

DRAFT
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HEADQUARTERS, US NORTHERN COMMAND
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USNORTHCOM BRANCH PLAN 3560
PANDEMIC INFLUENZA AND INFECTIOUS DISEASE RESPONSE

References: See Annex AA

1. Situation.

a. General. The causative agents of biological incidents are microorganisms (or toxins produced or derived from them) which causes disease in humans, plants or animals. They can be grouped into subcategories of pathogens and toxins. Pathogens can be viral, bacterial, rickettsia, or parasitic and toxins are essentially chemical poisons produced by or extracted from living organism such as bacteria, fungi, or animals. Each type poses unique response and recovery challenges. While most causative agents are naturally occurring, their development for deliberate use and potential for accidental release are also concerns for incident.

(1) A catastrophic biological incident could threaten the Nation's human, animal, plant, environmental, and economic health, as well as America's national security. Such an event would demand a rapid and effective response in order to minimize loss of life and other adverse consequences associated with the incident and to thwart ongoing threats and follow-on attacks in the case of suspected criminal activity or terrorism. The potential for a large biological incident to impact the United States is real.

(a) Scenarios and response plans should consider multiple events with scalable response requirements from a local/regional event to a more widely distributed catastrophic event.

(b) Unique or novel pathogens are likely to defy conventional diagnostic and treatment tools which can result in rapid spread throughout the world, posing risk to national security.

(c) Novel contagious pathogens capable of human-to-human transmission via aerosol with high virulence for which no MCM exists may present the greatest challenge to response and recovery.

(d) Environmental shifts, disasters or other events can change disease patterns, raising the risk of a biological incident. Diseases can change; minor

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46 and sudden genetic shifts can transform existing pathogens, making routine
47 outbreaks a source for potentially higher morbidity and/or mortality.

48

49 (e) Widespread and improper use of antibiotic, anti-viral, anti-malarial
50 treatments or other medical countermeasures (MCM) are accelerating the
51 emergence of drug-resistant pathogens that are unresponsive to available
52 pharmaceutical interventions.

53

54 (f) Biological threats will continue to evolve through natural agent
55 mutation, zoonotic spillover, amplification, spread of diseases, and intentional
56 engineering.

57

58 (g) Complex transmission pathways, where a virulent pathogen moves
59 between human and animal communities, require a high level of collaboration
60 and coordination.

61

62 (2) The deliberate employment of biologicals as a weapon does exist. Both
63 state and non-state actors have expressed interest. The response to the 2001
64 anthrax attacks in the United States demonstrated the difficulty of responding
65 to a deliberate biological incident and reinforced the need for seamless
66 interagency planning in advance of any deliberate incident.

67

68 (3) Unlike chemical and radiological hazards, biological incidents may
69 take days to months to develop, and with certain causative bacteria and
70 viruses may continue to spread from person-to-person. Also, there are limited
71 detection/warning capabilities for biologicals which means that an
72 outbreak/attack can go unrecognized and continue to spread before a clinical
73 diagnosis is made. This will be exacerbated if there are limited or no assays by
74 which to identify the organism and if the symptoms mimic naturally occurring
75 endemic outbreaks (e.g., seasonal flu).

76

77 (4) Planning and preparedness for a biological incident requires unique
78 considerations such as MCM. Roles and responsibilities of the public health
79 and medical community and the emergency management community will
80 intersect and need to be integrated with the operations community for mission
81 assurance.

82

83 (5) A serious biological incident may diminish the capacity and ability of
84 response entities to respond to the emergency. In addition, the risks to first
85 responders and receivers posed by certain pathogens are high. The recovery
86 from a biological incident may span months or even years based on the nature
87 of the biological and its ability to transmit.

88

89 (6) Coordinated messaging and information that adheres to principles of
90 risk communication, even in areas unaffected by the incident, are crucial to

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91 mitigating the impact of the incident and reducing panic and fear that might be
92 associated with the event. Federal communications should include integrated
93 web-based, telephonic, and graphic communications options. CDC will
94 coordinate with key state governments to build a graphic interface designed to
95 show outbreak cases, type of transmission, and risk assessment for future
96 transmission with considered application of those factors to adjust overseas
97 travel warnings. USNORTHCOM, should ensure its communications are
98 coordinated with appropriate DOD elements (i.e., public affairs, OSD HA, DHA,
99 etc) and consistent with other Federal government messaging. Early on in a
100 response, consideration for a local outbreak or outbreaks need to factor in
101 DOD installations working directly with their local civilian public health
102 counterparts to develop risk communication messages.
103

104 b. Scope. This Branch Plan, Pandemic Influenza and Infectious Disease
105 (PI&ID) Response to USNORTHCOM CONPLAN 3500-17, DSCA Response,
106 provides the overarching planning guidance for USNORTHCOM response
107 operations to an operationally significant infectious disease outbreak. This
108 may encompass a spectrum ranging from a localized epidemic (outbreak likely
109 to remain restricted to a limited geographical area – local or state level) to a
110 pandemic (high potential for rapid continuous and global intercontinental
111 spread). It is intended to address biological pathogens that adversely impact
112 human health and threatens impact mission assurance due to adverse health
113 effects to personnel, the US population, and/or impacts on freedom of
114 movement. With the potential to overwhelm state and local resources, the lead
115 federal agency (LFA), in this case the Department of Health and Human
116 Services (HHS), deems that interagency support is or will be required. This
117 Branch Plan supersedes and replaces USNORTHCOM CONPLAN 3591-09,
118 Response to Pandemic Influenza, which focused singularly on pandemic (novel)
119 influenza. This plan is developed in accordance with (IAW) the revised
120 Department of Defense Global Campaign Plan for Pandemic Influenza and
121 Infectious Disease (DOD GCP-PI&ID-3551-13), 15 October 2013 and
122 incorporates insights from several recent outbreaks including the 2009 H1N1
123 Pandemic Influenza, 2012 Middle Eastern Respiratory Syndrome Coronavirus
124 (MERS-CoV), 2013 H7N9 Avian Influenza, 2014 Ebola Virus Disease (EVD),
125 and 2015 Zika Virus outbreaks.
126

127 c. Background. The potential impact of disease outbreaks on military
128 operations is significant. There have been four influenza pandemics in recent
129 history: 1918, 1957, 1968, and 2009. In the 1918 "Spanish Flu" pandemic,
130 approximately one-third of the U.S. population was infected and 675,000
131 Americans died. Military fatalities from the Spanish Flu exceeded the total
132 number of combat related fatalities from World War I (WWI). It is estimated the
133 1918 pandemic killed 2 percent of the world's population; the average life
134 expectancy was reduced by 13 years. Influenza pandemics in 1957 ("Asian
135 Flu") and 1968 ("Hong Kong Flu") killed tens of thousands of Americans and

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136 millions across the world. While the 2009 H1N1 pandemic was generally
137 considered to be mild with approximately 60.8 million cases, over 274,000
138 related hospitalizations, and 12,469 deaths, it posed substantial challenges to
139 theater security cooperation, forward-basing, and freedom of movement.

140
141 (1) Additionally, at least thirty emerging infectious diseases including
142 Ebola Virus Disease (EVD), Severe Acute Respiratory Syndrome (SARS), H5N1
143 Avian Influenza (AI) and Nipah viruses have been discovered in the last thirty
144 years. Throughout a PI&ID outbreak, US military forces must remain dominant
145 across the full spectrum of military operations, preserving combat capabilities
146 in order to engage adversaries around the world.

147
148 (2) In March of 2014, EVD was confirmed in the West African Nation
149 of Guinea. While endemic only to this part of the world, the outbreak would
150 eventually spread to 9 additional countries resulting in over 29,000 cases with
151 12,000 deaths in 20 months. In the US, it resulted in a non-Stafford act public
152 health emergency.

153
154 (3) During recent outbreak responses, several different operational
155 coordination mechanisms were utilized by the Federal government. Some
156 operational or policy implementation matters were handled through the
157 Presidential Policy Directive (PPD) 1; National Security Council System, others
158 were coordinated with relevant stakeholders on an ad hoc basis, and still
159 others were addressed by departments and agencies working largely on their
160 own. This will likely be the norm in the future and will require flexibility on the
161 part of USNORTHCOM during outbreak crisis action planning to adjust and
162 engage with USG partners for coordination.

163
164 d. Disease of Operational Significance. For purposes of this plan, a disease
165 of operational significance is an infectious disease (natural, accidental, or
166 deliberate) likely to significantly impact the ability of the DOD to maintain
167 mission assurance or result in significant increases in requests for DOD
168 assistance. A disease of operational significance may create an environmental
169 and global disaster (pandemic) with the potential of incapacitating upwards of
170 40% of the overall workforce. Consideration of scalable affects to the DOD
171 workforce need to be evaluated in 5% increments from 5-40% to understand
172 impacts from different infection rates of biologicals and for mission assurance
173 and force health protection purposes. Similarly, efforts should be made to
174 understand how impacts of varying levels of absenteeism would impact essential
175 services. Beyond its primary negative effects, a disease of operational
176 significance will have secondary and tertiary effects which will significantly
177 threaten economic, political, and social stability of nations and regions.

178
179 (1) Characteristics of a disease of operational significance may include
180 one or more of the following: new (novel) to humans; infects humans causing

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181 serious morbidity (illness) and mortality (death); easily transmissible among
182 humans; able to spread globally (epidemic or pandemic) in a short period;
183 severe enough (morbidity and mortality) to cause significant absenteeism
184 (single parent, impact the family unit); limited or no natural protection or
185 available MCM (force health protection).

186

187 (2) A disease of operational significance may impact USNORTHCOM's
188 operating environment for up to 24 months. Impacts may include reduced
189 access and Freedom of Maneuver (domestically and internationally) and
190 reduced support from United States Government (USG)/Private Sector/other
191 nations.

192

193 (3) The disease may occur in humans, animals, or plants.

194

195 (4) Existing health care capacities (ability to prevent, treat, and manage
196 illness and the preservation of mental and physical well-being through services
197 of medical and allied health) to respond to a disease outbreak will vary based
198 on the type of disease e.g., greater capacity for non-sustained/low-level
199 endemic diseases and lesser capacity for regional/pandemic diseases.

200

201 e. Policy and Planning Guidance. Also see base plan.

202

203 (1) Unified Command Plan (UCP). States that CDRUSNORTHCOM is
204 responsible for synchronizing planning for DOD efforts in support of the U.S.
205 Government response to PI&ID, and will do so in coordination with other
206 combatant commands, the Services, and, as directed, appropriate U.S.
207 Government agencies.

208

209 (2) Guidance for the Employment of the Force (GEF). Domestic civil
210 authorities are adequately supported in preparing for, preventing, and
211 mitigating, and responding to the consequences of catastrophic events
212 (includes pandemic).

213

214 (3) Joint Strategic Capabilities Plan (JSCP). Directs GCCs to develop
215 plans to mitigate and respond to the effects of PI&ID with their respective
216 AORs. Also, directs coordination with relevant USG, NCO, and UN partners as
217 appropriate.

218

219 (4) DOD Global Campaign Plan (GCP) for Pandemic Influenza and
220 Infectious Disease (PI&ID)-3551-13 (DOD GCP-PI&ID-3551-13). Directs DOD
221 departments, components, GCCs, and the military services to plan for
222 supporting civil authorities and respond to an outbreak of an operationally
223 significant disease (by definition includes pandemic disease). Ensures that
224 DOD: supports USG-wide planning for PI&ID; is postured to support USG
225 efforts to mitigate the effects of PI&ID to protect the nation's welfare; and is

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226 planning will be coordinated with the primary Federal agencies responsible for
227 coordination with relevant domestic and international organizations. Planning
228 should involve other USG departments and agencies, in particular for the
229 GCCs; DOS, USAID, and HHS for foreign operations; and DHS, FEMA, USDA,
230 HHS, and CDC for domestic operations, and account for the integration of USG
231 and NGO efforts within each command's AOR. DOD's top priority: protection of
232 U.S. forces and associated resources necessary to maintain readiness and
233 conduct assigned missions in a PI&ID environment and continue performance
234 of DOD's National Essential Functions.
235

236 (5) National Strategy for Pandemic Influenza. Guides national
237 preparedness and response to an influenza pandemic, with the intent of (1)
238 stopping, slowing or otherwise limiting the spread of a pandemic to the United
239 States; (2) limiting the domestic spread of a pandemic, and mitigating disease,
240 suffering and death; and (3) sustaining infrastructure and mitigating impact to
241 the economy and the functioning of society.
242

243 (6) National Strategy for Pandemic Influenza Implementation Plan.
244 Clarifies the roles and responsibilities of governmental and non-governmental
245 entities, including Federal, State, local, and tribal authorities and regional,
246 national, and international stakeholders, and provides preparedness guidance
247 for all segments of society.
248

249 (7) DOD Implementation Plan for PI. Sets forth DOD guidance and
250 addresses key policy issues for pandemic influenza planning. Guidance enables
251 Combatant Commanders, Military Departments, and DOD agencies to develop
252 plans to prepare for, detect, respond to, and contain the effects of a pandemic
253 on military forces, DOD civilians, DOD contractors, dependents, and
254 beneficiaries. Additionally, directs planning to address the provision of DOD
255 assistance to civil authorities, both foreign and domestic, and to address
256 considerations for key security concerns, such as humanitarian relief and
257 stabilization operations that may arise as a result of a pandemic.
258

259 (8) National Strategy for Countering Biological Threats. Targeted to reduce
260 biological threats by: (1) improving global access to the life sciences to combat
261 infectious disease regardless of its cause; (2) establishing and reinforcing
262 norms against the misuse of the life sciences; and (3) instituting a suite of
263 coordinated activities that collectively will help influence, identify, inhibit,
264 and/or interdict those who seek to misuse the life sciences. It complements
265 existing policies, plans, and preparations to advance the U.S. Government's
266 (USG) ability to respond to public health crises of natural, accidental, or
267 deliberate origin.
268

269 (9) DOD Implementation Plan to the NSCBT. Outlines DOD roles and
270 contributions to the National Strategy for Countering Biological Threats with

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271 three overarching areas of emphasis. First, to identify the baseline of activity
272 that is already being done. Second, identify the gaps (authorities allowing
273 additional efforts within existing resources) that exist. Third, the
274 institutionalization of the effort across the DOD. USNORTHCOM and
275 USSTRATCOM both play a role in achieving the objectives and sub-objectives
276 outlined in the NSCBT due to their role as global synchronizers for PI&ID and
277 Combating Weapon of Mass Destruction (CWMD), respectively. Neither
278 USSTRATCOM nor USNORTHCOM is the lead for these objectives, but each
279 command plans activities in support of the strategy.
280

281 (10) National Strategy for Biosurveillance. The Strategy's expressed goal is
282 to achieve "a well-integrated national bio-surveillance enterprise that saves
283 lives by providing essential information for better decision making at all levels."
284 Core functions are to (1) scan and discern the environment, (2) identify and
285 integrate essential information, (3) alert and inform decision makers, and (4)
286 forecast and advise impacts. It sets forth the guiding principles, core functions
287 and crosscutting enablers to implement a foundation for U.S. biosurveillance
288 activities to enhance the nation's ability to detect, track, investigate and
289 navigate incidents affecting human health.
290

291 (11) Department of Defense Mission Assurance Strategy. The strategic
292 framework for mission assurance across DOD is organized along four pillars:
293 (1) identify and prioritize critical missions, functions, and supporting assets, (2)
294 develop and implement a comprehensive and integrated mission assurance risk
295 management framework, (3) use risk-informed decision making to optimize risk
296 management solutions, and (4) partnering to reduce risk – a shared
297 responsibility.
298

299 f. Supporting Plans. USNORTHCOM addresses PI&ID strategic and
300 operational requirements through the following series of connected plans:
301

302 (1) The USNORTHCOM Theater Campaign Plan (TCP) directs some of the
303 Phase 0 operations, actions, and activities (OAAs) that are required to prepare
304 for a PI&ID response and to support civil authorities in the Homeland. This
305 includes building the PI&ID response capacity of both DOD and Allies and
306 Partners.
307

308 (2) USNORTHCOM PI&ID Response branch plan directs the OAAs
309 required to execute a Phase 1-5 PI&ID response. As described below, PI&ID
310 Response branch plan aims to maintain mission assurance and provide
311 Defense Support to Civil Authorities (DSCA) and/or Foreign Disaster Relief
312 (FDR) as requested/directed.
313

314 (3) PI&ID DSCA response will be executed as a branch plan IAW
315 USNORTHCOM CONPLAN 3500 DSCA Response (reference xx) and partner

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316 nation response will be executed through this branch and IAW CONPLAN 3729,
317 International Disaster Response (reference xx).

318

319 (4) Should an operationally significant disease outbreak at any time be
320 determined as attributable, then the appropriate classified contingency
321 operation(s) described in Appendix 2, Combatting Weapons of Mass
322 Destruction (CWMD), to Annex C of the TCP may also be executed. Appendix 2
323 CWMD to TCP outlines the CONPLANS that direct the operations, actions, and
324 activities required to support civil authorities in preventing and responding to
325 the use of WMD in the Homeland.

326

327 (5) 3407 CBRN Prevent Plan supports USG law enforcement agencies in
328 preventing WMD (to include biologicals) entry into the US and search for WMD
329 when cued by intelligence.

330

331 (6) The Biological Incident Annex (BIA) to the Response and Recovery
332 Federal Interagency Operational Plans (FIOPs) includes the structure and
333 criteria for implementing an enhanced national-level operational coordination
334 procedures/mechanisms for a biological event.

335

336 (7) This CONPLAN is effective for planning upon receipt, and for
337 execution when directed.

338

339 g. Area of Concern.

340

341 (1) Area of Responsibility (AOR). See Base Plan.

342

343 (2) Area of Interest (AOI). USNORTHCOM's AOI includes the entire
344 globe, as operationally significant infectious disease could originate anywhere
345 in the world. USNORTHCOM will work with other Combatant Commanders,
346 Services, and Agencies, when a potential operationally significant infectious
347 disease is detected within the USNORTHCOM AOI but outside the
348 USNORTHCOM AOR. Within CONUS, USNORTHCOM's AOI extends to those
349 critical non-DOD events and infrastructure where the effects of infectious
350 disease may impact DOD operational capabilities or require DOD support for
351 protection or domestic incident management support.

352

353 (3) Operational Area (OA). See Base Plan.

354

355 (4) Area of Operations (AO). See Base Plan.

356

357 h. Deterrent Options.

358

359 (1) Force Health Protection (FHP). Traditional deterrent options against
360 a disease do not directly apply. However, following FHP measures and public

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361 health guidelines published in FHP guidance and on key DOD and interagency
362 (IA) websites (see examples at figure 1), can provide some deterrent/mitigation
363 options. The FHP measures outlined in the DOD Global Campaign Plan (GCP)
364 for PI&ID-3551-13 provide a unifying, synchronizing approach to
365 preparedness, response, and recovery from an installation to GCC/Global
366 perspective. Each level of command will utilize these FHP measures
367 commensurate with baseline guidance (in the USNORTHCOM AOR by Service
368 and/or USNORTHCOM) and the local situation (i.e., impacted area(s)). Some
369 general deterrent options would include: annual/seasonal flu shots, washing
370 hands frequently, cough etiquette, social distancing, etc.

371

372 (2) Diplomatic Flexible Deterrent Options. USG works with the Centers
373 for Disease Control and Prevention (CDC), World Health Organization (WHO),
374 the International Partnership on Avian and Pandemic Influenza, and through
375 diplomatic contacts to strengthen international mechanisms to respond to an
376 outbreak of influenza with pandemic potential. This includes support to
377 WHO's doctrine of international response and containment published in 2009,
378 which lays out the responsibilities of the international community and
379 countries with human outbreaks, and includes provisions to develop and
380 deploy critical resources needed to contain the virus.

381

382 (3) Military Flexible Deterrent Options. USNORTHCOM conducts
383 targeted Theater Security Cooperation (TSC) and Building Partner Capacity
384 (BPC) activities in coordination with other USG agencies to bolster and
385 integrate Partner Nation (PN) capacity to respond to PI&ID, and to improve the
386 interoperability and effectiveness of civilian and designated military critical
387 responders. TSC and BPC activities in USNORTHCOM's AOR include Global
388 Health Engagement activities such as medical readiness, training, and
389 exercises. Further, TSC and BPC activities are designed to assure success by
390 shaping perceptions and influencing behavior of both adversaries and allies.
391 The prevention of the proliferation of disease causing agents which could result
392 in accidental (e.g. misuse of life sciences) or deliberate release falls under the
393 responsibility of USSTRATCOM's GCP-CWMD and/or CWMD and/ or
394 Counterterrorism planning efforts for deterrent options.

395

396 i. Enemy/Threat. The most likely and significant threat (enemy) is a novel
397 respiratory disease, particularly a novel influenza disease. A disease of
398 operational significance (natural, accidental, or deliberate) will have rapid rates
399 of transmission that will result in debilitating illness in military forces at levels
400 significant enough to degrade combat readiness and effectiveness across
401 multiple GCCs. An outbreak in a single community can quickly evolve into a
402 multinational health crisis that causes millions to suffer, as well as spark
403 major disruption to every facet of society. Disease characteristics may include
404 high transmissibility or severity, and high likelihood of impact on force health
405 protection due to limited or no natural protection or MCM. Additionally, it will

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406 significantly impact domestic civil authorities and partner nations to the degree
407 that may result in significant requests for DOD support and/or secondary and
408 tertiary effects that may require U.S. involvement. Consideration needs to be
409 made in the planning phases to understand and plan for multiple scenarios
410 where local, regional, and global impacts are likely to best prepare
411 installations, the Services, and USNORTHCOM for preparedness and response
412 activities and ensure a common operating picture. These scenarios include
413 MERS-CoV (current transmission risks) for a local response, plague for a
414 regional response, and a novel influenza for a global response (understanding
415 that all of these events will begin at the local level).

416

417 (1) Enemy Center of Gravity (COG). The center of gravity of a pathogen is
418 its ability to become operationally significant and spread from the point of
419 emergence (i.e. diseases that have historically been operationally significant
420 and those pathogens such as H5N1 avian influenza that may become
421 operationally significant). An operationally significant disease can degrade
422 readiness and effectiveness of the force through illness and related
423 absenteeism, inhibit freedom of action through related restrictions (e.g., ports
424 of debarkation/embarkation), and generate requests to assist partners with
425 cascading impacts on critical infrastructure/key resources domestically and
426 internationally.

427

428 (a) Critical Capabilities. An infectious disease with operationally
429 significant characteristics can remain, in and of itself, relatively insignificant
430 unless conditions exist to foster its contact with hosts and propagate spread.
431 These conditions come from population and host, and environmental factors.
432 Population and host factors that enable diseases are immunologically
433 susceptible populations (little to no immunity), robust population mixing
434 (developed social contact and mobility networks), availability of local, regional
435 and global travel hubs/ports (e.g., international airport near point of
436 emergence), poor personal hygiene practices, and limited access to health care
437 or poor health care (limits ability to detect, diagnose and treat). Environmental
438 conditions that enable diseases are crowded living/work conditions, vector/
439 reservoir/ host interface (high exposure due to lack of preventive measures,
440 location), poor sanitation (increases exposure opportunity), climate conducive
441 to vector transmission, and high human/ animal interface.

442

443 (b) Critical Requirements. A crucial enabler for an infectious
444 disease to become operationally significant, which differentiates it from other
445 infectious diseases, is its characteristics. Characteristics more likely to be
446 found in operationally significant diseases include: moderate/high
447 pathogenicity /virulence, effective route(s) of transmission (airborne,
448 waterborne/food-borne, vector-borne), effective reservoirs (e.g., animal, human,
449 vector in which the pathogen lives and allows for transmission directly
450 /indirectly), environmentally robust (long survival outside of a host), long

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451 shedding and contagious period (favors transmission), and adaptability and
452 resistance to treatment/ countermeasures.

453

454 (c) Critical Vulnerabilities. The infectious disease is susceptible to
455 pharmaceutical interventions that can immunologically and/ or
456 prophylactically protect a host pre-exposure and/ or mitigate the effects of the
457 disease post exposure. The disease is susceptible to non-pharmaceutical
458 intervention measures such as disinfection, social distancing, hygiene
459 practices, vector control, culling, and personal protective equipment (PPE) ,
460 which can hinder its ability to spread.

461

462 (2) National Strategic Threats. An operationally significant disease
463 has serious national security implications for the United States. These
464 national security implications may include severe economic, political, and
465 social consequences both domestically and internationally. There will be
466 competing interests for resources globally. Competition for, and scarcity of
467 resources will include MCM (e.g. vaccines, antimicrobials, and antibody
468 preparations), non-pharmaceutical MCM (e.g. ventilators, devices, personal
469 protective equipment such as face masks and gloves), medical equipment, and
470 logistical support. This will have a significant impact on the availability of the
471 global workforce.

472

473 (a) While adversaries will also be susceptible, they may not be
474 impacted in the same manner or at the same time as US and allied forces. The
475 degree to which nations mitigate their own welfare and reintegrate individuals
476 into society will have a considerable impact on those secondary and tertiary
477 effects that pose potential problems to regional security. Key security
478 concerns that could arise from the political, social, and economic instabilities
479 include opportunistic aggression, opportunities for violent extremists to acquire
480 weapons of mass destruction (WMD), reduced partner capacity during and after
481 an outbreak, instability resulting from a humanitarian disaster, and decreased
482 distribution and production of essential commodities.

483

484 (b) The prevalence of significant disease coupled with instability
485 may result in reduced security capabilities, providing an opportunity for
486 international military conflict, increased terrorist activity, internal unrest,
487 political and/or economic collapse, humanitarian crises, and social change.

488

489 (3) Environmental Threats. A disease of operational significance may
490 impact USNORTHCOM's operating environment for up to 24 months. Impacts
491 may include reduced access and Freedom of Maneuver (domestically and
492 internationally) and reduced support from United States Government
493 (USG)/Private Sector/other nations.

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495 (4) Accidents/Misuse. The on-going evolution in life sciences
496 presents an inherent risk of misuse (or accidental release) of agents that have
497 similar characteristics as a naturally occurring PI&ID.
498

499 (5) Biological Hazard Binning Concept (BHBC). Currently, the DOD
500 and other US government agencies address biological hazards to the US and
501 global population based on individual biological hazards or diseases. This
502 approach requires planning, training, FHP guidance, and PPE to be focused on
503 individual biological hazards. To facilitate this approach for guidance and
504 planning purposes, USNORTHCOM groups biological hazards that will better
505 streamline and synchronize FHP and, possibly treatment to optimize DOD
506 asseets (personnel, capabilities, facilities, PPE, etc). Grouping biological
507 hazards within "bins" based on exposure / transmission routes and other
508 factors (availability of MCM/treatments, vaccines, etc) allows for a more
509 simplified planning and response approach, a more streamlined training
510 doctrine, more effective FHP guidance, and appropriate PPE recommendations.
511 Additionally, addressing biological hazards utilizing a BHBC approach would
512 be consistent with the current planning, training, and PPE approach for
513 chemical hazards CBRNE training models (i.e., MOPP levels).
514

515 (a) Framework. BHBC is broken into three main categories:
516 Contagious, Non-Contagious, and Plant/Animal. Under Contagious, there are 3
517 sub-categories: Contact, Respiratory, and Ingested. Under Non-Contagious,
518 there are 4 sub-categories: Contact, Respiratory, Ingested, and Vector Borne
519 (Table 1). See Table 2 for examples of disease categorized under BHBC.
520

521 1. The Contagious category contains biological hazards that
522 have sustainable person to person transmission.
523

524 2. The Non-contagious category contains biological hazards
525 where transmission is not sustainable from person to person.
526

527 3. The Plant/Animal category is for non-human diseases of
528 operational significance (e.g., may hinder mission assurance or result in a
529 request for DOD support to civil authorities).
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Biological Hazard Binning Concept (BHBC)			
Category	Contagious	Non-Contagious	Plant/Animal
Sub-Categories	Contact	Contact	
	Respiratory	Respiratory	
	Ingested	Ingested	
		Vector Borne	

Table 1, Biological Hazard Binning Concept

531
532

	Non-Contagious				Contagious			Others
Routes of Entry	Contact	Respiratory	Ingested	Vector Borne	Contact	Respiratory	Ingested	Plant/Animal
Diseases	Poison Ivy	<u>Legionellosis</u>	Bacillus Ricin	Zika Dengue Malaria	Viral Hemorrhagic Fever	Novel Influenza SARS/ MERS-COV	Salmonella E. Coli <u>Shigella</u>	Avian Influenza Foot/Mouth (FMD)
	Anthrax							
	<u>Glanders</u>							

Table 2, Examples. Note: It is possible for a biological hazard to be in more than one sub-category if there is more than one route of transmission/exposure. (i.e. Anthrax, Glanders, etc.)

