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OF THE AIR FORCE**



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Operations

DISEASE CONTAINMENT

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Air Force Manual (AFMAN) 10-2608, *Disease Containment*, implements *Department of Defense (DOD) Global Campaign Plan (GCP) for Pandemic Influenza and Infectious Disease (PI&ID) 3551-13*, and provides Air Force installations with the guidance necessary to develop installation-level disease containment plans (DCP) that ensure Force Health Protection (FHP) and Continuity of Operations (COOP) in accordance with (IAW) Department of Defense Directive (DODD) 2060.02, *Department of Defense Combating Weapons of Mass Destruction (WMD) Policy*, Department of Defense Instruction (DODI) 6200.03, *Public Health Emergency Management within the Department of Defense*, and DODD 6200.04, *Force Health Protection*. The resulting DCPs will allow installations to respond to public health emergencies and diseases of operational significance, while enabling mission recovery and sustainment. AFMAN 10-2608 implements provisions contained in Air Force Policy Directive (AFPD) 10-26, *Countering-Weapons of Mass Destruction Enterprise*, and AFPD 10-25, *Emergency Management*. It provides guidance for installations/wings to incorporate comprehensive disease containment planning as part of the all hazards planning directed by Air Force Instruction (AFI) 10-2501, *Air Force Emergency Management Program*, and supports implementation of AFI 10-2519, *Public Health Emergencies and Incidents of Public Health Concern*, which specifies the authority of Installation Commanders and assigns responsibilities for declaring, reporting, and managing a public health emergency.

This manual applies to all installations/wings and activities under Air Force command (hereafter referred to collectively as “installations”), to the Headquarters Air Force (HAF), to the Air Force Reserve Command, to the Air National Guard (ANG), and to other geographically separated

units (GSU). The ANG will supplement this manual to clarify the level of disease containment planning their forces can accomplish due to manning, mission, and funding constraints. The term “commanders,” as used in this manual, refers to commanders at the installation and wing (for Air Reserve Component) level unless specifically stated otherwise. The manual also applies to military personnel and, to the extent permissible by law, DOD civilian personnel, dependents of military or DOD civilian personnel, contractors, and other individuals visiting or who are 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, its territories, and possessions.

Air Force units in Joint Basing situations, whether in the supporting or supported role, must ensure their personnel are adequately protected and cared for during a public health emergency or disease of operational significance. IAW Joint Basing Implementation Guidance (JBIG), supported/supporting units should implement Memorandums of Agreement (MOA) to establish standards of support. (T-1) 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. MAJCOMs that cannot resolve discrepancies will coordinate with the appropriate HAF office to determine a solution.

This guidance is also applicable to domestic settings (as defined by continental United States (CONUS), Alaska, Hawaii, and U.S. territories), as well as in a deployed setting. In areas outside U.S. control, this manual 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).

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 manual 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 Office of Primary Responsibility (OPR) for non-tiered compliance items. This publication may be supplemented at any level. Direct Supplements must be routed to the OPR of this publication for coordination prior to certification and approval.

Ensure all records created as a result of processes prescribed in this publication are maintained IAW AFMAN 33-363, *Management of Records*, and disposed of IAW the *Air Force Records Disposition Schedule* located in the Air Force Records Information Management System. Refer

recommended changes and questions about this publication to the OPR using AF Form 847, *Recommendation for Change of Publication*; route AF Forms 847 from the field through the appropriate chain of command.

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Chapter 1

ROLES AND RESPONSIBILITIES

1.1. Purpose. This manual provides guidance for installations/wings to develop a comprehensive DCP and supports implementation of the *Air Force Counter-Biological Warfare Concept of Operations*. The manual outlines roles and responsibilities for disease containment planning; provides guidance related to planning and logistics considerations, including the basic assumptions that must be considered to understand the unique aspects of negating or mitigating the effects of a public health emergency or disease of operational significance; and provides a template for installation plans. Installations will be able to utilize DCPs to respond to any disease outbreak, whether naturally-occurring or deliberate, through the full spectrum of missions and operational environments.

1.2. Headquarters Air Force.

1.2.1. Deputy Chief of Staff for Manpower, Personnel, and Services (AF/A1) will:

1.2.1.1. Ensure guidance exists to address the following items in the event of a public health emergency or disease of operational significance: (1) child care for well (i.e., screened and identified as not sick) children of key personnel, (2) temporary housing, (3) educational needs, (4) financial assistance, (5) locator assistance, (6) family employment, (7) casualty assistance, (8) civilian personnel, and (9) food and water.

