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OF THE AIR FORCE**

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Operations

**PUBLIC HEALTH EMERGENCIES AND
INCIDENTS OF PUBLIC HEALTH
CONCERN**

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This publication implements Department of Defense Instruction (DoDI) 6200.03, *Public Health Emergency Management Within the Department of Defense*; DoDI 6440.03, *DoD Laboratory Network (DLN)*; GCP PI&ID 3551-13, *Department of Defense Global Campaign Plan for Pandemic Influenza and Infectious Disease*; Air Force Policy Directive (AFPD) 10-25, *Emergency Management*; and AFPD 10-26, *Counter-Chemical, Biological, Radiological, and Nuclear Operations*. This document provides guidance to protect Air Force-led installations, assets, personnel, and base population in the event of a public health emergency or incident of public health concern. This Instruction applies to all installations, including those with Limited Scope (LS) or Limited Scope with Inter-Service Support (LSSS), to activities under Air Force command (hereafter referred to collectively as “installations”), to the Air Reserve Component (ARC), and to geographically separated units (GSU), except where otherwise noted. Air National Guard (ANG) units will follow the guidelines outlined in **Chapter 6**. The term “commanders,” as used in this Instruction, refers to commanders at the installation and wing (for ARC) level unless specifically stated otherwise. For stand-alone Air Force Reserve installations, the Bioenvironmental Engineering/Public Health Office is the local equivalent to a Regular Air Force (RegAF) Military Treatment Facility’s Public Health Flight. Failure to observe the prohibitions and mandatory provisions in paragraphs 3.2.8., 3.2.9.2., 3.2.9.3., and 3.2.9.5. of this publication by military members is a violation of Article 92 of the Uniform Code of Military Justice (UCMJ).

Ensure that all records created as a result of processes prescribed in this publication are maintained in accordance with Air Force Manual (AFMAN) 33-363, *Management of Records*, and disposed of in accordance with (IAW) Air Force Records Disposition Schedule (RDS)

located in the Air Force Records Information Management System (AFRIMS). Refer recommended changes and questions about this publication to the Office of Primary Responsibility (OPR) using the AF Form 847, *Recommendation for Change of Publication*; route AF Forms 847 from the field through the appropriate functional chain of command.

The authorities to waive wing/unit level requirements in this publication are identified with a Tier (“T-0, T-1, T-2, T-3”) number following the compliance statement. See AFI 33-360, *Publications and Forms Management*, Table 1.1 for a description of the authorities associated with the Tier numbers. When complying with official policy, guidance, and/or procedures, a unit may request a waiver. The fundamental aim of a waiver must be to enhance mission effectiveness at all levels, while preserving resources and safeguarding health and welfare. When a commander approves a waiver, the commander is communicating to subordinates and superiors that the commander accepts the risk created by non-compliance. Each requirement mandated for compliance at the Wing level found within this Instruction is tiered, signifying the appropriate waiver authority to the requirement. Submit requests for waivers through the chain of command to the appropriate Tier waiver approval authority, or alternately, to the Publication OPR for non-tiered compliance items. This publication may be supplemented at any level. All direct supplements must be routed to the Office of Primary Responsibility (OPR) of this publication for coordination prior to certification and approval.

This Instruction *does not*: (1) take precedence over actions covered by AFRPD 10-8, *Defense Support of Civil Authorities* and AFI 10-801, *Defense Support of Civilian Authorities*; (2) apply to foreign disasters covered by AFRPD 10-25, *Emergency Management*, AFI 10-2501, *Air Force Emergency Management (EM) Program Planning and Operations*, AFMAN 10-2502, *Air Force Incident Management System (AFIMS) Standards and Procedures*, AFMAN 10-2503, *Operations in a Chemical, Biological, Radiological, Nuclear, and High-Yield Explosive (CBRNE) Environment*; or (3) integrate contingency war planning as a supplement to Air Force Installation response.

Accomplish collections and After-Action Reports for major operations, contingencies, key exercises and experiments, and other significant incidents and topics identified by leadership IAW AFI 90-1601, *Air Force Lessons Learned Program*. Post approved AARs to the Air Force Joint Lessons Learned Information System, either directly or by forwarding to LeMay Doctrine Center. The use of the name or mark of any specific manufacturer, commercial product, commodity, or service in this publication does not imply endorsement by the Air Force.

SUMMARY OF CHANGES

This document has been substantially revised to incorporate guidance previously contained in AFI 10-2603, *Emergency Health Powers on Air Force Installations*, and AFI 10-2604, *Disease Containment Planning* and must be completely reviewed. Major changes include: a new AFI 10 series number and new title. The changes in this document align it with DoDI 6200.03 and GCP PI&ID 3551-13. This Instruction provides additional guidance on emergency health powers, further delineates roles and responsibilities, clarifies authorities of installation commanders in regards to emergency health powers, summarizes disease containment planning and response for a public health emergency or incident of public health concern, introduces health protection

conditions, outlines available medical countermeasures and the appropriate process for acquisition/use of the Strategic National Stockpile, and includes specific guidance for the ANG.

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Chapter 1

PROGRAM OVERVIEW

1.1. Overview. This AFI specifies the authority of installation commanders and assigns responsibilities for declaring, reporting, and managing a public health emergency or incident of public health concern. Although ultimate responsibility and authority for managing such incidents falls to the installation commander, the entire installation and all functional organizations will have a role to play.

1.1.1. The Public Health Emergency Officer (PHEO) is one of the key subject matter experts who will serve as a resource to help guide the installation commander during these incidents. **(T-0).**

1.1.2. The Medical Treatment Facility Commander (MTF/CC) (for the ARC, Guard Medical Unit (GMU) commander and Reserve Medical Unit (RMU) commander) has responsibility for helping the installation commander with medical resources and capabilities. **(T-1).**

1.1.3. This Instruction applies to military personnel, civilian personnel, dependents of military or civilian personnel, and contractors present on an Air Force installation (collectively referred to as “non-military personnel”); Air Force facilities; Air Force-owned, leased, or managed infrastructure and assets critical to mission accomplishment; and other Air Force-owned, leased, or managed mission essential assets overseas and in the United States (U.S.), its territories, and possessions. In areas outside of U.S. control, this Instruction applies to the extent consistent with local conditions and treaty requirements, Status of Forces Agreements (SOFA), and other applicable arrangements with foreign governments and allied forces. Ultimately, U.S. prerogatives and control at overseas locations may require adjustment to accommodate the sovereignty interests of the host nation (HN), except as otherwise defined in applicable international agreements, such as SOFAs, defense cooperation agreements, and base rights agreements.

1.1.4. In addition, the AFI provides guidance on disease containment planning and response to a public health emergency or incident of public health concern. It identifies actions that installations/wings must take before, during, and after public health emergencies or incidents of public health concern to slow or stop the spread of the disease and ensure mission continuation. These actions are summarized in a set of standard Health Protection Conditions (HPCON) that define appropriate measures to take based on the disease’s mode of transmission. This AFI is complimentary to, synchronized with, and established in support of the Air Force Emergency Management program.

1.2. Public Health Emergencies.

1.2.1. DoDI 6200.03 defines a public health emergency as an occurrence or imminent threat of an illness or health condition that:

1.2.1.1. May be caused by any of the following: biological incident, either intentionally introduced or naturally-occurring; the appearance of a novel, previously controlled, or eradicated infectious agent or biological toxin; zoonotic disease; natural disaster; chemical attack or accidental release; radiological or nuclear attack or accident; or high-yield explosive detonation.

1.2.1.2. Poses a high probability of: a significant number of deaths in the affected population considering the severity and probability of the event; a significant number of serious or long-term disabilities in the affected population considering the severity and probability of the event; widespread exposure to an infectious or toxic agent, including those of zoonotic origin, that poses a significant risk of substantial public harm to a large number of people in the affected population; and/or healthcare needs that exceed available resources.

1.2.1.3. May require World Health Organization notification as a Public Health Emergency of International Concern IAW the International Health Regulations.

1.2.2. Specifically, the following diseases and public health conditions when taken in context of morbidity, mortality and geographic proximity to the installation may be grounds for the installation commander to declare a Public Health Emergency (**Attachment 2** provides a template for declaring a public health emergency):

1.2.2.1. One or more human cases of any of the following diseases that are unusual or unexpected and may have serious public health impact: smallpox, cholera, pneumonic plague, poliomyelitis due to wild-type poliovirus, human influenza caused by novel or re-emergent influenza viruses that are causing or have the potential to cause a pandemic, severe acute respiratory syndrome (SARS), and viral hemorrhagic fevers (e.g., Ebola, Lassa, Marburg).

1.2.2.2. Any other disease of special military, national, or regional concern (e.g., Dengue fever, Yellow fever, West Nile fever, Rift Valley fever, meningococcal disease) that is unusual and unexpected, may have a serious impact on public health or has a significant risk of spread and/or affecting the mission.

1.2.2.3. The occurrence of any item listed in **Paragraph 1.2.1** that overwhelms the local capabilities to respond to the situation, to include requesting assets from the Strategic National Stockpile (SNS). See **Chapter 5** for SNS planning requirements. **Note:** SNS assets will not be relied upon as part of an installation's initial response capability.

1.2.2.4. One or more cases of any disease that requires the use of quarantine to control. Orders for quarantine or for the apprehension, detention, or conditional release of personnel exposed to a contagious disease but without confirmed illness *may not be issued by the PHEO unless the installation commander has declared a public health emergency*. A Notice of Quarantine template is provided in **Attachment 3**. Orders regarding isolation and restriction of movement (ROM) of individuals with a confirmed illness may be issued during a public health emergency or during incidents of public health concern. A Notice of Isolation template is provided in **Attachment 4**.

1.2.3. Authority for Declaring a Public Health Emergency.

1.2.3.1. Installation Authority. The installation commander is the only authority who can declare a public health emergency on an Air Force installation. Commanders on ANG installations will coordinate with their Joint Forces Headquarters-State (JFHQ-State) and the National Guard Bureau (NGB) prior to declaring a public health emergency. **(T-0)**.

1.2.3.2. Local Authority. Some states and local governments can declare public health emergencies covering their jurisdictions.

1.2.3.3. National Authority. The Secretary of Health and Human Services (HHS) has the authority to declare a national public health emergency within U.S. borders.

1.3. Incidents of Public Health Concern.

1.3.1. There may be situations when a contagious disease or other biological incident has the potential to impact installation operations; however, it does not meet the criteria for an installation commander to declare a public health emergency. These incidents of public health concern must be managed in a similar fashion to a declared public health emergency.

1.3.2. Incidents of public health concern are defined as occurrences of an illness or health condition caused by an epidemic, or a serious and potentially fatal infectious agent that poses a substantial risk of human infection, but that does not constitute a public health emergency.

1.3.2.1. Examples of incidents of public health concern include a single case of infectious tuberculosis, or an adenovirus epidemic that is contained before leading to a significant number of deaths or long-term disabilities and that can be addressed using available healthcare resources.

1.3.2.2. Many of the directives issued in this Instruction apply to responding to an incident of public health concern. The PHEO will provide recommendations to the installation commander and/or the MTF/CC (for the ARC, GMU/CC or RMU/CC) on the actions necessary to respond, mitigate, and control the public health incident. **(T-0)**.

1.4. Situational Standards of Care. Public health emergencies may result in surge requirements that overwhelm the response capacity, capability, and resources of medical facilities and health care providers, resulting in an inability to meet normal standards of care. Under these conditions, it may be necessary to provide situational standards of care. Such situational standards will be directed IAW Enclosure 4 of DoDI 6200.03. **(T-0)**.

1.5. Installation Response Plans. Installations will develop disease containment guidance that summarizes the emergency health powers of commanders and ensures optimum medical and non-medical planning for and response to public health emergencies or incidents of public health concern. **(T-1)**. This guidance can be a stand-alone Disease Containment Plan (DCP) or part of the Installation Emergency Management Plan (IEMP) 10-2. Plans will ensure force health protection and continuity of operations (COOP) IAW DoDI 6200.03, GCP PI&ID 3551-13, AFPD 48-1, *Aerospace Medicine Enterprise* and AFPD 10-2, *Readiness*, and shall contain a minimum of nine sections: references, tasked organizations, situation, threat key assumptions, mission, execution, administration and logistics, and command and control. **(T-0)**.

1.6. Overseas Limitations. HN agreements, governmental oversight, and control of overseas installations may prevent commanders from unilaterally implementing many of the provisions of this Instruction. Ultimately, U.S. prerogatives and control at overseas locations are subject to the sovereignty of the HN, except as otherwise defined in applicable international agreements, such as SOFAs, defense cooperation agreements, and base-rights agreements.

1.6.1. A U.S. military commander's authority overseas extends generally only to U.S. service members, civilian employees of U.S. forces, U.S. Department of Defense (DoD) contractor employees (when specified by agreements), and the dependents of these categories of personnel.

1.6.2. A commander's authority may be limited in scope as it pertains to HN personnel. Overseas installations will review their respective HN agreements and incorporate guidance into existing installation emergency management and response plans (e.g., IEMP 10-2, DCP, and Medical Contingency Response Plan (MCRP)) and agreements. (T-2).

1.6.3. Many of the authorities cited in this publication cannot be implemented in an overseas environment without the cooperation of HN authorities, except to the extent specified by governing international agreements.

1.6.4. Should it be necessary to enter into international agreements to adequately address the requirements of this Instruction, Major Commands (MAJCOM) and Commanders of Air Force forces outside the continental United States (OCONUS) will consult AFI 51-701, *Negotiating, Concluding, Reporting, and Maintaining International Agreements*, and applicable combatant command regulations to determine whether authority exists, or must be requested, to negotiate and conclude such agreements.

1.7. ARC and GSU Limitations. ARC units and GSUs may not have the resident capability or personnel to prepare for or respond to a public health emergency or incident of public health concern. This will ultimately limit a commander's ability to implement some of the provisions of this Instruction, to include designating a PHEO. As a result, these LS and LSISS organizations must rely heavily on civilian agencies/local authorities for emergency response. LS MTFs are defined as units with less than 75 assigned personnel and do not require the designation of a PHEO if the supporting MTF's PHEO performs the duty for the supported MTF. LSISS MTFs are tenant units on installations where at least two Services share resources.