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(b) Planning. BHBC will simplify planning needs by reducing the number of plans necessary to respond to different biological hazards. Importantly, planning based on the BHBC will cover emerging biological hazards. BHBC based plans should be able to provide the contextual backdrop to discussions with senior leaders about force response capabilities and force health protection protocols.

(c) FHP. BHBC allows for the development of a more streamlined CONOPS focused on several bins and response to the route of transmission vice countless specific individual biological hazards. Simplified training bins would allow for better retention and sustainability of training. Through better recall of the necessary steps for FHP and a decrease in potential confusion between specific responses for individual biological hazards, frontline units will be better prepared to respond in a bio-challenged environment, even if the exact biohazard is not immediately known. Specifics to a particular disease, when available, will help refine FHP.

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(d) PPE Framework (Appendix XX). BHBC, due to its nature of grouping biological hazards, provides a concept of response that can be standardized based on route of transmission of the biological hazard. The standardization afforded to the BHBC is ideal for the development of standardized PPE logistical packages that could be tiered based on the bin. This standardized PPE logistical packaging will reduce confusion, ordering errors, and unnecessary redundancy while at the same time improving efficiency of ordering, storage, movement and utilization. Utilizing BHBC would provide a tiered approach to PPE similar to MOPP levels for other portions of CBRNE training and familiarization.

j. Friendly. This branch plan, as part of CONPLAN 3500, provides concepts of operation for support to and coordination with the spectrum of potential response partners including Federal, State, local, tribal, territorial, and private sector entities. Several key organizations are listed below. A more comprehensive list is found under Appendix 4 to Annex A.

(1) Friendly Centers of Gravity.

(a) Strategic. USNORTHCOM's COG is its people (active duty, reserve, DOD civilians, DOD contractors, dependents, and beneficiaries). A significant global outbreak will degrade USNORTHCOM's ability to conduct assigned missions in the AOR and potentially cause absenteeism among its personnel within and outside the AOR. Infectious diseases in the military cause lost duty time; increase the burden to the health care system for diagnosis, treatment, and evacuation, and decrease combat readiness.

1. Critical Capability. The CCDR and other decision makers (both military and civilian) must have accurate and timely awareness of the situation across the area of interest (AOI) in order to prepare for and respond to operationally significant outbreaks. Crucial strategic enablers that sustain USNORTHCOM operations in before, during and after an outbreak: informed FHP policy decisions, biosurveillance, interagency global surveillance program coordination, laboratory confirmatory analysis, medical intelligence and reporting requirements (shared situational awareness (SA)); medical capabilities; stockpile of medical supplies; establishment/ identification of infrastructure to evaluate and treat infected persons; and authority to vaccinate and isolate/ quarantine select personnel.

2. Critical Requirement.

a. Global Surveillance Efforts. The World Health Organization (WHO) leads the international effort to detect, identify, and track the spread of pandemic influenza. Their Epidemic and Pandemic Alert and

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599 Response System (EPR) tie together multiple national and international
600 capabilities, to include: the Global Outbreak Alert and Response Network
601 (GOARN); the WHO's Global Influenza Surveillance and Response System
602 (GISRS); and the U.S. Centers for Disease Control and Prevention (CDC) and
603 the Department of Homeland Security's (DHS) National Biosurveillance
604 Integration Center (NBIC).

605
606 b. DOD Surveillance Efforts. DOD sponsored
607 surveillance efforts will be performed by numerous organizations including the
608 DOD Global Emerging Infections Surveillance and Response System (DOD-
609 GEIS), the Services' Public Health Centers, and the Naval Health Research
610 Center (NHRC), as well as each DOD medical facility including shipboard
611 medical facilities.

612
613 c. Pandemic Threat Surveillance and Intelligence
614 Network. To be most effective, information and situational awareness must be
615 shared across USG agencies and with international partners. NCMI, the Armed
616 Forces Health Surveillance Branch (AFHSB), and other agencies are tasked
617 with maintaining a network that collects, analyzes, and disseminates
618 surveillance and intelligence information on outbreaks/ epidemics/ pandemics,
619 the effects on populations and nations, and the actions being taken to prepare
620 for and prevent, contain, respond to and recover from those effects. This
621 network must work with other DOD and non-DOD organizations to better
622 define and improve upon the current process for PI&ID surveillance.

623
624 3. Critical Vulnerabilities. Lack of communication and
625 synchronization among partners and stakeholders, inability or unwillingness to
626 share information/biosurveillance data, limited detection capabilities, and
627 limited laboratory confirmatory testing. Military forces will be
628 vaccinated/treated as soon as specific vaccine/pharmaceutical MCM becomes
629 available.

630
631 (b) Operational. The ability to provide military support to USG
632 domestic and international relief efforts in the AOR.

633
634 1. Critical Capability. Collaboration and communication
635 amongst stakeholders, synchronized plans, constant policy updates to FHP
636 measures, adherence of partner nations, the interagency and the DOD, to
637 abide by IHR reporting requirements, shared real-time intelligence and SA,
638 mandatory preventive care measures (including vaccinations), funding and
639 access to MCM, personal hygiene educational campaigns, access to surge
640 medical equipment, and PPE.

641
642 a. DOD readiness reporting. DOD global mission
643 accomplishment requires organizations to provide timely reporting using

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644 existing systems (e.g., Defense Readiness Reporting System (DRRS)) that
645 outline an accurate and timely assessment of the required forces to conduct
646 missions and sustain DoD mission assurance.

647

648 b. DoD transportation. DoD global mission
649 accomplishment requires the transportation infrastructure, both military and
650 civilian to support movement of forces, resources and other assets in response
651 to changes in priority despite systemic disruptions associated with an
652 operationally significant disease outbreak environment.

653

654 c. Projection of forces. DoD global mission
655 accomplishment requires the ability to properly position the requisite forces
656 with the required numbers, skills, and materiel support within an appropriate
657 C2 structure.

658

659 2. Critical Requirement.

660

661 a. Medical Threat Intelligence. USNORTHCOM must
662 closely coordinate medical threat intelligence with the interagency (DHS NBIC,
663 CDC, ect), U.S. Embassies and partner nations. Intelligence concerning PI&ID
664 will involve information on locations and severity of outbreaks as well as
665 actions being conducted by nations and organizations concerning PI&ID
666 prevention and containment procedures. N-NC Medical Operations Center and
667 the N-NC/J2 in collaboration with the NCMI, AFHSB, HHS/CDC, and DHS
668 NBIC will be a key provider of both classified and unclassified medical
669 intelligence to CDRUSNORTHCOM and to other designated USNORTHCOM
670 subordinate organizations.

671

672 b. Medical Surveillance. Detection and surveillance of
673 PI&ID is critical in determining mutations of the disease, its human-to-human
674 transmissibility, geographic spread of the disease, and the impacts that it will
675 have on affected populations. The front line surveillance source for early
676 indications of virus mutation and human-to-human transmission will be local
677 and international medical organizations or laboratories with operations in the
678 affected nations and USG organizations like CDC, NCMI, AFHSB, and DHS
679 NBIC. A USNORTHCOM Biological Threat Working Group composed of key
680 reps from the N-NC/SG, J2, J5, S&T and the N/J3 must ensure it is closely
681 tied to these front line resources as well as supporting organizations that will
682 perform some of the more in-depth analysis and tracking of disease strains to
683 make critical recommendations to the N2C2 and CDRUSNORTHCOM.

684

685 c. Trained, organized, and equipped units. Mission
686 accomplishment requires the ability of units to retain the requisite number of
687 trained personnel with adequate equipment and key classes of supply and/or
688 adequate and responsive logistical support to execute assigned.

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d. Ability to prevent, inhibit or reduce disease agent transmission, mitigate effects of infection and illness, and regenerate and sustain the force. This includes comprehensive medical health care; force health protection (FHP) measures; proactive procurement; responsive, tailored logistic support; continuity of essential services (e.g., electricity, water, telecommunications, etc.); risk communication and public health education, implementation of non-pharmaceutical interventions, and continuity of operations planning.

3. Critical Vulnerability.

a. Deficiencies and vulnerabilities that threaten the friendly operational COG include: lack of USG-PN communication and synchronization among NGO and OGAs and stakeholders, lack of safe and effective vaccines and other MCM, lack of adequate infrastructure, medical equipment and hospital surge capacity, or PPE; inability or unwillingness to share information/biosurveillance data, limited detection capabilities, and limited laboratory confirmatory testing. Additionally, US personnel travel frequently and may become exposed to or transmit disease during the process of travel. Overreliance on rapid-testing kits due to limited laboratory capacity (rapid tests lack the accuracy of laboratory confirmation) may cause errors in disease reporting incidence and diagnostic results accurately. Medical systems may be overwhelmed by a dramatic increase in patient numbers. Staff availability may also be limited as medical personnel become infected.

b. Nefarious elements looking to exploit the unstable environment created by an operationally significant outbreak may adversely impact personnel and/ or operations.

c. Degradation of unit readiness to non-mission capable status due to disease impacts could be caused by the lack of effective vaccines, antibiotics, antivirals, education, and planning.

(2) USNORTHCOM, Components, and Subordinate Units. See Appendix 4 (Friendly Forces) to Annex A (Task Organization). All USNORTHCOM components and subordinate units are subject to participate in PI&ID response operations.

(3) Supporting Commands and Agencies/Departments. See Appendix 4 (Friendly Forces) to Annex A (Task Organization).

(4) Key Interagency Partners. See Appendix 4 to Annex A (Task Organization) for a detailed listing and description. The critical mission partners for PI&ID response are DHHS, CDC, USDA, and FEMA. State and

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734 local governmental public health agencies have primary responsibility and
 735 authority for public health response to biological incidents within their
 736 jurisdictions and can implement quarantine and movement restrictions that
 737 can vary from federal guidance issued by the Centers for Disease Control and
 738 Prevention (CDC).
 739

Incident Type, Location	Lead Federal Authority
Response and Recovery (Consequence management for Human disease): a) Naturally occurring, domestic b) Intentional, domestic c) Naturally occurring, international* d) Intentional, international*	a) HHS b) HHS c) DOS d) DOS
Prevention and Protection (Crisis management): e) Domestic or foreign origin	e) FBI
Note: DHS/FEMA may be called upon to lead or provide supplemental operational coordination support for the primary authority during complex incidents.	

740
 741
 742 1. Department of Health and Human Services (HHS).
 743 HHS is the U.S. Government’s (USG) principal agency for protecting the health
 744 of all Americans. The mission of HHS is to enhance the health and well-being of
 745 Americans by providing for effective health and human services and by
 746 fostering sound, sustained advances in the sciences underlying medicine,
 747 public health, and social services. HHS Declaration of Public Health Emergency
 748 Section 319 of the Public Health Services Act (PHSA) authorizes the Secretary
 749 of HHS to determine that a PHE exists, if the Secretary determines a disease or
 750 disorder presents a PHE or that a PHE, including significant outbreaks of
 751 infectious diseases or bioterrorist attacks, otherwise exists. This declaration
 752 authorizes the Secretary to take appropriate actions consistent with other
 753 authorities to respond to the emergency, temporarily suspend or modify certain
 754 legal requirements, and expend available funds in the PHE Fund to respond to
 755 the PHE. The Secretary has broad authorities to respond to a public health
 756 emergency, regardless of whether a formal PHE is declared.

757
 758 2. U. S. Centers for Disease Control and Prevention
 759 (CDC). The CDC is an operational component of HHS that is responsible for
 760 the nation’s health protection. The CDC’s administration, scientists, and staff
 761 track diseases, research outbreaks, and respond to emergencies to protect the
 762 nation from health, safety, and security threats, both foreign and in the U.S.

763
 764 3. Food and Drug Administration (FDA). The Food and
 765 Drug Administration (FDA) is an agency within the U.S. Department of Health
 766 and Human Services responsible for protecting the public health by assuring
 767 the safety, effectiveness, quality, and security of human and veterinary drugs,

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768 vaccines and other biological products, and medical devices. The FDA is also
769 responsible for the safety and security of most of our nation's food supply.
770

771 a. FDA Emergency Use Authorization (EUA)
772 authority allows FDA to help strengthen the nation's public health protections
773 against CBRN threats by facilitating the availability and use of MCMs needed
774 during public health emergencies.

775 b. Under section 564 of the Federal Food, Drug,
776 and Cosmetic Act (FD&C Act), the FDA Commissioner may allow unapproved
777 medical products or unapproved uses of approved medical products to be used
778 in an emergency to diagnose, treat, or prevent serious or life-threatening
779 diseases or conditions caused by CBRN threat agents when there are no
780 adequate, approved, and available alternatives.
781

782 4. Department of Homeland Security. The Secretary of
783 DHS is the principal federal official for domestic incident management. The
784 Secretary is responsible for coordinating federal operations within the United
785 States to prepare for, respond to, and recover from terrorist attacks, major
786 disasters, and other emergencies, including biological incidents. DHS provides
787 biosurveillance capabilities to detect an intentional aerosolized biological agent
788 dispersion and to coordinate information sharing with federal partners on
789 health-related threats to humans, animals, and plants. If an incident response
790 progresses such that it requires multiagency participation, DHS will serve as
791 the Incident Coordinator.
792

793 5. Federal Emergency Management Agency (FEMA).
794 FEMA is an operational component of DHS that coordinates ESFs/RSFs) and
795 funding support to impacted areas during disasters. For biological incidents,
796 FEMA primarily manages coordinating centers, funding sources, non-medical
797 supply resourcing, and supporting ESFs/RSFs.
798

799 6. United States Department of Agriculture (USDA).
800 USDA serves as the USG's primary agency for the security and resilience in the
801 commercial production of food and consequence management of outbreaks
802 and/or attacks that may occur in animals used in the commercial production
803 of food. The USDA, HHS, DHS, and the FBI collaborate through surveillance
804 systems with states and private industries to protect the nation's food supply
805 from terrorist threats and to prepare for and respond to catastrophic disasters.
806

807 7. Customs and Border Protection (CBP). For biological
808 incidents suspected or detected inside or at U.S. borders or those individuals
809 that may travel to the United States from abroad, CBP may detain and/or
810 quarantine individuals until medical authorities have been alerted. CBP may
811 deny entry to non-U.S. citizens who are suspected of being infected with a
812 contagious disease.

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8. Department of State (DOS). As lead coordinating agency for USG response to foreign nation and/or U.S Chief of Mission (COM) requests for support, DOS is responsible for all communication and coordination between the USG and other nations regarding consequence management of a biological incident. DOS coordinates the U.S. support for foreign countries in mitigation, preparedness, and response operations to a biological incident that has the potential to adversely impact the United States or U.S. interests. Additionally, when necessary DOS coordinates requests to foreign countries for support of U.S. citizens located outside of the United States, requesting support from foreign nations where necessary. As the President's representative in a foreign country, the COM is responsible for the security of all USG personnel and their families on official duty abroad and the protection of private U.S. citizens. The COM is supported in security, health, and crisis planning and risk management by consular, diplomatic security, medical, and public affairs professionals and other subject matter experts on the Emergency Action Committee. Through the Emergency Action Plan, DOS and the U.S. Mission maintain formal processes for crisis management and coordination at U.S. diplomatic posts for incidents that affect the Mission or the host country, including biological incidents.

9. World Health Organization (WHO). World Health Organization can declare a Public Health Emergency of International Concern (PHEIC). A PHEIC is defined by the International Health Regulation (2005) as any extraordinary public health event, whether biological, chemical, or radiological that constitutes a public health risk to other countries through its international spread and impact and potential to require a coordinated international response. All countries notify potential PHEICs that they are aware of to the WHO through their IHR National Focal Points; however, only the Director-General of the WHO can determine whether an event constitutes an actual PHEIC. In accordance with IHR the United States would have 48 hours to assess and determine whether a potential PHEIC notification should be sent to the WHO. If the severity or impact of the biological incident poses a significant threat (through international spread) or may require a coordinated international response to contain, the Director-General of the WHO may declare the event a PHEIC.

(5) Operational Contract Support. See Annex W.

(6) Multinational Forces. It can be reasonably anticipated that a variety of organizations will either agree to or offer to participate in outbreak response operations. USNORTHCOM forces supporting this plan should be prepared to consider information sharing and coordination in a time sensitive environment.

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858 k. Assumptions.

859

860 (1) Full information about biological threats will not be immediately
861 available and will take hours to days (pathogen identification), days to weeks
862 (exposure areas/populations), or months (outbreak and secondary outbreak
863 rates; lethality; susceptibility to countermeasures) to become known or
864 apparent; Decisions will be required with incomplete information.

865

866 (2) The cause of a biological incident (e.g., intentional, accidental, or
867 naturally occurring) may not be readily apparent; the possibility the incident
868 was caused by a criminal act will be considered in the response.

869

870 (3) An infectious disease incident will include a wave of secondary
871 infections well beyond the region of the incident.

872

873 (4) The size, scope, and/or complexity of an outbreak may overwhelm
874 existing state and local capabilities and resources, causing significant strain on
875 the whole community/USG.

876

877 (5) There is potential for pathogens to be resistant to existing MCM or
878 for there to be no known MCM. As such, a vaccine or other MCM will not be
879 available for distribution for a minimum of 6-9 month period once the disease
880 is characterized and identified.

881

882 (6) Available, but limited MCM may fall short of the required demand
883 due to a variety of factors (e.g., geographical variance in the severity of the
884 outbreak, logistical issues, disruption to pharmaceutical production).

885

886 (7) Unique and unapproved or experimental therapies and diagnostic
887 tests may need to be used after appropriate regulatory approval (e.g., Food and
888 Drug Administration (FDA) Emergency Use Authorization (EUA)).

889

890 (8) The recall or activation of non-Active Duty personnel who work as
891 first responders and medical specialists in their civilian employment could be
892 counterproductive to a PI&ID response and may not be in the best interest of
893 USNORTHCOM or the nation.

894

895 (9) USNORTHCOM will have some warning of PI&ID (disease of
896 operational significance) before significant impacts occur and be able to
897 conduct mitigating measures.

898

899 (10) Stockpiled MCM will not be immediately sufficient or entirely
900 effective.

901

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902 (11) The Department of State's (DOS) remain/shelter-in-place policy
903 will be followed unless other conditions (e.g., civil disturbance or political
904 instability) force an evacuation. If a remain/shelter-in-place policy is not
905 feasible, USNORTHCOM may be called upon to assist in the transportation of
906 designated non-infected American citizens living abroad if deemed necessary.
907

908 (12) Medical facilities and resources (civilian and military) will be
909 overwhelmed during peak periods of outbreak.
910

911 (13) USNORTHCOM, under applicable authorities, will be requested to
912 provide some logistical support for international efforts.
913

914 (14) An outbreak will last between 6-12 weeks in one location with
915 waves following for a period of 12-24 months.
916

917 (15) Countries with degraded medical capability will likely experience
918 decreased stability and security.
919

920 (16) Due to the highly infectious nature of influenza and/ or infectious
921 disease, efforts at containment will be only partially effective at preventing
922 infection, but may reduce the speed of disease spread.
923

924 (17) Some nations will restrict transit of personnel.
925

926 (18) Implementation of COOP planning and COG activities is
927 anticipated depending on the pathogen's impact on the workforce. Prioritization
928 of capabilities will be necessary to balance competing missions and maximize
929 efficiency. Depending on the nature of the disease, absenteeism could be 20-
930 30% (or higher). This will stress primary military functions and missions and
931 also critical civilian functions, which may require DOD support.
932

933 (19) Local commercial support (including commodities, services and
934 contracted labor) to U.S. Forces within the AOR (Enduring Locations,
935 Contingency Locations, etc.) will be degraded.
936

937 (20) Freedom of movement and freedom of action will be impacted due
938 to localized restrictions undertaken to prevent further spread.
939

940 1. Limitations. See Base plan.
941

942 (1) Title 10 Army and Air Force military personnel shall not be employed
943 to enforce or execute civil laws as stated in Title 18, Section 1385 (Posse
944 Comitatus Act), (reference x), except as otherwise provided by law.
945

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946 (2) National Guard will normally respond in Title 32 or State Active
947 Duty status. Consideration should be given to using a Dual Status Commander
948 (Title 32 and Title 10 authority, see xxxx).

949 (3) Reserve Component mobilization authority, personnel, and time
950 limitations are defined in Title 10, United States Code (USC.) 12301, 12302,
951 1203, and 12304 and normally require 30 day notification for mobilizations
952 greater than 30 days. (reference x *Title 10, United States Code (USC), Sections*
953 *12301-12304, 12306, Statutes Affecting Reserve Components*)

954 (4) DOD forces/installations in the JOA will also be affected by the
955 natural or man-made disaster, decreasing response capabilities.

956
957 m. Legal Considerations. See Base plan.

958
959 (1) The Federal Government has legal authority to prioritize
960 distribution of vaccines and anti-virals (see ref. x, Title 42, USC, Sections 201
961 et seq., Public Health Services, Sections 264 et seq., Quarantines and
962 Inspections, and Sections 5121 et. seq., Robert T. Stafford Disaster Relief and
963 Emergency Assistance Act (as amended, April 2007).).

964
965 (2) State and local governments have the primary authority to
966 impose medical screening, restrictions on movement and assembly, isolation
967 and/or quarantine restrictions within their political jurisdictions. The Federal
968 Government's authority to impose restrictions on movement and assembly of
969 persons and to issue isolation and/or quarantine restrictions, is normally
970 limited to those cases involving movement of persons into the territorial
971 boundaries of the United States and movement of persons between states.

972
973 (3) DODD 6200.04 FHP. This Directive establishes policy and
974 assigns responsibility for implementing FHP measures, on behalf of all military
975 Service members during active and Reserve military Service, encompassing the
976 full spectrum of missions, responsibilities, and actions of the DOD components
977 in establishing, sustaining, restoring, and improving the health of their forces.

978
979 (4) Domestic law handbook [information on quarantine]

980
981 (5) Management of biologically contaminated human remains (B-CHR)

982
983 2. Mission. CDRUSNORTHCOM protects the force against pandemic influenza
984 and operationally significant infectious disease outbreaks in order to execute
985 assigned missions. When directed, USNORTHCOM conducts response
986 operations within designated operational areas (OAs) to support civil
987 authorities in response to an outbreak in order to save lives and minimize
988 human suffering.

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989

990 3. Execution.

991

992 a. Concept of Operations. The purpose of USNORTHCOM's branch plan is
993 to delineate DOD and CDRUSNORTHCOM policy for the employment of military
994 resources in support of PI&ID preparation and response operations. It assigns
995 responsibilities for carrying out this policy within USNORTHCOM's AOR. This
996 guidance will enable USNORTHCOM and its subordinate commands to develop
997 plans to prepare for an operationally significant outbreak and to mitigate and
998 respond to the effects of the outbreak on USNORTHCOM forces, civilians,
999 contractors, dependents, and beneficiaries.

1000

1001 (1) Commander's Intent.

1002

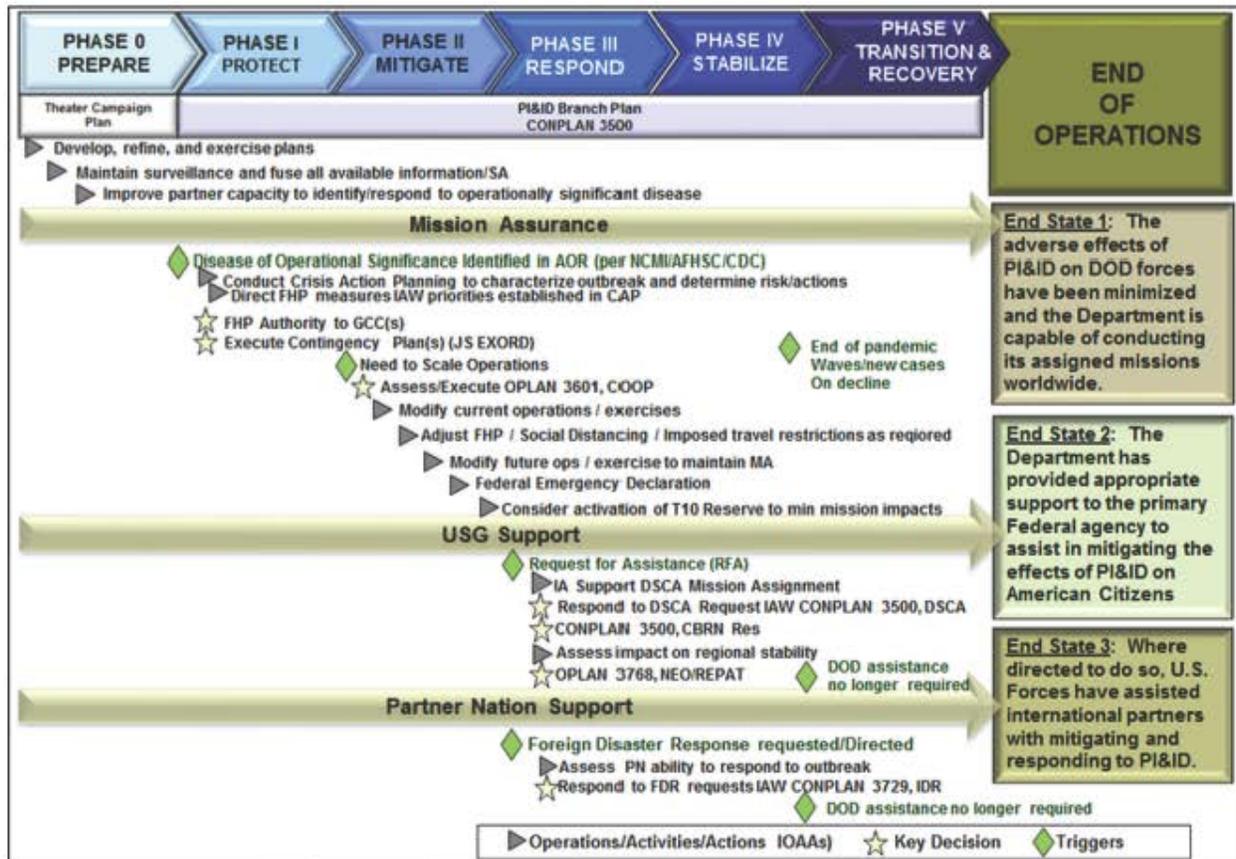
1003 (a) Purpose. To maintain mission assurance, mitigate the effects of
1004 the disease, and when requested, execute PI&ID related Defense Support of
1005 Civil Authorities (DSCA) and Foreign Disaster Response (FDR) operations in the
1006 USNORTHCOM Area of Responsibility (AOR).