1.2.1.2. In conjunction with Air Force Services Activity, establish special procedures to protect force support facilities. Special care must be taken to develop procedures that will minimize risk of contagion while allowing the facilities and services to be available for use by installation population.

1.2.1.3. Direct inventory of non-medical essential supplies to include food and water; and initiate a census of available force support facilities (e.g., fitness centers) that can serve as alternate medical care facilities.

1.2.2. Deputy Chief of Staff for Intelligence, Surveillance, and Reconnaissance (AF/A2) will coordinate on disease containment activities dealing with intelligence, surveillance, and reconnaissance matters to ensure compatibility with Intelligence Community guidance. These include, but are not limited to, coordinating new intelligence requirements to United States Northern Command (USNORTHCOM) for advocacy to Joint Staff, Office of the Secretary of Defense (OSD), and interagency partners, if applicable, for inclusion into revisions of DOD GCP PI&ID 3551-13.

1.2.2.1. Ensure FHP and disease-specific intelligence collection and analysis are fused with all aspects of Force Protection (FP) intelligence analysis.

1.2.3. Deputy Chief of Staff for Logistics, Installations, and Mission Support (AF/A4) will establish appropriate logistic and mission support policy and guidance to obtain and allocate resources IAW AFI 10-2501 and AFI 10-2519. AF/A4 will:

1.2.3.1. Release guidance to implement FP actions that protect personnel and facilities from public health emergencies or diseases of operational significance while on installations or geographically-separated facilities, during deployed operations, and

during civil support operations. Support Air Force components to geographic combatant commands (GCC) in working with interagency partners and HN agencies to ensure FP of forces during a public health emergency or disease of operational significance.

1.2.3.2. Ensure integration of emergency management capabilities related to disease containment planning, response, and recovery into Air Force policy and guidance for all hazards emergency management.

1.2.3.3. Direct inventory of non-medical essential supplies, including infection control material (e.g., hand sanitizer and antibacterial wipes), and ensure authorization for resupply.

1.2.3.4. Provide guidance for the use of military installations as Base Support Installations (BSI) or mobilization centers by federal response agencies, reception sites for international aid donations, and Intermediate Staging Bases for Noncombatant Evacuation Operations.

1.2.3.4.1. Establish civilian access control guidance to include a standard process of vetting of authorized civilian personnel in support of BSI operations during a public health emergency or disease of operational significance.

1.2.3.4.2. Limit access to specific/designated areas on DOD installations in support of BSI operations during a public health emergency or disease of operational significance.

1.2.3.5. Provide disease-specific guidance for air terminal (cargo and passenger) operations to help contain the spread of disease.

1.2.3.6. In coordination with AF/SG, provide guidance for the disposal of Category A contaminated waste.

1.2.4. Assistant Chief of Staff for Strategic Deterrence and Nuclear Integration (AF/A10) will provide policy and guidance to allow installations to prepare for, respond to, and recover operations following an outbreak of a disease of operational significance or declaration of public health emergency IAW AFI 10-2519. During such disease incidents, AF/A10 will utilize MAJCOM and installation reporting systems to track the ability to accomplish assigned missions. AF/A10 will:

1.2.4.1. Serve as the Air Force lead for PI&ID.

1.2.4.1.1. Provide supporting information to OSD agencies as required and/or requested for *Department of Defense Implementation Plan for Pandemic Influenza* task completion.

1.2.4.1.2. Oversee resource requirements for PI&ID planning.

1.2.4.1.2.1. Submit PI&ID resource requirements to conduct and/or participate in biennial planning conferences, biennial PI&ID tabletop planning exercises, and biennial coordination visits to USNORTHCOM.

1.2.4.1.2.2. Identify resource shortfalls to OSD, as applicable, to ensure execution of Phases 0 and 1, and to begin preparation for remaining phases.

1.2.4.1.2.3. Consolidate costs captured during Defense Support of Civil

Authorities (DSCA) operations for ultimate reimbursement from the primary agency IAW AFI 10-801, *Defense Support of Civilian Authorities (DSCA)*.

1.2.4.2. Develop and maintain Air Force PI&ID planning guidance (to include HAF) to support executive and DOD-level efforts to contain and mitigate the effects of PI&ID on military operations.

1.2.4.2.1. Coordinate Air Force PI&ID planning guidance with USNORTHCOM, via the Global Synchronizer Supporting Plan Review document, to ensure alignment with DOD GCP PI&ID 3551-13.