1.7.1. Commanders of GSUs will review their respective emergency management and response plans and incorporate measures from this AFI that are reasonable and appropriate given their GSU's hazard assessment. At a minimum, such measures will include coordination of emergency management plans and response procedures with applicable local and/or state authorities. (T-2).

1.7.2. The appointed state ANG Public Health Emergency Officer (State-PHEO) or ANG Public Health Emergency Officer Liaison (State-PHEO-LNO) will advise ANG installation commanders on potential public health emergency situations. (T-2).

1.7.3. Commanders of ANG units not co-located on RegAF military installations shall communicate identified health threats to the DoD installation PHEO in their catchment area. (T-2).

1.7.4. For stand-alone Air Force Reserve Command installations the Reserve PHEO shall be familiar with civilian agencies/local authorities for emergency response for that state. (T-2).

1.7.5. ARC units and GSUs shall negotiate and conclude memorandums of understanding (MOU) or memorandums of agreement (MOA) with appropriate local organizations when necessary to adequately address the requirements of this Instruction. (T-2).

1.8. Joint Base Requirements.

1.8.1. Air Force units in Joint Basing situations, in the supporting role, must comply with Air Force guidance to ensure installation personnel are adequately protected and cared for during public health emergencies or incidents of public health concern. IAW Joint Basing Implementation Guidance (JBIG), supported/supporting units should implement MOAs to

establish standards of support. The JBIG also establishes procedures for adjudicating differences and establishing Common Output Level Standards. Units that cannot meet Air Force requirements by exhausting the JBIG adjudication process must coordinate with their Major Command (MAJCOM) to alleviate discrepancies. **(T-1)**. MAJCOMs that cannot resolve discrepancies will coordinate with the appropriate Headquarters Air Force (HAF) office to determine a solution.

1.8.2. Air Force units hosted by another component, NATO, or on a coalition base will follow the host base protocols. To ensure adequate protection of personnel, commanders should determine the need for specific protection measures the host base cannot or is unable to provide in order to ensure personnel are adequately protected and cared for during public health emergencies or incidents of public health concern. In cases where there are no Air Force medical personnel who meet the qualifications of a PHEO assigned to the Air Force unit(s), the commander will contact the host organization and consult with the senior medical officer for guidance concerning public health emergencies or incidents of public health concern, and the minimum protection measures needed. **(T-2)**.

1.8.3. Joint base AF MTFs that are in a supported role will have the installation commander appoint the PHEO. **(T-1)**. In some joint base locations, it may be appropriate (through coordination with the tenant organization) to appoint an Alternate PHEO from a Service different to that of the PHEO, especially where a highly specialized skill set exists in a tenant organization. Joint basing standard operating procedures and tenant organization agreements should reflect the requirement to provide a single coordinated response to any public health emergency or incident of public health concern.

Chapter 2

ROLES AND RESPONSIBILITIES

2.1. Headquarters Air Force

2.1.1. Air Force Surgeon General (AF/SG) will establish policy and guidance and obtain and allocate medical resources to effectively prepare for, respond to, recover from, and mitigate a public health emergency or incident of public health concern IAW DoDI 6200.03, AFPD 10-25, AFPD 10-26, AFI 10-2501, and AFI 41-106, *Medical Readiness Program Management*. AF/SG will:

2.1.1.1. Provide medical guidance and oversight to MAJCOMs during public health emergencies or incidents of public health concern. Air Force Medical Support Agency (AFMSA) will support AF/SG to establish medical policy. Air Force Medical Operations Agency (AFMOA) will support AF/SG to implement medical policy and obtain and allocate resources.

2.1.1.2. Appoint a HAF PHEO and alternate PHEO from AFMSA to act as the Air Force Medical Service (AFMS) focal point for policy issues pertaining to public health emergencies.

2.1.1.3. Appoint a HAF Medical Emergency Manager from AFMSA and alternate (the alternate may be selected from one of the MAJCOMs) to act as the AFMS focal point for issues pertaining to medical emergency management and to assist the HAF PHEO on issues related to public health emergencies or incidents of public health concern.

2.1.1.4. Coordinate on DoD guidance concerning DoD stockpile procedures (i.e., access, release prioritization, terms of use, etc.).

2.1.1.5. Serve as the Air Force lead directorate for the DoD Laboratory Network (DLN). In that role, the AF/SG will:

2.1.1.5.1. Appoint an AF Laboratory Response Network Gatekeeper who will also serve as a representative to the DLN.

2.1.1.5.2. Provide AF/SG representatives to the DLN from the appropriate agencies as determined by the DLN charter.

2.1.1.5.3. Identify all laboratories, programs or activities with analytic or response capabilities related to Chemical, Biological, Radiological, and Nuclear (CBRN) agents, infectious diseases, and other all-hazards agents of military or national significance, and provide a listing of these to the DLN.

2.1.2. Deputy Chief of Staff for Operations (AF/A3) will support AF/SG3/5 and AF/A4C to establish operational policy and guidance to effectively prepare for, respond to, recover from, mitigate, sustain and recover operations from a public health emergency or incident of public health concern, including but not limited to biological terrorism warfare or naturally occurring disease outbreaks of operational significance IAW AFPD 10-26 and AFPD 10-25. In addition AF/A3 will provide operational guidance and oversight to MAJCOMs during public health emergencies or incidents of public health concern.

2.1.3. Deputy Chief of Staff for Logistics, Engineering and Force Protection (AF/A4) will establish appropriate logistic and mission support policy and guidance to obtain and allocate non-medical resources to prepare for, respond to, and recover from a public health emergency or incident of public health concern IAW AFI 10-2501. AF/A4 will:

2.1.3.1. Provide logistics and mission support guidance and oversight to MAJCOMs prior to and during public health emergencies or incidents of public health concern.

2.1.3.2. Ensure a representative is available to serve as the HAF emergency manager during public health emergencies or biological incidents of operational concern.

2.1.3.3. Ensure the HAF Emergency Management Working Group (EMWG) coordinates with the HAF Disease Containment Planning Group (See HAF COOP Operational Order (OPORD)) for issues related to disease containment and public health emergency response planning.

2.1.4. Director of Public Affairs (SAF/PA) through the AF SG/PA will work with the HAF PHEO or Alternate PHEO and AF/A4 EM Program leadership to ensure clear, effective, and coordinated communication before, during, and following a public health emergency or incident of public health concern. Specifically, SAF/PA through the AF SG/PA will establish measures to ensure effective communication in support of Air Force personnel and in conjunction with the other Services, DoD, combatant commands, and civil agencies in the event of a public health emergency or incident of public health concern.

2.1.5. Director of Lessons Learned (LeMay Doctrine Center) will collect, analyze, and provide analysis to AF/A10 and AF/SG on lessons learned from public health emergencies or incidents of public health concern.

2.1.6. Air Force Intelligence, Surveillance, and Reconnaissance Agency, under the control and authority of the AF/A2, will provide a representative to the DLN from the Air Force Technical Applications Center.

2.1.7. Assistant Chief of Staff Strategic Deterrence and Nuclear Integration (AF/A10) will:

2.1.7.1. Provide disease containment implementation guidance to MAJCOMs (to include ANG), Field Operating Agencies (FOA), and Direct Reporting Units (DRU).

2.1.7.2. Provide oversight for disease containment planning to ensure appropriate and effective response actions are detailed to meet requests of civil authorities when directed by the President of the United States or the Secretary of Defense using available forces that are not committed to other priorities providing for the nation's defense. In addition, if approved by appropriate officials, Air Force assets may be called upon to offset private sector shortfalls at ports, in transportation, or providing security IAW GCP PI&ID 3551-13.

2.1.7.3. Coordinate with AFDW/A3C and AF/A3OOA to ensure the Air Force COOP plan includes procedures to protect HAF staff during a public health emergency or incident of public health concern. (See *HAF COOP OPORD*).

2.2. Major Commands, Field Operating Agencies, and Direct Reporting Units.

2.2.1. MAJCOM (to include ANG), FOA, and DRU Commanders will ensure installations are organized, trained, and equipped to support disease containment planning and response to

public health emergencies or incidents of public health concern, including all aspects that may be unique to a particular command's mission, established relationships, and agreements with local communities, municipalities, and/or HN authorities. Specifically, MAJCOM/FOA/DRU commanders will: **(T-1)**.

2.2.1.1. Oversee the creation of MAJCOM/FOA/DRU-level plans related to preparedness for and response to a public health emergency or incident of public health concern. **Note:** if personnel are already accounted for in installation plans as directed by **Paragraph 2.3.1.1.**, MAJCOM/FOA/DRU-level plans are not required. **(T-1)**.

2.2.1.2. Incorporate public health emergency requirements and data into relevant procedures, education, and training materials as appropriate. **(T-1)**.

2.2.2. MAJCOM Emergency Manager (A4C) will serve as the EM Consultant for their respective commands. **(T-1)**.

2.2.3. MAJCOM Chief of Aerospace Medicine (SGP) or other appropriate Medical Officer will serve as the PHEO Consultant for their respective commands and have the following roles and responsibilities: **(T-1)**.

2.2.3.1. Complete all PHEO training requirements contained in AFI 41-106 and AFI 10-2501. **(T-0)**.

2.2.3.2. Provide expertise and guidance to installation PHEOs conducting emergency response actions as needed. **(T-1)**.

2.2.3.3. Maintain a listing of name, contact information, and training currency for all installation PHEOs and alternate PHEOs within their command. IAW AFI 41-106 this list will be consolidated with the Medical Treatment Facility Emergency Manager (MEM) list and provided to HAF PHEO and HAF MEM. **(T-1)**.

2.2.3.4. Provide MAJCOM-specific guidance on disease containment and public health emergency planning activities to supplement guidance from higher headquarters as necessary. **(T-1)**.

2.2.3.5. During public health emergencies or incidents of public health concern, coordinate medical information and requirements to HHQs and between MAJCOMs, as appropriate. **(T-1)**.

2.2.4. MAJCOM Chief of Medical Readiness (SGX) or other appropriate individual in SGX will serve as the MEM consultant for their respective commands and have the following roles and responsibilities: **(T-1)**.

2.2.4.1. Complete all MEM training requirements contained in AFI 41-106. **(T-0)**.

2.2.4.2. Provide expertise and guidance to installation MEMs conducting emergency response actions, as needed. **(T-1)**.

2.2.4.3. Maintain a listing of name, contact information, and training currency for all installation MEMs within their command and provide to MAJCOM PHEO consultant. **(T-1)**.

2.2.4.4. In concert with the MAJCOM PHEO Consultant, provide MAJCOM-specific guidance on public health emergency preparedness and planning activities to supplement guidance from HHQs, as necessary. **(T-1)**.

2.2.4.5. In concert with the MAJCOM PHEO Consultant and as appropriate, coordinate information and requirements to HHQs and between MAJCOMs during public health emergencies or incidents of public health concern. **(T-1)**.

2.2.4.6. In conjunction with MAJCOM A4C, ensure MEM guidance is consistent with the MAJCOM EM program policy and guidance. **(T-1)**.

2.2.5. AFMOA Commander will:

2.2.5.1. Execute AFMS public health emergency policy. **(T-1)**.

2.2.5.2. Designate an OPR to track the availability of medical supplies (i.e., vaccines, antivirals, antibiotics, supplies, and equipment) and communicate availability to HAF PHEO, HAF MEM, and SG leadership as appropriate. **(T-1)**.

2.2.6. AFMSA

2.2.6.1. HAF PHEO as appointed under AFMSA will:

2.2.6.1.1. Serve as the point of contact for execution of AFMS policy and provide reach back capability to MAJCOM PHEO consultants. **(T-1)**.

2.2.6.1.2. Serve as the AFMS co-representative to the Assistant Secretary of Defense for Health Affairs (ASD(HA)), the Assistant Secretary of Defense for Homeland Defense and Global Security(ASD(HD&GS)), and MAJCOMs for developing disease containment and public health emergency policy. **(T-1)**.

2.2.6.1.3. Act as the co-Air Force stakeholder to ensure joint training (e.g., DoD Public Health Emergency Management Course) for PHEOs is developed and maintained appropriately. **(T-1)**.

2.2.6.1.4. Lead efforts to integrate public health and medical preparedness and planning for public health emergencies or other biological incidents in to guidance using an all-hazards approach. **(T-1)**.

2.2.6.1.5. Review annually and update as necessary the standardized Public Health and Disease Outbreak Emergency Response Training template. Provide to installation PHEOs for use in meeting the senior leader training described in **Paragraph 4.4. (T-1)**.

2.2.6.2. HAF MEM as appointed under AFMSA will:

2.2.6.2.1. Serve as the AFMS co-representative to ASD(HA), ASD(HD&GS), and MAJCOMs for developing disease containment and public health emergency policy to include defense support to civil authorities (DSCA). **(T-1)**.

2.2.6.2.2. Act as the co-Air Force stakeholder to ensure joint training (e.g., DoD Public Health Emergency Management Course) for MEMs is developed and maintained appropriately. **(T-1)**.

2.2.6.2.3. Provide reach back capability to MAJCOM MEM consultants. **(T-1)**.

2.2.6.2.4. Assist the HAF PHEO with integration of public health and medical preparedness and planning for public health emergencies or other biological incidents. **(T-1)**.

2.2.6.2.5. Serve as the SG representative to the HAF level EMWG. **(T-1)**.

2.2.6.2.6. Maintain and provide Mass Prophylaxis Plan (MPP) template. **(T-1)**.

2.2.7. Commander, Air Force Research Laboratory will appoint a representative to the DLN. **(T-1)**.

2.2.8. 711th Human Performance Wing under control and authority of the AFRL Commander will appoint a representative to the DLN from the U.S. Air Force School of Aerospace Medicine. **(T-1)**.