1006

1007 (b) Method. USNORTHCOM's mission and end-state will be
1008 achieved in six phases through the execution of the operations, actions and
1009 activities (OAAs) listed below (see Figure 1). In general terms USNORTHCOM
1010 adopts an active, layered defense with respect to a disease of operational
1011 significance. Our first line of defense consists of Phase 0 – activities aimed at
1012 both the preparation and rehearsal of comprehensive and synchronized plans,
1013 and building internal and international capacity of partner nations and
1014 militaries in coordination with the International Health Community (IHC), and
1015 United States Government (USG) agencies. These activities will mitigate the
1016 risk associated with a significant outbreak and reduce the requirement for
1017 USNORTHCOM support. If an outbreak of operational significance does occur,
1018 USNORTHCOM Phase 1-5 actions balance CDRUSNORTHCOM's efforts
1019 between Mission Assurance, DSCA and FDR lines of effort. USNORTHCOM will
1020 rapidly implement appropriate Force Health Protection (FHP) measures and
1021 PI&ID related education to protect the force, and will posture to rapidly provide
1022 DSCA and FDR as required. Unless otherwise directed by Secretary of Defense
1023 (SecDef) or President of the United States (POTUS), Mission Assurance will take
1024 priority.

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1025

Figure 1, PI&ID Response Concept of Operations

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(c) End State. The adverse effects of PI&ID on USNORTHCOM forces have been minimized and USNORTHCOM is capable of conducting its assigned missions. USNORTHCOM has provided adequate support to civil authorities to assist in mitigating the effects of the outbreak, such that further DOD support is no longer required. See Figure 1.a., Objectives/Effects by Phase.

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Phases May Overlap

	PHASE 0 PREPARE	PHASE I PROTECT	PHASE II MITIGATE	PHASE III RESPOND	PHASE IV STABILIZE	PHASE V TRANSITION & RECOVERY
	Theater Campaign Plan	PI&D Branch Plan CONPLAN 3500				
Objectives and Desired Effects	<p>Obj 1: USNORTHCOM sustains mission assurance and the ability to accomplish assigned missions through timely implementation of appropriate Force Health protection measures is preserved.</p> <p>Obj 2: USNORTHCOM PI&D plans and executes activities in coordination with broader USG efforts to prepare for, detect, mitigate, respond to, and recover from the effects of a pandemic influenza or infectious disease outbreak.</p> <ul style="list-style-type: none"> • Maintains situational awareness • Update USNORTHCOM CONPLAN ICW relevant USG PI&D partners and international health organizations • Implement plans and preparedness activities across Command, interagency and PNs • Facilitated PNs PI&D plans, capabilities, and capacities through TSC and BPC • Implement routine FHP measures • Designate a Public Health Emergency Officer (PHEO) • USNORTHCOM has educated its population and conducted training on disease mitigation • Develop risk communication messages for future phases 	<p>Obj: Protect forces, DOD civilians, DOD contractors performing critical roles, dependents and beneficiaries, as well as the associated resources necessary to maintain readiness; work with the interagency and partner nations, to ensure DOD freedom of movement; coordinate communication strategies.</p> <ul style="list-style-type: none"> • Protect the force • Protect critical resource • Maintain shared situational awareness across the force • Coordinate with interagency and partner nations • Coordinate Strategic Communications • Implement additional FHP measures • Maintain freedom of movement 	<p>Obj: Protection of mission essential functions/mission assurance and the ability to achieve strategic objectives and to retain freedom of action</p> <ul style="list-style-type: none"> • Maintain ability to conduct mission essential functions • Maintain freedom of action • Maintain shared situational awareness • Coordinate with interagency and PNs • Coordinate Strategic Communications 	<p>Obj: Provide support to civil authorities and PNs as required. Continue to work with the interagency and partner nations, to ensure freedom of movement, and to coordinate communication strategies</p> <ul style="list-style-type: none"> • Prevent loss of life • Minimize human suffering • Maintain freedom of Movement • Sustain mission assurance • Coordinate with interagency and PN • Coordinate Strategic Communication • Sustain operations • Set conditions for transition to PN civil authorities (if Phase IV is not required) 	<p>OBJFOCUS Continue to provide support to civil authorities and scale operations for military and civil authorities as appropriate</p> <ul style="list-style-type: none"> • Lead Federal agency confirms appropriate military assistance levels provided • ICW lead Federal agency establish transition criteria • Mission assurance maintained • Coordinate with interagency and PN • Coordinate Strategic Communications • USG interest advanced 	<p>Obj: DOD forces have been relieved, and all forces have redeployed. DOD will redeploy remaining civil support response forces, reconstitute the force, and make any preparations required for follow on waves of the pandemic.</p> <ul style="list-style-type: none"> • USG and PN received support as requested • Transition all units back to parent commands • Maintain mission assurance • Coordinate with interagency and PNs • Coordinate Strategic Communications • Maintain international confidence in USG • Reconstitute USNORTHCOM forces • Prepare for subsequent waves of pandemic

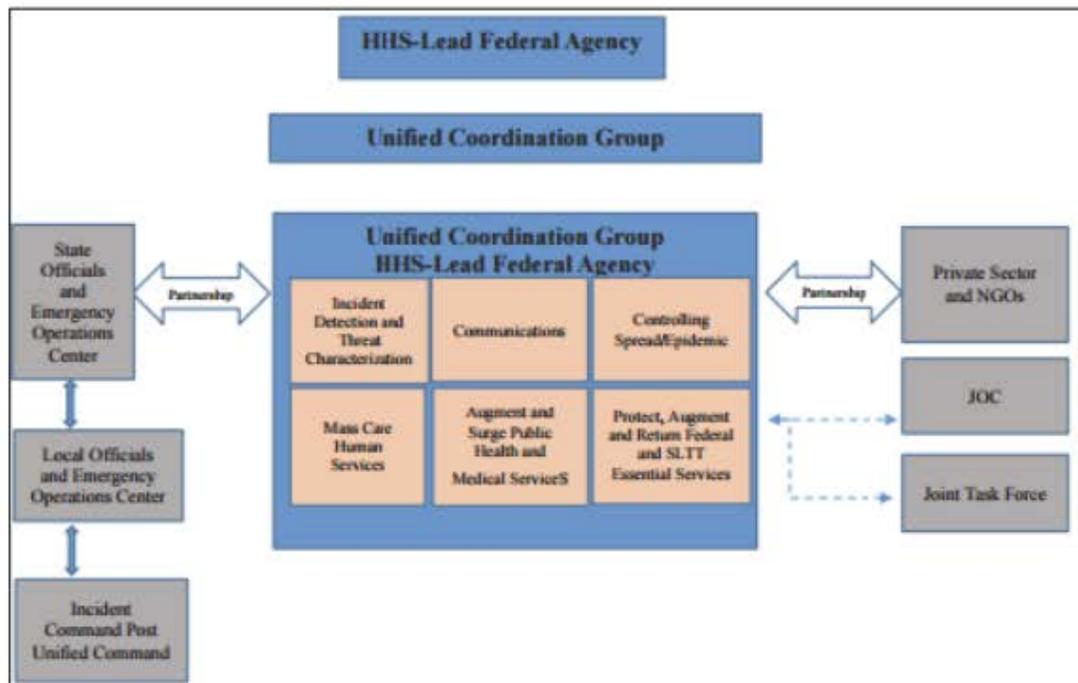
Figure 1.a., PI&D Response Objectives & Effects by Phase

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1037 (2) General. There are multiple ways in which an outbreak can unfold
 1038 depending on the nature and type of disease (respiratory, contact, etc) and its
 1039 location(s). As such, response will vary and therefore multiple USG response
 1040 plans exist (i.e., Biological Incident Annex (BIA) to the Response and Recovery
 1041 Federal Interagency Operational Plans (FIOP), Interagency Crisis Action Plan
 1042 for H7N9/MERS-CoV, etc). The USNORTHCOM response must be informed by,
 1043 and nested with these plans.

1044 (3) Unified Coordination. The purpose of unified coordination is to
 1045 integrate and synchronize the response and recovery activities of relevant
 1046 federal departments and agencies. Early and rapid unified coordination of
 1047 federal government resources is imperative at the outset of a biological incident
 1048 and can occur along a spectrum of activities. The LFA is responsible for
 1049 determining the relevant departments and agencies required for participation
 1050 in unified coordination and the level of unified coordination needed. This may
 1051 be required independent of any formal declarations. In the early stages of an
 1052 incident, unified coordination may be as simple as formalized communications
 1053 with minimal staffing between departments and agencies (e.g., weekly
 1054 meetings).

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Note: This figure represents a local level and may occur in those jurisdictions significantly affected by a large-scale biological incident. The UCG develops appropriate national-level response actions to such incidents while overseeing implementation of those response actions aimed ultimately at providing effective federal support to affected SLTT. The same operational areas/capabilities are identified, involving federal support to affected states/territories as well as private sector and to NGOs, but in addition, the UCG can maintain situational awareness of local incident command, JOCs, and/or joint task force functions. Given the wide variety of potential biologic scenarios, flexibility in implementation is critical.

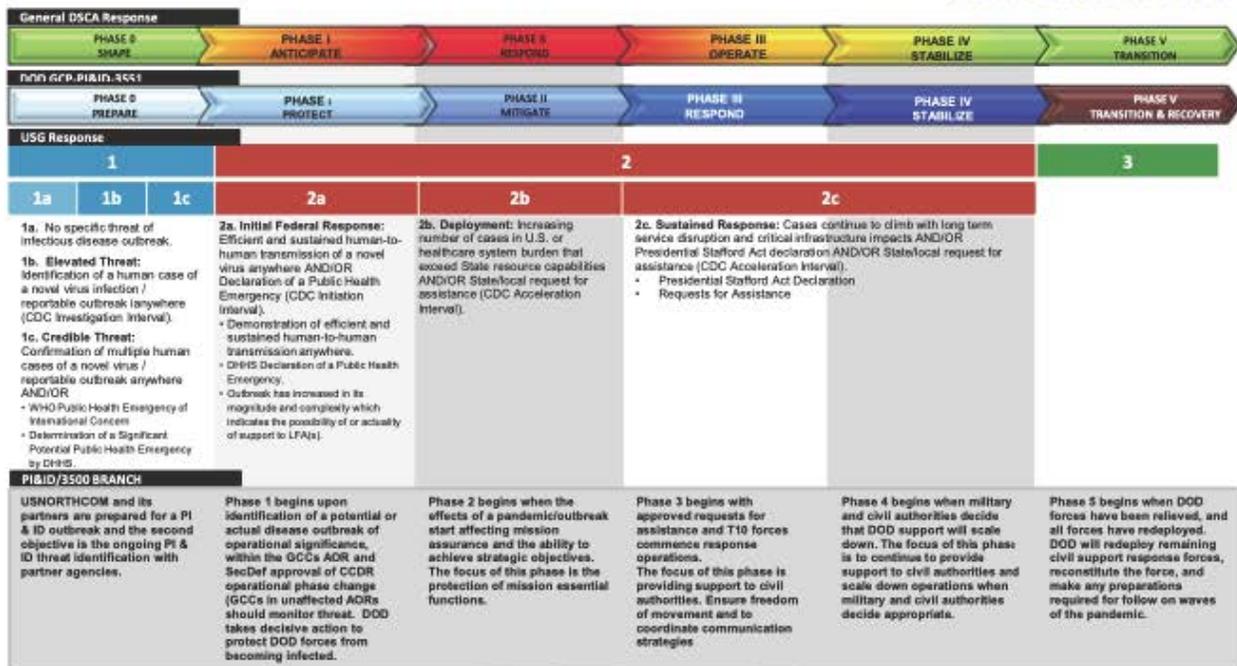
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(4) In general terms, the following figure depicts a crosswalk of related DoD and Interagency plans phasing:

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Phase Crosswalk



1067

1068 (5) USNORTHCOM Phasing. Phasing follows the DOD GCP-PI&ID and is
 1069 synchronous with CONPLAN 3500 and USG DSCA response phasing.
 1070 USNORTHCOM will accomplish this operation in six phases: Phase 0 – Prepare,
 1071 Phase 1 – Protect, Phase 2 – Mitigate, Phase 3 – Respond, Phase 4 – Stabilize
 1072 and Phase 5 – Transition & Recovery.

1073 (a) Phase 0 – Prepare (Steady State).

1074 1. Commander’s Intent. USNORTHCOM is prepared for
 1075 continued operations in the event of an operationally significant outbreak at
 1076 local, regional, or throughout the AOR. USNORTHCOM integrates planning
 1077 efforts with the interagency and PNs. The priority of effort is engaging
 1078 partners, medical intelligence/biosurveillance situational awareness, and
 1079 development/synchronization of strategic communication. Secondary efforts
 1080 are focused on plan development, synchronization, COOP planning, and
 1081 promulgation of information to educate the USNORTHCOM community on PI &
 1082 ID.

1083 2. Timing. This phase is ongoing.

1084 3. Objectives and Effects. The first objective is
 1085 USNORTHCOM and its partners are prepared for a PI & ID outbreak and the
 1086 second objective is the ongoing PI & ID threat identification with partner
 1087 agencies. Desired effects are: DOD, USNORTHCOM, interagency, state, tribal,

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1088 local, and international partners synchronize planning, response, and
1089 communications; USNORTHCOM, interagency, state, tribal, local, and
1090 international partners mitigate spread of virus.

1091 4. Risk.

1092 a. Lack of awareness will most likely result in a larger
1093 percentage of the population (including USNORTHCOM personnel) being
1094 exposed to, and potentially infected by a pathogen. Due to the delay in
1095 implementation of containment and mitigation measures (FHP), a degradation
1096 in the civil and defense sectors' ability to sustain essential functions may
1097 ensue.

1098 b. Any lack of partner nation capacity/ capability
1099 could degrade its ability to detect and respond to an outbreak and increase the
1100 likelihood of a foreign assistance requirement; possibly including
1101 USNORTHCOM support.

1102 c. Lack of integrated planning with the interagency
1103 community will negatively impact the timeliness and effectiveness of the
1104 USNORTHCOM response.

1105 5. Execution. Activities and operations executed during this
1106 phase are considered Steady-State Operations and will be executed as part of
1107 USNORTHCOM's TCP and are supported by subordinate Service Components
1108 and Selected Defense Agencies. These activities will continue through all
1109 phases. Phase 0 ends when a potential or actual disease of operational
1110 significance has been identified (assessed by NCMI and/or CDC and/or AFHS
1111 as posing a high risk to the US and/or DOD population) in the AOR that
1112 triggers SECDEF approval to change phases, receipt of an approved DOD MA,
1113 and/or JCS EXORD ordering execution of this branch plan.

1114 (b) Phase 1 – Protect.

1115 1. Commander's Intent. USNORTHCOM sustains mission
1116 assurance through timely implementation of appropriate FP and FHP measures
1117 (both pharmaceutical and non-pharmaceutical, education and training) to
1118 protect personnel and maintain the associated resources necessary to ensure
1119 readiness. USNORTHCOM works with the interagency and partner nations to
1120 ensure DOD freedom of movement and coordinate communication strategies.

1121 2. Timing. Phase 1 begins upon determination that a
1122 potential or actual disease of operational significance has been identified
1123 (assessed by NCMI and/or CDC and/or AFHS as posing a high risk to the US
1124 and/or DOD population) in the AOR and triggers SECDEF approval of
1125 CDRUSNORTHCOM's decision to transition from Phase 0 to Phase 1 (GCCs in

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1129 unaffected AORs will monitor situation and transition when deemed
1130 appropriate), or upon receipt of an approved DOD MA, and/or JCS EXORD
1131 ordering execution of this branch plan. This phase ends when the effect of the
1132 disease begins to impact mission assurance and the ability to achieve essential
1133 functions, mission, or strategic objectives (transition to Phase II), or the
1134 outbreak (infection rate) is on the decline and no additional risk is expected
1135 (transition to Phase 5).

1136 3. Objectives and Effects. The objective for this phase is the
1137 protection of U.S. forces, DOD civilians, DOD contractors, dependents and
1138 beneficiaries, as well as the associated resources necessary to maintain
1139 readiness, and to work with the interagency and partner nations to maintain
1140 DOD freedom of action to conduct assigned missions within the AOR. The
1141 priority of effort is engaging partners, medical intelligence/biosurveillance
1142 situational awareness, and development/synchronization of strategic
1143 communication. Secondary efforts are focused on plan development,
1144 synchronization, COOP planning, and promulgation of information to educate
1145 the USNORTHCOM community on PI & ID. USNORTHCOM is postured to take
1146 more significant actions should the impact of the Disease of Operational
1147 Significance further increase.

1148 4. Risk.

1149 a. Significant absenteeism of USNORTHCOM
1150 personnel, whether due to illness, fear, or primary care giver requirements, will
1151 degrade operations.

1152 b. Divergent strategic communication will lead to
1153 confusion and loss of confidence in USG/DOD.

1154 c. Lack of awareness may lead to incorrect application
1155 of resources/capabilities (medical-counter-measures, surge medical capability,
1156 etc.)
1157
1158
1159

1160 5. Execution. Actions taken in this phase include:
1161 maintaining situational awareness; modifying current operations/exercises and
1162 implementing Force Protection (FP) conditions and Force Health Protection
1163 (FHP) measures IAW crisis action planning (CAP) (FOC/Threat Assessment
1164 Group Recommendations/OPT Planning); influencing implementation of
1165 common FHP measures through service/component Surgeons (vaccination,
1166 social distancing, increased hygiene protocols etc) based on USNORTHCOM
1167 priorities determined through CAP until GCC FHP authority is granted to
1168 CDRUSNORTHCOM for the AOR; implementing focused education regime for
1169 personnel with supporting info messages to families; reviewing, rehearsing, and
1170 executing containment strategies (social distancing, isolation, travel

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1171 restrictions) found in HOI 10-170 and COOP Plans; prepositioning key
 1172 supplies, and preparation for implementation of appropriate restrictions. CDR
 1173 USNORTHCOM will request PI&ID FHP authority from JS for all DOD elements
 1174 and personnel within the AOR (per DODD 6400.02, CCDRs have overall
 1175 responsibility for FHP for forces assigned or attached to their command).
 1176 Success in this phase is defined as keeping forces intact and maintaining
 1177 mission assurance. See Figure 2.
 1178
 1179

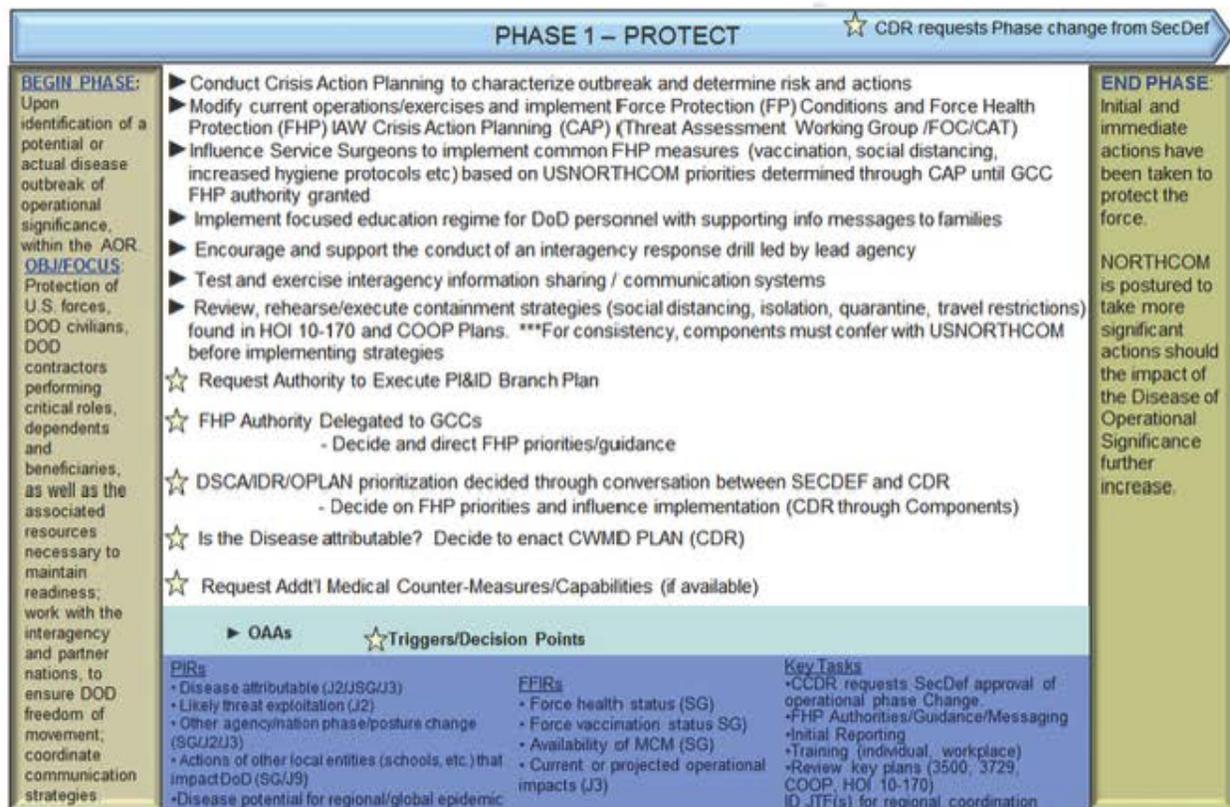


Figure 2, PI&ID Response Phase 1 - Protect

1183 (c) Phase 2 – Mitigate.

1184 1. Commander's Intent. The Command will support USG
 1185 efforts in responding to effects of disease geographically. Priority of effort is on
 1186 preparations to ensure freedom of action to conduct assigned missions in the
 1187 face of an impending operationally significant disease event. Secondary effort
 1188 is coordination with stakeholders IOT maintain situational awareness and
 1189 ensure appropriate contracts, requirements, and agreements are in place.
 1190 USNORTHCOM is postured to maintain mission assurance.

1191 2. Timing. This phase begins when the effects of an
 1192 outbreak start affecting mission assurance / ability to achieve essential

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1193 functions and/or strategic objectives. This phase ends when significant
1194 protective and mitigating actions have been taken and USNORTHCOM remains
1195 postured to maintain mission assurance, conduct HD, and respond to USG
1196 requests for support. USNORTHCOM, upon receipt of an approved request for
1197 assistance will either transition to Phase III or if the infection rate is on the
1198 decline and no further pandemic waves are expected will transition to Phase 5.

1199 3. Objectives and Effects. USNORTHCOM takes more
1200 significant actions to further protect the force in order to maintain mission
1201 assurance: modify current ops/exercises and implement FP Conditions and
1202 FHP measures IAW CAP recommendations, ensure QRFs/RRFs and DSCA/IDR
1203 responders are appropriately vaccinated / protected (if available), coordinate
1204 with IA for anticipated requirements from DOD, BPT Deploy JTF(s),
1205 USNORTHCOM components take measures to protect the USNORTHCOM
1206 population in the localized region(s) while maintaining freedom of action to
1207 conduct assigned missions. USNORTHCOM remains postured to conduct HD
1208 and to respond to DSCA and FDR requests for support.

1209 4. Risk.

1210 a. Mission essential functions may be degraded if non-
1211 mission essential operations are not re-prioritized/curtailed.
1212

1213 b. Restrictions on freedom of action will degrade world-
1214 wide missions and ability to project forces.
1215

1216 5. Execution. Actions taken in this phase involve directing
1217 more specific FP and FHP measures to ensure the disease does not degrade
1218 USNORTHCOM capabilities and supporting infrastructure that would prevent
1219 forces from being able to deploy, be sustained, and protect U.S. vital interests
1220 within the AOR. In particular, measures are taken to ensure disease
1221 transmission from human-to-human is inhibited through non-pharmaceutical
1222 and pharmaceutical intervention, bio-surveillance monitoring and timely
1223 sharing of information. Other key OAAs include preparing DSCA and IDR
1224 response forces to deploy if requested and authorized IAW CONPLAN 3500 and
1225 3729 respectively. This phase may also include the decision to execute
1226 USNORTHCOM's Continuity of Operations Plan (ref xxxx). See Figure 3.
1227

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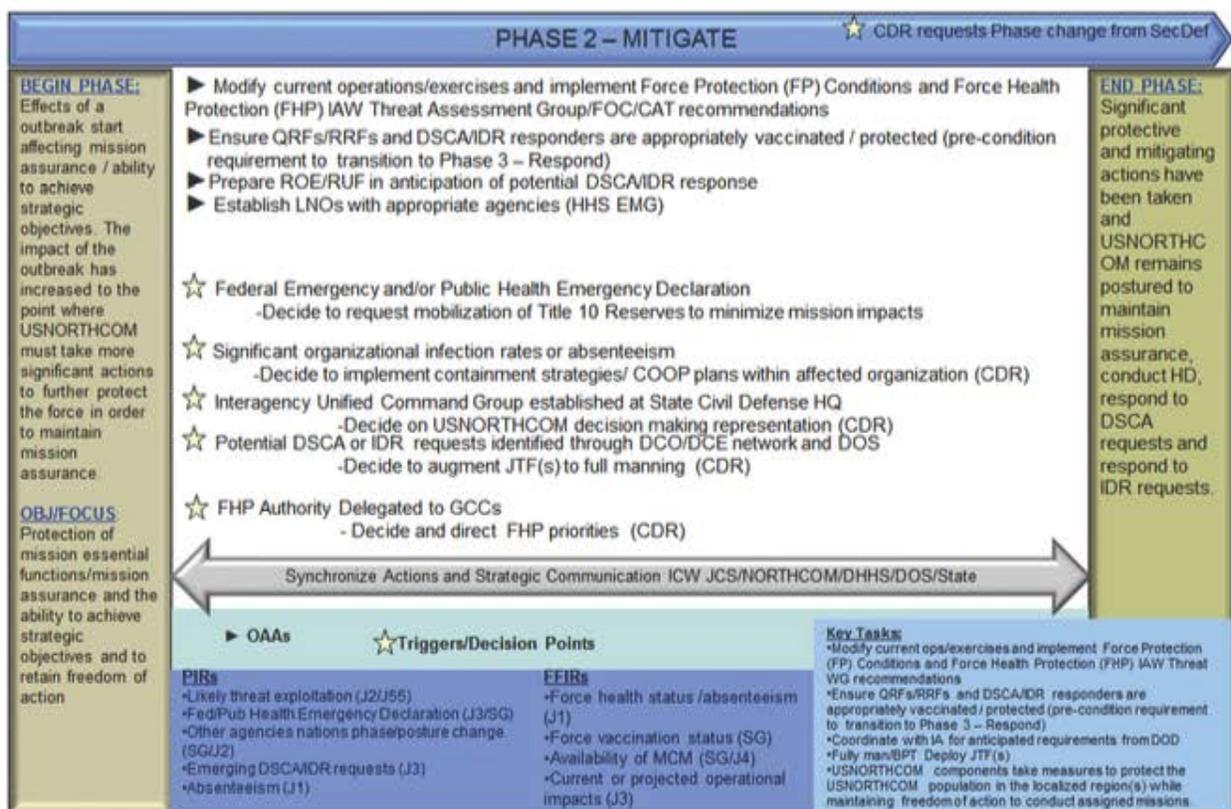


Figure 3, PI&ID Response Phase 2 - Mitigate

(d) Phase 3 – Respond.

