and OCONUS notifications; all of the routing procedures outlined in Figure 1 apply to the corresponding blocks in Figure 2.

Figure 1. Notification Routing Procedures (Overview)

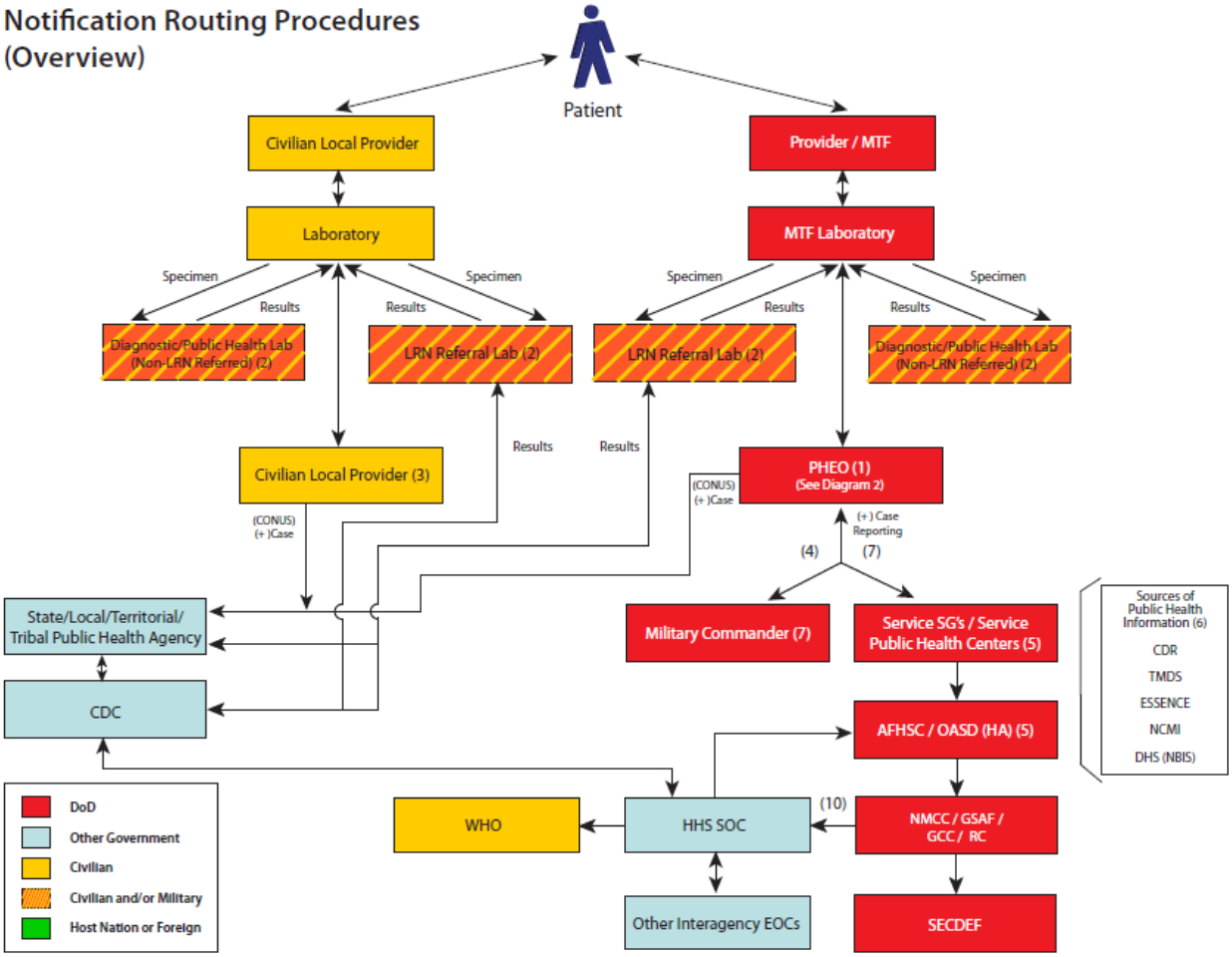
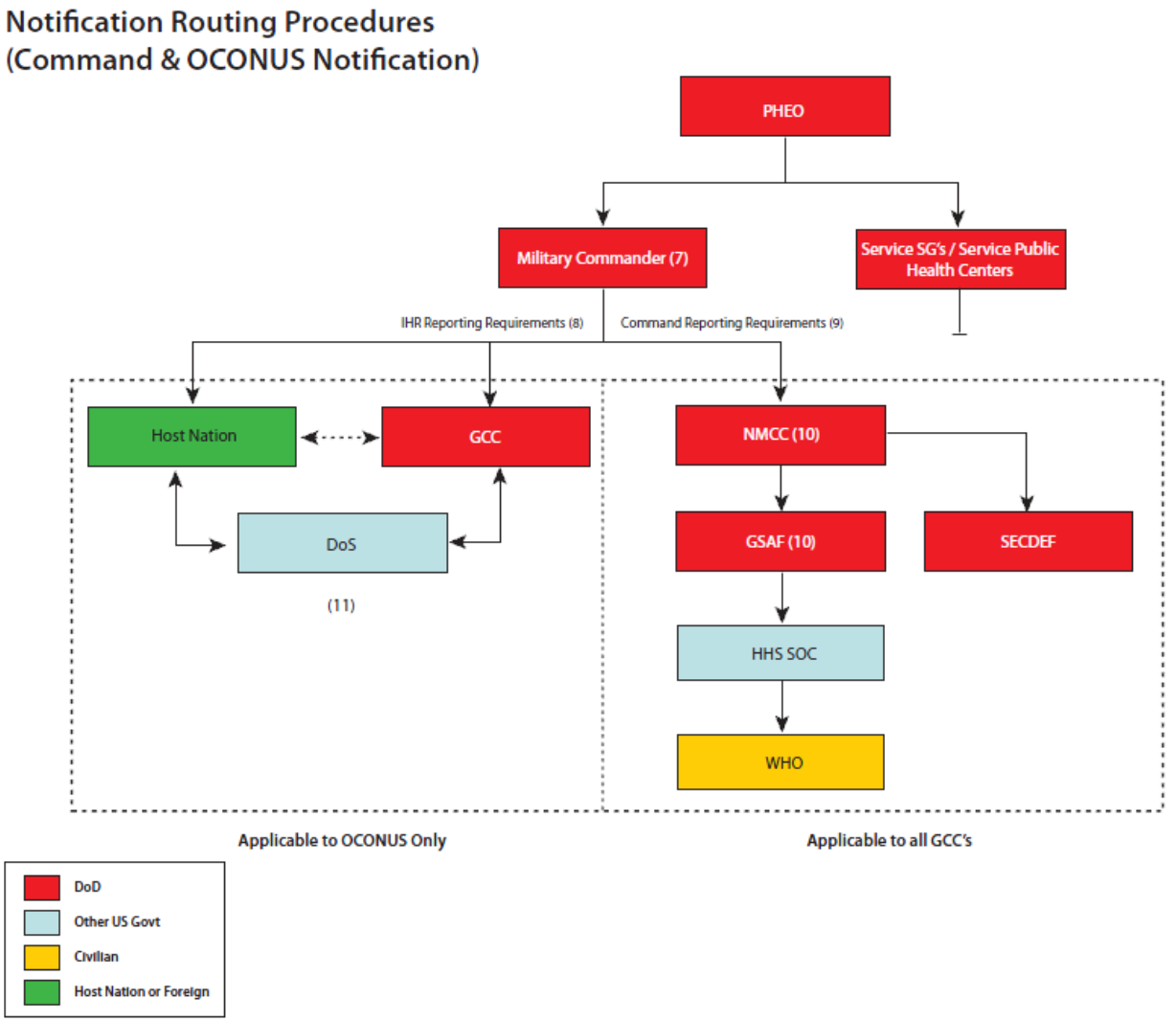