2.3. Installations

2.3.1. Commander. The installation commander is responsible for protecting assigned Air Force units, tenant units, GSUs, joint or coalition forces, government organizations, civilians, civilian contractors, military dependents, HN or third country civilians, and guests (where applicable) present on their installation during a public health emergency or incident of public health concern. In addition, it is their responsibility to ensure mission essential operations on the installation continue with little to no interruption. To that end, the installation commander will:

2.3.1.1. Appoint Wing XP or equivalent organization as OPR for and to monitor development of disease containment guidance—either as a stand-alone DCP or as a separate Annex in the IEMP 10-2—that allows the installation to effectively prepare for, respond to, and recover from public health emergencies or incidents of public health concern. **(T-0)**.

2.3.1.1.1. Wing XP will coordinate with the EMWG to ensure all functional organizations provide input and insight and with the Installation Emergency Manager (IEM) if incorporation into the IEMP 10-2 is determined to be the most appropriate course of action. **(T-2)**.

2.3.1.1.2. Resulting guidance must meet federal, state, and local regulations and all applicable HN arrangements or agreements (e.g., SOFA), and should be shared among and across Service Components, DoD agencies, and community organizations to ensure a coordinated and synchronized effort. **(T-0)**.

2.3.1.2. Ensure all units/tenants comply with requirements for preventing and controlling diseases, injuries, and other reportable conditions IAW current Air Force guidance and MTF/CC recommendations. **(T-2)**.

2.3.1.3. Establish a passenger-screening capability and conduct planning for the reception, quarantine, and/or isolation of arriving passengers with disease symptoms or suspected of having been exposed to contagious disease. This task only applies at installations with air passenger terminals and will be done in conjunction with the MTF/CC or ARC equivalent. For stand-alone AF Reserve Command installations, follow local protocols. For the ANG, follow local and state ANG protocols. **(T-1)**.

- 2.3.1.4. Designate, in writing, an installation PHEO and an alternate PHEO to provide medical and/or public health recommendations in response to public health emergencies. If the installation has associated GSUs, DRUs, or FOAs, designate additional PHEOs, as appropriate. **(T-0)**.
- 2.3.1.5. Consult with the installation PHEO prior to declaring a public health emergency. **(T-1)**.
- 2.3.1.6. Ensure the PHEO, alternate PHEO, and IEM have adequate support to accomplish their mission. **(T-3)**.
- 2.3.1.7. Exercise those emergency health powers within his/her inherent authority necessary to respond to the public health emergency or incident of public health concern, and coordinate all emergency health power actions, to include planning and response, with local and HN officials. **(T-0)**. **Chapter 3** provides a listing of emergency health powers available to an installation commander following the declaration of a public health emergency.
- 2.3.1.8. Report declaration of a public health emergency via an Operational Event/Incident Report-3 (OPREP-3). Report IAW AFI 10-206, *Operational Reporting*, whenever national-level interest has been determined. **(T-1)**.
- 2.3.1.8.1. All OPREP-3 for pandemic influenza incidents will be reported to the National Military Command Center with a courtesy copy provided to the NORAD-USNORTHCOM Command Center or IAW applicable combatant command requirements. **(T-0)**.
- 2.3.1.8.2. All OPREP-3 reports containing medically-relevant information should be coordinated with the PHEO. **(T-3)**.
- 2.3.1.8.3. Declarations will terminate automatically in 30 days, unless renewed and rereported. Declarations may be terminated sooner by the commander who made the declaration, any senior commander in the chain of command, the Secretary of the Air Force, or the Secretary of Defense. **(T-0)**.
- 2.3.1.9. Manage all public health emergencies IAW AFIMS. See AFMAN 10-2502 for AFIMS guidance. **(T-1)**.
- 2.3.1.10. Ensure close coordination of Wing XP with the EMWG, as well as regular discussion of public health emergency planning and response during EMWG meetings. **(T-3)**. Refer to **Chapter 4** for Disease Containment Planning and Response requirements.
- 2.3.1.11. In carrying out activities under this Instruction, cooperate with authorized law enforcement agencies investigating an actual or potential terrorist act, crime, or other relevant public health emergency. This includes reasonable steps to preserve potential evidence of criminal activity. **(T-0)**.
- 2.3.1.12. Approve and forward requests for delivery and transfer of SNS assets for sustainment of a response to a public health emergency or incident of public health concern within the Continental United States (CONUS). **(T-0)**. See **Chapter 5**.

2.3.1.13. Provide manpower and/or materiel support to local authorities in certain limited circumstances when responding to a public health incident (i.e., public health emergency, incident of public health concern, or DSCA). **(T-3)**.

2.3.1.13.1. Execute such support unilaterally at the request of local authorities utilizing immediate response authority when faced with imminently serious conditions resulting from any civil emergency that requires immediate action to save lives, prevent human suffering, or mitigate great property damage IAW AFI 10-801 and 10-2501. **(T-3)**.

2.3.1.13.2. Use Medical War Reserve Materiel to save life or prevent undue suffering, IAW AFI 41-209, *Medical Logistics Support*. **(T-3)**.

2.3.1.13.3. Seek approval from HHQs prior to providing support in all other circumstances. Generally, any support provided by the Air Force is enacted through AFIMS and the National Response Framework (NRF) and may be limited by federal laws and regulations (e.g., *Posse Comitatus Act*). **(T-1)**.

2.3.1.14. Ensure relevant communications are executed by Public Affairs (PA) in coordination with all appropriate installation/command stakeholders. **(T-0)**.

2.3.1.15. Ensure disaster mental health (DMH) services are available through a DMH team in response to a public health emergency or incident of public health concern (or delegate this responsibility to the MTF/CC). For the ANG, refer to Chapter 6. **(T-0)**.

2.3.1.15.1. Appoint a licensed mental health provider trained in DMH services as the DMH team lead, which has overall responsibility for DMH Team training and service implementation. **(T-0)**.

2.3.1.15.2. Integrate disaster mental health response into related DMH teams (IAW AFI 44-153, *Disaster Mental Health Response & Combat and Operational Stress Control*) for preparedness and response with other DoD installation and military command emergency response plans. **(T-0)**.

2.3.1.15.3. Enter into agreements, as needed, with other installations, Reserve units, ANG units, and/or civilian providers to ensure access to a DMH team when the personnel and resources necessary for such a team are not present on the installation. **(T-0)**.

2.3.2. Mission Support Group Commander (MSG/CC) is responsible for ensuring the resources necessary to support installation response to a public health emergency or incident of public health concern. The MSG/CC will:

2.3.2.1. As the EMWG chair, participate in the development of installation disease containment and public health emergency response plan(s). **(T-3)**.

2.3.2.2. Provide food and quality of life services to installation personnel placed under ROM constraints IAW installation disease containment guidance. **(T-1)**.

2.3.2.3. Assist the PHEO in the identification of appropriate isolation and quarantine facilities. **(T-3)**.

2.3.3. Staff Judge Advocate General (JAG) is the legal point of contact for installation activities related to the preparation for and response to a public health emergency or incident of public health concern. The JAG will:

2.3.3.1. Provide legal advice (e.g., declaration of a public health emergency, vaccination and prophylaxis of military and non-military members, rules for the use of force to enforce quarantine and isolation, coordination with local authorities, etc.) to the commander and staff, including deployed elements, in response to a biological incident. **(T-1)**.

2.3.3.2. Provide legal services to personnel and their dependent family members affected by a biological incident, in order to facilitate a more rapid return to legal stability and independence. **(T-2)**.

2.3.3.3. Participate in the development of installation disease containment and public health emergency response plan(s). **(T-3)**.

2.3.4. Public Affairs Officer (PAO) is responsible for internal and external public information communications on an installation during a public health emergency or response to an incident of public health concern. The PAO will:

2.3.4.1. Incorporate disease containment guidance as part of the Emergency Public Information function. Coordinate with appropriate functional experts as required. **(T-1)**.

2.3.4.2. Coordinate with the PHEO, Public Health Officer (PHO), IEM, Bioenvironmental Engineering (BE) Officer, MEM, Crisis Action Team (CAT) director, and Emergency Operations Center (EOC) Director on public emergency communication products generated by the installation. The aforementioned should also coordinate with local authorities to ensure clear, effective, and coordinated risk communication before, during, and after contagious disease outbreaks. **(T-3)**.

2.3.4.3. Participate in the development of installation disease containment and public health emergency response plan(s). **(T-3)**.

2.3.5. Chaplain provides guidance on religious, ethical, moral, morale and quality of life matters as they pertain to a public health emergency or response to an incident of public health concern. The Chaplain will:

2.3.5.1. Participate in the development of installation disease containment and public health emergency response guidance as it pertains to religious accommodation. **(T-3)**.

2.3.5.2. Identify areas within the guidance where Chaplain Corps support (e.g., Mortuary Affairs and Medical Services) is required or recommended. **(T-3)**.

2.3.6. Medical Treatment Facility Commander (MTF/CC) or ARC equivalent (GMU/CC or RMU/CC) is responsible for airbase medical operations. Specifically, the MTF/CC or ARC equivalent will:

2.3.6.1. Nominate a primary and alternate PHEO to the installation commander as specified in [Paragraph 2.3.1.4](#) **(T-3)**. The PHEO and alternate PHEO must possess the following qualifications and skills, and will be required to take training courses both prior to and upon assignment to the position. **(T-1)**.

2.3.6.1.1. The PHEO and alternate PHEO must have experience and training in functions essential to effective public health emergency management (e.g., National Incident Management System (NIMS), NRF). **(T-1)**.

2.3.6.1.2. The primary PHEO must be a senior AFMS officer with a clinical degree (e.g., MD, DO, or DVM) and a Master of Public Health (or equivalent) degree, with at least four years of experience in public health or preventive medicine. For Reserve, the primary PHEO must be a senior AFMS officer with a clinical degree (e.g. MD, DO, or DVM) and with some experience in public health or preventive medicine. This section does not apply to an ANG GMU. For the ANG guidance, refer to Chapter 6 of this instruction. **(T-1)**.

2.3.6.1.3. The primary PHEO must be a member of the installation Threat Working Group (TWG). In addition, it is recommended that he/she be a member of the EMWG. **(T-3)**.

2.3.6.1.4. The alternate PHEO must be a senior Medical Corps or Public Health officer with at least four years of experience in public health or preventive medicine. If the primary PHEO is a DVM, the alternate PHEO must be a senior Medical Corps officer. **(T-1)**.

2.3.6.1.5. The primary and alternate PHEO must obtain an active national security clearance at the SECRET level. **(T-2)**.

2.3.6.1.6. PHEO and alternate PHEO training requirements provide the minimum knowledge necessary for a PHEO to effectively support the installation commander during a public health emergency or incident of public health concern. Consult AFI 41-106 and AFI 10-2501 for specific training courses. **(T-1)**.

2.3.6.1.7. The alternate PHEO will perform all primary PHEO roles, which may include advising incident commanders during a public health incident, when the primary PHEO is not available. As such, the alternate PHEO must complete all PHEO training requirements and be fully engaged in disease containment and public health emergency planning, preparedness, and response activities. **(T-1)**.

2.3.6.2. Designate, in writing, a MEM. **(T-0)**. The MEM must possess the following qualifications and skills, and will be required to take training courses both prior to and upon assignment to the position. **(T-1)**.

2.3.6.2.1. The MEM will be a service member (Medical Readiness Officer or DoD civilian employee (Medical Readiness Manager) or other qualified individual) who is a member of the MTF. **(T-2)**.

2.3.6.2.2. The MEM must have experience and training in functions essential to effective public health emergency management (e.g., NIMS, NRF, AFIMS). **(T-1)**.

2.3.6.2.3. The MEM will be the designated MTF representative to the EMWG. **(T-3)**. In addition, it is recommended that he/she also be a member of the TWG.

2.3.6.2.4. The MEM must obtain an active national security clearance at the SECRET level. **(T-2)**.

- 2.3.6.2.5. MEM training requirements provide the minimum knowledge necessary to effectively work with the PHEO and support the MTF/CC during a public health emergency or medical surge event. See AFI 41-106 for specific training courses. **(T-1)**.
- 2.3.6.3. Nominate a licensed mental health provider as the DMH Team Chief to the installation commander as specified in **Paragraph 2.3.1.15.1** For the ANG, refer to Chapter 6. **(T-3)**.
- 2.3.6.4. Authorize state-licensed and credentialed, but non-privileged healthcare providers by granting temporary privileges to provide care within their facilities when necessary to respond to emergency requirements or as appropriate and IAW applicable laws and policies. **(T-1)**.
- 2.3.6.5. Oversee identification/designation of MTF key response personnel (e.g., local civilian first responders/receivers) and coordinate with Security Forces to allow appropriate access to the installation and the ability to perform assigned job functions. **(T-2)**.
- 2.3.6.6. Authorize direct purchase of emergency medical supplies without base contracting approval when necessary to save life or prevent suffering. Use this means of procurement only when prime vendor, decentralized blanket purchase agreement, or Government Purchase Card sources are unable to support emergency requirements (refer to AFI 41-209 for specific procedures). **(T-3)**.
- 2.3.6.7. Upon direction from the installation commander, direct pharmacy to employ mass prophylaxis point of dispensing (POD). **(T-1)**.
- 2.3.6.8. Ensure a coordinated medical response IAW AFIMS. **(T-1)**.
- 2.3.6.8.1. Ensure the installation PHEO, PHO, and MEM coordinate with appropriate local, city, county, and state health departments. **(T-1)**.
- 2.3.6.8.2. Coordinate planned disease containment techniques (i.e., DCP, IEMP MCRP, MPP, etc.) with co-located Reserve and Guard Medical Unit commanders and provide information and assistance to ANG subordinate units as necessary. **(T-1)**.
- 2.3.6.9. In conjunction with functional subject matter experts, provide the installation commander, the CAT director, and/or the EOC Director with medical response recommendations and mitigation procedures to include health risks, benefits, and operational implications. **(T-1)**.
- 2.3.6.10. Advise commanders/installation leadership, as necessary, of health risks associated with enforcing ROM and procedures for safe handling of personnel. **(T-2)**.
- 2.3.6.11. Support the installation commander with the integration of public health and medical preparedness into other installation/command emergency response plans. **(T-2)**.
- 2.3.6.12. Coordinate with the MSG to take reasonable and necessary measures for testing and safely transferring or temporarily disposing of human remains in order to prevent the spread of disease. Ensure proper labeling, identification, and records regarding the circumstances of death and disposition. Ensure contaminated remains are handled IAW

AFI 41-210, *TRICARE Operations and Patient Administration Functions* and AFI 34-242, *Mortuary Affairs Program*. **(T-1)**.