1. Commander’s Intent. Provide approved support to civil authorities and PNs as required. Ensure freedom of action to conduct assigned missions and protect key personnel.

2. Timing. This phase begins upon receipt of approved requests for DSCA (see reference - CONPLAN 3500) and/or FDR (CONPLAN 3729) and/or the decision to deploy Title 10 response capabilities. This phase ends when mission assurance is maintained for all assigned missions and forces have been deployed to support authorized Federal military DSCA and/or FDR response operations.

3. Objectives and Effects. Taking broader measures to protect the USNORTHCOM population while maintaining the freedom of action to conduct assigned missions as authorized the Secretary of Defense and requested by the Lead Federal Agency which is in direct support to USG’s efforts to delay or halt a pandemic wave or infectious disease. Coordinate with interagency and partner nation to prevent loss of life, minimize human suffering, maintain public confidence, coordinate strategic communication, and sustain operations.

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1248

4. Risk.

1249

a. Failure to provide support to domestic PI&ID response may lead to loss and/or suffering in affected nation(s).

1251

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b. Failure to provide support to PNs may lead to instability and require future and more significant U.S. involvement.

1254

1255

c. Failure to provide support could erode domestic and international confidence in USG and fail to advance U.S. interests.

1257

1258

5. Execution. Provide support to civil authorities and PNs

1259

as required responding to DSCA and FDR requests IAW CONPLAN 3500 and CONPLAN 3729 respectively, while continuing to maintain appropriate FP and

1260

FHP measure. Continue to work with the interagency and partner nations to ensure freedom of movement and to coordinate communication strategies.

1262

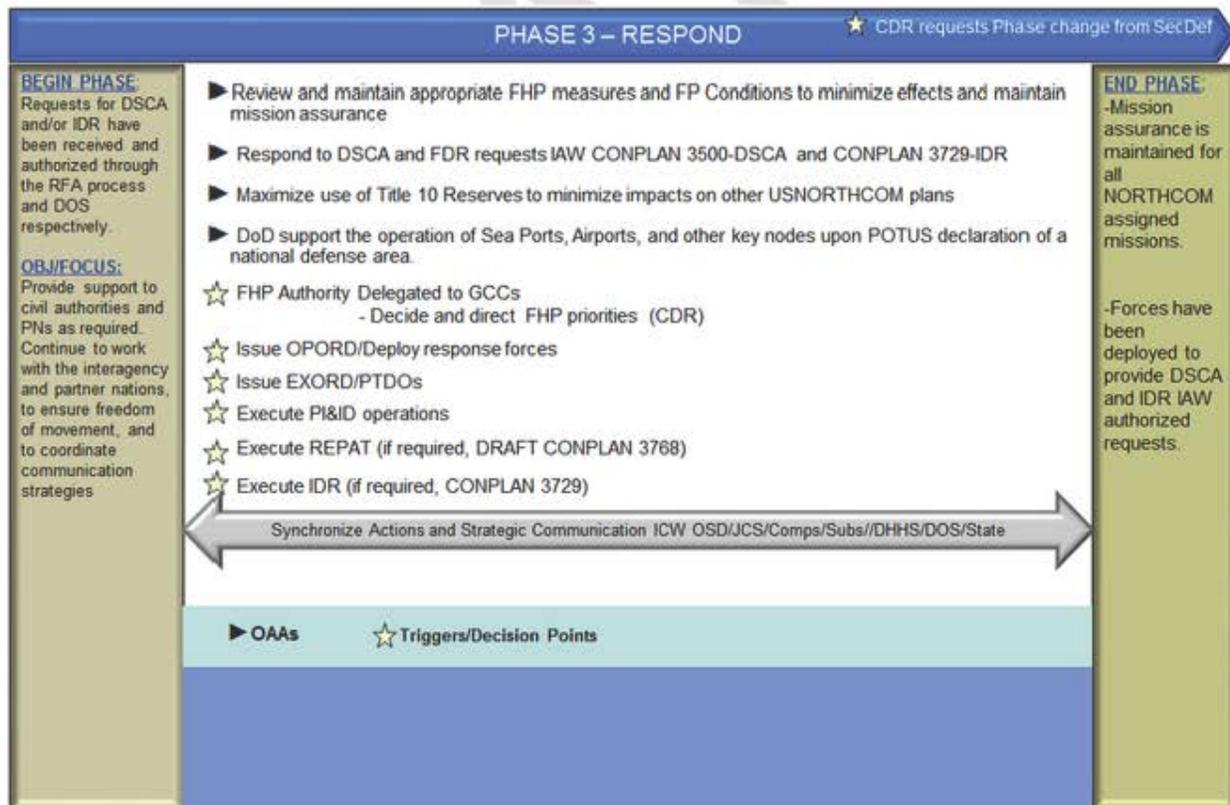
Monitor threat actors, whether traditional or asymmetric, domestic or

1263

international, and ensure they are deterred or prevented from exploiting actual or perceived weaknesses created by the PI&ID environment. See Figure 4.

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Figure 4, PI&ID Response Phase 3 - Respond

1270

(e) **Phase 4 – Stabilize.**

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1271 1. Commander's Intent. As the LFA and/or DOS (USAID /
1272 OFDA) determines DOD support is no longer required, USNORTHCOM will
1273 begin to scale down military support/ operations as appropriate.

1274 2. Timing. Phase IV begins when military and civil
1275 authorities determine that DOD support can begin to scale down. Phase IV
1276 ends when all authorized DSCA and IDR requests have been responded to and
1277 domestic and international agencies have the capacity to respond without
1278 continued USNORTHCOM support.

1279 3. Objectives and Effects. USNORTHCOM continues to
1280 protect the force with appropriate FHP measures and maintains mission
1281 assurance. In consultation with the interagency and partner nation lead
1282 federal agencies establishes transition criteria and validates appropriate
1283 military assistance levels while remaining vigilant for possible follow on waves
1284 of the disease outbreak.

1285 4. Risk.

1286 a. USNORTHCOM, due to the effects of the disease on
1287 its personnel and resources, may not have the capacity to effectively support
1288 the USG/PN with the support required.

1289 b. Failure to provide timely/adequate assistance to PN
1290 will result in additional human deaths and suffering and could erode
1291 confidence in DOD and possibly the USG.

1292 c. Failure to adequately support USG lead federal
1293 agency could negatively impact relations between DOD and interagency and/or
1294 PNs.

1295 5. Execution. Review and maintain appropriate FHP
1296 measures and FP Conditions to minimize effects and maintain mission
1297 assurance. Continue to provide approved DSCA and IDR operations and define
1298 transition criteria with interagency and PNs and scale down operations when
1299 military and civil authorities decide appropriate. See Figure 5.
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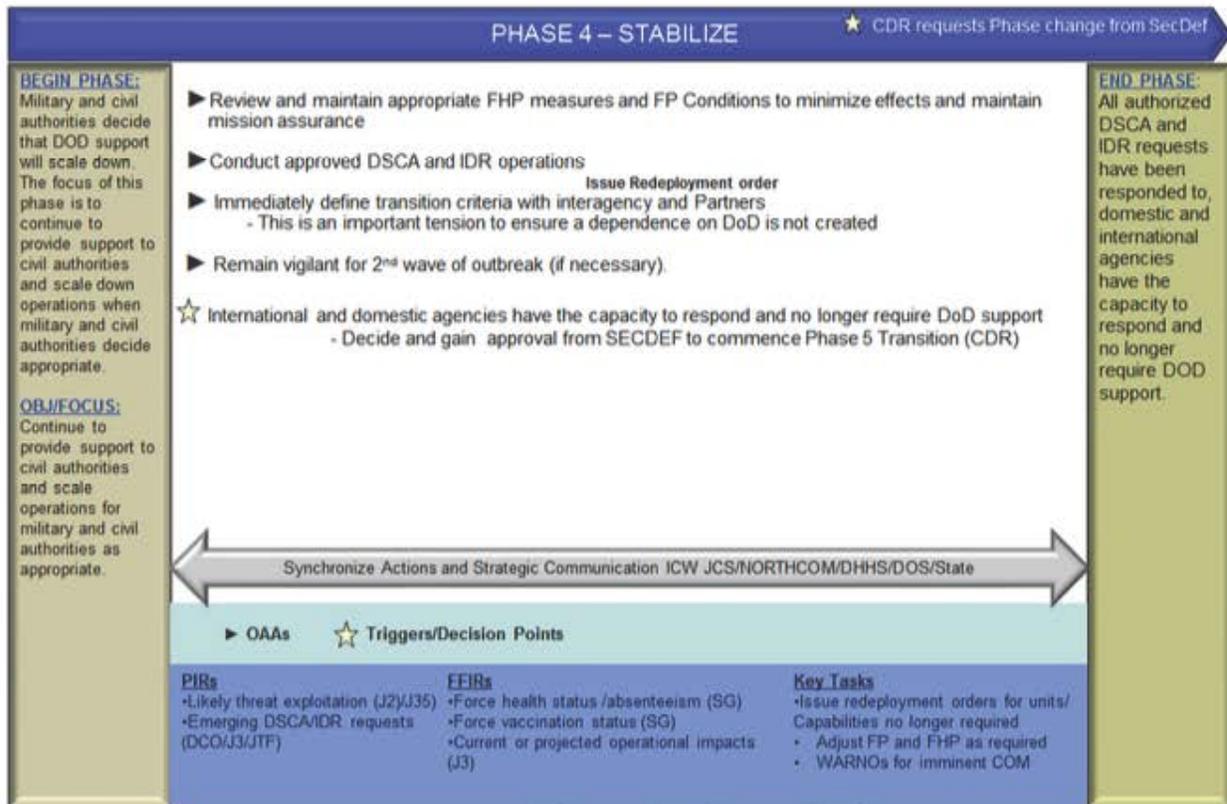


Figure 5, PI&ID Response Phase 4 - Stabilize

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(f) Phase 5 – Transition and Recover.

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1. Commander’s Intent. Redeploy response forces, reconstitute the force, and make any preparations required for follow on waves of the outbreak/event.

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1312
1313
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1315

2. Timing. Phase V begins when DSCA and IDR response forces have commenced re-deployment to home locations. This phase ends when DSCA and IDR response forces have returned to home locations, have been reconstituted, and returned to original C2 arrangements and/or the disease is no longer of operational significance.

1316
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1320
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1323

3. Objectives and Effects. The first objective for this phase is the reconstitution of USNORTHCOM assets. The second is to support all efforts to establish conditions that require a return to a previous phase: Disease does not impair key population, preclude operations, negate critical capabilities or supporting infrastructure; USNORTHCOM, interagency, and international partners synchronize planning, response, and communications; and traditional and emerging threats do not exploit a PI&ID environment. Lessons learned are identified and plans are updated accordingly.

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1324 4. Risk. The failure to reconstitute the force in time for
 1325 subsequent outbreak waves will negatively impact the ability of USNORTHCOM
 1326 to maintain mission assurance and support domestic and international
 1327 partners.

1328 5. Execution. The focus of this phase is transition from
 1329 support to domestic and international operations to redeploying the forces to
 1330 homes stations for reconstitution and preparation for subsequent outbreak
 1331 waves. USNORTHCOM conducts force recovery operations and as directed will
 1332 support efforts to re-establish normal support conditions with key partners.
 1333 Additionally, USNORTHCOM will continue to work with the interagency and
 1334 PNs, to ensure freedom of movement, and to coordinate strategic
 1335 communications, conduct AARs from previous operations and update plans
 1336 accordingly. Success in this phase is defined as: USNORTHCOM and assets
 1337 returned to Steady-State Operations. See figure 6.
 1338

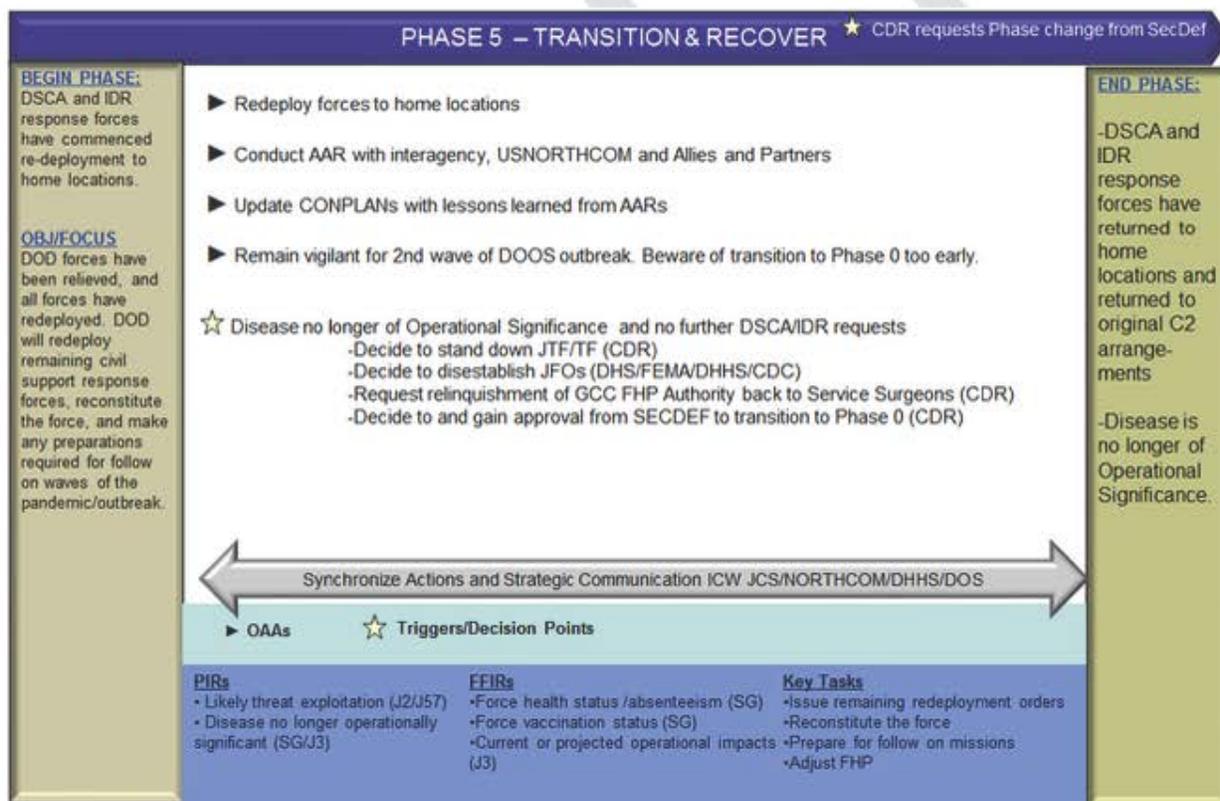


Figure 6, PI&ID Response Phase 5 – Transition & Recover

1339
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 1341
 1342 b. Tasks. Refer to the Base Plan and the CJCS DSCA EXORD, for more
 1343 details.
 1344

- (1) NORAD-USNORTHCOM Staff.

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1347 (a) Director of Personnel, N-NC/J1. See Base plan and
1348 Headquarters Operating Instruction (HOI) 10-170 (reference, ??)

1349
1350 1. Provide planning representation to crisis action planning
1351 and boards, centers, cells, and working groups as required.

1352
1353 2. Keep command apprised of existing and emerging OPM
1354 guidance as related to operationally significant disease outbreaks. Make
1355 available current and subsequent updates to personnel policies and
1356 procedures, relative to operationally significant disease outbreaks, for
1357 command-wide dissemination via PA developed platforms and command J14
1358 portal.

1359
1360 3. Provide personnel accountability, monitor casualty
1361 reporting and maintain accountability of command Individual Medical
1362 Readiness (IMR) related to operationally significant disease outbreak.

1363
1364 4. Establish processes for NORAD and USNORTHCOM and
1365 its subordinates to have ready access to information on locations and
1366 availability of high demand/low density personnel assets relevant to PI&ID
1367 (mission assurance).

1368
1369 (b) Director of Intelligence, N-NC/J2. See Enclosure B
1370 (Intelligence) to this PI&ID Response Branch Plan.

1371
1372 1. Develop and recommend PIRs as part of CDR's CCIR to
1373 provide timely intelligence and open-source reporting in support of this plan
1374 and adjust accordingly base on specific disease threats.

1375
1376 2. Task/coordinate theater and request national intelligence
1377 collection and other support per Enclosure B to support planning and
1378 operations.

1379
1380 3. Coordinate with N-NC/SG for the monitoring of disease
1381 occurrence in the AOR. Collaborate annually to identify "top five" potential
1382 disease of operational significance for the USNORTHCOM AOR and update
1383 Enclosure B to this branch plan accordingly.

1384 (c) Director of Operations, NC/J3.

1385
1386 1. IAW the Battlestaff Standard Operating Procedures
1387 (BSOP) establish the USNORTHCOM Future Operations Center (FOC) to
1388 conduct crisis action planning in support of this branch plan and lead
1389 directorate for Crisis Action Planning and execution in support of PI&ID
1390 operations.

1391

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1392 2. Develop and recommend FFIRs as part of CCDR's CCIR to
1393 provide timely critical status updates on friendly forces IOT aid CCDR decision-
1394 making.

1395
1396 3. Recommend decisions for Commander's approval in
1397 support of the established operation order as necessary.

1398
1399 4. Conduct Critical Infrastructure Protection (CIP) and Anti-
1400 terrorism FP planning with Service component commands and other agencies
1401 as necessary to support response.

1402
1403 5. ICW SG and J2, maintain and coordinate theater level all
1404 domain situational awareness for the emergence and spread of a disease of
1405 operational significance in the USNORTHCOM AOI, trends, events, and
1406 activities through all phases ICW components and other USNORTHCOM
1407 elements and staffs.

1408
1409 6. In coordination with PA, lead the development of a
1410 Strategic Communication framework from which guidance is provided and
1411 coordinate activities and internal messaging within USNORTHCOMM and
1412 external with other Unified, Sub-Unified commands, Components, Direct
1413 Reporting Units and USG agencies as required.

1414
1415 7. Establish N2C2 communication with USG, other GCCs,
1416 international and between interagency partners including partnering nation
1417 emergency operations centers. Identify preferred unclassified collaboration
1418 tools for information sharing. Promote, contribute to, and coordinate PI&ID
1419 situational awareness efforts with components, other USG organizations, allies
1420 and partners.

1421
1422 8. ICW SG, prioritize FHP to reduce degradation of priority
1423 capabilities and implement force posture, FP, FHP and containment strategies
1424 to minimize exposure of Joint Forces in disease environments.

1425
1426 9. Act as primary USNORTHCOM point of contact for Lead
1427 Federal Agencies (primarily DHHS and FEMA).

1428
1429 10. Notify JS/OSD of phase changes and FHP guidance
1430 changes.

1431
1432 11. Advise CDRUSNORTHCOM, who exercises TACON (for
1433 FP) authority for DOD elements, on personnel and facilities located within the
1434 AOR to ensure effective FP of DOD forces under all operating conditions and
1435 environments.

1436

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1437 12. ICW J5, SG, and Service Components, facilitate the
1438 identification, prioritization, and protection planning of Defense Critical
1439 Infrastructure (DCI) in accordance with and synchronized with the AOR
1440 pandemic strategy. Act as the Office of Primary Responsibility (OPR) for DCI
1441 related concerns.

1442
1443 13. ICW J2/JIOC and SG, prepare threat warning(s) and
1444 notify travelers in affected areas.

1445
1446 14. BPT establish and lead crisis action planning and
1447 develop an EXORD that implements and directs Phase 1-5 OoAs in response to
1448 a disease of operational significance in the USNORTHCOM AOR.

1449
1450 15. Ensure HQ USNORTHCOM, subordinate, and
1451 component Continuity Of Operations Plan (COOP) activities enable mission
1452 assurance in an operationally significant disease environment when PI&ID
1453 effects and associated FHP measures degrade mission capabilities. Key
1454 differences from normal COOP activities are that mission related impacts will
1455 likely be primarily to the work force and secondarily to infrastructure. The
1456 plan must consider the ability to accomplish the mission with a severely
1457 degraded workforce due to PI&ID related impacts including but not limited to
1458 absenteeism, travel restrictions, containment strategies, and second and third
1459 order effects of the disease(s).

1460
1461 16. BPT execute USNORTHCOM CONPLAN 3500, DSCA
1462 Response should a PI&ID related DSCA request be received.

1463
1464 17. BPT execute the USNORTHCOM CONPLAN 3729 should
1465 a PI&ID related FDR request be received.

1466
1467 18. BPT conduct/support DOD NEO/Repatriation or early
1468 return of dependents.

1469
1470 18. Determine command and control relationships with key
1471 partner nations and regions.

1472
1473 19. Support all efforts to contain the disease geographically

1474
1475 20. Refine COOP PLAN and include operationally significant
1476 disease, social distancing, restriction of movement procedures,
1477 medical/logistical support, continuity of operations, mission accomplishment,
1478 and support to higher. Identify 2nd and 3rd order effects of PI & ID on ability
1479 to conduct COOP, support assigned/attached forces/missions, and ability to
1480 provide Force Health Protection (ICW w SG).

1481

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1482 (d) Director of Logistics, N-NC/J4.

1483
1484 1. Maintain an updated logistics sustainability analysis for
1485 this branch plan.

1486
1487 2. ICW Service Components, plan, coordinate, and manage
1488 theater and operational logistics for USNORTHCOM PI&ID operations.

1489
1490 3. ICW DLA, maintain SA on USNORTHCOM critical
1491 supplies for PI&ID (PPE, vaccine, antivirals, etc). ICW SG, maintain Joint
1492 Medical Asset Repository (JMAR) visibility.

1493
1494 4. ICW Service Components and DLA identify critical
1495 supplies, goods, or services that require priority delivery from
1496 industry/suppliers to ensure COOP and sustainment of key populations.

1497
1498 5. BPT coordinate large-scale logistics operations to
1499 maintain flow of critical supplies to military base installations in the AOR if a
1500 disease of operational significance results in interruption of commercial
1501 transportation and/or trade.

1502
1503 6. BPT establish vaccine acquisition and distribution
1504 networks that acquire vaccine directly from the manufacturers and distribute
1505 them to USNORTHCOM components using USNORTHCOM logistics networks.

1506
1507 7. Maintain visibility on US and international airports and
1508 seaports that are considered strategic and that may be restricted due to an
1509 operationally significant disease outbreak ICW with USTRANSCOM, identify
1510 alternatives to ensure freedom of movement for DOD forces into/out of the
1511 USNORTHCOM AOR.

1512
1513 8. Assess sustainment stock levels, and mitigate any
1514 shortfalls necessary to meet the logistical requirements associated with a
1515 significant PI & ID event.

1516
1517 9. ICW J3 BPT implement prioritized medical material
1518 distribution plan, to include enroute security, for PI & ID vaccines, anti-virals,
1519 and other medical materiel consistent with J3 operational priorities and forces
1520 available.

1521
1522 10. BPT coordinate with NDDOC/AMC/USTRANSCOM for
1523 MILAIR or commercial air return of dependents/pets to home of record and
1524 potentially infected DOD personnel and/or AMCITs from OCONUS.

1525

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1526 11. ICW N-NC/SG, BPT establish and/or support
1527 appropriate outbreak related medical operations IAW Health and Human
1528 Services (HHS) guidelines and screening criteria at aeromedical evacuation (AE)
1529 hubs and Aerial Ports of Debarkation (APOD)/Sea Ports of Debarkation (SPOD).
1530

1531 (e) Director of Strategy, Policy, and Plans, N-NC/J5.

1532
1533 1. Submit a strategic assessment to SECDEF as part of its
1534 yearly Campaign Assessment describing the Command's progress toward
1535 achievement of the GEF prioritized PIID end states via TCP annual assessment.
1536

1537 2. Coordinate PI&ID related policy issues with N-NC/J52,
1538 OSD, and Joint Staff respectively.
1539

1540 3. Maintain this branch plan in a "living state" to CONPLAN
1541 3500 and as a supporting plan to the DOD GCP-PI&ID-3551 and adjust as
1542 guidance or changes to the environment dictate. Coordinate required policy
1543 adjustments with OSD and required authorities and planning support with the
1544 Joint Staff.
1545

1546 4. In the designated DOD Global Synchronizer for PI&ID
1547 role, coordinate the revision and review of GCC, SVC, and select DA supporting
1548 plans to the DOD GCP-PI&ID-3551.
1549

1550 5. Develop and execute USNORTHCOM led global synch
1551 conferences and planning efforts for GCP 3551.
1552

1553 6. Coordinate with component commands to review
1554 supporting plans and planning activities in a recurring information sharing
1555 forum.
1556

1557 7. N-NC/J59, Security Cooperation Division.
1558

1559 a. ICW SG coordinate Phase 0 health engagements
1560 across the USNORTHCOM AOR. Engagements shall align with planning
1561 guidance from the TCP and shall build the capacity for partner nations and
1562 partner nation militaries to reduce susceptibility to diseases and mitigate the
1563 effects of operationally significant outbreaks should one occur.
1564

1565 b. Establish Phase 0 - Security Cooperation and
1566 Partner Activities (SCPA) priorities and incorporate planning and opportunities
1567 into annual TCP, Theater Security Cooperation Annex (Annex P, TCP).
1568

1569 c. Work with target nation militaries to assess existing
1570 laboratory capacity, rapid response teams and portable field assay testing

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1571 equipment. ICW international military partners develop solutions for identified
1572 national and regional military gaps.

1573
1574 (g) Director, Cyberspace Operations, N-NC/J6.

1575
1576 1. Provide Command, Control, Communications, and
1577 Computer (C4) systems planning to enable a common operating picture by
1578 mapping/fusing extant information flows and resources to fulfill C2 and C4
1579 requirements in support of mission execution.

1580
1581 2. Establish plans to ensure communication with all PI&ID
1582 response elements to include liaisons with DoS, international organizations
1583 and partner nations.

1584
1585 3. Develop and test Social Distancing/Telework plans ISO
1586 mission critical and support functions (phase 0/1).

1587
1588 4. Coordinate the synchronization of the cyberspace domain
1589 and provide decision makers and mission partners with the processes and
1590 architecture that facilitate relevant, accurate, and timely information in order
1591 to achieve decisive levels of shared and accessible knowledge.

1592
1593 (h) Director of Joint Training and Exercises, N-NC/J7.

1594
1595 1. Support branch plan with the overall exercise program
1596 that delineates the planning, execution, and assessment of joint training and is
1597 consistent with the Commander's training vision.

1598
1599 2. ICW NC/J3, N-NC/J5, and N-NC/SG, determine exercise
1600 requirements for CONPLAN 3500, PI&ID Branch Plan, and assist in developing
1601 appropriate mechanisms to exercise the plan within existing Joint Exercise
1602 Program and service component events.

1603
1604 3. As required, establish linkages with interagency
1605 (DHHS/CDC/FEMA) PI&ID exercise programs.

1606
1607 (i) Director of Requirements, Analysis, and Resources, N-NC/J8.