1.2.4.2.2. Provide the necessary policy and guidance to enable installations to identify FP-related plans that ensure FHP and COOP IAW DODI 6200.03; DODD 6200.04; DODD 3020.26, *Department of Defense Continuity Programs*; and AFI 10-208, *Air Force Continuity of Operations (COOP) Program*, and that consider the nineteen critical planning categories outlined in the *Department of Defense Implementation Plan for Pandemic Influenza*.

1.2.4.2.3. Support MAJCOMs in synchronizing installation plans with corresponding GCC PI&ID plans. In case of conflict, the HAF and installation plans will conform to the GCC plans (unless the requirement exceeds the GCC plan).

1.2.4.2.4. Review Air Force PI&ID planning guidance IAW DOD GCP PI&ID 3551 revision cycle.

1.2.4.3. Establish guidelines and procedures for the recall of Air Force Reserve personnel with critical skill sets IAW policy guidance from the Office of the Assistant Secretary of Defense (ASD) Reserve Affairs.

1.2.4.4. Perform the following PI&ID Reporting activities:

1.2.4.4.1. Establish reporting procedures for combatant command Air Force components as required.

1.2.4.4.2. During a public health emergency or disease of operational significance, provide Situation Reports (SITREP) as directed by the Joint Staff.

1.2.4.4.3. Ensure reporting is accomplished IAW Annex R of DOD GCP PI&ID 3551-13.

1.2.4.5. In coordination with SAF/PA, develop and provide detailed information on the internal communication plan to be used during a public health emergency or disease of operational significance.

1.2.4.6. Ensure adequate consideration of Antiterrorism (AT) Operations; chemical, biological, radiological, and nuclear (CBRN) incidents; and Critical Infrastructure Program elements when planning and executing FP in support of the global PI&ID mission.

1.2.4.7. Coordinate with all service components and the National Guard Bureau on any affected command movements and/or relocations.

1.2.4.8. Be prepared to provide information to the Chief of Staff of the Air Force (CSAF) in response to data calls related to the ten potential Secretary of Defense (SecDef) decision points detailed in Appendix 19 to Annex C of the DOD GCP PI&ID 3551-13.

1.2.5. The Judge Advocate General (AF/JA) will:

1.2.5.1. Provide legal analysis and review of Air Force use of emergency health powers.

1.2.5.2. Provide guidance regarding policy and legislative issues and/or changes that will enhance support to affected DOD personnel and family members.

1.2.6. Assistant Secretary, Financial Management and Comptroller (SAF/FM) will provide PI&ID programming support to AF/A10-S.

1.2.7. Secretary of the Air Force Office of Public Affairs (SAF/PA) will ensure clear, effective, and coordinated communication before, during, and following a public health emergency or disease of operational significance IAW AFI 10-2519. Specifically, SAF/PA will:

1.2.7.1. Communicate/disseminate public health advisories, communication themes, and other messages consistent with ASD for Public Affairs and ASD for Homeland Defense and Global Security guidance, as well as National and DOD policy and guidance.

1.2.7.2. Synchronize and integrate key themes and messages, in coordination with the other Services, the combatant commands, DOD agencies, and civil agencies to support DOD GCP PI&ID 3551-13 objectives by working with AF/SG to:

1.2.7.2.1. Build awareness of the PI&ID threat in each area of responsibility (AOR) prior to a public health emergency or disease of operational significance.

1.2.7.2.2. Inform and reassure key populations. Develop a comprehensive internal and external public affairs (PA) strategy (as directed) that supports the DOD objectives and is synchronized with DOD GCP PI&ID 3551-13.

1.2.7.2.3. Educate audiences on mitigation and encourage preparedness.

1.2.7.2.4. Communicate Air Force's primary mission, capacity to support others when requested and approved, and capability to defeat attempts to exploit PI&ID.

1.2.8. Air Force Surgeon General (AF/SG) will establish medical policy and obtain and allocate medical resources to prepare for, respond to, and recover from a public health emergency or disease of operational significance IAW AFI 10-2519 and AFI 41-106, *Medical Readiness Program Management*. During a public health emergency or disease of operational significance, AF/SG will provide medical guidance and oversight to MAJCOMs and will:

1.2.8.1. Be prepared to issue specific Air Force guidance to service members if a disease-specific vaccine is or becomes available. Air Force guidance will be based on published DOD and Office of the ASD for Health Affairs policies.

1.2.8.2. Ensure adequate stocking and sourcing of materiel necessary to respond, IAW AFI 41-209, *Medical Logistics Support*. See DOD GCP PI&ID 3551-13, Annex Q, for recommended medical assets.