2.3.6.13. Coordinate with appropriate MSG office and local veterinarian for transferring or temporarily disposing of animal remains in order to prevent the spread of disease IAW DoDD 6400.04E, *DoD Veterinary Public and Animal Health Services*. **(T-0)**.

2.3.6.14. Paragraphs 2.3.6.4. to 2.3.6.13. responsibilities apply to the ANG GMUs, as applicable. **(T-1)**.

2.3.7. Public Health Emergency Officer is the central point of contact and clearinghouse for health-related information during a declared public health emergency. The PHEO will:

2.3.7.1. Advise the installation commander when it is appropriate to declare a public health emergency and on the implementation of emergency health powers IAW relevant public health laws, regulations, and policies. The PHEO will use the definition of a public health emergency as defined in **Paragraph 1.2** to aid the commander in determining whether or not a public health emergency exists. **(T-1)**.

2.3.7.1.1. Upon initial declaration of a public health emergency, the PHEO ensures notification of the MTF/CC, MAJCOM/SGP, and installation Public Health. **(T-1)**.

2.3.7.1.2. Following the initial declaration, coordinate with Public Health to ensure information is relayed to the United States Air Force School of Aerospace Medicine (USAFSAM) and the local civilian health department. USAFSAM will become the clearinghouse of epidemiological information to the MAJCOMs and AFMOA, and will provide information to AFMSA during on-going public health emergencies. **(T-1)**.

2.3.7.2. Work closely with installation personnel and local public health authorities to identify, confirm, and control a public health emergency that may affect the installation. **(T-0)**.

2.3.7.3. Support preparedness for public health and medical surge capacity in collaboration with the MEM as appropriate. **(T-2)**.

2.3.7.4. Develop procedures to implement the declaration of a public health emergency. This includes implementation of procedures in the installation's DCP or IEMP 10-2, and the creation of/update to an annex to the MCRP on the MTF's response to a public health emergency or incident of public health concern. **(T-1)**.

2.3.7.5. In collaboration with the PHO, maintain situational awareness of public health and medical threats to ascertain the existence of cases suggesting a public health emergency and conduct epidemiological investigations. **(T-1)**.

2.3.7.6. Collaborate with the PHO, BE, Infection Control Officer, and other members of the EMWG, as needed, to provide proper control measure recommendations to the installation and MTF commanders. **(T-1)**.

2.3.7.7. In coordination with PA, communicate with the installation population and appropriate state, local, tribal and territorial (SLTT) and HN public health officials during declared public health emergencies. **(T-1)**. **Note:** The Public Health Office serves as the primary liaison with civilian health officials and will facilitate this requirement for the

PHEO. (T-1). The PHEO should have situational awareness of civilian agency preparedness and response activities and develop contacts with key agency leaders with the assistance of the MEM (see [Paragraph 2.3.8](#)).

- 2.3.7.7.1. Coordinate with PA on development of communication materials to educate base population on actions to take to limit the spread of a disease before, during, and after a public health emergency or incident of public health concern. (T-1).
- 2.3.7.7.2. Coordinate with civilian agencies to ensure the assumption of disease containment and public health emergency responsibilities by civilian agencies for other-than-U.S. military personnel and non-Air Force property is consistent with the protection of military installations, facilities, and personnel. Responsibility will only be given to civilian agencies with appropriate jurisdiction over the persons or property. (T-1).
- 2.3.7.7.3. Coordinate with installation PA to share epidemiologic information with SLTT or HN officials responsible for public health and public safety. (T-1). Such information may include personally identifiable health information only to the extent necessary to protect the public health and safety and as otherwise permitted by law, IAW DoD 6025.18-R, *DoD Health Information Privacy Regulation*.
- 2.3.7.8. Notify the installation Antiterrorism Officer (ATO) and TWG through applicable military channels of any information indicating a possible terrorist incident or other crime. Cooperate with authorized law enforcement agencies investigating any such incidents. (T-2).
- 2.3.7.9. Recommend to installation commanders when access to the SNS is warranted to sustain the response to a public health emergency or incident of public health concern. (T-1).
- 2.3.7.10. Recommend diagnosis, treatment, and prophylaxis of affected individuals or groups and populations in consultation with appropriate clinical staff. (T-2).
- 2.3.7.11. Establish procedures for all non-military personnel subject to quarantine or isolation who contest their detention to present information requesting an exemption or release. The installation commander will be the final authority for resolution. (T-1).
- 2.3.7.12. Ensure every individual subject to quarantine or isolation is provided written notice of the reason and the plan of examination, testing, and/or treatment designed to resolve the reason for the quarantine or isolation. (T-2).
- 2.3.7.13. Delegate, as necessary or desired, oversight of select actions in this Instruction to the alternate PHEO, Public Health personnel, or qualified individuals during a declared public health emergency to better manage the evolving situation. Those to whom this authority is delegated will keep the PHEO informed of the progress and outcomes of those actions. (T-3).
- 2.3.7.14. Determine what local authority (i.e., local, county, state) has the ability to declare a public health emergency. Assess the need to coordinate with this external authority and the impacts an external declaration would have on the mission and the installation. (T-1).

2.3.7.15. Provide Public Health and Disease Outbreak Emergency Response Training for installation senior leadership once every 24 months. Contact AFMSA/SG3X for template (see [Paragraph 2.2.6.1.5](#)). (T-1).

2.3.8. Medical Treatment Facility Emergency Manager or ARC equivalent coordinates medical planning and preparedness using an all-hazards approach for public health emergencies or biological incidents of operational concern, and assists in the execution of emergency response management activities on behalf of the MTF/CC or ARC equivalent. During public health emergencies, the MEM will be an alternate central point of contact and, in support of the PHEO, a clearinghouse for health-related information. At stand-alone AFRC installations the ARC equivalent for the MEM will be the ARC PHEO in partnership with the Bioenvironmental Engineering/Public Health office. According to DoDI 6200.03 and this AFI, the MEM responsibilities fall into five major categories and include: (T-1).

2.3.8.1. Act as primary point of contact with the IEM and serve as the MTF lead for military/civilian coordination as it relates to medical emergency management. (T-2).

2.3.8.1.1. Establish working relationships with public health officials, emergency medical services, and medical/health/behavioral care providers, to increase coordination of medical response and recovery for a public health emergency. Work with the installation EM office to facilitate cross-functional collaboration with local emergency management agencies, fire officials, law enforcement and the local emergency planning committees (LEPC). **Note:** IAW AFI 10-2501, the installation commander will appoint in writing a primary and alternate representative to the LEPC to officially speak on behalf of the installation. (T-2).

2.3.8.1.2. Coordinate public health issues (e.g., additional requirements and/or resources) with the PHEO/alternate PHEO, PHO, BE, and others as appropriate. (T-2).

2.3.8.1.3. Coordinate planning and execution of disease containment and public health emergency response plans (i.e., DCP, MCRP) with local officials. (T-2).

2.3.8.1.4. Based on the MTF's capability to provide and/or arrange for emergency care and transport of casualties resulting from medical contingencies, determine need for and coordination of, and maintenance of MOUs/MOAs/Mutual Aid Agreements (MAA) with civilian agencies so that necessary resources can be obtained and effectively utilized during an incident. (T-2).

2.3.8.1.5. Represent medical unit at installation EMWG. Present MTF response capability assessment for inclusion into the installation's integrated response capability assessment. (T-2).

2.3.8.2. Ensure the Integrated Risk Management process described in AFI 10-2501 and all mitigating actions are considered in executing MTF emergency management activities. (T-1).

2.3.8.2.1. Collaborate with the ATO to receive appropriate level of information from installation groups (e.g., Antiterrorism Working Group TWG, and Vulnerability Assessment Team) to gather any and all pertinent information necessary to develop realistic planning factors in an all-hazards approach for public health emergencies or

- incidents of public health concern. Review material with PHEO, PHO, and BE and address any issues at the EMWG. **(T-1)**.
- 2.3.8.2.2. Work in coordination with PHEO, PHO, IEM, CAT director, EOC Director, BE, and wing PA in development and delivery of incident-specific, science-based risk-communication activities, messages and products before, during, and after a public health emergency or incident of public health concern. **(T-1)**.
- 2.3.8.3. Ensure MTF EM plans are comprehensive, integrated, and compliant with DoDI 6200.03; AFPD 10-25; AFI 10-2501; AFI 10-208, *Air Force Continuity of Operations (COOP) Program*; and AFI 41-106. **(T-1)**.
- 2.3.8.3.1. Coordinate with the PHEO and PHO to determine the medical unit's capabilities to support installation disease containment and public health emergency response requirements identified in installation plans (i.e., DCP, IEMP, and MCRP). **(T-2)**.
- 2.3.8.3.2. Coordinate with the PHEO and PHO to address public health aspects of mass care, special needs populations, patient evacuation, and shelter-in-place so that the impact on the health and well-being of the vulnerable population is reduced during an incident. **(T-1)**.
- 2.3.8.3.3. Incorporate Joint Commission or the Accreditation Association for Ambulatory Health Care emergency management standards into the MCRP. **(T-1)**.
- 2.3.8.3.4. Provide medical input to the IEMP IAW AFI 10-2501. **(T-1)**.
- 2.3.8.3.5. Collaborate with PHEO, PHO, Wing XP, and EMWG members to create, update and revise the installation's disease containment and public health emergency response guidance. **(T-1)**.
- 2.3.8.4. Support MTF/CC or officer in charge in the coordination and integration of EM-related training and exercises to include public health emergency response and disease containment. **(T-3)**.
- 2.3.8.4.1. In collaboration with the unit Medical Inspection Team Chief, MCRP Team Chiefs, and PHEO, determine exercise goals and objectives to fully test medical response capabilities as noted in response plans (e.g., DCP, IEMP, and MCRP). **(T-3)**.
- 2.3.8.4.2. Assist with exercise scenario design and development to ensure medical strengths are recognized and areas for improvement are identified and corrected. **(T-3)**.
- 2.3.8.5. Serve as the primary advocate to ensure appropriate medical resource needs are identified to execute mission requirements. **(T-2)**.
- 2.3.8.5.1. Integrate the acquisition, delivery, and distribution procedures of all available public health and medical material caches, to include Home Station Medical Response (HSMR) and SNS, into installation response plans (e.g., DCP, IEMP, and MCRP). **(T-2)**.

2.3.8.5.2. Identify training and exercise funding requirements through the unit Medical Readiness Committee (MRC) to include Medical Counter CBRN program requirements. **(T-2)**.

Chapter 3

EMERGENCY HEALTH POWERS FOR INSTALLATION COMMANDERS

3.1. Public Health Emergency Declaration. In response to a suspected or confirmed public health emergency, the installation commander in consultation with the PHEO, may declare a public health emergency and implement relevant emergency health powers as described in this chapter. To the extent necessary for protecting or securing military property or places and associated military personnel, such powers may also extend to non-military personnel who are present on Air Force installations.

3.1.1. Emergency health powers prescribed in this Instruction shall not provide for the apprehension, detention, or conditional release of individuals except for the purpose of preventing the introduction, transmission, or spread of such communicable diseases as may be specified in Executive Orders of the President upon the recommendation of the National Advisory Health Council and Surgeon General of the United States (i.e., Executive Order 13295, *Revised List of Quarantinable Communicable Diseases*, amended by Executive Order 13375, *Amendment to Executive Order 13295 Relating to Certain Influenza Viruses and Quarantinable Communicable Diseases*). **(T-0)**.

3.1.2. Overseas installation commanders will exercise emergency health powers in agreement with HN authorities under applicable international agreements. **(T-0)**. The PHEO will function as the installation commander's primary public health advisor during an emergency regardless of HN actions. **(T-0)**.

3.2. Legal Authorities. IAW DoDI 6200.03, during a declared public health emergency, the installation commander, as reasonable and necessary for the emergency response, has the legal authority to:

3.2.1. Collect specimens and perform tests on installation property or on any animal or disease vector, living or deceased. **(T-0)**.

3.2.2. Close, evacuate, decontaminate, or destroy any affected material, asset, or facility. However, to the fullest extent possible under the circumstances, evidence should be preserved so appropriate investigations and/or remedial actions can be taken. **Note:** Commanders can close installation facilities or the entire base prior to confirmatory identification, which may take several days. **(T-0)**.

3.2.3. Assert control over any animal or disease vector that endangers public health. **(T-0)**.

3.2.4. Use facilities, materials, and services for communications, transportation, shelter, fuel, food, clothing, healthcare, and other purposes as appropriate to control or restrict the distribution of commodities throughout the response. **(T-0)**.

3.2.5. Control evacuation routes, incoming, and outgoing traffic on the installation. **(T-0)**.

3.2.6. Take measures to safely contain and dispose of infectious waste. **(T-0)**.

3.2.7. Obtain needed healthcare supplies IAW AFI 41-209, and control use and distribution of such supplies to achieve the greatest public health benefit. **(T-2)**.

3.2.7.1. Installation commanders have local purchase approval authority for medical and non-medical materiel, as well as services. **(T-2)**.

3.2.7.2. Installation commanders may delegate this approval authority to an authorized representative (usually the MTF/CC). **(T-2)**.

3.2.8. Direct military personnel to submit to medical examinations and/or testing as necessary to diagnose or treat the condition causing the public health emergency or incident of public health concern. Non-military personnel may be required to submit to a physical examination and/or undergo testing or treatment as a condition of exemption or release from ROM. The PHEO will coordinate such actions with local health authorities as necessary. Privileged providers will be responsible for all examinations and testing. Failure by military members to submit to medical examinations and/or testing as necessary to diagnose or treat the condition causing the public health emergency or incident of public health concern is a violation of Article 92 of the UCMJ. **(T-0)**.