1608
1609 1. Synchronize ongoing USNORTHCOM PI&ID assessments
1610 and analyze plan maintenance activities. Capture capability requirements and
1611 shortfalls and integrate with appropriate DOD programmatic activities.

1612
1613 2. Advocate for PI&ID resources through the Planning,
1614 Programming, Budget and Execution (PPBE), Integrated Priority List (IPL) and

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1615 Joint Capabilities Integration Development System (JCIDS) processes when
1616 directed by CDRUSNORTHCOM.
1617

1618 3. Assist in the alignment of security cooperation activities
1619 (that will be used to achieve CONPLAN Phase 0 end states) with TCP All
1620 Hazards Sub-campaign IMOs, and assist in the development of a framework to
1621 monitor and assess the performance of these through the TCP assessment. In
1622 coordination with the J55, review changes or modifications needed to the TCP
1623 and produce a strategic assessment as required.
1624

1625 (j) Director of Interagency Coordination, N-NC/J9.
1626

1627 1. Facilitate USNORTHCOM interface and information
1628 sharing with interagency partners, specifically DHHS, the LFA for Medical and
1629 Public Health response.
1630

1631 2. ICW N-NC/SG, N-NC/J4, and N-NC/J59, establish Phase
1632 0 - SCPA priorities and incorporate PI&ID planning and IMOs into the TCP.
1633

1634 3. Support pandemic Surveillance and Detection through
1635 consolidation, documentation and reporting of USG agency, International
1636 organizations, NGOs and private sector surveillance and detection programs.
1637

1638 4. ICW the N-NC/SG and established BSOP procedures,
1639 monitor and report, as necessary, PI&ID related results of USG infectious
1640 disease surveillance programs: Global Disease Detection (GDD), Field
1641 Epidemiology Training Program (FETP), Integrated Disease Surveillance and
1642 Response (IDSR), and Global Emerging Infections Surveillance and Response
1643 System (GEIS).
1644

1645 (k) Staff Judge Advocate (N-NC/JA).
1646

1647 1. Support the conduct of PI&ID response operations IAW
1648 Appendix 4 to Annex E-Legal.
1649

1650 2. Monitor USNORTHCOM PI&ID activities and advise
1651 CDRUSNORTHCOM and JTF or MILFOR Commander of legal/regulatory
1652 implications on current and planned activities, policies, and procedures
1653 through all operational phases.
1654

1655 3. Provide guidance to component commands and JTFs on
1656 handling of IDPs, refugees, modification to SROE, treatment of civilian
1657 casualties and any additional requested items through all operational phases.
1658

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1659 4. Coordinate with N-NC/J4 and N-NC/J9 to confirm that
1660 diplomatic clearances, over flight, basing rights, access agreements and
1661 facility/ equipment usage authorizations have been requested and obtained to
1662 the extent possible.

1663
1664 (l) Public Affairs, N-NC/PA.

1665
1666 1. Educate key audiences on the importance of preparation
1667 in the event an operationally significant disease is identified (during Phases 0
1668 through II), develop fact sheets or other general information on USNORTHCOM
1669 outbreak preparation and mitigation activities ICW N-NC/SG for distribution to
1670 various target groups, including professional and community groups. Ensure
1671 national consistency of locally produced fact sheets and ensure N-NC PA does
1672 not message ahead of local, state, and federal messaging when inappropriate to
1673 do so.

1674
1675 2. Monitor public affairs teams deployed ISO outbreak
1676 operations.

1677
1678 3. Act as focal point of all CDRUSNORTHCOM public
1679 announcements concerning foreign outbreak efforts. Prepare public affairs
1680 guidance, as required.

1681
1682 4. Coordinate for the dispatch of news stories and
1683 photographs with the Office of the Assistant SECDEF (Public Affairs) for release
1684 to national and local media as well as USNORTHCOM command/internal
1685 information media.

1686
1687 5. Refine themes and messages for communication activities
1688 (protect, mitigate, respond, and stabilize).

1689
1690 a. DoD's first priority is focused on protecting the force
1691 and sustaining DoD mission assurance.

1692
1693 b. Education and understanding will enhance
1694 preparedness.

1695
1696 c. Preparedness is essential to mitigate effects of an
1697 outbreak.

1698
1699 d. During an outbreak, the protection of DoD
1700 personnel and their families is a high DoD priority.

1701
1702 e. Openness and communication among mission
1703 partners will enhance preparedness for an outbreak.

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f. Adverse effects of PI – ID on DoD forces will be minimized and DoD is capable of conducting its assigned missions worldwide.

g. The Department is capable of providing appropriate support to the primary Federal agency to assist in mitigating the effects when requested and directed.

h. When directed to do so, US forces are capable of assisting international partners to mitigate and respond to PI – ID.

(m) Command Surgeon, N-NC/SG.

1. Monitor disease occurrence in the AOR. ICW J2, DIA/NCMI, and AFHSB utilize medical intelligence, environmental surveillance, health surveillance, and early warning system efforts to identify, monitor, and track the emergence and spread of a disease of operational significance in the USNORTHCOM AOI. This includes analysis and evaluation of the environment, and prioritization of regional threats based on epidemiology, infrastructure, and potential for operational impact. This work is to be done in collaboration with DOD components and other international and federal agencies (WHO, DHS/NBIC, and HHS/CDC, etc.).

2. IAW DODI 6200.03 (Public Health Emergency Management within the Department of Defense) reporting requirements for Biological Events to include USNORTHCOM.

3. IAW DODD 6200.04 (Force Health Protection) develop and promulgate FHP guidelines for assigned/attached forces and/or AOR (either upon receipt of JS EXORD granted AOR authority, or ICW JS Surgeon and SVC Surgeons) to ensure baseline FHP is being met. Protect forces and preserve operational readiness through FHP education and training on the operationally significant threats, personal protective measures, MCM, non-medical therapeutics treatment, prophylaxis, and personnel protective equipment (PPE). As required, recommend implementation of FHP protocols.

3. Establish priorities for immunization/prophylaxis against operationally significant disease outbreaks (particular attention to Novel Influenza).

4. Assess USNORTHCOM force health preparedness status.

5. Update recommendations for prophylaxis and treatment with antivirals/MCM (if available).

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- 1749 6. Assess effectiveness of treatment and infection control
1750 measures in the AOR.
1751
- 1752 7. Ensure IMR addresses and includes the administration of
1753 prophylaxis for personnel traveling to affected areas.
1754
- 1755 8. ICW the NC/J3 coordinate medical requests for public
1756 health and preventive medicine assistance with the USG lead.
1757
- 1758 9. ICW the N-NC/J4 coordinate medical aspects of patient
1759 evacuation.
1760
- 1761 10. Coordinate medical assets as required and monitor
1762 medical support requirements during an operationally significant disease
1763 outbreak.
1764
- 1765 11. Synchronize and coordinate DOD medical activities
1766 with local, interagency, partner nation and NGO/IO medical activities.
1767
- 1768 12. ICW N-NC/J59 coordinate Phase 0 health engagements
1769 across the USNORTHCOM AOR. Engagements shall align with planning
1770 guidance from the TCP and shall build the capacity for partner nations and
1771 partner nation militaries to reduce susceptibility to diseases and mitigate the
1772 effects of operationally significant outbreaks should one occur.
1773
- 1774 13. Coordinate with JS and the OSD to develop theater
1775 stockpiles and for access to and release of the DOD stockpile of MCM/PPE,
1776 through Office of the Assistant Secretary of Defense for Health Affairs (ASD-HA)
1777 and Joint Staff IAW existing policies and guidelines.
1778
- 1779 14. BPT to establish priorities for allocation and distribution
1780 of FHP materials. Authorize and direct the distribution of MCM and other
1781 stockpiled assets to installations within the USNORTHCOM AOR.
1782
- 1783 15. ICW Component Surgeons, identify the requirement for
1784 components to develop, maintain, and coordinate (for non-medical
1785 support/requirements) installation-level medical response plans to include
1786 evaluation and prioritization of medical requirements and to estimate medical
1787 capabilities and surge capacities.
1788
- 1789 16. Develop and execute a theater distribution and tracking
1790 plan for medications, vaccines, ventilators, and other medical
1791 supplies/equipment in coordination with USTRANSCOM, Defense Logistics
1792 Agency (DLA), N-NC/J4, Single Integrated Medical Logistics Management
1793 (SIMLM), and Theater Lead Agent for Medical Materiel (TLAMM).

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17. Ensure awareness of bed capacity across respective AORs. Obtain surge capacity data with National Disaster Medical System (NDMS) partners, as applicable, on a recurring basis, while also pursuing ways to incorporate community/PN efforts that are not included in this data.

18. Coordinate with USTRANSCOM and NDMS service coordinators, as applicable, in patient movement planning efforts.

19. ICW N-NC/J4, BPT establish and/or support appropriate outbreak related medical operations IAW Health and Human Services (HHS) guidelines and screening criteria at aeromedical evacuation (AE) hubs and Aerial Ports of Debarkation (APOD)/Sea Ports of Debarkation (SPOD).

20. ICW the JS Surgeon and Service Surgeons, ensure DoD/Service guidance and clinical practice guidelines specific to the outbreak event are adequate and being disseminated.

(n) Deputy Chief of Staff for Communications Synchronization, N-NC/ CSSC. Support the conduct of PI&ID response operations IAW Annex Y-Communications Synchronization and Annex C-Operations.

(o) Director, Office of the Command Chaplain, N-NC/HC.

1. Provide and coordinate religious support to the Command and authorized DOD personnel, in order to ensure the free exercise of religion for forces conducting PI&ID response operations IAW Appendix 6 (Chaplain Activities) to Annex E-Personnel.

2. USNORTHCOM/HC establishes theater religious support (RS) policy, provides RS to the Command, and coordinates RS activities of subordinate commands and joint task force(s) for all phases of PI&ID operations.

3. RSTs provide RS to authorized DOD personnel during all phases of PI&ID operations. Service components and JTFs provide religious support to service personnel through assigned RSTs.

4. CDRUSNORTHCOM will employ strategic communication and public information plans in coordination with civil authorities in order to mitigate fear and miscommunication. Chaplains will contribute to this mission by advising the command on the impact of religion during operationally significant disease outbreak operations.

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1838 5. Establish guidelines for pastoral care in a reduction
1839 contact environment.

1840
1841 (p) Director, Washington Office, (N-NC/WO). As the situation
1842 dictates and in response to the CDR's requirements, the N-NC/WO Director
1843 deploys appropriate representation to DOD and non-DOD operations centers
1844 that may include, but are not limited to: DHHS Secretary's Operations Center
1845 (SOC), FEMA National Operations Center (NOC).

1846
1847 (2) USNORTHCOM Components. See Base plan Component Tasks.

1848
1849 (a) Commander, - Air Forces Northern (CDRAFNORTH).

1850
1851 1. Conduct planning and develop supporting plan(s) for
1852 PI&ID response that at a minimum:

1853
1854 a. Detail actions for mission assurance, USG support,
1855 and PN support operations.

1856
1857 b. Submit supporting plan to USNORTHCOM J5.
1858 Provide supporting planback-brief to USNORTHCOM leadership.

1859
1860 2. IAW Annex J and the base plan, BPT to be designated as
1861 a CDR-DOD Title 10 HQs overall operational level commander to execute C2
1862 and synchronize efforts to provide DOD support within the affected area
1863 and/or provide forces IAW Global Force Management (GFM) guidance to
1864 conduct operations in support of directed efforts to respond to a PI&ID event.

1865
1866 3. As directed in the USNORTHCOM TCP and TSC Annex,
1867 and in consultation with N-NC/SG, N-NC/J4, and N-NC/J59, coordinate and
1868 conduct Phase 0 health engagements across the USNORTHCOM AOR IOT build
1869 the capacity for partner nations and partner nation militaries to reduce the
1870 host nation's susceptibility to diseases and mitigate the effects of an
1871 operationally significant outbreak should one occur.

1872
1873 4. BPT lead, or participate in, responses in the AOR as
1874 directed ISO the Lead Federal Agency (DHHS and/or FEMA) efforts in affected
1875 areas of operational significance.

1876
1877 5. IAW DODI 6200.03 (reference x.), and ICW N-NC/SG,
1878 protect assigned forces and preserve operational readiness through education
1879 and training on the PI&ID threat, personal protective measures, prophylaxis,
1880 and PPE. As required, implement FP/FHP measures to protect forces, families
1881 and readiness.

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1883 6. Monitor for potential operationally significant outbreaks
1884 (N-NC/SG, NCMI, Center for Disease Control, WHO) to establish and maintain
1885 situational awareness.

1886
1887 7. Coordinate public affairs messages with USNORTHCOM
1888 on activities that will impact USNORTHCOM AOR in order to ensure
1889 synchronization of CDRs communications strategy.

1890
1891 8. As required, monitor and report to USNORTHCOM health
1892 of forces assigned/attached to USNORTHCOM IOT support situation
1893 awareness/understanding and support requisite decision points IAW Annex R.

1894
1895 9. As required, report status to USNORTHCOM of
1896 installations/bases/posts in USNORTHCOM AOR to support situational
1897 awareness and anticipate capabilities IAW Annex R.

1898
1899 10. Advise CDRUSNORTHCOM on the impact of PI on the
1900 operational status of Service installations in the NC AOR IOT provide SA to
1901 CDRUSNORTHCOM.

1902
1903 11. Serve as the USNORTHCOM designated theater JFACC.
1904 BPT provide theater support to CDRUSNORTHCOM and localized support for
1905 established JTF(s), the JFLCC (to include the DCO), or other components as
1906 designated in conducting PI&ID operations in the USNORTHCOM AOR.
1907 Coordinate with JFLCC, JFMCC, and Alaskan Command (ALCOM) JFACC
1908 (11th Air Force).

1909
1910 12. BPT rapidly establish theater airlift of international relief
1911 supplies, USNORTHCOM assets and/or other assets into countries affected by
1912 PI&ID outbreak. Conduct planning and take actions during Prepare Phase to
1913 establish necessary agreements, or if unable, at least lay the groundwork for
1914 such agreements, in order to rapidly establish operations during Mitigate
1915 and/or Respond Phase. Coordinate with N-NC/J4 (NDOC) and USTRANSCOM
1916 as required. Assume limited or no PN support would be available to support
1917 operations.

1918
1919 (b) Commander, - U.S. Army North (CDRUSARNORTH).

1920
1921 1. Conduct planning and develop supporting plan(s) for
1922 PI&ID response that at a minimum:

1923
1924 a. Detail actions for mission assurance, USG support,
1925 and PN support operations.

1926

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- 1927 b. Submit supporting plan to USNORTHCOM J5.
1928 Provide supporting plan back-brief to USNORTHCOM leadership.
1929
- 1930 2. IAW Annex J and the base plan, BPT to be designated as
1931 a CDR-DOD Title 10 HQs overall operational level commander to execute C2
1932 and synchronize efforts to provide DOD support within the affected area
1933 and/or provide forces IAW Global Force Management (GFM) guidance to
1934 conduct operations in support of directed efforts to respond to a PI&ID event.
1935
- 1936 3. As directed in the USNORTHCOM TCP and TSC Annex,
1937 and in consultation with N-NC/SG, N-NC/J4, and N-NC/J59, coordinate and
1938 conduct Phase 0 health engagements across the USNORTHCOM AOR IOT build
1939 the capacity for partner nations and partner nation militaries to reduce the
1940 host nation's susceptibility to diseases and mitigate the effects of an
1941 operationally significant outbreak should one occur.
1942
- 1943 4. BPT lead, or participate in, responses in the AOR as
1944 directed ISO the Lead Federal Agency (DHHS and/or FEMA) efforts in affected
1945 areas of operational significance.
1946
- 1947 5. IAW DODI 6200.03 (reference x.), and ICW N-NC/SG,
1948 protect assigned forces and preserve operational readiness through education
1949 and training on the PI&ID threat, personal protective measures, prophylaxis,
1950 and PPE. As required, implement FP/FHP measures to protect forces, families
1951 and readiness.
1952
- 1953 6. Monitor for potential operationally significant outbreaks
1954 (N-NC/SG, NCMI, Center for Disease Control, WHO) to establish and maintain
1955 situational awareness.
1956
- 1957 7. Coordinate public affairs messages with USNORTHCOM
1958 on activities that will impact USNORTHCOM AOR in order to ensure
1959 synchronization of CDRs communications strategy.
1960
- 1961 8. As required, monitor and report to USNORTHCOM health
1962 of forces assigned/attached to USNORTHCOM IOT support situation
1963 awareness/understanding and support requisite decision points IAW Annex R.
1964
- 1965 9. As required, report status to USNORTHCOM of
1966 installations/bases/posts in USNORTHCOM AOR to support situational
1967 awareness and anticipate capabilities IAW Annex R.
1968
- 1969 10. Advise CDRUSNORTHCOM on the impact of PI on the
1970 operational status of Service installations in the NC AOR IOT provide SA to
1971 CDRUSNORTHCOM.

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2014

11. Serve as the USNORTHCOM designated theater JFLCC. BPT provide theater support to CDRUSNORTHCOM and localized support for established JTF(s) or other components as designated in conducting PI&ID operations in the USNORTHCOM AOR. Coordinate with JFMCC, JFACC, and ALCOM.

12. BPT source additional JTFs headquarters upon identification of force requirements and as requested by USNORTHCOM and directed by SecDef IOT ensure HQ elements rapid availability to support potential USG efforts in multiple regions.

(c) Commander, U.S. Navy North (COMUSNAVNORTH).

1. Conduct planning and develop supporting plan(s) for PI&ID response that at a minimum:

a. Detail actions for mission assurance, USG support, and PN support operations.

b. Submit supporting plan to USNORTHCOM J5. Provide supporting plan back-brief to USNORTHCOM leadership.

2. IAW Annex J and the base plan, BPT to be designated as a CDR-DOD Title 10 HQs overall operational level commander to execute C2 and synchronize efforts to provide DOD support within the affected area and/or provide forces IAW Global Force Management (GFM) guidance to conduct operations in support of directed efforts to respond to a PI&ID event.

3. BPT lead, or participate in, responses in the AOR as directed ISO the Lead Federal Agency (DHHS and/or FEMA) efforts in affected areas of operational significance.

4. IAW DODI 6200.03 (reference x.), and ICW N-NC/SG, protect assigned forces and preserve operational readiness through education and training on the PI&ID threat, personal protective measures, prophylaxis, and PPE. As required, implement FP/FHP measures to protect forces, families and readiness.

5. Monitor for potential operationally significant outbreaks (N-NC/SG, NCMI, Center for Disease Control, WHO) to establish and maintain situational awareness.

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2015 6. Coordinate public affairs messages with USNORTHCOM
2016 on activities that will impact USNORTHCOM AOR in order to ensure
2017 synchronization of CDRs communications strategy.
2018

2019 7. As required, monitor and report to USNORTHCOM health
2020 of forces assigned/attached to USNORTHCOM IOT support situation
2021 awareness/understanding and support requisite decision points IAW Annex R.
2022

2023 8. As required, report status to USNORTHCOM of
2024 installations/bases/posts in USNORTHCOM AOR to support situational
2025 awareness and anticipate capabilities IAW Annex R.
2026

2027 9. Advise CDRUSNORTHCOM on the impact of PI on the
2028 operational status of Service installations in the NC AOR IOT provide SA to
2029 CDRUSNORTHCOM.
2030

2031 10. Identify major seaports which are considered strategic
2032 junctures for major military deployments, access preparedness and response
2033 capabilities.
2034

2035 11. BPT rapidly establish movement of international relief
2036 supplies, USNORTHCOM assets and Sea Port of Embarkation / Debarkation
2037 SPOE/SPOD operations in countries affected by PI&ID outbreak. Assume
2038 limited PN support would be available for port operations.
2039

2040 12. BPT resupply ships for long-term sequester. Coordinate
2041 for resupply for ships for at least 45 days.
2042

2043 13. BPT cancel ports visits or utilize alternate major
2044 seaports that are considered strategic junctures for major military
2045 deployments, access preparedness and response capabilities.
2046

2047 14. Consider re-routing vessels and aircraft where countries
2048 prohibit arrival or alternatives to provision of sovereign information required to
2049 preserve and protect health.
2050

2051 15. Serve as the USNORTHCOM designated theater JFMCC.
2052 BPT provide theater support to CDRUSNORTHCOM and localized support for
2053 established JTF(s), the JFLCC, or other components as designated in
2054 conducting PI&ID operations in the USNORTHCOM AOR. Coordinate with
2055 JFLCC, JFACC, and ALCOM.
2056

2057 (d) Commander, U.S. Marine Forces North (COMMARFORNORTH).
2058

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- 2059 1. Conduct planning and develop supporting plan(s) for
2060 PI&ID response that at a minimum:
2061
2062 a. Detail actions for mission assurance, USG support,
2063 and PN support operations.
2064
2065 b. Submit supporting plan to USNORTHCOM J5.
2066 Provide supporting planback-brief to USNORTHCOM leadership.
2067
2068 2. IAW Annex J and the base plan, BPT to be designated as
2069 a CDR-DOD Title 10 HQs overall operational level commander to execute C2
2070 and synchronize efforts to provide DOD support within the affected area
2071 and/or provide forces IAW Global Force Management (GFM) guidance to
2072 conduct operations in support of directed efforts to respond to a PI&ID event.
2073
2074 3. As directed in the USNORTHCOM TCP and TSC Annex,
2075 and in consultation with N-NC/SG, N-NC/J4, and N-NC/J59, coordinate and
2076 conduct Phase 0 health engagements across the USNORTHCOM AOR IOT build
2077 the capacity for partner nations and partner nation militaries to reduce the
2078 host nation's susceptibility to diseases and mitigate the effects of an
2079 operationally significant outbreak should one occur.
2080
2081 4. BPT lead, or participate in, responses in the AOR as
2082 directed ISO the Lead Federal Agency (DHHS and/or FEMA) efforts in affected
2083 areas of operational significance.
2084
2085 5. IAW DODI 6200.03 (reference x.), and ICW N-NC/SG,
2086 protect assigned forces and preserve operational readiness through education
2087 and training on the PI&ID threat, personal protective measures, prophylaxis,
2088 and PPE. As required, implement FP/FHP measures to protect forces, families
2089 and readiness.
2090
2091 6. Monitor for potential operationally significant outbreaks
2092 (N-NC/SG, NCMI, Center for Disease Control, WHO) to establish and maintain
2093 situational awareness.
2094
2095 7. Coordinate public affairs messages with USNORTHCOM
2096 on activities that will impact USNORTHCOM AOR in order to ensure
2097 synchronization of CDRs communications strategy.
2098
2099 8. As required, monitor and report to USNORTHCOM health
2100 of forces assigned/attached to USNORTHCOM IOT support situation
2101 awareness/understanding and support requisite decision points IAW Annex R.
2102

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2103 9. As required, report status to USNORTHCOM of
2104 installations/bases/posts in USNORTHCOM AOR to support situational
2105 awareness and anticipate capabilities IAW Annex R.
2106

2107 10. Advise CDRUSNORTHCOM on the impact of PI on the
2108 operational status of Service installations in the NC AOR IOT provide SA to
2109 CDRUSNORTHCOM.
2110

2111 11. BPT serve as the USNORTHCOM designated theater
2112 JFLCC and provide theater support to CDRUSNORTHCOM and localized
2113 support for established JTF(s) or other components as designated in
2114 conducting PI&ID operations in the USNORTHCOM AOR. Coordinate with
2115 JFMCC, JFACC, and ALCOM.
2116

2117 (e) Commander, Special Operations Command North
2118 (CDRSOCNORTH).
2119

2120 1. As directed in the USNORTHCOM TCP, TSC Annex, and
2121 in consultation with the N-NC/SG, N-NC/J4, and N-NC/J59, coordinate and
2122 conduct Phase 0 health engagements across the AOR IOT build the capacity for
2123 partner nations and partner nation militaries to reduce the host nation's
2124 susceptibility to diseases and mitigate the effects of a PI&ID outbreak should
2125 one occur.
2126

2127 2. BPT lead, or participate in, PI&ID responses in the AOR
2128 as directed ISO the Lead Federal Agency (DHHS, FEMA or USAID/OFDA) and
2129 international efforts in affected areas in response to a disease of operational
2130 significance.
2131

2132 3. IAW DODI 6200.03 (reference x.), and ICW N-NC/SG,
2133 protect assigned forces and preserve operational readiness through education
2134 and training on the PI&ID threat, personal protective measures, prophylaxis,
2135 and PPE. As required, implement FP/FHP measures to protect forces, families
2136 and readiness.
2137

2138 4. Serve as the Joint Special Operations Component
2139 Commander (JFSOCC) in the USNORTHCOM AOR. BPT execute C2 of SOF
2140 supporting PI&ID operations.
2141

2142 (f) Commander, Alaskan Command (CDRALCOM).
2143

2144 1. Conduct planning and develop supporting plan(s) for
2145 PI&ID response that at a minimum:
2146

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2147 a. Detail actions for mission assurance, USG support,
2148 and PN support operations.
2149

2150 b. Submit supporting plan to USNORTHCOM J5.
2151 Provide supporting plan back-brief to USNORTHCOM leadership.
2152

2153 2. IAW Annex J and the base plan, BPT to be designated as
2154 a CDR-DOD Title 10 HQs overall operational level commander to execute C2
2155 and synchronize efforts to provide DOD support within the ALCOM JOA to
2156 conduct operations in support of directed efforts to respond to a PI&ID event.
2157

2158 3. BPT lead, or participate in, responses in the AOR as
2159 directed ISO the Lead Federal Agency (DHHS and/or FEMA) efforts in the
2160 ALCOM JOA.
2161

2162 4. IAW DODI 6200.03 (reference x.), and ICW N-NC/SG,
2163 protect assigned forces and preserve operational readiness through education
2164 and training on the PI&ID threat, personal protective measures, prophylaxis,
2165 and PPE. As required, implement FP/FHP measures to protect forces, families
2166 and readiness.
2167

2168 5. Monitor for potential operationally significant outbreaks
2169 (N-NC/SG, NCMI, Center for Disease Control, WHO) to establish and maintain
2170 situational awareness in the ALCOM JOA.
2171

2172 6. Coordinate public affairs messages with USNORTHCOM
2173 on activities that will impact ALCOM JOA in order to ensure synchronization of
2174 CDRs communications strategy.
2175

2176 7. As required, monitor and report to USNORTHCOM health
2177 of forces assigned/attached to ALCOM IOT support situation
2178 awareness/understanding and support requisite decision points IAW Annex R.
2179

2180 (g) Commander, Joint Force Headquarters National Capital Region
2181 (CDR JFHQ-NCR).
2182

2183 1. Conduct planning and develop supporting plan(s) for
2184 PI&ID response that at a minimum:
2185

2186 a. Detail actions for mission assurance, USG support,
2187 and PN support operations.
2188

2189 b. Submit supporting plan to USNORTHCOM J5.
2190 Provide supporting plan back-brief to USNORTHCOM leadership.
2191

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2192 2. IAW Annex J and the base plan, BPT to be designated as
2193 a CDR-DOD Title 10 HQs overall operational level commander to execute C2
2194 and synchronize efforts to provide DOD support within the JFHQ-NCR JOA to
2195 conduct operations in support of directed efforts to respond to a PI&ID event.
2196

2197 3. BPT lead, or participate in, responses in the AOR as
2198 directed ISO the Lead Federal Agency (DHHS and/or FEMA) efforts in the
2199 JFHQ-NCR JOA.
2200

2201 4. IAW DODI 6200.03 (reference x.), and ICW N-NC/SG,
2202 protect assigned forces and preserve operational readiness through education
2203 and training on the PI&ID threat, personal protective measures, prophylaxis,
2204 and PPE. As required, implement FP/FHP measures to protect forces, families
2205 and readiness.
2206

2207 5. Monitor for potential operationally significant outbreaks
2208 (N-NC/SG, NCMI, Center for Disease Control, WHO) to establish and maintain
2209 situational awareness in the JFHQ-NCRJOA.
2210

2211 6. Coordinate public affairs messages with USNORTHCOM
2212 on activities that will impact JFHQ-NCR JOA in order to ensure
2213 synchronization of CDRs communications strategy.
2214

2215 7. As required, monitor and report to USNORTHCOM health
2216 of forces assigned/attached to JFHQ-NCR IOT support situation
2217 awareness/understanding and support requisite decision points IAW Annex R.
2218

2219 (3) Joint and Service Force Providers (JFPs). The Joint Staff J3 serves as
2220 the primary joint force coordinator for conventional forces and in this capacity
2221 provides recommended global sourcing solutions and associated force sourcing
2222 risk assessments for SecDef approval. When directed by SecDef, the Joint Staff
2223 sources conventional forces and resources to assist civil authorities within the
2224 USNORTHCOM AOR. CDRUSSOCOM is the joint force provider for SOF.
2225

2226 (4) Services.