1.2.8.3. Ensure plans are in place to implement changes in medical materiel supply chain support when a Joint Task Force is established.

1.2.8.4. Author Air Force policy and guidance supporting GCC efforts to execute a theater distribution plan for antivirals, vaccines, ventilators, and other medical supplies/equipment.

1.2.9. Director of LeMay Center for Doctrine Development and Education will:

1.2.9.1. Oversee Air Force Lessons Learned Program (AFLLP) and Air Force participation in Joint Lessons Learned Program.

1.2.9.2. Serve as chief lessons learned advisor to Secretary of the Air Force and CSAF.

1.2.9.3. Ensure AFLLP meets the goals of Air Force leadership and the needs of Airmen and commanders at all levels.

1.2.9.4. Upon CSAF approval, manage annual CSAF priority-aligned Lesson Learned Focus Areas for collection.

1.2.9.5. Request each HAF 2-letter office (Secretariat and Air Staff) identify a point of contact (POC) for AFLLP and address their observations through AFLLP.

1.2.9.6. Appoint the Director of Air Force Lessons Learned to:

1.2.9.6.1. Serve as OPR for AFLLP.

1.2.9.6.2. Provide guidance and establish processes for Air Force Lesson Process (AFLP) to include developing standards for major activities under AFLLP.

1.2.9.6.3. Assist in capturing and disseminating relevant observations and lessons using Air Force Joint Lessons Learned Information System and AFI 90-1601, *Air Force Lessons Learned Program*.

1.3. Major Commands, Air National Guard, Direct Reporting Units, and Forward Operating Agencies.

1.3.1. MAJCOMs, ANG, DRUs, and FOAs will:

1.3.1.1. Expand COOP plans to address unique requirements of PI&ID, including incorporation of social distancing and shelter-in-place techniques. **Note:** If host installation disease containment guidance addresses MAJCOM/ANG/DRU/FOA staff, units may reference the installation plan or incorporate specific requirements in their COOP Plan. Consult AFI 10-208 for additional information on identifying mission essential functions (MEF) and COOP planning.

1.3.1.2. Exercise the PI&ID portion of their COOP plan biennially as required IAW DOD GCP-PI&ID 3551-13.

1.3.1.3. Follow host installation or host facility guidance for PI&ID planning, lacking any guidance establish a work group to discuss, plan, and train for PI&ID threats, at a minimum of semi-annually. Stand-alone DRUs and FOAs should consult publication OPR for assistance and/or identification of subject matter expert POCs.

1.3.2. MAJCOMs and ANG will:

1.3.2.1. Assist installations with preparation of disease containment guidance—Installation Emergency Management Plan (IEMP) 10-2, DCP, and/or Medical Contingency Response Plan (MCRP).

1.3.2.2. During a public health emergency or disease of operational significance, maintain command and control (C2) of assigned installations—for ANG the governor of each state in conjunction with the Adjutant General will maintain C2. As required, stand up or leverage an existing working group (e.g., EMWG) of appropriate subject matter experts to discuss and provide guidance to installations from Higher Headquarters (HHQ) and/or MAJCOM/ANG level.

1.3.2.3. Ensure installations have required training materials, equipment, and resources to properly implement preventive health measures for personnel and their families. For Air Force Reserve stand-alone installations, resources are not directed towards beneficiaries and dependents of Air Force Reserve members.

1.3.2.4. Ensure subordinate assigned and attached units report information pertinent to the Priority Intelligence Requirements (PIR) listed in Appendix 1 to Annex B (classified supplement) of DOD GCP PI&ID 3551-13 and other intelligence requirements using established reporting procedures.

1.3.2.5. Ensure subordinate assigned and attached units report information pertinent to PIR relating to PI&ID, at the highest possible priority.

1.3.2.6. Ensure subordinate assigned and attached units submit information of intelligence value as soon as possible and pass critical information via the most expeditious means available.

1.3.2.7. Ensure subordinate assigned and attached units fuse FHP and disease-specific intelligence collection and analysis with all aspects of FP intelligence analysis.

1.4. Installation. The bulk of disease containment activities occur at the individual level (e.g., airmen, civilian, contractor, or dependent), thus the majority of planning and preparation activities occur at the installation level. **Note:** Air Reserve Component (ARC) units and GSUs may not have the resident capability or personnel to prepare for or respond to a public health emergency or disease of operational concern. This will ultimately limit a commander's ability to implement some of the provisions of this Manual or other functions of responsibility. The Ground Reserve Medical Unit at Air Force Reserve stand-alone installations will coordinate Memorandums of Understanding (MOU) between Reserve Wing and local civilian public health authorities to enable a joint response to public health emergencies or diseases of operational significance affecting the installation population.