3.2.9. Restrict movement of military and non-military persons to prevent the introduction, transmission, and spread of communicable diseases or any contaminant that could affect human health. **(T-0)**.

3.2.9.1. The needs of persons or groups of persons quarantined or isolated shall be addressed in a systematic and competent fashion. Places of quarantine shall be maintained in a safe and hygienic manner, designed to minimize transmission of infection/contamination or other harm to persons subject to quarantine. Adequate food, clothing, medical care, and other necessities will be provided as expeditiously as possible under the circumstances. **(T-0)**.

3.2.9.2. Persons subject to quarantine or isolation shall obey the rules and orders established by the installation commander in consultation with the PHEO, shall not go beyond the quarantine premises, and shall not put himself/herself in contact with any person not subject to quarantine, except as the installation commander authorizes. Public Health will assist the PHEO with tracking of persons subject to quarantine or isolation. Failure by military members, who are subject to quarantine or isolation, to obey the rules and orders established by the installation commander; to remain within the quarantine premises; or to refrain from putting himself/herself in contact with any person not subject to quarantine (except as the installation commander authorizes) is a violation of Article 92 of the UCMJ. **(T-0)**.

3.2.9.3. No person may, without authorization, enter quarantine or isolation premises. A person who by reason of unauthorized entry poses a danger to public health becomes subject to quarantine. Unless authorized, failure by military members to refrain from entering quarantine or isolation premises is a violation of Article 92 of the UCMJ. **(T-0)**.

3.2.9.4. Quarantine or isolation will be accomplished through the least restrictive means available, consistent with protection of public health. Quarantine or isolation of any person shall be terminated when no longer necessary to protect public health. **(T-0)**.

3.2.9.5. Military personnel may be ordered to submit to diagnostic or medical treatment for the condition causing the public health emergency or incident of public health concern IAW Centers for Disease Control and Prevention (CDC) and Food and Drug Administration guidelines. Failure by military members to submit, when ordered, to

diagnostic or medical treatment (IAW CDC and Food and Drug Administration guidelines) for the condition causing the public health emergency or incident of public health concern is a violation of Article 92 of the UCMJ. (T-0).

3.2.9.6. In the case of persons other than military personnel, ROM may include isolation or limiting ingress and egress to, from, or on an Air Force installation. Persons other than military personnel may be required, as a condition of exemption or release from ROM, to submit to vaccination or treatment diagnostics as necessary. Submitting to vaccination, treatment, or diagnostic testing for the condition causing the public health emergency or incident of public health concern may be a requirement for returning to work or gaining access to an Air Force installation. In the U.S., coordinate all ROM actions involving non-military personnel through the nearest CDC Quarantine Officer and/or SLTT health department officials. (T-0).

3.2.9.7. Quarantine or isolation measures may be implemented in healthcare facilities, living quarters, or other appropriate buildings on an Air Force installation. These measures do not lessen the responsibilities of the medical unit to provide medical care to infected persons to the standard of care feasible given resources available. (T-0).

3.2.9.8. In the case of ROM of persons other than military personnel on U.S. installations, the PHEO will coordinate through his/her respective medical chain of command in relation to CDC actions under quarantine authorities provided in this Instruction; DoDI 6200.03; Sections 243, 248, 249 and 264-272 of Title 42 of the U.S. Code; Parts 70 and 71 of Title 42 of the Code of Federal Regulations (CFR); and Executive Orders 13295 and 13375. (T-0).

3.2.9.9. With regard to emergency health powers, an installation commander's authority may be limited in scope as it pertains to HN personnel. Non-domestic installations will review their respective HN agreements and incorporate into their DCP the authority local commanders possess as it pertains to HN personnel. Coordination of ROM actions will be sought with the Department of State and appropriate HN public health officials. (T-0).

3.3. Violation of Restriction of Movement. Individuals and groups subject to quarantine shall be advised that violators may be charged with a crime pursuant to law (including Section 797 of title 50, United States Code; Section 1382 of title 18, United States Code; or Parts 70 and 71 of title 42, Code of Federal Regulations) and subject to punishment of a fine or imprisonment for not more than 1 year, or both. (T-0).

3.3.1. In the case of U.S. military personnel, these potential sanctions are in addition to applicable provisions of the UCMJ, to the extent allowed by law. (T-0).

3.3.2. Those individuals or groups not subject to military law and who refuse to obey or otherwise violate an order under this Instruction may be detained by the Military Commander until appropriate civil authorities can respond. (T-0).

3.4. Contesting Restriction of Movement. Any persons subject to quarantine or isolation who contest the reason for quarantine/isolation will be provided an opportunity to present information supporting an exemption or release. The installation commander or a designated representative will make the final determination on all requests for exemption or release. (T-0).

3.4.1. Upon receiving a request for exemption or release, the PHEO will immediately provide the information to the installation commander. **(T-0)**.

3.4.2. The PHEO will consult with appropriate medical and legal personnel regarding the request for exemption or release to ensure he or she is informed of all pertinent facts prior to providing a recommendation to the installation commander. **(T-0)**.

3.4.3. The PHEO will provide the requesting member with the commander's or designated representative's written decision on the quarantine exemption as soon as possible, but no more than 24 hours after receipt of the member's initial request. **(T-0)**.

Chapter 4

DISEASE CONTAINMENT PLANNING AND RESPONSE

4.1. Purpose. Effective base-wide disease containment planning coordinates unit capabilities and integrates medical and non-medical measures implemented by all personnel before, during, and after a public health emergency or incident of public health concern.

4.2. Assumptions. A biological incident may not result in noticeable effects for hours or days. Responses to a biological incident are further complicated by the variety of potential pathogens, limitations in accurate detection and identification, and disease-specific treatment requirements.

4.3. Planning. The more prepared an installation is prior to a biological incident, the greater the potential number of options available for the installation commander to mitigate the effects of the incident. Sound preparation through disease containment planning will ensure commanders have the greatest range of options available to respond to a given trigger event while appropriately balancing mission requirements with the risk to personnel. The EMWG will support the planning process by providing a forum for disease containment planning and public health emergency preparedness and response activities for the installation. **(T-2)**.

4.3.1. The EMWG will stand up a public health emergency sub-working group or committee, as necessary, to review and discuss health threat situations (e.g., identified spread of human-to-human transmission of highly-pathogenic avian influenza in another country or region) and potential local actions (e.g., distribution of prophylaxis, PA guidance, etc.) that may be required. **(T-1)**. The public health emergency sub-working group or committee will:

4.3.1.1. Assist Wing XP (or equivalent as appointed by the installation commander) with development of the DCP as a stand-alone document or as an annex to the IEMP 10-2 (see **Paragraph 2.3.1.1**). Installation disease containment and public health emergency response guidance must be maintained and current to ensure appropriate enactment and enforcement during a public health emergency on the installation IAW this document and AFI 10-2501. **(T-1)**.

4.3.1.2. Work with the All Hazards Planning Team, a subset of the installation EMWG, to coordinate non-medical procedures that support the health risk and medical needs to public health incidents and emergencies. **(T-3)**.

4.3.1.3. Develop procedures for declaring and reporting a public health emergency. **(T-1)**.

4.3.1.4. Ensure local and national statutes are reviewed to allow public health intervention and implementation of ROM measures (to include quarantine and isolation) in a lawful and timely manner. **(T-1)**.

4.3.1.5. Identify personnel responsible for coordination and enforcement of ROM, quarantine, and isolation measures. **(T-1)**.

4.3.1.6. Ensure protocols to address the needs of persons subject to emergency health powers are developed in installation plans. **(T-1)**.

4.3.2. Coordinate activities with the MRC on disease containment or public health emergency matters to include mass prophylaxis planning and surge capability requirements. **(T-2)**.

4.3.3. Assist installation IG with the planning and execution of disease containment and public health emergency response exercises. Ensure planned exercises are done IAW AFI 90-201, *The Air Force Inspection System*. **(T-2)**.

4.4. Training. The EMWG will assist the PHEO to tailor the standard training template (see [Paragraph 2.2.5.2.3](#)) in order to execute an installation-specific Public Health and Disease Outbreak Emergency Response Training Program for installation senior leadership once every 24 months and track training through EMWG minutes. Contact AFMSA/SG3X for template (see [Paragraph 2.2.6.1.5](#)). **(T-2)**.

4.4.1. Public Health and Disease Outbreak Emergency Response Training is a mandatory requirement for the following installation leadership positions: **(T-1)**.

4.4.1.1. Installation Commander.

4.4.1.2. Installation Vice-Commander.

4.4.1.3. All Group Commanders

4.4.1.4. The following squadron commanders due to their prominent roles in the execution of the provisions in this Instruction: Aerospace Medicine, Civil Engineer, Logistics Readiness, Medical Operations, Security Forces, and Force Support. **(T-3)**.

4.4.2. All members of the EMWG, command chief master sergeant and all group chief master sergeants, deputy group commanders, and other key individuals identified by the installation are also highly encouraged to attend. **(T-3)**.

4.5. Response. The following HPCON framework clarifies much of the uncertainty associated with biological incidents and allows installation commanders to select a response that is appropriate given the scope and severity of the situation. The HPCON framework stratifies health-protection measures into categories beginning with simple standard precautions and gradually increasing the level of effort and costliness from category to category, with the most intrusive and costly measures grouped together in HPCON D. In addition, standardizing the responses within categories ensures a measured local response that is understood by all—up, down, and across command chains—just like MOPP levels. **(T-1)**.

4.5.1. HPCON 0 – Normal Operations.

4.5.1.1. Other than diseases endemic to the area surrounding the installation, there are no known health risks to personnel.

4.5.1.2. Personnel are trained and instructed to use standard precautions—such as routine hand hygiene, respiratory hygiene, diet, exercise, vaccinations, avoidance, insect (i.e., DEET, permethrin), environmental arthropod control (as part of a comprehensive integrated pest management control strategy)—to protect themselves and others from the spread of disease.

4.5.2. HPCON A – Limited Disease Threat.

4.5.2.1. There is a limited threat to personnel based on the existence of a disease or unusual human health threat that has the potential to rapidly move into the local area. **Note:** The local area will be defined by each installation as consisting of a pre-determined distance or a list/map depicting by-name counties surrounding the installation.

4.5.2.2. When HPCON A is initiated a health alert is communicated to personnel, making them aware of the potential risk. Functional personnel are instructed to review applicable plans and verify preparation such as training, stocks of countermeasures, force posture, etc. Personnel will be instructed that if new cases are identified, they should follow the directions given to them by health care personnel, which may include implementing social distancing to prevent disease spread.

4.5.2.3. Any identified cases of the disease/health threat will be immediately reported via Command and Public Health chains.

4.5.2.4. Medical personnel will continue to follow standard precautions.

4.5.3. HPCON B – Moderate Disease Threat.

4.5.3.1. There is a moderate disease threat and/or a real risk of exposure to personnel due to a significant outbreak of disease in the local area or imminent spread of disease to the local area. HPCON B would be employed by the Commander if notified by the PHEO that there has been an initial case identification of a contagious disease, such as a novel influenza, or a dramatic increase in the risk of acquiring a new significant disease from the environment within the local area.

4.5.3.2. During HPCON B, personnel will be asked to take basic disease containment measures including implementation of strict hygiene measures (i.e., no handshaking; wiping down common use items/items located in public waiting areas with disinfectant prior to each shift) and avoidance of affected environmental exposures (i.e., vectors or contaminated food or water). Those affected by the disease will also be asked to follow social distancing procedures, which may include self-isolation.

4.5.3.3. Medical personnel will follow standard and disease-applicable precautions (i.e., contact, droplet, respiratory, airborne).

4.5.4. HPCON C – Substantial Disease Threat.

4.5.4.1. There is a substantial threat of disease for personnel due to a local epidemic outbreak of a disease with a high morbidity rate, imminent spread of such a disease to the local area, and/or a wide area of contamination that requires special or costly avoidance procedures.

4.5.4.2. Stringent disease containment measures, such as broad social distancing (i.e., school closures, cancellation of meetings/socials/TDYs, etc.) and possible medical countermeasures (i.e., distribution of prophylaxis, mass vaccinations, etc.) are implemented at this level. Alternate measures, including shelter-in-place, may be implemented in the event of a wide-area airborne hazard.

4.5.4.3. Medical personnel will follow standard and disease-applicable precautions (i.e., contact, droplet, respiratory, airborne).

4.5.5. HPCON D – Severe Disease Threat.

4.5.5.1. A local epidemic with a high mortality rate or imminent spread of such a disease to the local area will drive enactment of HPCON D.

4.5.5.2. Extremely intrusive or costly disease containment measures (i.e., formal quarantine, mass evacuation due to wide-spread contamination, mass decontamination, and/or directing members to exclusively subsist on secure food/water) will likely be required.

4.5.5.3. Medical personnel will follow standard and disease-applicable precautions (i.e., contact, droplet, respiratory, airborne).

Figure 4.1. Health Protection Measures

Situation	HPCON	Example Health Protection Measures
Normal baseline	0	Routine: Standard precautions such as routine hand washing, cough on sleeve, diet, exercise, vaccinations, education, stockpiling, planning, routine health alerts, etc.
Report of unusual health risk or disease	A	Limited: Health Alert, communicate risk and symptoms, review plans, verify preparation: training, stocks, posture, prepare to diagnose, isolate, and report new cases
Outbreak or heightened exposure risk	B	Moderate: Strict hygiene (no handshaking, wipe common-use items) if exposed: self-isolate (wear mask or remain home), avoid contaminated water/food or risk area, vector control
High morbidity epidemic or contamination	C	Substantial: Social distance (limit: meetings, socials, TDYs) shelter in-place indoors or if directed don respirators, mass distribution of medical countermeasures if applicable
High mortality epidemic or contamination	D	Severe: Restrict movement (quarantine), mass evacuation, mass decontamination, subsist on secure food/water sources

Chapter 5

STRATEGIC NATIONAL STOCKPILE AND MEDICAL COUNTERMEASURE PLANNING REQUIREMENTS

5.1. Medical Countermeasure Sources. Public health emergency medical countermeasures are used to prevent or mitigate the health effects of CBRN threats and naturally-occurring epidemics. Medical countermeasures include both pharmaceuticals (e.g., vaccines, antibiotics, antivirals, antitoxins, etc.) and non-pharmaceuticals for MTF personnel (e.g., diagnostics, ventilators, personal protective equipment such as face masks and gloves, and other devices).