2227 (a) Ensure all MTFs:
2228

2229 1. Review plans/infection control procedures
2230

2231 2. Coordinate with local health officials for PH guidance
2232 during outbreaks
2233

2234 3. Conduct facility gap analysis (surge resources)
2235
2236

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- 2237 4. Validate Tamiflu and PPE stock levels.
2238
2239 5. BPT leverage medical and public health surge capacity.
2240
2241 6. Report shortfalls of staff and supplies through
2242 installation commanders.

2243
2244 (b) Ensure Installation Commanders:
2245

- 2246 1. Plan for supply and resupply in a PI&ID environment
2247 where they will be subject to prolonged COOP execution and shelter-in-place
2248 policy, restricted transportation capabilities, and shortages of critical supplies.
2249
2250 2. Update PI&ID plans to address operationally significant
2251 disease.

2252
2253 (c) Services are responsible for coordinating FHP actions (e.g.,
2254 movement restrictions, appropriate staffing of medical facilities, isolation) with
2255 USNORTHCOM to ensure minimal impact to operations in the AO. Assigned
2256 personnel will fall under the FHP actions of the JTF/TF Commander.
2257

2258 (5) Geographic Combatant Commands. Geographic Combatant
2259 Commanders (GCCs) are the supported commanders within their respective
2260 AORs. All other combatant commanders are supporting commanders for PI&ID
2261 response operations. When directed by the SecDef, GCCs are supporting
2262 CCDRs to CDRUSNORTHCOM for PI&ID operations in the USNORTHCOM OA.
2263 SecDef will set priority of effort.
2264

2265 (6) CDRUSSTRATCOM.
2266

2267 (a) When directed by the SecDef, CDRUSSTRATCOM supports
2268 designated supported Combatant Commanders by ensuring the conduct of
2269 assigned missions and by making recommendations on the allocation of
2270 intelligence, surveillance and reconnaissance (ISR) assets during operations in
2271 a global PI&ID environment. Additionally, USSTRATCOM will oversee the
2272 deployment of strategic, high priority assets to ensure Continuity of Operations
2273 (COOP) and will synchronize global CWMD planning efforts in accordance with
2274 UCP responsibilities as they relate to biological threats.
2275

2276 (b) When directed by the SecDef, CDRUSSTRATCOM supports
2277 CDRUSNORTHCOM by conducting space operations, space control support
2278 and Nuclear Weapons Control during PI operations in the USNORTHCOM OA
2279 and managing FHP and deployment of strategic, high priority assets to ensure
2280 COOP. USSTRATCOM, through the Center for Combating Weapons of Mass
2281 Destruction (SCC-WMD), will provide situational awareness and planning

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2282 support upon request. Situational awareness support includes the biological
2283 (BIO) common operational picture

2284

2285 (7) CDRUSTRANSCOM. When directed by the SecDef,
2286 CDRUSTRANSCOM employs strategic common-user air, land, and sea
2287 transportation for deployment and redeployment of forces engaged in
2288 contingency response operations in a global PI&ID environment. Additionally
2289 CDRUSTRANSCOM provides air refueling assets and air evacuation assets for
2290 patient movement as required.

2291

2292 (8) Chief, National Guard Bureau (CNGB).

2293

2294 (a) Exchange daily SITREPs with the NORAD-USNORTHCOM
2295 Command Center on National Guard activities in the USNORTHCOM AOR.

2296

2297 (b) Share COP information concerning National Guard forces
2298 responding to a PI&ID event in a State status or Title 32 status to the NORAD-
2299 USNORTHCOM Command Center, to include forces responding under EMAC.

2300

2301 (c) Coordinate with USNORTHCOM and subordinate
2302 headquarters with integrating/synchronizing Federal and non-Federal military
2303 planning, response, deployment/redeployment and transition efforts.

2304

2305 (d) Coordinate with USNORTHCOM for liaison with the
2306 CDRUSNORTHCOM designated TF/JTF to avoid on-site duplication of
2307 missions, ensure unity of effort, and share force protection and COP
2308 information.

2309

2310 (9) Supporting Defense Agencies. As directed by SecDef, provide the
2311 following resources and/or capabilities:

2312

2313 (a) Defense Threat Reduction Agency (DTRA). Provide support and
2314 technical advice to assist with developing scenarios to prepare for and models
2315 for operationally significant outbreaks in concert with USG and public/private
2316 counterparts.

2317

2318 1. Provide support and technical expertise to PI&ID operations to
2319 include 24 hours a day/7 days a week technical reach back assistance to
2320 federal, state and local agencies.

2321

2322 2. Provide deployable planning, technical support and
2323 consequence management teams as required.

2324

2325 3. Provide CBRNE (specifically disease) modeling as requested.

2326

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2327 4. Leverage Cooperative Biological Engagement Program to
2328 strengthen partner nation's capabilities for biosurveillance, early detection,
2329 diagnostic and reporting, and biological safety and security for Especially
2330 Dangerous Pathogens (EDP).
2331

2332 (b) National Geospatial Intelligence Agency (NGA). Provide geospatial
2333 intelligence (GEOINT) to include imagery, imagery intelligence, and geospatial
2334 information and service products data and associated services in support of
2335 PI&ID contingency response operations for USNORTHCOM as directed.
2336

2337 (c) Defense Information Systems Agency (DISA). Ensure
2338 USNORTHCOM, supporting commands and agencies receive timely and
2339 effective command, control, communications, computers, and intelligence (C4I)
2340 support, and other support as required.
2341

2342 (d) Defense Logistics Agency (DLA). Coordinate with USNORTHCOM
2343 and Service components for subsistence, clothing, individual equipment,
2344 petroleum, construction materials, personal demand items, medical materials
2345 and repair parts support. Provide integrated material management and supply
2346 support for all DLA managed material. Provide property and hazardous
2347 material (HAZMAT) disposal services. Provide USNORTHCOM visibility over
2348 general support to a LFA per interagency agreement that is not directly
2349 providing DSCA. Execute DSCA within the USNORTHCOM AOR ISO
2350 CDRUSNORTHCOM.
2351

2352 (e) Defense Intelligence Agency (DIA), National Center for Medical
2353 Intelligence (NCMI). Provide support to USNORTHCOM PI&ID missions to
2354 include: situational awareness, disease impact characterization assessments,
2355 disease operational risk assessments, and dynamic threat assessment. If
2356 information is unclassified results should be consolidated with and distributed
2357 by AFHSB (or other appropriate Defense Health Agency or SG office) to allow
2358 maximum dissemination with USNORTHCOM stakeholders and integrate FHP
2359 recommendations from DHA and elsewhere (see annex B).
2360

2361 c. Coordinating Instructions.
2362

2363 (1) Planning should involve other USG departments and agencies,
2364 including but not limited to DHHS, CDC, FEMA, and USDA for domestic
2365 operations DOS, USAID/OFDA, and HHS for foreign operations, and account
2366 for the integration of USG and NGO efforts within the AOR.
2367

2368 (2) CDRUSNORTHCOM shall be the coordinating authority for any
2369 USNORTHCOM members (military and civilian) conducting PI&ID operations in
2370 the USNORTHCOM AO. Such forces, with the exception of US Transportation
2371 Command (USTRANSCOM) forces not assigned to the NORTHCOM Deployment

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2372 and Distribution Operations Center (NDDOC) shall become OPCON to
2373 CDRUSNORTHCOM upon arrival at duty location for PI&ID.

2374

2375 (3) Military, DOD civilian and contract personnel will deploy in
2376 accordance with NORAD and USNORTHCOM Instruction 44-163, Individual
2377 Medical Readiness, and FHP guidance per Department of Defense Instruction
2378 (DoDI) 6025.19, Individual Medical Readiness (IMR), and DoDI 6490.03,
2379 Deployment Health.

2380

2381 (4) All strategic communications and public affairs messaging will be
2382 consistent with ASD(PA) and ASD (HD&ASA) guidance which will support the
2383 overall USG messaging.

2384

2385 (5) This document is effective for planning upon receipt and for
2386 execution upon notification. Subordinate plan revisions are due NLT 60 days
2387 following approval of the plan.

2388

2389 (6) CDRUSNORTHCOM will notify the SECDEF of phase changes, and
2390 coordinate requirements with Joint Staff.

2391

2392 (7) CJCSI 3121.018, Standing Rules of Engagement/Standing Rules for
2393 the Use of Force for U.S. Forces are in effect until superseded by competent
2394 authority.

2395

2396 (8) Service components will capture costs during all phases of the
2397 response for ultimate reimbursement from the primary agency.

2398

2399 (9) DIRLAUTH is granted for subordinate coordination with external
2400 organizations and agencies, as appropriate. However, the chain of command
2401 must maintain accurate awareness of what external coordination is taking
2402 place to ensure an overall unified effort and consistency of policy
2403 implementation. Subordinate organizations must keep this headquarters
2404 informed of these external coordination.

2405

2406 (10) Commander's Critical Information Requirements (CCIRs).

2407

2408 (a) Priority Intelligence Requirements (PIR). See Annex B.

2409

2410 1. PIR 1: What are the efforts of international partners,
2411 countries or organizations to detect, mitigate or respond to an infectious
2412 disease outbreak of operational significance (epidemic or of pandemic
2413 potential)? (OPR: DIA/NCMI)

2414

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2415 2. PIR 2: Identify the new or novel influenza virus or other
2416 respiratory pathogen (emerging or engineered) with pandemic potential. (OPR:
2417 DIA/NCMI)

2418
2419 3. PIR 3: Has an infectious disease of operational
2420 significance (epidemic or of pandemic potential) been detected in or introduced
2421 into a geographic area where there is little or no assessed population
2422 immunity? (OPR: DIA/NCMI)

2423
2424 4. PIR 4: Provide medical intelligence analysis concerning the
2425 health and medical threat implications of a pandemic caused by either
2426 influenza or another emerging respiratory pathogen. (OPR: DIA/NCMI)

2427
2428 5. PIR 5: What are the foreign governments' political,
2429 military, medical and social responses to infectious disease outbreaks? (OPR:
2430 JIOC-N)

2431
2432 6. PIR 6: Will a state, non-state or transnational actor take
2433 advantage of the PI&ID situation? (OPR: JIOC-N)

2434
2435 (b) Friendly Force Information Requirements (FFIR).

2436
2437 1. Are Force Health Protection capabilities available?

2438
2439 2. Have DOD personnel been potentially exposed to disease?

2440
2441 3. Is operational Readiness affected?

2442
2443 4. Requirements for possible NEO/ Repat support?

2444
2445 5. Civil unrest another GCC—NC AOR?

2446
2447 6. Effects to Mission Assurance?

2448
2449 7. Are key population and critical staff absenteeism rates
2450 above normal?

2451
2452 8. Are priority missions not being performed?

2453
2454 9. What is the status and adequacy of essential supplies?

2455
2456 9. Localized public health measures implemented?

2457
2458 10. What is the health status of the force?

2459

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2475

11. Are RFAs for domestic/international support?
12. Are critical infrastructure/operations being impacted?
13. Have key partner nation/s readiness been impacted?
14. Change in disease behavior?
15. FHP guidance issued by another GCC?
16. Introduction with section of indigent population?
17. Exposed US Citizen returning to CONUS?

(11) Decision Support Framework.

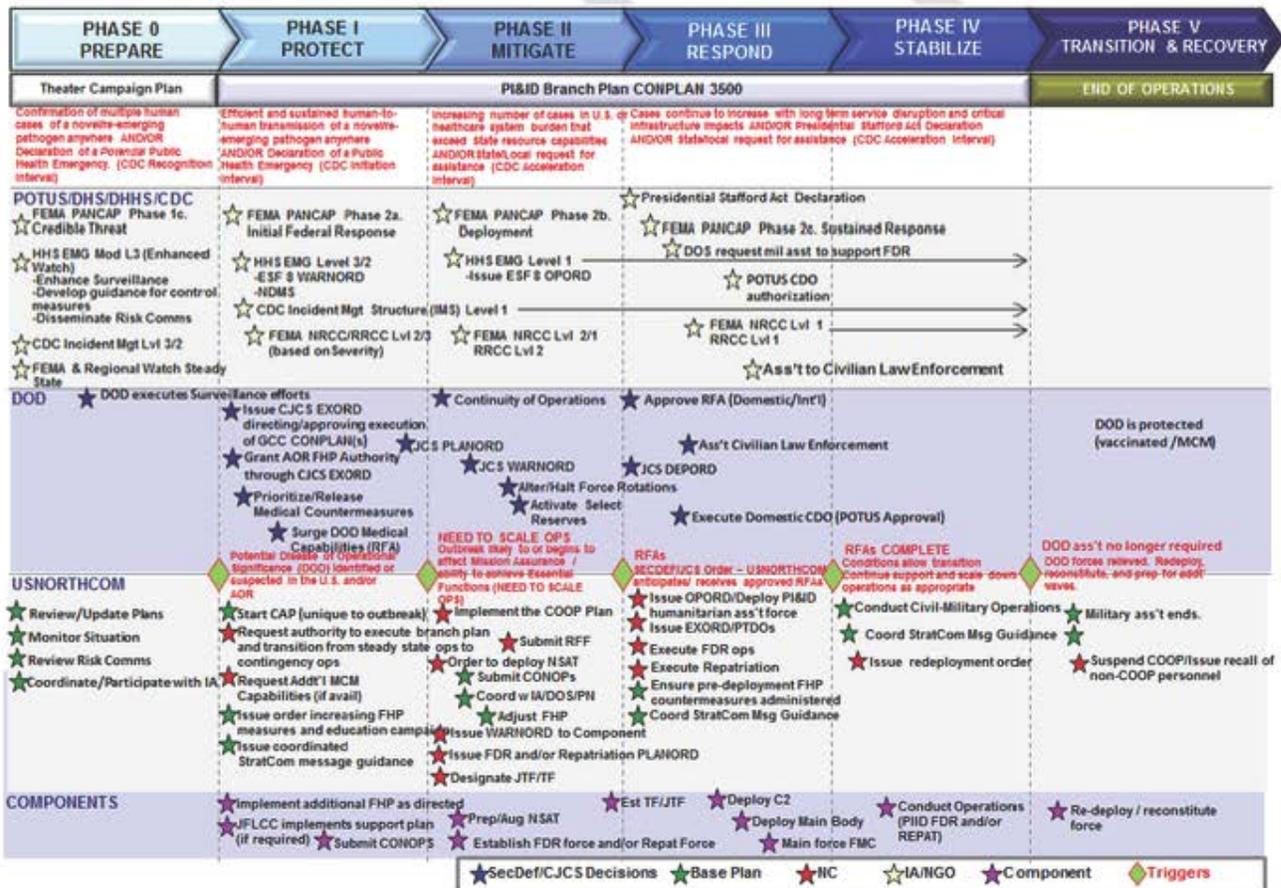


Figure 7, PI&ID Response Decision Support Framework

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2477
2478
2479
2480
2481

4. Administration and Logistics.

- a. Concept of Support. The concept of logistics for PI&ID operations, to

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2482 include deployment, sustainment, and combat service support (CSS) efforts will
2483 be flexible and tailored to support the mission requirements. At the tactical
2484 level, support will be provided, to the extent possible, using the designated
2485 BSI (or multiple installations) as the hub supporting JTF/TF operations. See
2486 Annex D for more detail.

2487
2488 b. Logistics. See Base Plan and Annex D. The principle materiel
2489 requirements for a PIID event include specially formulated influenza vaccine,
2490 antiviral drugs, ventilators and personal protective equipment. The DOD will
2491 coordinate its purchases of antiviral drugs and influenza vaccine through the
2492 Defense Supply Center Philadelphia. The DOD has begun to stockpile Tamiflu,
2493 which is used to prevent and treat influenza and believed to be effective against
2494 pandemic influenza (PI). Stockpiles are not released to the Services or
2495 Geographical Combatant Commanders, but remain within the control of the
2496 Assistant Secretary of Defense (Health Affairs) (ASD (HA)), and may be
2497 transported to different locations depending on the overall risk and mission.
2498 The ASD (HA) is vested with the authority to release all or a portion of the
2499 stockpile to JCS and/ or the Services after PIID event is confirmed.

2500
2501 c. Personnel. See Annex E.

2502
2503 d. Public Affairs. See Annex F. A comprehensive information campaign
2504 should begin immediately for USNORTHCOM and the US interagency to build
2505 cooperation to with regard to the PI&ID risk. Objectives of this information
2506 campaign should include building awareness and encouraging. Populations in
2507 and around affected areas must be educated on the characteristics of the
2508 threat, personal protective measures, and government plans to respond to
2509 outbreaks. Appropriate responses and compliance to instructions by civilian
2510 populations in affected areas will be essential to the ability to successfully
2511 mitigate outbreak impacts. The public information campaign to support
2512 education on the threat and appropriate actions is a critical element of an
2513 effective comprehensive partnership effort to combat the risk of PI&ID.

2514
2515 e. Meteorological and Oceanographic (METOC) Operations. Refer to
2516 USNORTHCOM Theater Campaign Plan - Annex H.

2517
2518 f. Geospatial Information and Services. See Annex B.

2519
2520 g. Medical Services. See Enclosure B to this Branch Plan. During PI&ID
2521 operations, medical and public health needs will be significant factors. The
2522 National Disaster Medical System (NDMS), which includes DOD coordination
2523 with participating non-Federal fixed hospitals and DOD provided patient
2524 evacuation, will provide Federal-level medical response when applicable and
2525 able. A pandemic or large scale operationally significant disease environment
2526 will reduce the effectiveness of NDMS. Therefore, NDMS will not be used for

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2527 movement of influenza patients and will be of limited functionality in the event
2528 of a mass casualty event requiring patient movement/regulation from an area
2529 impacted by another disaster. Other DOD medical capabilities external to
2530 NDMS should be requested if it is determined necessary to augment or sustain
2531 the NDMS/local response in order to save lives and minimize human suffering.
2532 The time sensitive nature of the requirements necessitates early and rapid
2533 interagency coordination to be effective. Restrictions on the use of military
2534 medical stockpiles and on the military immunizing civilians may need to be
2535 addressed in mission planning. JFHQ-State accessing Strategic National
2536 Stockpile resources through respective state health departments is encouraged.

2537

2538 5. Command and Control.

2539

2540 a. Command. See Base Plan and Annex J.

2541

2542 (1) Command Relationships. See Base Plan and Annex J.

2543

2544 (2) Command Posts. NORAD-USNORTHCOM Command Center (N2C2).

2545 The N2C2, USNORTHCOM's primary incident awareness center, is situated in

2546 Building 2 on Peterson Air Force Base, Colorado. The N2C2 monitors and

2547 coordinates domestic event activities, initiates activation messages and drafts

2548 the Commander's estimate. The NORAD and USNORTHCOM battle staffs

2549 operate under three core operational centers, current operations, future

2550 operations and future plans. The core centers plan and conduct current and

2551 future operations, establish appropriate C2, and oversee the execution of

2552 operations orders.

2553

2554 (3) Succession of Command. See Base Plan and Annex A.

2555

2556 b. Command, Control, Communications, and Computer (C4) Systems. See
2557 Annex K.

2558

2559

2560

2561 LORI J. ROBINSON

2562 General, USAF

2563 Commander

2564

2565 Enclosures

2566

2567 A -- Intelligence

2568 B -- Medical

2569 C -- TBD

2570 D -- TBD

2571

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2593 HEADQUARTERS, U.S. NORTHERN COMMAND
2594 250 Vandenberg Street, Suite B016
2595 Peterson AFB, CO 80914-3270
2596 DD MMM 20YY

2597
2598 ENCLOSURE A TO TAB D PI&ID RESPONSE BRANCH PLAN TO APPENDIX 1
2599 TO ANNEX C TO USNORTHCOM CONPLAN 3500 – 14
2600 INTELLIGENCE

2601
2602 References:

- 2603 a. (U) DIA/NCMI, Defense Intelligence Study DIA-16-1405-629.B, “Dynamic
2604 Threat Assessment 3551: Pandemic Influenza”, 3 Jun 2014 (S//REL TO
2605 USA, FVEY)
- 2606
2607 b. (U) DIA/NCMI, Defense Intelligence Reference Document DIA-16-1204-
2608 533, “Evaluating the Operational Impact of Emerging Infectious
2609 Diseases in the U.S. Military”, 26 Apr 2012 (U)
- 2610
2611 c. (U) CJCSM 3150.01B, “Joint Reporting Structure General Instructions”,
2612 16 Jun 2008 (U)
- 2613
2614 d. (U) DIA, Defense Intelligence Agency Instruction 5240.400, “Information
2615 Security Program”, 2 Apr 2014 (U)
- 2616
2617 e. (U) DIA/NCMI DI-1812-1533-09 “Warning Assessment for Pandemic
2618 influenza”, 28 April 2009 (U)

2619
2620 1. Situation.

2621
2622 a. Characteristics of the Operational Environment (OE). See Annex B to
2623 CONPLAN 3500.

2624
2625 (1) Physical Areas and Factors. See Annex B to CONPLAN 3500.

2626
2627 (2) Information Environment. See Annex B to CONPLAN 3500.

2628
2629 (3) Systems Perspective. See Annex B to CONPLAN 3500.

2630
2631 b. Crisis Environment.

2632
2633 (1) DIA assesses with high confidence that any highly contagious
2634 infectious disease resulting in near simultaneous debilitating illness across
2635 multiple geographic commands will, at a minimum, negatively impact the
2636 availability of U.S. military personnel for duty. Novel respiratory diseases with a
2637 short incubation period, such as influenza viruses, pose the most likely

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2638 pandemic threat. An influenza pandemic is a global event that affects all
2639 populations to varying degrees, and transmission can occur in waves over
2640 many months. DIA assesses that a pandemic, which would entail a multiyear
2641 new operating environment, will give rise to political, social, and economic
2642 instabilities that could, in turn, lead to opportunistic aggression, increased
2643 terrorist activity, internal unrest, political/economic collapse, humanitarian
2644 crises, and dramatic social change, especially when coupled with high
2645 morbidity and mortality.

2646
2647 (2) Although novel influenza viruses currently pose the most likely
2648 pandemic threat, any pathogen that has a short incubation period and is
2649 readily transmissible among an almost universally susceptible population has
2650 the potential to become a pandemic.

2651
2652 (3) Initial recognition, identification and characterization of an
2653 emerging or re-emerging pathogen can take several weeks or possibly months,
2654 during which time regional and/or global movement of infected individuals will
2655 occur, thereby facilitating disease spread.

2656
2657 (4) Mitigating morbidity and mortality will define how a country will
2658 emerge post-pandemic. Even the most industrialized countries will have
2659 insufficient hospital beds, specialized equipment such as mechanical
2660 ventilators, and pharmaceuticals readily available to adequately treat their
2661 populations during a clinically severe pandemic. The degree to which countries
2662 can mitigate morbidity and mortality and affect messaging during a pandemic
2663 and reintegrate recovering people back into society will have considerable
2664 impact on the magnitude of secondary and tertiary economic, political,
2665 security and social effects.

2666
2667 (5) The top concerns for emerging/re-emerging infectious diseases of
2668 operational significance and diseases with pandemic potential in the
2669 USNORTHCOM AOR are depicted in the table listed below. The top five
2670 priorities, in no particular order, are highlighted in orange. The prioritization
2671 and content is based on our assessment using NCMI's "Evaluating the
2672 Operational Impact of Emerging Infectious Diseases in the U.S. Military" (ref b),
2673 "Guide to Emerging Infectious Disease Threats" (linked to ref a) and CDC's
2674 Category A agents and diseases listing. See CDC's site at
2675 <http://emergency.cdc.gov/agent/agentlist-category.asp> for more information
2676 on categories.