Figure 2. Notification Routing Procedures (Command and OCONUS Notification)



ENCLOSURE 6

EXPLANATORY TEXT OF FIGURES 1 AND 2

1. PHEOs will normally be notified of test results from MTF laboratories. In some Combatant Commands, the Surgeon's Office may perform duties similar to that of the PHEO.

2. LRN laboratories may be either civilian or Department of Defense. The LRN referral laboratories shall report positive results to the SLTT Public Health Agency and both negative and positive results to the CDC.

3. There is currently no formal organizational mechanism guaranteeing laboratory results received by a civilian provider will be shared with either DoD MTFs or PHEOs.

4. Bilateral information exchange may be needed for case confirmation and validation.

5. While AFHSC primary notification is to the ASD(HA) and NMCC/GSAF, other recipients of the notification shall include the ASD(HD&ASA), the Service Surgeons General, GCC, and others as required.

6. The components and/or data sources listed provide and receive information from many organizations. For purposes of this Instruction, however, the Service Public Health Centers, the AFHSC, and the NMCC are specifically listed.

7. Depending upon theater, operational, or regional policies, the Military Commander shall notify the appropriate authorities within their technical chain of command. This may include the Service major command, the Service Chiefs, the Combatant Command, and/or the Service component, a joint task force, a subunified commander, or other entity as established.

8. International Health Regulation reporting policy is in accordance with determinations made by the relevant Combatant Command, chief of mission, and host nation.

9. Command reporting follows Combatant Command tactics, techniques, and procedures and standard operating procedures established for line notification to the NMCC. Additionally, before United States Northern Command (USNORTHCOM) regional joint task forces are operational, Services should notify the NMCC/GSAF in accordance with the decision algorithm for reporting diseases provided in Enclosure 7 of this Instruction. Once USNORTHCOM regional joint task forces are operational, reporting shall be in accordance with USNORTHCOM notification policy guidance.

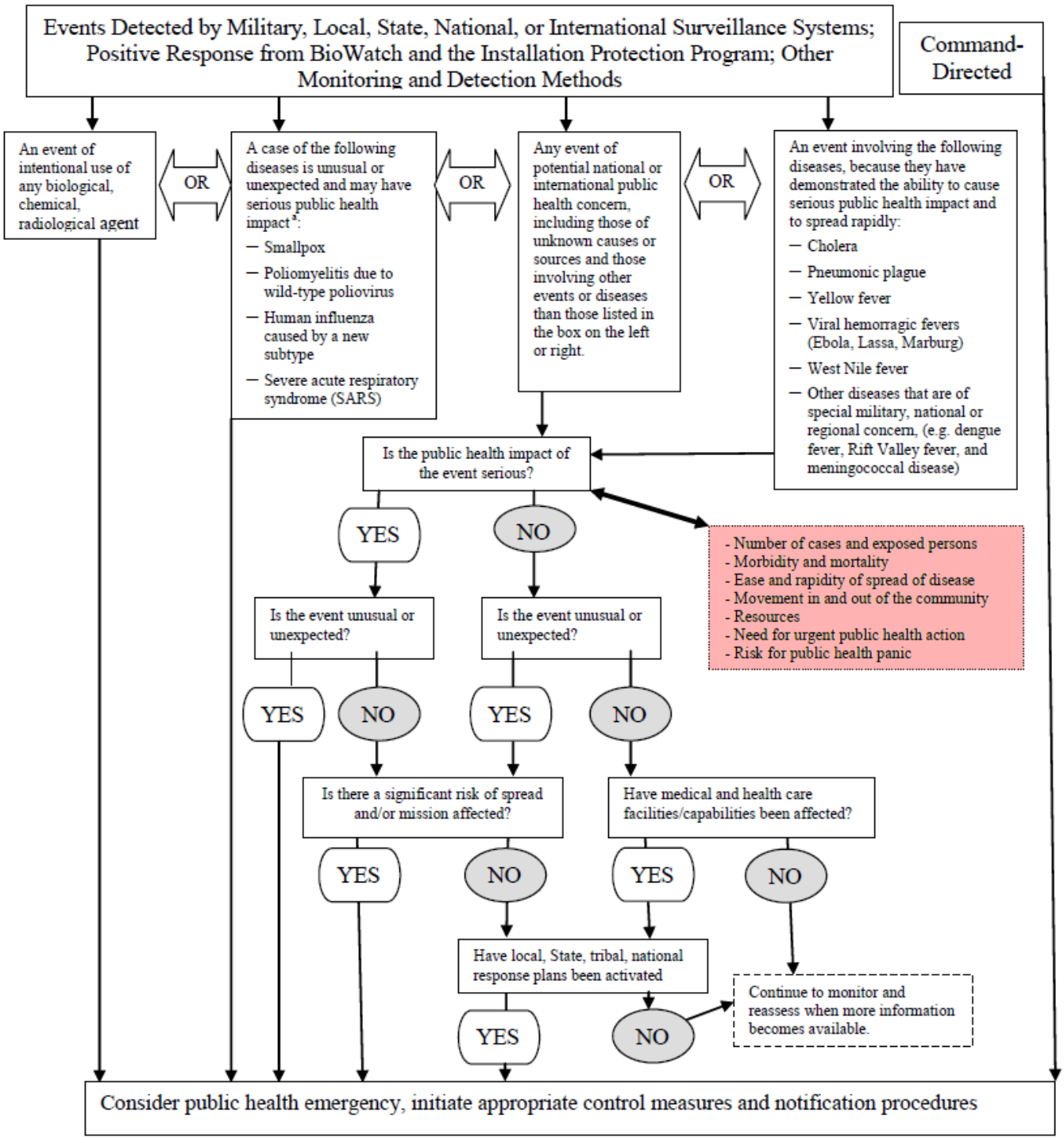
10. While the NMCC/GSAF primary notification is to the HHS SOC, other entities that shall be notified include the Secretary of Defense GSAF, Combatant Commands, Services, affected major commands, and international organizations, as appropriate.