5.1.1. The SNS is a national repository of prophylaxis and treatment medications, as well as medical supplies and equipment established by the CDC. The SNS is designed to supplement and re-supply SLTT public health agencies in the event of a national emergency. It is capable of delivering vast amounts of medical countermeasures (e.g., sufficient antibiotics for 10-day regimens for over 400,000 people) within 12 hours to anywhere in the U.S. or its territories. The SNS is the primary domestic source for medical countermeasures in a large-scale public health emergency.

5.1.2. Air Force installations will maintain a medical initial response capability for responding to public health emergencies through the HSMR program. **(T-1)**. Air Force Tactics, Techniques, and Procedures (AFTTP) 3-42.32, *Home Station Medical Response to Chemical, Biological, Radiological, and Nuclear (CBRN) Events*, provides additional information on the HSMR program.

5.1.3. Air Force installations will consider and plan for the use of DoD contingency material stockpiles to respond to a public health emergency or incident of public health concern. **(T-0)**.

5.1.3.1. The DoD has established a limited number of contingency material stockpiles in CONUS, Europe, and the Pacific Rim.

5.1.3.2. The DoD has established agreements with HHS and CDC for access to SNS assets in the event of a domestic public health emergency. In addition, DoD has the capability to send medical countermeasures from various sources via the Defense Logistics Agency to both CONUS and OCONUS military installations.

5.1.3.3. During a public health emergency or incident of public health concern, the installation PHEO will contact his/her MAJCOM PHEO Consultant and/or HAF PHEO for information on availability of DoD contingency material prior to requesting access to SNS material. For additional information on DoD contingency material stockpiles, contact AFMSA/SG3XP. **(T-2)**.

5.2. Strategic National Stockpile Planning Guidance. All Air Force installations in the U.S. and its territories must develop MOUs/MOAs with their SLTT health agencies to receive SNS assets during a public health emergency or incident of public health concern. This section does not apply to an ANG GMU. For the ANG guidance, refer to Chapter 6 of this instruction. **(T-1)**.

5.2.1. MOUs/MOAs will be signed by the installation commander and the senior representative from the coordinating agency (e.g., director of the county/state health

department) and will be reviewed by the installation base legal office prior to the installation commander's signature. (T-1).

5.2.2. All MOUs/MOAs will contain a minimum of the following sections: introduction and/or background, purpose of the memorandum, agreement terms and conditions, effective period, modifications or amendments, and termination. (T-1).

5.3. Mass Prophylaxis Point of Dispensing. A POD refers to the set-up and operations of a mass prophylaxis or vaccination clinic to rapidly distribute and administer medication regimens to identified populations and to educate recipients about the risks and benefits of the medical countermeasure regimen during a public health emergency. This section does not apply to an ANG GMU. For the ANG guidance, refer to Chapter 6 of this instruction.

5.3.1. IAW DoDI 6200.03, military installations are prohibited from serving as open PODs for SNS assets. An open POD is open to the public and available to all members of the local community who arrive for treatment. Installations may not provide medical countermeasures to non-beneficiary populations. (T-0).

5.3.2. Installations are required to serve as closed PODs for SNS assets. A closed POD is only available to certain target populations. Target populations for installations to consider include initial victims or cases, emergency responders, critical and mission-essential personnel, population living on the installation, population working on the installation, or the entire beneficiary population at risk. (T-0).

5.3.3. All Air Force installations must have an MPP that is incorporated within their disease containment planning and response guidance (i.e., DCP, IEMP). The MPP must incorporate prophylaxis guidance and agreements discussed in [Paragraph 5.2](#) Contact AFMSA/SG3X for template (see [Paragraph 2.2.6.2.6](#)). (T-1).

5.3.4. All installations must develop an MOU/MOA with their SLTT health agencies. This information can be combined with the MOU/MOA developed for receiving SNS assets ([Paragraph 5.2](#)). The MOU/MOA must specify the planned installation capability and the planned support capability by the local health agency and contain the components specified in [Paragraph 5.2.2](#) (T-1).

5.4. Receiving, Staging, and Storage (RSS) Sites.

5.4.1. Air Force installations are authorized to serve as RSS sites. This decision must be made by the installation commander in consultation with his/her PHEO and other applicable persons (e.g., MTF/CC, MSG/CC, JAG, etc.). However, the decision to serve as an RSS site should be made very judiciously and must consider the requirements of the RSS site, the ability of the installation to operate the RSS site during a public health emergency or incident of public health concern, and the populations that the material at the RSS site is intended to cover. This section does not apply to an ANG GMU. For the ANG guidance, refer to Chapter 6 of this instruction. (T-3).

5.4.1.1. Costs and manpower requirements associated with becoming an RSS site should be incurred by the installation (and not the MTF). (T-1).

5.4.1.2. Installations should only serve as RSS sites in order to assist with storing material designated for beneficiary populations or for other government agencies.

Installations should not serve as RSS sites to store material designated for mass civilian populations. **Note:** an exception to this point may be made for ANG installations. **(T-2)**.

5.4.1.3. All installations that will serve as an RSS site must develop an MOU/MOA with their SLTT health agencies. This MOU/MOA must be separate from any other established MOUs/MOAs, signed by the installation commander, and contain the components specified in **Paragraph 5.2.2 (T-1)**.

5.4.2. Installations that agree to serve as an RSS site must gain approval prior to signing the MOU/MOA. **(T-1)**.

5.4.2.1. The installation commander must report the request to serve as an RSS site through his/her chain of command to the Secretary of the Air Force for approval. The HAF PHEO will forward the request to the Office of the Assistant Secretary of Defense for Health Affairs and the appropriate geographic combatant commander. **(T-1)**.

5.4.2.2. ANG units will coordinate requests for approval to be RSS sites through their chain of command, their JFHQ-State, NGB and not through the DoD. **(T-1)**.

5.5. Overseas Installations. Air Force OCONUS installations have an initial response capability for responding to public health emergencies through the HSMR program. HSMR provides a capability to manage and treat at least 300 CBRN casualties for at least 24 hours using the 886 AS equipment packages, including AS 886E, Pharmaceuticals.

5.5.1. Should a public health emergency or incident of public health concern occur at an OCONUS Air Force installation and exceed the capabilities of the HSMR program, the decision to request additional medical countermeasures must be made by the installation commander in conjunction with his/her PHEO's recommendation and should only be made after a public health emergency has been declared. **(T-3)**.

5.5.1.1. The installation will need to specify the amount and type of materials required and describe the scope and details of the public health emergency. **(T-1)**.

5.5.1.2. This request must be made through the installation's chain of command to the Geographic Combatant Commander, who will forward the request to the Secretary of Defense. **(T-1)**.

5.5.1.3. In the event of a larger-scale public health emergency or incident of public health concern, Air Force OCONUS installations will receive additional medical countermeasures and material from DoD contingency material stockpiles or from other sources acquired by DoD. Material will be shipped via the Defense Logistics Agency, who will send the material through the appropriate Theater Lead Agent for Medical Material. OCONUS PHEOs will coordinate with the MAJCOM PHEO Consultant to ensure appropriate coordination requirements for requesting and receiving medical countermeasures are described within their disease containment/public health emergency response plans. **(T-2)**.

5.5.2. All OCONUS Air Force installations will develop plans to serve as a closed POD to that installation's entire beneficiary population. The installation must have an MPP that is incorporated within their disease containment planning and response guidance (i.e., DCP, IEMP). Contact AFMSA/SG3X for template (see **Paragraph 2.2.6.2.6 (T-1)**).

Chapter 6

AIR NATIONAL GUARD

6.1. Purpose. This chapter specifies the role of the Air National Guard (ANG) and the GMU, its planning factors and outlines the flow of information in the event of a public health emergency or incident of public health concern. It identifies the roles and responsibilities of key players in the reporting and information flow.

6.1.1. GMUs not co-located with a RegAF installation do not have the resident capability or personnel to prepare for and respond to a public health emergency. This limitation necessitates the support and interdependence on the civilian emergency medical system, airport municipals, or local agencies to include state or regional health departments and ultimately limit the ANG wing installation commander's ability to implement many of the provisions found in this instruction and their RegAF counterpart's DCP. As a result, the ANG installation must rely heavily on civilian agencies/local authorities for emergency response through the use of MAA and MOU. **(T-1).**

6.1.2. ANG installations are authorized to serve as a Receiving, Staging and Storage Site (a.k.a. CDC closed POD site). This decision must be made by the installation commander in consultation with their Wing-PHEO-POC or Wing-PHEO-LNO and other applicable persons (e.g., State-PHEO-LNO, MDG/CC, MDG/SGP, MSG/CC, JAG, JFHQ etc.) and approved by the joint surgeon (NGB-JSG) and air surgeon (NGB/SGP). **(T-1).**

6.1.2.1. The decision to serve as an RSS/POD site should be made deliberately and must consider the requirements of the site, the ability of the installation to operate the site during a public health emergency or incident of public health concern, and the populations that the material at the RSS site is intended to cover. Other factors to be considered prior to applying to be an RSS/POD site include the availability of 24 hour security to safeguard stockpiles of supplies, environmentally controlled warehousing, the physical security of installation, 24 hour access to manpower and transportation vehicles. Note: all costs associated with becoming and maintaining the RSS/POD site are incurred by the installation. Installations should only assist with storing material designated for installation populations or for other government agencies and should not serve as a site to store material designated for mass civilian populations. **(T-3).**

6.1.3. Isolation and Quarantine. State health authorities have the primary role in imposing and enforcing quarantine as specified under state law with the use of civilian forces. ANG installations do not have the resources to support isolation and/or quarantine procedures so it is critical that the GMU establish agreements with local civilian hospitals. The CDC has certain limited authority. State resources must be exhausted or the threat must come from outside the country prior to CDC involvement. **(T-3).**

6.1.4. Treatment and Ambulances. ANG GMUs are not MTFs. ANG GMUs do not possess, maintain, or operate ambulances and are not authorized to provide medical treatment. ANG installations are dependent upon the local community to respond to medical or other emergencies and IAW AFI 41-106 will have MAAs/MOUs with local civilian agencies to provide medical transport, treatment and other emergency services. **(T-3).**

6.2. Roles and Responsibilities.

6.2.1. Governor. As the state's chief executive, the governor is responsible for the public safety and welfare of the people in his or her state. During a proclaimed emergency or disaster, a governor has extraordinary powers, including the authority to call up the ANG or Army National Guard (NG), order evacuations, access emergency resources including emergency funding, seize property and suspend state laws and regulations.

6.2.2. The Adjutant General (TAG). In most states, TAG is appointed by the governor and serves as commander of that state's military assets to include the ANG and NG. Some TAGs also serve as the Director of the Division of Emergency Management and Director of Homeland Security for their state.

6.2.3. ANG PHEO. The NGB/SGP Chief of Aerospace Medicine will serve as the primary PHEO consultant for the ANG and will:

6.2.3.1. Complete PHEO training requirements listed in AFI 41-106. **(T-1)**.

6.2.3.2. Provide expertise and guidance as needed to state and Wing(s). **(T-2)**.

6.2.3.3. Maintain contact information for all State-PHEO (or State-PHEO-LNOs). **(T-3)**.

6.2.3.4. Provide NGB-specific guidance on disease containment and public health emergency planning activities to supplement guidance from Office of the Secretary of Defense (OSD), AF, and JFHQState, as necessary. **(T-1)**.

6.2.3.5. Coordinate information and requirements to OSD, AF, JFHQ-State, and ANG installations during public health emergencies. **(T-2)**.

6.2.3.6. Coordinate formal communications with the ANG CAT for relay to Installation Command Centers. **(T-3)**.

6.2.4. NGB/SGPM or GS equivalent will assume the role of alternate PHEO and accomplish training as directed by AFI 41-106. **(T-1)**.

6.2.5. ANG MEM. The NGB/SGAX Medical Readiness Officer or GS equivalent will serve as the MEM consultant for the ANG and will:

6.2.5.1. Complete all MEM training requirements listed in AFI 41-106. **(T-1)**.

6.2.5.2. Provide expertise and guidance to ANG installations on conducting emergency response actions. **(T-2)**.

6.2.5.3. In concert with the ANG PHEO, provide ANG-specific guidance on public health emergency preparedness and planning activities to supplement guidance as necessary. **(T-1)**.

6.2.6. State Air Surgeon (SAS). The SAS is the senior military medical officer for the state, charged with creating a framework to facilitate and enable the ANG medical response within the state or region. Upon appointment as the SAS, he/she will be designated the State-PHEO-LNO. If PHEO training has been accomplished, the SAS can become the State-PHEO. In the SAS absence, the senior most ranking medical official/officer in that state/district or territories will be temporarily appointed as the acting State-PHEO-LNO.

6.2.6.1. The State-PHEO-LNO shall provide input about the state's military medical capability and the availability of any military medical resources, agent-specific information, risk communication, and provide situational awareness of the ANG medical capabilities to the governor, TAG, NGB-JSG, NGB/SG and local GMU.

6.2.6.2. The SAS monitors their state's medical statistics to ensure a viable and healthy force for local and worldwide deployment is available. The SAS coordinates with other SASs within the Federal Emergency Management Agency regions and Emergency Management Assistance Compact (EMAC) regions to identify and coordinate regional military medical response capabilities and operations if needed.

6.2.7. Joint Force Headquarters-State. JFHQ-State is responsible to:

6.2.7.1. Provide command and control of all military forces in the state or territory for the governor, or in the case of the District of Columbia, the Secretary of the Army.

6.2.7.2. Support Joint Task Force-State (JTF-State) Commanders and all NG units within the state, and act as an information channel to the NGB Joint Coordination Center and combatant commanders for public health emergencies.

6.2.7.3. Coordinate additional support as required, such as mobilization of personnel, equipment or providing other response capabilities.