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Pathogen/Agent/Disease	Pathogen Characteristics	Population/Host Factors	Environmental Factors
Avian Influenza A Virus (H7N9)	<ul style="list-style-type: none"> - H2H transmissible, but not sustained at this time - Mutation tendencies of the virus may enable sustained H2H transmission and trigger a potential pandemic 	Treatment with antivirals; no vaccine currently available; social interactions will contribute to spread if the virus mutates to enable sustained H2H transmission	If a mutation enables sustained H2H transmission, then crowded living conditions will contribute to the spread of the disease
Corona Virus	<ul style="list-style-type: none"> - H2H transmissible; however, no sustained H2H transmission with MERS-CoV - Corona virus infections common around the world; exceptions are MERS-CoV and SARS-CoV - Specific host unknown 	No specific treatment or vaccine	For MERS-CoV: close contact such as care-giver situation increases exposure to virus and illness
Plague (<i>Yersinia pestis</i>)	<ul style="list-style-type: none"> - Several forms: Pneumonic (H2H transmissible), Bubonic (most common, not H2H) and Septicemic (not H2H) - Early identification and treatment of pneumonic plague is essential 	No human immunity; treatment available; no vaccine; social interactions and travel patterns contribute to increased spread of bacteria	Crowded living conditions favorable to spread of pneumonic plague

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<p>Viral hemorrhagic fevers (filoviruses [Ebola, Marburg] and arenaviruses [Lassa, Machupo])</p>	<ul style="list-style-type: none"> - H2H transmissible - Various hosts (animal/rodent, insect and human); host for ebola and Marburg unknown 	<p>No human immunity; supportive therapy, no specific treatment</p>	<p>Crowded living conditions, vector exposure and poor sanitation/ infection control will contribute to spread</p>
<p>Smallpox (variola major)</p>	<ul style="list-style-type: none"> - H2H transmissible - Humans are only natural host - Host is usually debilitated once contagious; most contagious once rash on tongue and in mouth appears 	<p>No specific treatment; vaccine available, however, routine vaccination stopped because disease was considered eradicated;</p>	<p>Crowded living conditions favorable for spread of smallpox</p>
<p>Dengue hemorrhagic fever</p>	<ul style="list-style-type: none"> - Not H2H - Mosquito is primary vector - Localized or regional epidemic possible 	<p>No specific treatment, frequently requires hospitalization</p>	<p>Areas with high mosquito population are favorable to transmission</p>
<p>Chikungunya</p>	<ul style="list-style-type: none"> - Not H2H- Food/waterborne- May lead to localized or regional epidemics 	<p>No specific treatment</p>	<p>Areas with high mosquito population are favorable to transmission</p>

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West Nile encephalitis	<ul style="list-style-type: none">- Not H2H- Mosquito is primary vector- 70-80% of infected persons are asymptomatic- Less than 1% develop severe illness, such as encephalitis or meningitis- Regional epidemic possible	Persons with certain medical conditions are at higher risk of serious illness; no specific treatment or vaccine	Areas with high mosquito population are favorable to transmission
Yellow Fever	<ul style="list-style-type: none">- Not H2H- Mosquito is primary vector- Localized or regional epidemic possible	No specific treatment; vaccine available; yellow fever patients should be hospitalized for supportive care and close observation	Areas with high mosquito population are favorable to transmission
Anthrax (<i>Bacillus anthracis</i>)	<ul style="list-style-type: none">- Not possible to result in pandemic- Not H2H transmissible- Contact with/exposure to spores required to become ill; inhaled, ingested or contact through open wound (cutaneous)	No human immunity; treatment available	Person-to-person transmission has been reported through cutaneous anthrax, where discharge from skin lesions may be infectious

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Botulism (Clostridium botulinum toxin)	<ul style="list-style-type: none">- Not possible to result in pandemic- Not H2H transmissible- Foodborne, infant or wound botulism- 3-5% fatality rate	No human immunity; antitoxin available	<ul style="list-style-type: none">- Foodborne botulism due to improper food handling- Most wound botulism cases are associated with black-tar heroin injection
Tularemia (Francisella tularensis)	<ul style="list-style-type: none">- Not H2H transmissible- Infection through animal and insect hosts, or through inhaled bacteria	No human immunity; treatment available; vaccine under review	Crowded living conditions and proximity to animals may cause low level to regional epidemics
Cholera (Vibrio cholerae)	<ul style="list-style-type: none">- Not H2H- Food/waterborne- May lead to localized or regional epidemics	Treatment with rehydration and antibiotics;	Poor sanitation levels, to include food and water contamination, will increase risk of exposure and spread
Hantavirus Pulmonary Syndrome	<ul style="list-style-type: none">- Not H2H- Host in rodent population	No specific treatment; supportive care	Exposure to areas with active rodent inhabitation increases chances of exposure to virus

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(6) A PI&ID-related crisis would severely threaten NORAD or USNORTHCOM missions if the disease were to impact continuity of government, command and control, indications and warning capabilities or critical response forces.

c. Friendly.

(1) The primary responsibility for DOD medical intelligence analysis and dissemination concerning the health and medical threat and implications of PI&ID resides with the Defense Intelligence Agency (DIA) primarily through the National Center for Medical Intelligence (NCMI). NCMI will provide intelligence warning of diseases with pandemic potential and provide intelligence assessments of potential impact, implications, outlook and opportunities associated with the spread of a disease with pandemic potential. NCMI will also provide intelligence warning and finished all source medical intelligence analysis regarding foreign emerging/re-emerging infectious diseases of operational significance to the Combatant Commanders, the DOD, and the U.S. government as a whole. NCMI will provide information regarding foreign medical capability to plan for, report, identify and respond to PI&ID threats.

(2) HHS and CDC will be the primary source of reporting on PI&ID threats within the US homeland.

(3) JIOC-N will be responsible for supporting assessments of key second and third order impacts of the PI&ID on AOR countries, as specified in the Unified Command Plan. These assessments are addressed through PIRs 5 and 6.

d. Legal Considerations. See base plan.

2. Mission. JIOC-N supports USNORTHCOM in operations to prepare for, detect, mitigate, respond to, and recover from the effects of a pandemic influenza or infectious disease outbreak of operational significance in order to sustain assigned missions and provide support to primary Federal agencies and international partners to protect the Nation's interests. JIOC-N, ICW the Department of Defense Intelligence Community (DOD IC) works with interagency and international partners to provide Indications and Warning (I&W) of PI and infectious diseases of operational significance, track global disease spread, monitor secondary and tertiary effects of PI&ID on state and non-state actors and assure mission readiness to continue key DOD intelligence functions during a PI&ID environment.

3. Execution.

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a. Concept of Intelligence Operations.

(1) DOD IC works as part of an interagency and international effort to provide early detection of infectious diseases with pandemic potential and operational significance. Early detection gives international organizations, U.S. Government (USG), and partner nations the opportunity to respond to and mitigate the effects of PI&ID. The Defense Intelligence Agency (DIA) in collaboration with JIOC-N and DOD IC provide indications and warning of diseases with pandemic potential to facilitate force health protection, analysis and assessments of secondary and tertiary effects, situational awareness of partner nation actions and responses, and synchronize DOD national intelligence support operations in response to PI&ID and in support of USG efforts as requested and authorized. This plan is linked to certain biological warfare (BW) aspects of USSTRATCOM GCP-CWMD, and certain terrorist use of BW of USSOCOM CONPLAN 7500, DOD Campaign Plan for the Global War on Terrorism. A biological attack (see GCP-CWMD, PIR #6) may be initially indistinguishable from a naturally occurring infectious disease outbreak and will require the same suite of public health and medical responses. Even a small, unexplained PI&ID outbreak could require a great deal of epidemiologic and forensic investigation to distinguish between a naturally occurring event, an accident or a deliberate attack. Regardless, the intelligence required to support FHP measures and PI&ID contingency branch plans will be the same. If epidemiologic and forensic investigations reveal the outbreak is due to a deliberate release by a terrorist organization, refer to contingency branch plans to CONPLAN 7500.

(2) JIOC-N, ICW the intelligence community, other GCCs' JIOCs and DOD Agencies, interagency and international partners, contributes to the situational awareness of pathogens and infectious diseases which may result in a pandemic or increased demands for civil support in the USNORTHCOM AOR.

(3) Maintaining situational awareness of PI&ID spread allows the DOD IC to monitor secondary and tertiary impacts of PI&ID, with focus on political, military, economic, social, infrastructure and information (PMESII) impacts. Accurate assessments of secondary and tertiary impacts provide important context to ongoing activities of both state and non-state actors and are important for USG decision-making. JIOC-N, in collaboration with other GCC and Functional Combatant Command (FCC) JIOCs and DOD Agencies, monitor secondary and tertiary impacts of PI&ID with emphasis on potential for regional instability, and the resultant impacts on mission assurance and strategic objectives.

(4) Faced with potential manning shortfalls during a pandemic or infectious disease situation, the JIOC-N sustains mission assurance to continue key intelligence functions. The emergence of PI&ID will likely have

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2769 significant impact on JIOC-N personnel available for duty, with upwards to
2770 40% absentee rates among all segments of the population. JIOC-N will
2771 prioritize essential intelligence functions and develop redundancies and
2772 discontinue non-essential functions.

2773

2774 b. Tasks.

2775

2776 (1) Priority Intelligence Requirements (PIRs). PIRs 1 to 3 are steady
2777 state requirements, and PIRs 4 to 6 are contingency requirements. See Exhibit
2778 1 to Enclosure B (classified) for a baseline of information requirements:

2779

2780 (a) PIR 1: What are the efforts of international partners,
2781 countries or organizations to detect, mitigate or respond to an infectious
2782 disease outbreak of operational significance (epidemic or of pandemic
2783 potential)? (OPR: DIA/NCMI)

2784

2785 (b) PIR 2: Identify the new or novel influenza virus or other
2786 respiratory pathogen (emerging or engineered) with pandemic potential. (OPR:
2787 DIA/NCMI)

2788

2789 (c) PIR 3: Has an infectious disease of operational
2790 significance (epidemic or of pandemic potential) been detected in or introduced
2791 into a geographic area where there is little or no assessed population
2792 immunity? (OPR: DIA/NCMI)

2793

2794 (d) PIR 4: Provide medical intelligence analysis concerning
2795 the health and medical threat implications of a pandemic caused by either
2796 influenza or another emerging respiratory pathogen. (OPR: DIA/NCMI)

2797

2798 (e) PIR 5: What are the foreign governments' political,
2799 military, medical and social responses to infectious disease outbreaks? (OPR:
2800 JIOC-N)

2801

2802 (f) PIR 6: Will a state, non-state or transnational actor take
2803 advantage of the PI/ID situation? (OPR: JIOC-N)

2804

2805 (2) Intelligence Tasks.

2806

2807 (a) Defense Intelligence Agency (DIA).

2808

2809 1. DIA – Directorate for Analysis (DIA/DI). DI will
2810 provide analytical assessments of:

2811

2812 a. General information on foreign military
2813 capabilities, transportation systems, information infrastructure and
2814 communications, environmental factors, economy, culture, and social issues

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2815 that might affect the ability of USNORTHCOM to conduct military operations,
2816 provide humanitarian or medical support or to respond militarily to crises that
2817 threaten U.S. interests.

2818
2819 b. Emerging political, military, cultural, social or
2820 economic crises due to PI&ID.

2821
2822 c. Any evidence of efforts by foreign governments
2823 or other actors to exploit disease outbreaks, including efforts to actively use
2824 pathogens as a weapon.

2825
2826 d. Surveillance of PI&ID conducted IAW
2827 interagency cooperation, non-government organizations and scientific
2828 institutions operating in conjunction with USG efforts.

2829
2830 2. DIA – National Center for Medical Intelligence
2831 (DIA/NCMI). DIA/NCMI will provide intelligence warning of diseases with
2832 pandemic potential and provide intelligence assessments of potential impact,
2833 implications, outlook and opportunities associated with the spread of a
2834 potentially pandemic disease. NCMI will also provide intelligence warning and
2835 finished all source medical intelligence analysis regarding foreign emerging/re-
2836 emerging infectious diseases of operational significance to the USNORTHCOM,
2837 the DOD, and the U.S. government as a whole. NCMI will provide information
2838 regarding foreign medical capability to plan for, report, identify and respond to
2839 PI&ID threats. NCMI will provide analytical assessments of:

2840
2841 a. The accuracy and reliability of foreign
2842 reporting on extent and severity of PI&ID outbreaks and factors which would
2843 influence reporting accuracy including adequacy of reporting systems or efforts
2844 to suppress information.

2845
2846 b. The capability of foreign countries to respond
2847 to outbreaks including treatment facilities, medical staff, vaccination, antivirals
2848 and other medications used, medical infrastructure, and quarantine efforts.

2849
2850 (b) NRO. Provide reconnaissance support IAW USG laws to
2851 support PI&ID monitoring.

2852
2853 (c) DTRA. DTRA will provide PI&ID situational awareness
2854 and contribute to global situational awareness tool. DTRA may also leverage
2855 the Cooperative Biological Engagement Program to strengthen state capabilities
2856 for surveillance, and early detection for animal and human pandemic
2857 influenza.

2858
2859 (d) USSTRATCOM. Provide situational awareness on CWMD
2860 threats, including biological threats.

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(e) JIOC-N.

1. Steady state tasks. During Phase 0 (Prepare), J25P will be the directorate's primary point of contact for supporting PI- and ID-related activities and monitoring. J23 will be the lead for preparing for crisis support.

a. Establish and maintain relationship with SG and J9 to ensure information sharing across the command as appropriate for the unique USNORTHCOM AOR. (OPR: J25P)

b. ICW NCMI and NORAD and USNORTHCOM SG and J9, develop AOR specific PI&ID analysis and evaluation of the environment and prioritization of regional threats based on epidemiology, infrastructure and potential enemy capabilities, intentions and COAs. Include potential impact on PMESII systems on our partners and priority countries. (OPR: J25P)

c. Assist SG and J5 in identifying the top five priorities for emerging/re-emerging infectious diseases of operational significance and diseases with pandemic potential in our AOR. (OPR:J25P)

d. JIOC-N will coordinate PI-ID-specific collection and production requirements with JS J25 in support of the PIRs specified in Exhibit 1 to Enclosure B. Information sharing requirements will be coordinated with J25S. (OPR: J25P; OCR: J23)

e. Develop appropriate interagency and international relationships and communications pathways to share PI&ID intelligence. (OPR: J25P)

f. BPT continue mission essential intelligence functions during a pandemic. (OPR: J23; OCRs: J21, J22, J24, J25P)

g. Coordinate with DIA efforts to provide indications and warning for emergence of PI&ID. Participate in PI Community of Interest, hosted by JS/J25. (OPR: J25P)

h. BPT support USG efforts as requested and authorized. (OPR: J23; OCR: J25P)

2. Contingency tasks. JIOC-N will transition to crisis support operations IAW the NORAD-USNORTHCOM intelligence operating instruction when CDR NORAD-USNORTHCOM considers moving to Phase 1 (Protect). At this point, J25P will transition into a supporting role to J23, who

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2907 will then coordinate intelligence support to the command, IAW PIRs 4 through
2908 6.

2909

2910 a. ICW NCMI, provide intelligence warning and
2911 analysis regarding foreign emerging/re-emerging infectious diseases of
2912 operational significance and diseases with pandemic potential. (OPR: J23;
2913 OCR: J25P)

2914

2915 b. Provide intelligence analysis to support
2916 evaluating the operational impact of emerging infectious diseases, as per ref b,
2917 and assessments concerning the health threat and implications, outlook and
2918 opportunities associated with the spread of a potentially pandemic
2919 disease. Information on transmissibility and severity are vital in determining
2920 the appropriate type of FHP measures to ensure DOD forces are ready and
2921 capable of supporting USG and partner nation efforts to mitigate a PI&ID
2922 outbreak and manage second and third order effects. (OPR: J23; OCR: J25P)

2923

2924 c. Monitor PMESII aspects of affected areas to
2925 provide early warning of instability, opportunistic aggression, indications of
2926 military conflict, increased terrorist activity, reduced partner nation capacities,
2927 internal unrest, political or economic collapse, and humanitarian crises. (OPR:
2928 J23; OCR: J25P)

2929

2930 d. Maintain situational awareness of partner
2931 nation actions and responses, if not provided in a collaborative manner
2932 through medical or operational channels. Accurate information on partner
2933 nation responses will provide context to the impact of the disease on partner
2934 capabilities and potential vulnerabilities. (OPR: J23; OCR: J25P)

2935

2936 e. Support lead agencies as requested and
2937 authorized. (OPR: J23; OCR: J25P)

2938

2939 (3) Orders to Subordinate Units. See Annex B to CONPLAN 3500.

2940

2941 (4) Requirements to Higher and Supporting Organizations.

2942

2943 (a) Defense Intelligence Agency (DIA).

2944

2945 1. DIA – Directorate for Analysis (DIA/DI). Provide
2946 analytical assessments of:

2947

2948 a. General information on foreign military
2949 capabilities, transportation systems, information infrastructure and
2950 communications, environmental factors, economy, culture, and social issues
2951 that might affect the ability of USNORTHCOM to conduct military operations,

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2952 provide humanitarian or medical support or to respond militarily to crises that
2953 threaten U.S. interests.

2954
2955 b. Emerging political, military, cultural, social or
2956 economic crises due to PI&ID.

2957
2958 c. Any evidence of efforts by foreign governments
2959 or other actors to exploit disease outbreaks, including efforts to actively use
2960 pathogens as a weapon.

2961
2962 d. Surveillance of PI&ID conducted IAW
2963 interagency cooperation, non-government organizations and scientific
2964 institutions operating in conjunction with USG efforts.

2965
2966 2. DIA – National Center for Medical Intelligence
2967 (DIA/NCMI).

2968
2969 a. Provide intelligence warning of diseases with
2970 pandemic potential and provide intelligence assessments of potential impact,
2971 implications, outlook and opportunities associated with the spread of a
2972 potentially pandemic disease.

2973
2974 b. Provide intelligence warning and finished all
2975 source medical intelligence analysis regarding foreign emerging/re-emerging
2976 infectious diseases of operational significance to the USNORTHCOM, the DOD,
2977 and the U.S. government as a whole.

2978
2979 c. Provide information regarding foreign medical
2980 capability to plan for, report, identify and respond to PI&ID threats. NCMI will
2981 provide analytical assessments of:

2982
2983 i. The accuracy and reliability of foreign
2984 reporting on extent and severity of PI&ID outbreaks and factors which would
2985 influence reporting accuracy including adequacy of reporting systems or efforts
2986 to suppress information.

2987
2988 ii. The capability of foreign countries to
2989 respond to outbreaks including treatment facilities, medical staff, vaccination,
2990 antivirals and other medications used, medical infrastructure, and quarantine
2991 efforts.

2992
2993 (b) NRO. Provide reconnaissance support IAW USG laws to
2994 support PI&ID monitoring.

2995
2996 (c) DTRA. DTRA will provide PI&ID situational awareness
2997 and contribute to global situational awareness tool. DTRA may also leverage

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2998 the Cooperative Biological Engagement Program to strengthen state capabilities
2999 for surveillance, and early detection for animal and human pandemic
3000 influenza.

3001

3002 (d) USSTRATCOM. Enable DOD's ability to provide global
3003 CWMD situational awareness, including biological threats.

3004

3005 c. Collection. See Appendix 12 to Annex B to CONPLAN 3500.

3006

3007 (1) Signals Intelligence (SIGINT). See Appendix 2 to Annex B to
3008 CONPLAN 3500.

3009

3010 (2) Geospatial Intelligence (GEOINT). See Appendix 12 to Annex B
3011 to CONPLAN 3500. Imagery intelligence can be used prior to the onset of a
3012 pandemic to establish a baseline essential to detecting and determining
3013 abnormal activity. After a potential onset of a pandemic, imagery can be used
3014 to confirm unusual activity, providing insight into foreign responses to the
3015 spread of disease and potential follow-on impacts. Imagery reports will be
3016 shared with Service component commands, U.S. Country Teams and the
3017 national intelligence community.

3018

3019 (3) Human Intelligence (HUMINT). See Appendix 5 to Annex B to
3020 CONPLAN 3500.

3021

3022 (4) Measurement and Signature Intelligence (MASINT). See
3023 Appendix 8 to Annex B to CONPLAN 3500.

3024

3025 (5) Counterintelligence (CI). See Appendix 3 to Annex B to
3026 CONPLAN 3500.

3027

3028 (6) Open Source Intelligence (OSINT). OSINT collection manager
3029 receives, validates and manages OSINT collection requirements and
3030 coordinates tasking for DNI's Open Source Center (OSC). Note: Within N-NC,
3031 local OSINT research and production requirements are internally tasked
3032 through the RFI process managed by J25, Mission Support.

3033

3034 (7) ISR. See Appendix 15 to Annex B.

3035

3036 d. Processing and Evaluation. See Annex B.

3037

3038 e. Analysis and Production. See Appendix 13 to Annex B to CONPLAN
3039 3500.

3040

3041 (1) All Source Intelligence Analysis and Production. DIA, through
3042 NCMI, is the Responsible Analytical Center (RAC) for medical intelligence
3043 analysis and production concerning a pandemic, in collaboration with JIOC-N

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3044 and other GCCs/FCCs and DOD IC. NCMI will provide intelligence warning of
3045 diseases with pandemic potential and provide intelligence assessments of the
3046 implications, outlook and opportunities associated with the spread of a
3047 potentially pandemic disease. NCMI will also provide intelligence warning and
3048 finished all source medical intelligence analysis regarding foreign emerging/re-
3049 emerging infectious diseases of operational significance to the Combatant
3050 Commanders, the DOD, and the U.S. government as a whole. NCMI will
3051 provide information regarding foreign medical capability to plan for, report,
3052 identify and respond to PI&ID threats.

3053

3054 (2) General Reporting. Information pertinent to the PIRs as
3055 outlined in Exhibit 1 to Enclosure B to Tab D to Appendix 1 to Annex C to
3056 CONPLAN 3500 will be reported using established reporting procedures and in
3057 accordance with Appendix 13 to Annex B to CONPLAN 3500.

3058

3059 f. Dissemination and Integration. As the RAC, DIA/NCMI is responsible
3060 for dissemination of medical intelligence products concerning the emergence of
3061 a pandemic virus OCONUS, in collaboration with GCCs/FCCs and DOD IC.
3062 Products are posted at <https://www.ncmi.dia.smil.mil/subject/epi.php> for
3063 easy access. JIOC-N, in collaboration with DOD IC, is responsible for
3064 dissemination of products assessing key second and third order impacts of the
3065 pandemic on AOR countries. See Appendix 14 to annex B to CONPLAN 3500.

3066

3067 (1) Timely intelligence reports and assessments will be produced at
3068 the lowest classification level possible with the intent of sharing as much
3069 intelligence as possible with interagency and international partners and first
3070 responders on the emergence of a virus or significant infectious disease with
3071 pandemic potential. Classified products will also be reviewed for releasability
3072 to foreign nations.

3073

3074 (2) Request for Information (RFI) management and dissemination
3075 will be via COLISEUM in accordance with established procedures.

3076

3077 (3) Information will be classified according to source and content.
3078 Sensitive medical reporting with potential to cause damage to national security
3079 should be brought before an original classification authority prior to release.
3080 Refer to Defense Intelligence Agency Instruction DIAI 5240.004, Information
3081 Security Program for classification policy and guidelines.

3082

3083 g. Coordinating Instructions.

3084

3085 (1) Review current DIA/NCMI Warning Assessment for Pandemic
3086 influenza for PI and ID indicators.

3087

3088 (2) Review current DIA Dynamic Threat Assessment 3551 for
3089 situational awareness.

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(3) Participate in Pandemic Influenza and Infectious Disease conferences and biennial table top exercises hosted by NORAD-USNORTHCOM or Joint Staff (JS) when scheduled.

(4) Familiarization with USSTRATCOM CGP-CWMD.

(5) Familiarization with USSOCOM CONPLAN 7500.

(6) Disclosure of Intelligence / Releasability to Partner Nation Forces. Guidelines for foreign disclosure of intelligence information are provided by NORAD-USNORTHCOM FDO IAW National Disclosure Policy. These guidelines are specific to an operation and will vary considerably based on the nations participating and the nature of the operation. Defense Intelligence Community organizations and JIOC-N should to the maximum extent possible write intelligence reports for the widest possible release, preferably at the REL FVEY level. When appropriate, Emergency Dissemination Authority (EDA) may be obtained through NORAD-USNORTHCOM Commander or FDO.

4. Administration and Logistics.

a. Shortfalls and Limiting Factors. J2 has accepted risk in this mission area. There are no analysts dedicated to this mission set on a full-time basis.

b. Mitigation. J25P will provide planning and operational support for PI- and ID-related issues during Phase 0. During crisis, coordination of intelligence support will transition to J23, and J25P assumes a supporting role. This transition of support and associated responsibilities will be exercised in small group training scenarios and TTX when available.

c. Miscellaneous. Role of J23 is codified in the intelligence operating instruction.

d. Logistics. See base plan.

e. Reporting. See Annex R.

5. Command and Control.

a. Command Relationships. See base plan.

b. Communications. See base plan.

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3136 LORI J. ROBINSON
3137 General, USAF
3138 Commander
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3140
3141 Exhibit
3142 1—Priority Intelligence Requirements (PIRs) (classified)
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HEADQUARTERS, U.S. NORTHERN COMMAND
250 Vandenberg Street, Suite B016
Peterson AFB, CO 80914-3270
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ENCLOSURE B TO TAB D PI&ID RESPONSE BRANCH PLAN TO APPENDIX 1
TO ANNEX C TO USNORTHCOM CONPLAN 3500 – 14
MEDICAL

1. Medical PPE Options in Response to PI&ID

(a) To mitigate risks to DoD medical personnel operating in environments with infectious diseases of operational concern, this plan establishes a medical PPE framework to expand the scope of current DoD PPE guidance beyond pandemic influenza (PI) and EVD medical responses to a wider range of PI&IDs. The medical PPE framework is based on the U.S. Centers for Disease Control and Prevention Healthcare Infection Control Practices Advisory Committee “2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings.” It consists of two parts: 1) four PPE levels for diseases, each addressing a category of diseases defined by characteristics of the infection and condition and modes of transmission, and 2) a list of PPE items designated for each PPE level to protect body parts of concern (surface exposure areas/routes). The levels of protection offered by the recommended PPE ranges from least to most protective (Level I to IV) based on various exposure and disease variables.

(b) It is important for the N-NC Components to develop training and logistical arrangements compatible to the PPE levels defined in this plan to ensure smooth expansion of medical PPE guidance from individual diseases to disease levels. In particular, the Military Services must analyze and determine appropriate types and quantities of PPE for each level and efficient distribution methods, in terms of centralized or fixed-facility based stockpiles. Military medical treatment facilities should conduct hazard vulnerability analyses and undergo the associated PPE selection process in an infectious disease outbreak incident response, as the hazards in each work environment can be unique and their characteristics must be evaluated accordingly. Additional policy and guidance will be provided as needed to enable comprehensive, responsive, and effective disease prevention and medical care to DoD personnel.

(c) Medical PPE Levels and Options. Below is a brief description of varying levels of PPE ensembles to protect healthcare workers (HCWs). Tables 1 and 2 provide additional information on the medical PPE levels and PPE options, respectively.

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3213 (1) For treatment of some contagious diseases (e.g., common cold and
3214 seasonal influenza) or non-contagious diseases (e.g., anthrax and tularemia),
3215 Level I PPE will provide sufficient protection to HCWs from possible infection.
3216 This level of PPE can also be used for zoonotic or plant diseases as a way to
3217 contain the spread and thus control the associated economic loss.

3218
3219 (2) Levels II and III PPE recommendations focus on primary modes of
3220 transmission with Level II PPE being designed to protect against droplet and
3221 contact transmission and Level III PPE intended to protect against airborne
3222 transmission (i.e., inhalation hazards (aerosols)). Consideration should also be
3223 given to medical procedures that may aerosolize fluids and particles from
3224 contact diseases and create inhalation hazards. For example, if a patient with
3225 a viral hemorrhagic fever is undergoing intubation, bronchoscopy, or other
3226 medical procedures that can aerosolize the virus, HCWs should use PPE at
3227 Level III or higher.

3228
3229 (3) Level IV PPE offers the highest level of protection to its users by
3230 protecting all routes of entry into the human body, i.e. contact, inhalation, and
3231 ingestion. Level IV PPE is suitable for diseases with undetermined modes of
3232 transmission or due to suspected deliberate release. In cases where patients
3233 are affected by diseases that are highly contagious; have high case-fatality
3234 ratios (CFRs); or may result in severe, persistent, recurrent, or irreversible
3235 morbidity, etc., use of Level IV PPE and other disease containment measures
3236 should be considered to protect HCWs and other patients. Another factor to
3237 consider during the PPE selection process for an infectious disease outbreak
3238 incident response is the availability of MCM, e.g. vaccines and therapeutic
3239 regimens. The lack of MCM for diseases such as severe acute respiratory
3240 syndrome (SARS), EVD, and Middle East respiratory syndrome should be
3241 considered to determine whether HCWs use PPE with the highest level of
3242 protection.

3243
3244 **Table 1. Medical PPE Levels and Disease Conditions/Characteristics**

3245

Medical PPE Levels	Disease Conditions/Characteristics	Examples Of Diseases
Level I	Non-Contagious and Some Contagious Disease	Anthrax, tularemia, ricin and some contagious disease (e.g., common cold and seasonal influenza)
Level II	Contact and droplet hazards by body fluids only (limited aerosol risk)	Viral hemorrhagic fevers
Level III	Airborne and/or droplet hazards that may require elements of airborne precautions for aerosol-generating procedures	PI, tuberculosis, smallpox, pneumonic plague
Level IV	Diseases with undetermined modes of transmission or require precautions (airborne and droplet) addressing factors such as a high CFR or severe morbidity, lack of MCM, and other factors	Novel influenza, SARS, EVD due to suspected deliberate release with undetermined modes of transmission, EVD undergoing aerosolizing activities: e.g., childbirth, dialysis, etc.