11. Based upon discussions among each host nation, GCC, and chief of mission, PHEICs involving U.S. Government affiliated personnel and their dependents will be reported to the WHO.

ENCLOSURE 7

PUBLIC HEALTH EMERGENCY DECISION

Figure 3. Public Health Emergency Decision Algorithm



[a] As per WHO case definitions.

This algorithm is adapted from the WHO International Health Regulations (2005), Annex 2

GLOSSARY

PART I. ABBREVIATIONS AND ACRONYMS

AFHSC	Armed Forces Health Surveillance Center
ANG	Air National Guard
ARNG	Army National Guard
ASD(GSA)	Assistant Secretary of Defense for Global Strategic Affairs
ASD(HA)	Assistant Secretary of Defense for Health Affairs
ASD(HD&ASA)	Assistant Secretary of Defense for Homeland Defense and Americas' Security Affairs
~~DoD CIO~~	~~DoD Chief Information Officer~~
ASD(NCB)	Assistant Secretary of Defense for Nuclear and Chemical and Biological Defense Programs
ASD(SO/LIC)	Assistant Secretary of Defense for Special Operations and Low-Intensity Conflict
CBDP	Chemical and Biological Defense Program
CDC	Centers for Disease Control and Prevention
CDR	Clinical Data Repository
DA&M	Director of Administration and Management
DHA	*Defense Health Agency*
DHS	Department of Homeland Security
DMH	disaster mental health
DMHR	Disaster Mental Health Response
DoD CIO	*DoD Chief Information Officer*
DoDD	DoD Directive
DoDI	DoD Instruction
DOS	Department of State
DUSD(I&E)	Deputy Under Secretary of Defense for Installations and Environment
EOC	Emergency Operations Center
ESSENCE	Electronic Surveillance System for Early Notification of Community-based Epidemics
GCC	Geographic Combatant Commander
GSAF	Global Situational Awareness Facility
HA/DR/GH	Humanitarian Assistance, Disaster Relief, and Global Health
HHS	Department of Health and Human Services
IEM	installation emergency management
IEMWG	Installation Emergency Management Working Group
IHR	International Health Regulations

LRN	Laboratory Response Network
MEM	MTF Emergency Manager
MHS	Military Health System
MTF	military treatment facility
NBIS	National Biosurveillance Integration System
NCMI	National Center for Medical Intelligence
NGB	National Guard Bureau
NIMS	National Incident Management System
NMCC	National Military Command Center
NRF	National Response Framework
OIC	officer in charge
OCONUS	outside the continental United States
PHEIC	Public Health Emergency of International Concern
PHEO	Public Health Emergency Officer
POD	point of dispensing
RC	Reserve Components
RDA	research, development, and acquisition
RSS	receipt, staging, and storage
SECDEF	Secretary of Defense
SG	Surgeon General
SLTT	State, local, tribal, territorial
SNS	Strategic National Stockpile
SOC	Secretary Operations Center
SOP	standard operating procedure
~~TMA~~	~~TRICARE Management Activity~~
TMDS	Theater Medical Data Storage
U.S.C.	United States Code
USD(AT&L)	Under Secretary of Defense for Acquisition, Technology, and Logistics
USD(P&R)	Under Secretary of Defense for Personnel and Readiness
USNORTHCOM	United States Northern Command
WHO	World Health Organization
WMD	weapons of mass destruction

PART II. DEFINITIONS

All terms and definitions are for the purpose of this Instruction unless otherwise noted.

all hazards. As defined in Reference (k).

chief of mission. Defined in Joint Publication 1-02 (Reference (am)).