6.2.7.4. Support units in their state or territory, providing command and control of NG medical forces.

6.2.8. Joint Task Force-State. JTF-State provides command and control of all state military assets deployed in support of civil authorities or a specific incident, and facilitates the flow of information between the JFHQ-State and the deployed units. Specifically, the JTFState commander:

6.2.8.1. Works closely with the incident commander in an effort to maintain situational awareness of SLTT actions to ensure the adequacy and effectiveness of response, support, and safety activities.

6.2.8.2. Serves as the senior military commander on the scene and is therefore responsible for the safe and efficient employment of all assigned military forces.

6.2.8.3. May request JFHQ-State activation and deploy additional units (e.g., EMAC requests), if additional forces are required.

6.2.9. GMU/Installation Requirements:

6.2.9.1. Each ANG installation may be unique in their full-time manning and may not have the resident full-time capability needed to fully address PHEO program specifics. Therefore, based upon the distinctive manning and the installation abilities they shall, at a minimum, appoint one PHEO POC alternate:

6.2.9.1.1. Wing-PHEO-POC (Required). Each installation commander will appoint a full-time Wing-PHEO-POC. The full-time Wing-PHEO-POC shall be any medical AFSC that resides within the full-time manpower document that has the knowledge to provide information to the SAS on biological/disease outbreaks of significance on or near the installation and coordinate response efforts in absence of the SAS/State-PHEO. Recommended training consists of items found under MEM or PHEO

training requirements. At a minimum the individual shall have a working knowledge of federal, state and local response capabilities, counter-disease planning and/or epidemiological investigation knowledge.

6.2.9.1.2. The Wing-PHEO-POC or Wing-MEM-POC serves as the primary liaison with local civilian health officials and will coordinate local requirements with the STATE-PHEO-LNO and installation commander. **(T-1)**.

6.2.10. ANG Installation Commander. The ANG Installation Commander shall:

6.2.10.1. Review their respective emergency response plans and incorporate measures that are reasonable and appropriate given their situation. At a minimum, such measures will include coordination of emergency response procedures, plans and MOUs/MAAs/MACs with applicable local and/or state authorities. **(T-2)**.

6.2.10.1.1. Will follow the installation commander's guidelines and response plans upon which the GMU resides. **(T-2)**.

6.2.10.1.2. Appoint full-time personnel (Installation XP or equivalent) to plan for and prepare an installation level response plan for a public health emergency or incident of public health concern. **(T-2)**.

6.2.10.2. Coordinate all disease containment and public health emergency activities with JFHQ-State and with NGB (ANG PHEO or ANG MEM), as necessary. **(T-2)**.

6.2.10.3. Appoint at a minimum, one full-time medical staff as referenced in paragraph 6.2.9.1.1. in this instruction. **(T-2)**.

6.2.10.4. Ensure involvement with state/local emergency response exercises and training using scenarios that consider naturally-occurring outbreaks and contingencies that result in public health emergencies or incidents of public health concern requiring an ANG medical response. **(T-3)**.

6.2.10.5. Document involvement of public health/medical exercises with the state/territory and lessons learned in wing-level working group minutes. **(T-3)**.

6.2.11. The assumption is that local GMU personnel are critical to functioning in their primary Air Force specialty code in support of the ANG unit emergency response or call up. Removing a GMU staff member to perform PHEO or MEM tasks is not required; however there must be at least one full-time designated local medical representative as outlined in paragraph 6.2.9.1.1. who will:

6.2.11.1. Coordinate information concerning local medical activities and readiness information with the state, installation commanders, PA, unit personnel or others, as needed or directed. **(T-2)**.

6.2.11.2. Establish contact with NGB/SGP or NGB/SGPM to provide or request guidance or subject matter expertise as needed. **(T-3)**.

JOHN B. COOPER, Lieutenant General, USAF
DCS/Logistics, Engineering & Force Protection

Attachment 1**GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION*****References***

- DoDI 6200.03, *Public Health Emergency Management Within the Department of Defense*, 5 March 2010
- GCP PI&ID 3551-13, *Department of Defense Global Campaign Plan for Pandemic Influenza and Infectious Disease*, 14 March 2014
- AFPD 10-25, *Emergency Management*, 28 Apr April 2014
- AFPD 10-26, *Counter-Chemical, Biological, Radiological, and Nuclear Operations*, 26 September 2007
- AFI 33-360, *Publications and Forms Management*, 25 September 2013
- AFPD 10-8, *Defense Support of Civil Authorities (DSCA)*, 15 February 2012
- AFI 10-801, *Defense Support of Civilian Authorities (DSCA)*, 19 September 2012
- AFI 10-2501, *Air Force Emergency Management (EM) Program Planning and Operations*, 24 January 2007
- AFI 90-1601, *Air Force Lessons Learned Program*, 18 December 2013
- AFMAN 10-2502, *Air Force Incident Management System (AFIMS) Standards and Procedures*, 25 September 2009
- AFMAN 10-2503, *Operations in a Chemical, Biological, Radiological, Nuclear, and High-Yield Explosive (CBRNE) Environment*, 7 July 2011
- AFMAN 33-363, *Management of Records*, 1 March 2008
- AFPD 48-1, *Aerospace Medicine Enterprise*, 23 August, 2011
- AFPD 10-2, *Readiness*, 6 November 2012
- AFI 51-701, *Negotiating, Concluding, Reporting, and Maintaining International Agreements*, 16 August 2011
- Joint Basing Implementation Guidance*, 22 January 2008
- AFI 41-106, *Medical Readiness Program Management*, 22 April 2014
- National Response Framework*, May 2013, Second Edition
- AFI 10-206, *Operational Reporting*, 11 June 2014
- AFI 41-209, *Medical Logistics Support*, 6 Oct 2014
- AFI 44-153, *Disaster Mental Health Response & Combat and Operational Stress Control*, 29 May 2014
- National Incident Management System*, December 2008
- DoDD 6400.04E, *DoD Veterinary Public and Animal Health Services*, 27 June 2013

AFI 34-242, *Mortuary Affairs Program*, 2 April 2008

AFI 41-210, *TRICARE Operations and Patient Administration Functions*, 6 June 2012

DoD Regulation 6025.18-R, *DoD Health Information Privacy Regulation*, 24 January 2003

AFI 10-208, *Air Force Continuity of Operations (COOP) Program*, 15 December 2011

Executive Order 13295, *Revised List of Quarantinable Communicable Diseases*, 31 July 2014

Executive Order 13375, *Amendment to Executive Order 13295 Relating to Certain Influenza Viruses and Quarantinable Communicable Diseases*, 1 April 2005

Title 42, United States Code, Sections 243, 248, 249, 264-272

Title 42, Code of Federal Regulations, Part 70, *Interstate Quarantine*, current edition

Title 42, Code of Federal Regulations, Part 71, *Foreign Quarantine*, current edition

Title 50, United States Code, Section 797

AFI 90-201, *The Air Force Inspection System*, 2 August 2013

AFTTP 3-42.32, *Home Station Medical Response to Chemical, Biological, Radiological, and Nuclear (CBRN) Incidents*, 15 October 2013

Prescribed Forms

None

Adopted Forms

AF Form 847, *Recommendation for Change of Publication*.

Abbreviations and Acronyms

AFDW—Air Force District of Washington

AFI—Air Force Instruction

AFIMS—Air Force Incident Management System

AFMAN—Air Force Manual

AFMOA—Air Force Medical Operations Agency

AFMS—Air Force Medical Service

AFMSA—Air Force Medical Support Agency

AFPD—Air Force Policy Directive

AFTTP—Air Force Tactics, Techniques, and Procedures

ANG—Air National Guard

ARC—Air Reserve Component

ASD(HA)—Assistant Secretary of Defense, Health Affairs

ASD(HD&GS)—Assistant Secretary of Defense for Homeland Defense and Global Security

ATO—Antiterrorism Officer

ATWG—Antiterrorism Working Group
BE—Bioenvironmental Engineering
CAT—Crisis Action Team
CBRN—Chemical, Biological, Radiological, and Nuclear
CBRNE—Chemical, Biological, Radiological, Nuclear, and High-Yield Explosive
CDC—Centers for Disease Control and Prevention
CFR—Code of Federal Regulations
CONUS—Continental United States
COOP—Continuity of Operations
DCP—Disease Containment Plan
DLN—Defense Laboratory Network
DMH—Disaster Mental Health
DoD—Department of Defense
DoDI—Department of Defense Instruction
DRU—Direct Reporting Unit
DSCA—Defense Support to Civil Authorities
EMAC—Emergency Management Assistance Compact
EMWG—Emergency Management Working Group
EOC—Emergency Operations Center
GSU—Geographically Separated Unit
GMU—Guard Medical Unit
HAF—Headquarters Air Force
HHS—Department of Health and Human Services
HN—Host Nation
HPCON—Health Protection Condition
HSMR—Home Station Medical Response
IAW—In Accordance With
IEM—Installation Emergency Manager
IEMP—Installation Emergency Management Plan
JAG—Judge Advocate General
JBIG—Joint Basing Implementation Guidance
JFHQ—State -Joint Forces Headquarters - State

JTF—State -Joint Task Force – State

LEPC—Local Emergency Planning Committees

LS—Limited Scope

LSISS—Limited Scope Inter-service Support

MAA—Mutual Aid Agreements

MAJCOM—Major Command

MCRP—Medical Contingency Response Plan

MEM—Medical Treatment Facility Emergency Manager (Wing Medical Emergency Manager for ANG)

MDG—Medical Group

MOA—Memorandum of Agreement

MOU—Memorandum of Understanding

MPP—Mass Prophylaxis Plan

MRC—Medical Readiness Committee

MTF—Medical Treatment Facility

MTF/CC—Medical Treatment Facility Commander

NG—National Guard

NGB—National Guard Bureau

NGB—JSG -National Guard Bureau Joint Surgeon

NGB/SG—National Guard Bureau Air Surgeon

NIMS—National Incident Management System

NRF—National Response Framework

OCONUS—Outside the Continental United States

OPR—Office of Primary Responsibility

OPREP—3 -Operational Event/Incident Report-3

OPORD—Operational Order

OSD—Office of the Secretary of Defense

PA—Public Affairs

PAO—Public Affairs Officer

PHEO—Public Health Emergency Officer

PHEO—LNO -Public Health Emergency Officer - Liaison Officer

PHO—Public Health Officer

POD—Point of Dispensing

RegAF—Regular Air Force

RMU—Reserve Medical Unit

ROM—Restriction of Movement

RSS—Receiving, Staging, and Storage

SARS—Severe Acute Respiratory Syndrome

SAS—State Air Surgeon

SGP—Chief of Aerospace Medicine

SGPM—Installation Public Health

SLTT—State, Local, Tribal and Territorial

SNS—Strategic National Stockpile

SOFA—Status of Forces Agreements

TAG—The Adjutant General

TWG—Threat Working Group

UCMJ—Uniformed Code of Military Justice

USAFSAM—United States Air Force School of Aerospace Medicine

Terms

12-hour Push Package— Part of the SNS, 12-hour Push Packages are caches of pharmaceuticals, antidotes, and medical supplies designed to provide rapid delivery of a broad spectrum of assets for an ill-defined threat in the early hours of an incident. These Push Packages are positioned in strategically located, secure warehouses ready for immediate deployment to a designated site within 12 hours of the federal decision to deploy SNS assets.

All—hazards Approach – A methodology to develop emergency management strategies for all different types of potential incidents. “All-hazards” include any incident, natural or manmade that warrants action to protect life, property, health, and safety of military members, dependents, and civilians at risk, and minimize any disruptions of installation operations.

Antiterrorism— Defensive measures used to reduce the vulnerability of individuals and property to terrorist acts, to include limited response and containment by local military forces.

Biological Agent— A microorganism that causes disease in personnel, plants, or animals or causes the deterioration of material.

CBRN Incident— The deliberate or inadvertent release of chemical, biological, radiological, or nuclear devices with potential to cause significant numbers of casualties and high levels of destruction.

Communicable Disease— An illness due to an infectious agent or its toxic product, which may be transmitted from a reservoir to a susceptible host either directly as from an infected person or animal or indirectly through an intermediate plant or animal host, vector, or the inanimate environment.

Communicable Period— The time during which an infectious agent may be transferred directly or indirectly from an infected person to another person, from an infected animal to humans, or from an infected person to animals, including arthropods.

Confirmatory Testing— A process that provides for the identification of a suspect biological warfare agent by means of devices, materials, or technologies that detect biological markers using two or more independent biological marker results.

CBRN Consequence Management— Air Force CBRN consequence management involves responding to the effects of CBRN use against the U.S., its military forces, and its interests abroad, by assisting the U.S. and its allies to restore essential services in a permissive environment.

Contact— A person or animal having contact with an infected person or animal or a contaminated environment resulting in an opportunity to acquire the infection/disease of interest.

Close Contact. Having cared for, lived with or been in close proximity with an infected person. Examples of close contact include kissing or embracing, sharing eating or drinking utensils, close conversation (< 3 feet), physical examination, and any other direct physical contact between persons. Close contact does not include activities such as walking by a person or briefly sitting across a waiting room or office.

Household Contact. A close contact living in the same household as an infected person.

Continuity of Operations— An effort within individual organizations to ensure they can continue to perform their essential functions during a wide range of emergencies, including localized acts of nature, accidents, and technological or attack related emergencies. COOP involves plans and capabilities covering the same functional objectives of Continuity of Government, must be maintained at a high level of readiness and be capable of implementation both with and without warning. COOP is not only an integral part of Continuity of Government and Enduring Constitutional Government (ECG), but is simply "good business practice" - part of the Department of Defense's fundamental mission as a responsible and reliable public institution.

Crisis Management— Measures to identify, acquire, plan, and use the resources needed to anticipate, prevent, and resolve a threat or act of terrorism.

Disease Vector— An organism, such as an insect, that transmits disease-causing pathogens.

First Responders— Firefighters, law enforcement and/or security personnel, and emergency medical personnel who provide the initial, immediate response.

Installation— A grouping of facilities, located in the same vicinity, which support particular functions. Installations may be elements of a base.