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Table 2. Medical PPE Options.

PPE	Protected Body Parts	Types Of Hazards Protected Against	Level IV	Level III	Level II	Level I
Coverall Suits ¹	Body	Contact (Blood/Body Fluids)	X			
Gown	Body	Contact (Blood/Body Fluids)	X	X	X	
Apron	Body	Contact (Blood/Body Fluids)	X			
Scrubs, Top	Body	Contact (Blood/Body Fluids)	X	X	X	X
Scrubs, Bottom	Body	Contact (Blood/Body Fluids)	X	X	X	X
Filtering Facepiece Respirator ²	Face/Respiratory Tract	Inhalation (Aerosolized Droplets)	X	X		
Surgical Masks	Face/Respiratory Tract	Contact (Blood/Body Fluids)			X	X
Face Shield	Face/Respiratory Tract	Contact (Blood/Body Fluids)	X	X	X	
Goggles	Face	Contact (Blood/Body Fluids)	X	X	X	
Full-facepiece air purifying respirator (APR) or powered air purifying respirator (PAPR) ³ , or helmet/hood PAPR	Face/Respiratory Tract	Inhalation (Aerosolized Droplets)	X			
Helmet/hood PAPR	Face/Head/Neck	Contact (Blood/Body Fluids)	X			
Surgical Hood or Head/Neck Cover	Head/Neck	Contact (Blood/Body Fluids)	X	X	X	
Shoes	Foot	Contact (Blood/Body Fluids)	X	X	X	X
Boot Covers	Foot	Contact (Blood/Body	X		X	

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		Fluids)				
PVC Boots	Foot	Contact (Blood/Body Fluids)	X			
Hand Sanitizer	Hand	Contact (Blood/Body Fluids)	X	X	X	X
Duct Tape	Hand	Contact (Blood/Body Fluids)	X			
Nitrile Gloves ⁴	Hand	Contact (Blood/Body Fluids)	X	X	X	X

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3249 Notes:

3250 1. Coverall suits are acceptable although not an ideal alternative to gowns and
3251 aprons. The ease of donning and doffing of gowns and aprons make them
3252 preferred options for body protection, considering the risk of cross-
3253 contamination is low when the donning and doffing of PPE is simple.

3254 2. National Institute for Occupational Safety and Health-certified filtering
3255 facepiece respirators with appropriate filter designation (e.g., N95) may be used
3256 in conjunction with face shield or goggles, and surgical hood or head/neck
3257 cover. This combination of respiratory protection and other protective
3258 equipment and clothing is an acceptable alternative to full-facepiece APRs or
3259 PAPRs with surgical hood or head/neck covers, or helmet/hood PAPRs in cases
3260 where precautions warrant respiratory, face, and head and neck protection.

3261 3. PAPR unit includes cartridge(s), charger, breathing tube, and battery.

3262 4. Double gloves must be used in cases of viral hemorrhagic fevers (e.g., EVD).

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3266 EXHIBIT 1 BIOLOGICAL DETECTION TO ENCLOSURE B TO TAB D PI&ID RESPONSE
 3267 BRANCH PLAN TO APPENDIX 1 TO ANNEX C TO USNORTHCOM CONPLAN 3500 – 14
 3268 MEDICAL

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 3270 Biological Agent Detection is defined as identification of a biological pathogen of
 3271 concern. There are numerous ways in which initial detection could occur,
 3272 including presentation of disease in humans or animals (domestically or
 3273 internationally), detection through syndromic surveillance, alerts from
 3274 environmental surveillance systems or international partners, and normal
 3275 operations and surveillance efforts conducted by law enforcement or other
 3276 departments and agencies. **Details are provided in Appendix 3: Support and**
 3277 **Coordination Elements.** Table X provides examples of some potential sources of
 3278 initial information with follow-on verification processes. It should be noted that
 3279 in some instances, detection can predictably occur after the outbreak/incident
 3280 is well underway resulting in numerous infections prior to initial detection.
 3281

Source of Information	Examples of Initial Intelligence Received	Verification Processes	Methods of Information Sharing
Individual practitioner or healthcare facility laboratory	<ul style="list-style-type: none"> • Suspected sentinel case reported through local public health • Confirmed sentinel case reported through local public health 	<ul style="list-style-type: none"> • Private sector, LRN, or CDC laboratory confirmation may be required 	HAN, NPIC, COCA
Individual facility, local or state health department surveillance systems	<ul style="list-style-type: none"> • Influx of patients with similar symptoms indicating potential new disease pathogen 	<ul style="list-style-type: none"> • Private sector, LRN, or CDC laboratory confirmation may be required • Epidemiologic investigation to confirm patterns of similarity 	HAN, NPIC, COCA
Identification of novel or atypical pathogen in federal, SLTT, or private sector laboratory	<ul style="list-style-type: none"> • Individual not originally suspected but “surprise” diagnosis received through secondary testing 	<ul style="list-style-type: none"> • Private sector, LRN, or CDC laboratory confirmation may be required 	HAN, NPIC, COCA, NPHIC, PACL, NBIS Protocol
Novel emerging or reemerging infection reported under international health	<ul style="list-style-type: none"> • New pathogen or pathogen of concern evolving in a situation in which spread to 	<ul style="list-style-type: none"> • Multiple international partners as well as international 	HAN, NPIC, COCA, NPHIC, PACL, NBIS protocol

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Source of Information	Examples of Initial Intelligence Received	Verification Processes	Methods of Information Sharing
regulations from overseas source	United States is possible	assistance provided by USG	
Zoonotic outbreak identified by private sector, SLTT, or federal providers or laboratories	<ul style="list-style-type: none"> Zoonotic pathogen identified in an animal population with potential for causing concerning human disease 	<ul style="list-style-type: none"> USDA, CDC, SLTT, NAHLN, or private sector laboratory confirmation all possible 	HAN, NPIC, COCA, NPHIC, PACL, NBIS Protocol
Law enforcement intelligence	<ul style="list-style-type: none"> Credible threat of deployment of pathogen of concern 	<ul style="list-style-type: none"> Law enforcement investigations paired with public health expertise 	LES Bulletin, NSC/Deputies Committee Process, NICCL
Public media	<ul style="list-style-type: none"> Announced release of pathogen of concern 	<ul style="list-style-type: none"> Multiple entities/processes at various levels potentially involved 	NSC/DC Process, NICCL, follow on HAN, NPIC, COCA, NPHIC, PACL
BioWatch or other environmental sampling	<ul style="list-style-type: none"> Pathogen of concern detected in environment leading to a BioWatch Actionable Result or BAR 	<ul style="list-style-type: none"> BioWatch has internal verification processes and may conduct additional sampling If another environmental sample, may require USG support to SLTT sample to verify 	BioWatch National Conference Call, NSC/Deputies Committee Process, NICCL, follow on HAN, NPIC, COCA, NPHIC, PACL, NBIS Protocol

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Incidents involving biological pathogens occur regularly but usually do not rise to the level of requiring the coordination of multiple federal agencies and departments. Notification, coordination, and collaboration efforts are ongoing, occurring as part of regular public health activities.

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A critical initial consideration regarding any identified pathogen is whether or not it is contagious. Contagious diseases capable of person-to-person spread or spread between people and animals significantly alter the approach to response at all levels. In addition, there are various methods of spread, and degrees of infectivity, viability, and virulence which may not be known initially.

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EXHIBIT 2 NOTIFICATION METHODS TO ENCLOSURE B TO TAB D PI&ID RESPONSE
BRANCH PLAN TO APPENDIX 1 TO ANNEX C TO USNORTHCOM CONPLAN 3500 – 14
MEDICAL

The following table (see FEMA BIA) lists examples of information sharing processes with descriptions of when they are utilized. For purposes of this annex, notification is most appropriately utilized to describe the process in which the LFA “notifies” interagency partners when unified coordination is required. HHS maintains predesignated points of contact among the interagency but may also request DHS/FEMA to assist with obtaining appropriate Department and Agency representation during initial unified coordination efforts.

Information Sharing Process	Description
BioWatch National Conference Call	Occurs within 2 hours of the BAR declaration and after the local jurisdictional BioWatch Advisory Committee (BAC) call. It begins with a summary of laboratory testing data and a summary of the current local situation by the BAC chair and other local public health, law enforcement, and emergency management representatives to provide situational awareness of follow-on activities and potential requests for assistance from other Federal Agencies (DHS, CDC, FBI, EPA, or the Strategic National Stockpile [SNS]) and a decision regarding the next conference call time.
Clinician Outreach and Communication Activity (COCA)	Provides timely, accurate, and credible information to clinicians related to emergency preparedness and response and emerging public health threats. COCA fosters partnerships with national clinician organizations to strengthen information-sharing networks before, during, and after a PHE.
National Security Council Deputies Committee (NSC) Process	Coordination can occur for a biological incident through the process outlined in PPD-1. The NSC is the President's principal means for coordinating the implementation of national security policy. The Principals Committee is the senior interagency forum for national security policy issues. The Deputies Committee is responsible for day-to-day crisis management. Interagency Policy Committees manage the development and implementation of policy.
Health Alert Network (HAN)	CDC's primary method of sharing public health information with public information officers, federal and SLTT-area public health practitioners, clinicians, and public health laboratories. There are jurisdictional HAN programs from 50 states and the District of Columbia, 8 territories as well as Chicago, Los Angeles, and New York City metropolitan areas.
HHS Public Affairs Conference Line (PACL)	Provides a conference line to allow telephone connectivity for public affairs staff supporting Emergency Support Function (ESF) #8. This conference line provides HHS public affairs personnel to work from dispersed sites during the crisis yet be able to receive guidance or direction or to provide information to those needing it.
National Incident Coordination Conference Line (NICCL)	While DHS traditionally leads the NICCL for transmission and exchange of critical and timely incident information among federal authorities, HHS, when needed, can coordinate communications information related to the public health and medical aspects of a response, particularly in a public health-specific emergency such as a pandemic disease.
National Public Health Information Coalition (NPHIC)	Leverages a network of state and local public health communicators to exchange information and increase the likelihood of consistent messaging and communication activities between federal and SLTT-area governments regarding the emergency and its impact on health.
National Biosurveillance Integration System (NBIS) Protocol	Mechanism to bring federal NBIS partners together on a short-notice teleconference to share information on a potentially significant biological incident. It can be initiated at the request of any NBIS partner and is an example of a unique capability of the National Biosurveillance Integration Center (NBIC) that helps enable national biosurveillance integration. The Protocol is activated when a situation meets one or more of the threshold criteria and is requested by a NBIS agency.
National Response Center (NRC)	As a part of the National Response System, the NRC is the sole national point of contact for reporting all oil, chemical, radiological, biological, nuclear, and etiological discharges

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3312 EXHIBIT 3 LABORATORY NETWORKS IN THE US TO ENCLOSURE B TO TAB D
3313 PI&ID RESPONSE BRANCH PLAN TO APPENDIX 1 TO ANNEX C TO USNORTHCOM
3314 CONPLAN 3500 – 14
3315 MEDICAL
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Lab Network	Description
LRN	Provides analytical support informing public health assessments of the potential for human illness associated with exposure and the scope of associated risk. The LRN also provides for definitive testing of both environmental and clinical samples, as well as limited supporting analysis of food samples that may be implicated as part of epidemiological investigations associated with incident response to cases of human illness.
ERLN	Provides consistent analytical capabilities, capacities, and quality data in a systematic, coordinated response. ERLN integrates capabilities of existing public sector laboratories with accredited private sector labs to support environmental responses. EPA's ERLN is solely dedicated to the testing of environmental samples.
NAHLN	Nationally coordinated network and partnership of federal, state, and university-associated animal health laboratories. NAHLN laboratories provide animal health diagnostic testing, methods research and development, and expertise for education and extension to detect biological threats to the nation's animal agriculture, thus protecting animal health, public health, and the nation's food supply.
NPDN	Provides a cohesive, distributed system to quickly detect and identify pests and pathogens of concern. NPDN laboratories immediately report their findings to appropriate responders and decision makers. To accomplish this mission, the NPDN has invested in diagnostic laboratory infrastructure and training, developed an extensive network of first detectors through education and outreach, and enhanced communication among public agencies and stakeholders responsible for responding to and mitigating new outbreaks.
FERN	Integrates the nation's food-testing laboratories at the federal and SLTT levels into a network that is able to respond to emergencies involving biological, chemical, or radiological contamination of food. The FERN structure is organized to ensure federal and state inter-agency participation and cooperation in the formation, development, and operation of the network.

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3320 EXHIBIT 4 LIST OF VACCINES LICENSED FOR IMMUNIZATION AND DISTRIBUTION
3321 IN THE US TO ENCLOSURE B TO TAB D PI&ID RESPONSE BRANCH PLAN TO
3322 APPENDIX 1 TO ANNEX C TO USNORTHCOM CONPLAN 3500 – 14
3323 MEDICAL
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3325 <http://www.fda.gov/BiologicsBloodVaccines/Vaccines/ApprovedProducts/ucm093833.htm>
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EXHIBIT 2 LIST OF LICENSED BIOLOGICAL PRODUCTS IN THE US TO ENCLOSURE

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B TO TAB D PI&ID RESPONSE BRANCH PLAN TO APPENDIX 1 TO ANNEX C TO

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USNORTHCOM CONPLAN 3500 – 14

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MEDICAL

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<http://www.fda.gov/BiologicsBloodVaccines/ucm133705.htm>

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ENCLOSURE C TO TAB D PI&ID RESPONSE BRANCH PLAN TO APPENDIX 1 TO ANNEX C TO USNORTHCOM CONPLAN 3500 – 14 IDENTIFICATION OF BIOLOGICAL INCIDENTS

Source of Information	Examples of Initial Intelligence Received	Verification Processes	Methods of Information Sharing
Individual practitioner or healthcare facility lab	<ul style="list-style-type: none"> Suspected sentinel case reported through local public health Confirmed sentinel case reported through local public health 	<ul style="list-style-type: none"> Private sector, LRN, or CDC laboratory confirmation may be required 	HAN, NPIC, COCA
Individual facility, local or state health department surveillance systems	<ul style="list-style-type: none"> Influx of patients with similar symptoms indicating potential new disease pathogen 	<ul style="list-style-type: none"> Private sector, LRN, or CDC laboratory confirmation may be required Epidemiologic investigation to confirm patterns of similarity 	HAN, NPIC, COCA
Identification of novel or atypical pathogen in federal, SLTT, or private sector laboratory	<ul style="list-style-type: none"> Individual not originally suspected but “surprise” diagnosis received through secondary testing 	<ul style="list-style-type: none"> Private sector, LRN, or CDC laboratory confirmation may be required 	HAN, NPIC, COCA, NPHIC, PACL, NBIS Protocol
Novel emerging infection reported under IHR from overseas source	<ul style="list-style-type: none"> New pathogen or pathogen of concern evolving in a situation in which spread to United States is possible 	<ul style="list-style-type: none"> Multiple international partners as well as international assistance provided by USG 	HAN, NPIC, COCA, NPHIC, PACL, NBIS protocol
Zoonotic outbreak identified by private sector, SLTT, or federal providers or laboratories	<ul style="list-style-type: none"> Zoonotic pathogen identified in an animal population with potential for causing concerning human disease 	<ul style="list-style-type: none"> USDA, CDC, SLTT, NAHLN, or private sector laboratory confirmation all possible 	HAN, NPIC, COCA, NPHIC, PACL, NBIS Protocol
Law enforcement	<ul style="list-style-type: none"> Credible threat of deployment of pathogen 	<ul style="list-style-type: none"> Law enforcement investigations paired 	LES Bulletin, NSC/Deputies

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Source of Information	Examples of Initial Intelligence Received	Verification Processes	Methods of Information Sharing
intelligence	of concern	with public health expertise	Committee Process, NICCL
Public media	<ul style="list-style-type: none"> • Announced release of pathogen of concern 	<ul style="list-style-type: none"> • Multiple entities/processes at various levels potentially involved 	NSC/DC Process, NICCL, follow on HAN, NPIC, COCA, NPHIC, PACL
BioWatch or other environmental sampling	<ul style="list-style-type: none"> • Pathogen of concern detected in environment leading to a BioWatch Actionable Result or BAR 	<ul style="list-style-type: none"> • BioWatch has internal verification processes and may conduct additional sampling • If another environmental sample, may require USG support to SLTT sample to verify • USPS has a robust program on mail-borne biological threats 	BioWatch National Conference Call, NSC/Deputies Committee Process, NICCL, follow on HAN, NPIC, COCA, NPHIC, PACL, NBIS Protocol

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3343 ENCLOSURE D TO TAB D PI&ID RESPONSE BRANCH PLAN TO APPENDIX 1 TO
 3344 ANNEX C TO USNORTHCOM CONPLAN 3500 – 14
 3345 BIOLOGICAL COMMUNICATION RESOURCES
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Information Sharing Process	Description
BioWatch National Conference Call	Occurs immediately following the local jurisdictional BioWatch Advisory Committee (BAC) call and begins with a summary by the BAC chair of the current situation, follow-on actions, requests for federal assistance from the various agencies (DHS, CDC, FBI, EPA, or the SNS) and a decision regarding the next conference call time.
Clinician Outreach and Communication Activity (COCA)	Provides timely, accurate, and credible information to clinicians related to emergency preparedness and response and emerging public health threats. COCA fosters partnerships with national clinician organizations to strengthen information-sharing networks before, during, and after a PHE.
National Security Council (NSC) Deputies Committee Process	Coordination can occur for a biological incident through the process outlined in Presidential Policy Directive 1. The NSC is the President's principal means for coordinating the implementation of national security policy. The Principals Committee is the senior interagency forum for national security policy issues. The Deputies Committee is responsible for day-to-day crisis management. Interagency Policy Committees manage the development and implementation of policy.
Health Alert Network (HAN)	CDC primary method of sharing public health information with public information officers, Federal and SLTT-area public health practitioners, clinicians; and public health laboratories. There are jurisdictional HAN programs from 50 states and the District of Columbia, 8 territories, as well as Chicago, Los Angeles, and New York City metropolitan areas.
HHS Public Affairs Conference Line (PACL)	Provides a conference line to allow telephone connectivity for public affairs staff supporting ESF #8. This conference line provides HHS public affairs personnel to work from dispersed sites during the crisis yet be able to receive guidance or direction or to provide information to those needing it.
National Incident Coordination Conference Line (NICCL)	While DHS traditionally leads the NICCL for transmission and exchange of critical and timely incident information among federal authorities, HHS, when needed, can coordinate communications information related to the public health and medical aspects of a response, particularly in a public health specific emergency such as a pandemic disease.
National Public Health Information Coalition (NPHIC)	Leverages a network of state and local public health communicators to exchange information and increase the likelihood of consistent messaging and communication activities between federal and SLTT-area governments regarding the emergency and its impact on health.
NBIS Protocol	Mechanism to bring federal NBIS partners together on a short-notice teleconference to share information on a potentially significant biological incident. It can be initiated at the request of any NBIS partner and is an example of a unique capability of the NBIC that helps enable national biosurveillance integration. The Protocol is activated when a situation meets one or more of the threshold criteria and is requested by a NBIS agency.
Epidemiologic Data	Sources of information may include clinical, epidemiologic, and laboratory data from different sources such as providers/private sector, local, state, and federal public health.

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GLOSSARY

Aerosol. A mixture of small droplets of liquid or small particles dispersed as a fine mist, fog, or cloud.

Biological Agent

1. (DOD) A microorganism (or a toxin derived from it) that causes disease in personnel, plants, or animals or causes the deterioration of materiel. Source: JP 3-11.

2. (CFR) Any microorganism (including, but not limited to, bacteria, viruses, fungi, or protozoa), or infectious substance, or any naturally occurring, bioengineered, or synthesized component of any such microorganism or infectious substance, capable of causing: (1) Death, disease, or other biological malfunction in a human, an animal, a plant, or another living organism; (2) Deterioration of food, water, equipment, supplies, or material of any kind; or (3) Deleterious alteration of the environment. Source: 7 CFR Part 331

Biological Hazard. (DOD) An organism, or substance derived from an organism that poses a threat to human or animal health. Source: JP 3-11
Biological warfare. The employment of BW agents to produce casualties in personnel or animals, or damage to plants or materiel; or defense against such employment.

Biological weapon. Biological agent loaded into a munition (e.g., missile warhead, aerosol sprayer). The term biological weapon is often erroneously used to describe a biological agent. (Biological Agent + Munition = Biological Weapon). DHS, Key Planning Factors for Response to Bio Attack

Biosurveillance. Process of active data-gathering with appropriate analysis and interpretation of biosphere data that might relate to disease activity and threats to human or animal health – whether infectious, toxic, metabolic, or otherwise, and regardless of intentional or natural origin – in order to achieve early warning of health threats, early detection of health events, and overall situational awareness of disease activity

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. Communicable diseases spread from one person to another or from an animal to a person. The spread often happens via airborne viruses or bacteria, but also through blood or other bodily fluid. The terms infectious and contagious are also used to describe communicable disease.

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3396 **Contagious**. 1. Of or relating to contagion. 2. Transmissible by direct or
3397 indirect contact; communicable. 3. Capable of transmitting disease; carrying a
3398 disease.

3399

3400 Contagious Disease. See communicable disease.

3401

3402 **Emerging infectious disease**. Any previously unknown communicable illness
3403 or any previously controlled contagion whose incidence and prevalence are
3404 suddenly rising. In recent years, some emerging (and re-emerging) infections
3405 have been bovine spongiform encephalopathy (mad cow disease), Ebola
3406 hemorrhagic fever, cholera, plague, hemolytic uremic syndrome caused by
3407 *Escherichia coli* O157:H7, drug-resistant strains of enterococcus, the human
3408 immunodeficiency virus, SARS, and antibiotic-resistant organisms, among
3409 many others.

3410

3411 **Force health protection (FHP)**. All measures taken by commanders,
3412 supervisors, individual Service members, and the military health system to
3413 promote, protect, improve, conserve, and restore the mental and physical
3414 well-being of Service members across the range of military activities and
3415 operations. These measures enable the fielding of a healthy and fit force,
3416 prevention of injuries and illness and protection of the force from health
3417 hazards, and provision of medical and rehabilitative care to those who become
3418 sick or injured anywhere in the world.

3419

3420 **Immunization**. The process of rendering an individual immune to specific
3421 disease causing agents. Immunization most frequently refers to the
3422 administration of a vaccine to stimulate the immune system to produce an
3423 immune response (i.e., active immunization). That process may require weeks
3424 to months and administration of multiple doses of vaccine. Passive
3425 immunization occurs with administration of antibodies to provide prompt but
3426 relatively short term immunity.

3427

3428 **Infectious Disease**. Disease resulting from the presence and activity of a
3429 pathogenic microbial agent.

3430

3431 **Infectious Disease (of Operational Significance)**. "An infectious disease
3432 (natural, accidental, or deliberate) likely to significantly impact the ability of
3433 DOD to maintain mission assurance or likely to result in significant increases
3434 in requests for DOD assistance. The disease may occur in humans, animals or
3435 plants. Disease characteristics may include: high transmissibility or severity,
3436 and high likelihood of impact on force health protection due to limited or no
3437 natural protection or medical countermeasures." *JSCP*

3438

3439 **Medical countermeasures**. Includes both biologic and pharmaceutical medical
3440 countermeasures (e.g. vaccines, antimicrobials, and antibody preparations),

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3441 non-pharmaceutical medical countermeasures (e.g. ventilators, devices,
3442 personal protective equipment such as face masks and gloves), and public
3443 health interventions (e.g. contact and transmission interventions, social
3444 distancing, and community shielding) to prevent and mitigate the health effects
3445 of biological agents. (Office of Science and Technology Policy, White House)

3446
3447 **Medical countermeasure dispensing.** The ability to provide medical
3448 countermeasures (including vaccines, antiviral drugs, antibiotics, antitoxin,
3449 etc.) in support of treatment or prophylaxis (oral or vaccination) to the
3450 identified population in accordance with public health guidelines and/or
3451 recommendations. (CDC Public Health Preparedness Capabilities, Mar 2011)

3452
3453 **Mission Assurance.** 1. The ability to achieve strategic objectives (reference (c)).
3454 2. A process to protect or ensure the continued function and resilience of
3455 capabilities and assets—including personnel, equipment, facilities, networks,
3456 information and information systems, infrastructure, and supply chains—
3457 critical to performance of DOD mission-essential functions (MEFs) in any
3458 operating environment or condition. (DOD Mission Assurance Strategy and will
3459 be incorporated into DODD 3020.40).

3460
3461 **Non-pharmaceutical Intervention.** Non-technical measures (e.g., social
3462 distancing, isolation, quarantine, personal protective equipment) to prevent
3463 illness and death due to an attack.

3464
3465 **Pathogen.** An organism (i.e., viruses, bacteria) that infects its host and causes
3466 disease.

3467
3468 **Personal Protective Equipment.** Equipment (e.g., gloves, respirators,
3469 hazardous material suits, etc.) that helps protect responders from being
3470 exposed and infected by a biological agent.

3471
3472 **Pharmaceutical Intervention.** Medical supplies (e.g., vaccines, medicines,
3473 diagnostics and other tools) that can be used to prevent illness or death in a
3474 population targeted by an attack (also referred to as medical counter measures
3475 – MCM).

3476
3477 **Pandemic (Influenza).** “A worldwide epidemic when a new or novel strain of
3478 influenza virus emerges in which humans have little or no immunity, and
3479 develops the ability to infect and be passed between humans.”

3480 *Implementation Plan for the National Strategy for Pandemic Influenza*
3481

3482 PI&ID includes influenza viruses and other highly transmissible diseases that
3483 are novel or new, with the following characteristics: 1) easily transmissible
3484 among humans, 2) global (rapid local/regional) spread in a short period of time
3485 (such as a season), and 3) broad susceptibility among the majority of the
3486 human population. *GEF*

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3488 **Re-Emerging Disease.** Any condition, usually an infection, that had decreased
3489 in incidence in the global population and was brought under control through
3490 effective health care policy and improved living conditions, reached a nadir,
3491 and, more recently, began to resurge as a health problem due to changes in the
3492 health status of a susceptible population

3493 Examples Cholera, dengue, diphtheria, malaria, tuberculosis

3494

3495 **Strategic National Stockpile (SNS).** The Federal cache of pharmaceuticals,
3496 vaccines, medical supplies, equipment, and other items established to augment
3497 local supplies of critical medical countermeasures that may be needed for a
3498 public health emergency or disaster. The SNS is managed by the CDC and
3499 includes (1) the 12-Hour Push Packages positioned in strategically located,
3500 secure warehouses ready for immediate deployment to a designated site within
3501 12 hours of the federal decision to deploy SNS assets, (2) SNS-managed
3502 inventory, and (3) vendor-managed inventory (to increase efficiency and reduce
3503 cost of stockpiling). SNS holdings are supplied to state and local jurisdictions
3504 at their request upon federal authorization. The statutory mission of the SNS is
3505 to provide for the emergency Stockpile (SNS) health security of the United
3506 States (42 USC 247d-6b(a)). (DHHS PHEMCE Strategy, 2012)

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