Cities Readiness Initiative. A Federally funded, CDC-managed effort to prepare major cities and metropolitan areas to respond to a large-scale bioterrorist event by dispensing antibiotics and other medical supplies to the entire identified population within 48 hours of the decision to do so.

Closed POD. A site intended for the dispensation of medications to a select or pre-defined population, not the general public.

communicable disease. An illness due to a specific infectious agent or its toxic products that arises through transmission of that agent or its products from an infected and/or affected individual, animal, or a reservoir to a susceptible host, either directly or indirectly through an intermediate animal host, vector, or the inanimate environment

DMH. Provision of prevention, outreach, screening, triage, psychological first aid, education, and referral services to individuals and groups who have had or may have had exposure to an all-hazards incident.

DMHR team. Designated team that provides command consultation, prevention, outreach, screening, triage, psychological first aid, education, and referral services following an all-hazards incident.

isolation. The separation of an individual or group infected and/or suspected to be infected with a communicable disease from those who are healthy in such a place and manner to prevent the spread of the communicable disease.

LRN. A diverse national/international laboratory network of local, State, and Federal public health, hospital-based, food testing, veterinary and environmental testing laboratories that provide rapid detection assays and laboratory diagnostics and the capacity to respond to biological and chemical terrorism and other public health emergencies. The LRN is a reciprocal multi-agency collaboration/partnership involving key stakeholders in the preparation and response to biological and chemical terrorism. The CDC, the Federal Bureau of Investigation, the Department of Defense, and the Association of Public Health Laboratories are its founding partners. The mission of the LRN and its partners is to maintain an integrated national and international network of laboratories that are fully equipped to respond quickly to acts of chemical or biological terrorism, emerging infectious diseases, and other public health threats and emergencies.

Military Commander. As defined in Enclosure 1 of Reference (i).

MTF. A facility established for the purpose of furnishing medical and/or dental care to eligible individuals.

MTF Commander or OIC. The commander or officer in charge of a facility established for the purpose of furnishing medical and/or dental care to eligible individuals.

Open POD. A public site designed for dispensation of medications to the general population.

POD. A location where pharmaceuticals and other medications are distributed to the end user; these facilities may range from small clinics to large operations with multiple staging and operations areas; these facilities may also support a range of methods of distributing drugs and medications to the patients.

public health emergency. An occurrence or imminent threat of an illness or health condition that may be caused by a biological incident, manmade or naturally occurring; the appearance of a novel, previously controlled, or eradicated infectious agent or biological toxin; natural disaster; chemical attack or accidental release; radiological or nuclear attack or accident; high-yield explosive detonation; and/or zoonotic disease. An occurrence or imminent threat of an illness or health condition that may pose a high probability of a significant number of deaths in the affected population considering the severity and probability of the event; a significant number of serious or long-term disabilities in the affected population considering the severity and probability of the event; widespread exposure to an infectious or toxic agent, including those of zoonotic origin, that poses a significant risk of substantial future harm to a large number of people in the affected population; and/or health care needs that exceed available resources. And/or an occurrence or imminent threat of an illness or health condition that may require notification to the WHO as a potential PHEIC in accordance with Reference (l).

quarantinable disease. Defined in Reference (n).

quarantine. The separation of an individual or group that has been exposed to a communicable disease, but is not yet ill, from others who have not been so exposed, in such manner and place to prevent the possible spread of the communicable disease.

restriction of movement. Limiting people's movement to prevent or limit the transmission of a communicable disease, including limiting ingress and egress to, from, or on a military installation, isolation, or quarantine.

RSS site. Sites that accept SNS assets (i.e., Push-Packages). As such, they would ideally include significant warehouse space, as well as cargo management and logistics assets. They should not be accessible to the public.

Service Public Health Centers. Navy and Marine Corps Public Health Center, U.S. Air Force School of Aerospace Medicine, U.S. Army Center for Health Promotion and Preventive Medicine.

SNS. A national repository of antibiotics, chemical antidotes, antitoxins, life-support

medications, intravenous administration fluids and sets, airway maintenance supplies, and medical/surgical items. The SNS is designed to supplement and re-supply State and local public health agencies in the event of a national emergency anywhere and at any time within the United States or its territories.

telemedicine. Defined in Reference (am).

terrorism. Defined in Reference (am).

zoonotic disease. Diseases transmissible under natural conditions from vertebrate animals to humans.