Installation Commander— The individual responsible for all operations performed by an installation.

Medical Treatment Facility— A facility established for the purpose of furnishing medical and/or dental care to eligible individuals.

Medical Treatment Facility Emergency Manager (MEM)— An individual appointed by the MDG/CC from Medical Readiness or other appropriate office who supports the Wing Commander, Public Health Emergency Officer, and the Installation Emergency Manager. The MEM is responsible for medical specific actions required to plan for, respond to, recover from,

and mitigate the impacts of all hazards (including but not limited to the public health and medical needs of victims during and after an attack, disaster, or other incident/accident). The term MEM as it applies at the MAJCOM level is used to point out the consultant who insures execution of AFMS policy on Public Health Emergencies and Incidents of Public Health Concern. The individual provides guidance and reach back capability for installation MEMs and advocates for medical specific and public health equities in support of the overarching Air Force Emergency Management Program.

Memorandum of Agreement— An agreement that defines areas of responsibility and agreement between two or more parties, normally at headquarters or MAJCOM level. MOAs normally document the exchange of services and resources and establish parameters from which support agreements may be authorized.

Memorandum of Understanding— An umbrella agreement that defines broad areas of mutual understanding between two or more parties, normally at MAJCOM or higher level.

Morbidity— Any departure, subjective or objective, from a state of physiological or psychological well-being.

Mortality Rate— A measure of the frequency of occurrence of death in a defined population during a specified interval of time.

Natural Disaster— An emergency posing significant danger to life and property that results from a natural cause.

Non-Military Personnel— Civilian personnel, dependents of military or civilian personnel, contractors, and other individuals visiting or who are present on an Air Force installation.

National Response Framework— Guides how the Nation conducts All-Hazards response. The Framework documents the key response principles, roles, and structures that organize national response. It describes how communities, states, the federal government, private-sector and non-governmental partners apply these principles for a coordinated, effective national response. It describes special circumstances where the federal government exercises a larger role, including incidents where federal interests are involved and catastrophic incidents where a state would require significant support. It allows first responders, decision makers, and supporting entities to provide a unified national response.

Public Health Emergency— An occurrence or imminent threat of an illness or health condition that may be caused by a biological incident, manmade or naturally occurring; the appearance of a novel or previously controlled or eradicated infectious agent or biological toxin; natural disaster; chemical attack or accidental release; radiological or nuclear attack or accident; or high-yield explosives that pose a high probability of a significant number of deaths, serious or long-term disabilities, widespread exposure to an infectious or toxic agent, and/or healthcare needs that exceed available resources.

Public Health Emergency Officer— An individual selected by the MTF/CC and appointed by the Wing/CC. This is one of the key subject matter experts who will serve as a resource to help guide the installation commander during incidents of a public health emergency or incidents of a public health concern.

Quarantinable Communicable Disease— Consistent with Executive Order 13295, as amended by Executive Order 13375, includes Cholera or suspected Cholera, Diphtheria, infectious

Tuberculosis, Plague, Smallpox, Yellow Fever, SARS, Viral Hemorrhagic Fevers (Lassa, Marburg, Ebola, Congo-Crimean, South American, and others not yet isolated or named), and influenza caused by novel or re-emergent influenza viruses that are causing, or have the potential to cause, a pandemic. Any subsequent changes to Executive Order 13295 are automatically incorporated into this definition.

Restriction of Movement— Limiting personnel movement to prevent or limit the transmission of a communicable disease, including limiting ingress and egress to, from, or on a military installation; isolation; and/or quarantine.

Social Distancing. Intervention applied to specific groups, an entire community, or a region designed to reduce interactions and thereby transmission risk within the group. Examples include implementing altered work schedules (e.g., telework, staggered shifts) and replacing face—to-face meetings with teleconferences.

Quarantine. Voluntary or compulsory separation and ROM of persons who are not ill but have been exposed to an infectious agent and therefore may become infectious, for the purpose of preventing or limiting the spread of disease.

Working Quarantine. Persons are permitted to work but must observe activity restrictions while off duty. Monitoring for fever and other symptoms before reporting for work is usually required. Use of appropriate personal protective equipment while at work is required.

Isolation. The separation of a person or group of persons infected with a communicable disease, while such disease is in a communicable stage, from other people to prevent the spread of infection.

Strategic National Stockpile— A national repository of medicine and medical supplies maintained by the CDC. The SNS supplements overwhelmed or depleted state and local medical materiel to protect the American public if there is a public health emergency or incident of public health concern (e.g., CBRN incidents, natural disasters, industrial accidents, terrorist attacks, and contagious disease outbreaks) severe enough to cause local supplies to run out.

Terrorism— The calculated use of unlawful violence or threat of unlawful violence to inculcate fear; intended to coerce or to intimidate governments or societies in the pursuit of goals that are generally political, religious, or ideological.

Vulnerability— The susceptibility of a nation or military force to any action by any means through which its war potential or combat effectiveness may be reduced or its will to fight is diminished.

Zoonotic Disease— A disease that can be transmitted from animals to people or, more specifically, a disease that normally exists in animals but that can infect humans. There are multitudes of zoonotic diseases that are caused by bacteria, viruses, or parasites. Zoonotic diseases can be acquired from vector, food, or water sources or through direct contact with animals. Zoonotic diseases can cause a wide variety of symptoms such as diarrhea, muscle aches, and fevers, and can be life threatening.

Attachment 2

TEMPLATE: DECLARATION OF A PUBLIC HEALTH EMERGENCY

A2.1. General. The content that follows will be added to installation or wing letterhead (as appropriate) with the appropriate information completed in the italicized fields contained within brackets. The document will be signed by the installation commander. Upon signing, the information therein must be communicated to the installation population using the most effective and timely means available (e.g., featured at a Commander's Call, an e-mail from the commander to the base population, photocopies of the memorandum handed out at the gates, closed-circuit television announcement, etc.). Additional guidance or information on the public health emergency will be formulated by the PHEO and attached to this memorandum prior to distribution. The content should be altered, as necessary, for use in overseas areas depending on the SOFA, basing arrangements, or other understandings with local officials. **(T-0)**.

Figure A2.1. Template: Declaration of A Public Health Emergency

{DATE}
MEMORANDUM FOR RECORD
FROM: {Wing or Installation Commander Designation}
SUBJECT: Declaration of a Public Health Emergency
<p>I have been notified by my Public Health Emergency Officer (PHEO) of a possible public health situation on our installation involving <i>{agent or disease name}</i> that requires immediate action. Based on the PHEO's recommendations and the results of a preliminary investigation, I am declaring a public health emergency in accordance with Air Force Instruction (AFI) 10-2519, <i>Public Health Emergencies and Incidents of Public Health Concern</i>. This declaration will terminate automatically 30 days from the date of this memorandum unless it is renewed and re-reported, or terminated sooner by myself or a senior commander in the chain of command.</p> <p>The installation PHEO and medical personnel are hereby directed to identify, confirm, and control this public health emergency utilizing all the necessary means outlined in AFI 10-2519. To implement my direction, the PHEO may issue guidance that affects installation personnel and property, and other individuals working, residing, or visiting this installation (e.g., closing base facilities, restricting movement, or implementing quarantine for select individuals).</p> <p>The installation command and the PHEO will coordinate activities and share information with state, local, tribal and territorial {Note: for OCONUS commands, replace "state, local, tribal and territorial" with "host nation"} officials responsible for public health and public safety to ensure our response is appropriate for the public health emergency. Shared information may include personally identifiable health information only to the extent necessary to protect the public health and safety.</p> <p>Any person who refuses to obey or otherwise violates an order during this declared public health emergency will be detained. Those not subject to military law will be detained until civil authorities can respond. Violators of procedures, protocols, provisions, and/or orders issued in conjunction with this public health emergency may be charged with a crime under the Uniform</p>

Code of Military Justice and/or under Title 42, United States Code, Section 271. Pursuant to 42 U.S.C. 271, violators are subject to a fine up to \$1,000 or imprisonment for not more than one year, or both.

{Signature Block}

Attachment 3

TEMPLATE: NOTICE OF QUARANTINE

A3.1. General. The content that follows will be added to installation or wing letterhead (as appropriate) with the appropriate information completed in the italicized fields contained within brackets. The document will be signed by the PHEO, and photocopies will be provided to all individuals subject to quarantine. A copy of the Declaration of a Public Health Emergency (**Attachment 2**) signed by the installation commander will be attached. Any supporting information or guidance deemed necessary can also be attached to this notice. The content should be altered, as necessary, for use in overseas areas depending on the SOFA, basing arrangements, or other understandings with local officials. (T-0).

Figure A3.1. Template: Notice of Quarantine

<i>{DATE}</i>
MEMORANDUM FOR INDIVIDUALS SUBJECT TO QUARANTINE
FROM: Public Health Emergency Officer (PHEO), <i>{Wing or Installation Designation}</i>
SUBJECT: Notice of Quarantine
<p>In response to a declared public health emergency by the installation commander, this is a formal notice that we are invoking quarantine procedures. As the installation's PHEO, I am providing you the following directions and information on the situation.</p> <p><i>{Name, identifying information or other description of the individual, group of individuals or geographic location subject to the order.}</i></p> <p><i>{A brief statement of the facts warranting the quarantine.}</i></p> <p><i>{Conditions for termination of the order.}</i></p> <p><i>{Specified duration of quarantine.}</i></p> <p><i>{The place or area of quarantine.}</i></p> <p><i>{No contact with non-quarantined individuals except as approved by the PHEO.}</i></p> <p><i>{Symptoms of the subject disease and a course of treatment.}</i></p> <p><i>{Instructions on the disinfecting or disposal of any personal property.}</i></p> <p><i>{Precautions to prevent the spread of the subject disease.}</i></p> <p>Any persons subject to quarantine have the right to contest the reason for quarantine. Information supporting an exemption or release can be provided to me or one of my designated representatives, who will provide the information to the installation commander (or a designated representative) for final determination. The total time from submission to response will not exceed 24 hours.</p> <p>Procedures for the declaration of a public health emergency, quarantine, and the actions prescribed above are found in Department of Defense Instruction 6200.03, <i>Public Health Emergency Management Within the Department of Defense</i>, and Air Force Instruction 10-2519,</p>

Public Health Emergencies and Incidents of Public Health Concern. It is DoD and Air Force policy that military installations, property, and personnel and other individuals working on, residing on, or visiting military installations will be protected under applicable legal authorities against communicable diseases associated with biological warfare or terrorism or other public health emergency. Violators of procedures, protocols, provisions, and/or orders detailed in this memorandum may be charged with a crime under Title 42, United States Code, Section 271 and subject to punishment of a fine up to \$1,000 or imprisonment for not more than one year, or both.

A wide range of professionals, in addition to myself, are working hard to ensure you receive the highest quality medical care and are released from quarantine as soon as possible. These actions are necessary to safeguard the health of your loved ones and ensure the safety of the general public.

{NAME IN ALL CAPS, Rank}, USAF
Public Health Emergency Officer
{Wing or Installation Designation}

Attachment:

Declaration of Public Health Emergency

Attachment 4

TEMPLATE: NOTICE OF ISOLATION

A4.1. General. The content that follows will be added to installation or wing letterhead (as appropriate) with the appropriate information completed in the italicized fields contained within brackets. The document will be signed by the PHEO, and photocopies will be provided to all individuals subject to isolation. A copy of the Declaration of a Public Health Emergency (**Attachment 2**) signed by the installation commander will be attached. Any supporting information or guidance deemed necessary can also be attached to this notice. The content should be altered, as necessary, for use in overseas areas depending on the Status of Forces Agreement, basing arrangements, or other understandings with local officials. (T-0).

Figure A4.1. Template: Notice of Isolation

<i>{DATE}</i>
MEMORANDUM FOR INDIVIDUALS SUBJECT TO ISOLATION
FROM: Public Health Emergency Officer (PHEO), <i>{Wing or Installation Designation}</i>
SUBJECT: Notice of Isolation
<p>Due to your diagnosis of <i>{specify communicable disease of concern}</i>, this is a formal notice that we are invoking isolation procedures. As the installation's PHEO, I am providing you the following directions and information.</p> <p><i>{Name, identifying information or other description of the individual, group of individuals or geographic location subject to the order.}</i></p> <p><i>{A brief statement of the facts warranting the isolation.}</i></p> <p><i>{Conditions for termination of the order.}</i></p> <p><i>{Specified duration of isolation.}</i></p> <p><i>{The place or area of isolation.}</i></p> <p><i>{No contact with non-isolation individuals (except as approved by the PHEO) or protocols for individuals entering isolation premises.}</i></p> <p><i>{Symptoms of the subject disease and a course of treatment.}</i></p> <p><i>{Precautions to prevent the spread of the subject disease.}</i></p> <p>Any persons subject to isolation have the right to contest the reason for isolation. Information supporting an exemption or release can be provided to me or one of my designated representatives, who will provide the information to the installation commander (or a designated representative) for final determination. The total time from submission to response will not exceed 24 hours.</p> <p>Procedures for the declaration of a public health emergency, isolation, and the actions prescribed above are found in Department of Defense Instruction 6200.03, <i>Public Health Emergency Management Within the Department of Defense</i>, and Air Force Instruction 10-2519,</p>

Public Health Emergencies and Incidents of Public Health Concern. It is DoD and Air Force policy that military installations, property, and personnel and other individuals working on, residing on, or visiting military installations will be protected under applicable legal authorities against communicable diseases associated with biological warfare or terrorism or other public health emergency. Violators of procedures, protocols, provisions, and/or orders detailed in this memorandum may be charged with a crime under Title 42, United States Code, Section 271 and subject to punishment of a fine up to \$1,000 or imprisonment for not more than one year, or both.

A wide range of professionals, in addition to myself, are working hard to ensure you receive the highest quality medical care and are released from isolation as soon as possible. These actions are necessary to safeguard the health of your loved ones and ensure the safety of the general public.

{NAME IN ALL CAPS, Rank}, USAF
Public Health Emergency Officer
{Wing or Installation Designation}

Attachment:

Declaration of Public Health Emergency