1.4.1. Installation Commander will:

1.4.1.1. Direct the EMWG to oversee development of a DCP/IEMP 10-2 appendix using the format provided in **Chapter 3**, which is synchronized with DOD GCP PI&ID 3551-13. Installation plans should also align with applicable GCC Campaign Plans. (T-0; DOD GCP PI&ID 3551-13)

1.4.1.2. Ensure the installation plan is supported by sufficient C2 capabilities and other equipment to respond properly to public health emergencies or diseases of operational significance. (T-2)

1.4.1.3. Train and exercise the plan IAW AFI 90-201, *The Air Force Inspection System*. (T-1)

1.4.1.3.1. Invite local communities, municipalities, and/or HN authorities to participate in exercises, as appropriate; and that installation personnel, including those assigned to tenant units and GSUs, participate to the maximum extent possible. (T-2)

1.4.1.3.2. Include mass prophylaxis and/or immunization, medical surge capability, and disease containment strategies (e.g., stand up a quarantine facility) in disease containment and public health emergency response exercises. (T-1)

1.4.1.4. Direct installation participation in applicable federal, state, tribal, and local agency disease containment planning, training, and exercise activities. (T-2)

1.4.1.5. Communicate changes in mission capability to HHQ due to manpower shortages caused by a public health emergency or disease of operational significance. (T-1)

1.4.1.6. In coordination with the Medical Treatment Facility (MTF) commander, the Public Health Emergency Officer (PHEO), and/or ANG PHEO/Wing-PHEO-POC, determine prioritization of limited stocks of vaccine and other medical countermeasures IAW applicable HHQ guidance. (T-1)

1.4.1.7. Capture costs related to DSCA operations for ultimate reimbursement from the primary agency, obtain reimbursable authority from U.S. Army North (the Executive Agent for Domestic Emergencies) upon tasking, ensure SAF/FM has identified Emergency and Special program codes to track expenses, and submit reimbursement requests to Defense Finance and Accounting Service IAW AFI 65-601 Vol. 1, *Budget and Guidance Procedures*. Report these values through MAJCOM to AF/A10. (T-1)

1.4.2. Medical Treatment Facility Commander (MTF/CC) will:

1.4.2.1. Estimate surge capacity requirements based upon the population at risk, risk severity, and projected affected population factors. (T-2)

1.4.2.2. Coordinate with the Security Forces Squadron (SFS) for physical security aspects of restriction of movement (ROM), just-in-time vaccination, and mass prophylaxis distribution operations. (T-2)

1.4.2.3. Direct Bioenvironmental Engineering, in coordination with Civil Engineering, to collect, prepare, and transport environmental samples to approved testing laboratories during war and terrorist incidents. Consult Medical Laboratory and Security Forces concerning local processes and procedures, and keep the PHEO apprised of the situation. (T-2)

1.4.2.4. Ensure the installation has ready access to an initial supply of medical countermeasures and other essential medical supplies to respond to a public health emergency or disease of operational significance. (T-2)

1.4.2.5. Be prepared to initiate immunization of key population once a vaccine is available and approved for use IAW AFI 44-102, *Medical Care Management*. (T-1)

1.4.2.6. Ensure preparation of MTFs to provide mass distribution of medications to care for potentially large numbers of patients. (T-2)

1.4.2.7. Ensure the MTF Emergency Manager coordinates with both state and local public health authorities to ensure the MTF receives medication/supplies through the Strategic National Stockpile (SNS). Utilize [Attachment 2](#) to report SNS use to HHQ. (T-1)

1.4.3. Public Health Emergency Officer will, upon request, provide the Installation Commander with information on significant PI&ID threats and provide recommendations of phase-appropriate countermeasures and training IAW HHQ's guidance. (T-1)

1.4.4. Wing Plans and Programs will monitor development and maintenance of installation disease containment guidance IAW AFI 10-2519. (T-0; DOD GCP PI&ID 3551-13)

1.4.5. Unit Intelligence, in compliance with AFI 14-104, *Oversight of Intelligence Activities*, will:

1.4.5.1. Monitor theater, defense, and national classified and open-source intelligence, including counterterrorism and CBRN websites and databases. (T-2)

1.4.5.2. Provide intelligence warnings. (T-2)

1.4.5.3. Provide threat assessments. (T-2)

1.4.5.4. Support Installation Commanders, Air Force Office of Special Investigations, and SFS in their designated working groups. (T-1)

1.4.5.5. Report information pertinent to the PIR listed in Appendix 1 to Annex B (classified supplement) of DOD GCP PI&ID 3551-13 and other intelligence requirements using established reporting procedures. (T-0; DOD GCP PI&ID 3551-13)

1.4.5.6. Report information pertinent to PIR relating to PI&ID, at the highest possible priority. (T-1)

1.4.5.7. Submit information of intelligence value as soon as possible and pass critical information via the most expeditious means available. (T-1)

1.4.5.8. Fuse FHP and disease-specific intelligence collection and analysis with all aspects of FP intelligence analysis. (T-2)

1.4.6. Mission Support Group Commander will:

1.4.6.1. Ensure the installation plans for identification, purchase, storage, management, and distribution of non-medical supplies for sustainment during response to a public health emergency or disease of operational significance. (T-2)

1.4.6.2. Ensure sufficient quantities of non-food and non-medical items exist to support disease containment procedures (i.e., isolation and quarantine). (T-2)

1.4.6.3. Develop a plan for transportation assets to be utilized during public health emergencies or diseases of operational significance (e.g., moving patients and medical support teams), including procedures for decontaminating vehicles. (T-2)

1.4.6.4. Direct SFS (**Note:** For Wings with a Security Forces Group, the Security Forces Group Commander (SFG/CC) will direct the actions of security forces) to:

1.4.6.4.1. Oversee enforcement of ROM—secure and control access into quarantine and isolation facilities and areas cordoned as a result of the biological incident. (T-2)

- 1.4.6.4.2. Coordinate with MTF/CC for physical security of installation mass prophylaxis dispensing operations including physical security of dispensing site(s), enforcement of vehicle and pedestrian traffic flow in and around dispensing site(s), and crowd control. (T-2)
- 1.4.6.4.3. Plan for installation security with diminished forces and increased risk of local population entry attempts. (T-2)
- 1.4.6.4.4. Ensure Integrated Base Defense Plan:
 - 1.4.6.4.4.1. Provides guidance for security of critical supplies and services, and security of installation personnel to maintain operational readiness in support of DOD missions. (T-2)
 - 1.4.6.4.4.2. Utilizes AT program standards IAW DOD GCP PI&ID 3551-13 and AFI 10-245, *Antiterrorism (AT)*. (T-1)
 - 1.4.6.4.4.3. Incorporates plans for security procedures and additional manpower requirements in support of isolation/quarantine sites and facilities for deploying/re-deploying forces. (T-2)
- 1.4.6.5. Direct Civil Engineer Squadron to:
 - 1.4.6.5.1. Advise on individual and collective protection measures. (T-2)
 - 1.4.6.5.2. Through the EMWG, pre-identify facilities for isolation and quarantine. (T-2)
 - 1.4.6.5.3. Provide specific expertise and guidance to commanders concerning hazards involved in terrorist or enemy attacks involving biological agents and conducting sustained operations in a biologically-contaminated environment. (T-2)
 - 1.4.6.5.4. Assist units in determining material requirements for biological defense avoidance, protection, and contamination control. (T-2)
 - 1.4.6.5.5. Ensure DCP is appropriately incorporated or referenced within the IEMP 10-2. (T-3)
 - 1.4.6.5.6. Coordinate with installation Bioenvironmental Engineer Flight to submit wartime and terrorist biological incident-related environmental release information. (T-2)
 - 1.4.6.5.7. Coordinate with Bioenvironmental Engineering to collect, prepare, and transport environmental samples to approved testing laboratories during war and terrorist incidents. Consult Medical Laboratory and Security Forces concerning local processes and procedures, and keep the PHEO apprised of the situation. (T-2)
 - 1.4.6.5.8. Accomplish appropriate biological-related reports according to CBRN Warning and Reporting guidance. Submit wartime and terrorist biological incident-related operational incident report (OPREP-3) and CBRN reports IAW AFI 10-206, *Operational Reporting*, and AFI 10-2501. (T-1)
 - 1.4.6.5.9. Provide on-scene toxic corridor calculations using available software. (T-3)

1.4.6.5.10. Establish initial biological decontamination capability for responders and victims. (T-2)

1.4.6.5.11. Establish and maintain an explosive ordinance disposal capability (if assigned) to respond to terrorist incidents involving biological agents. (T-2)

1.4.6.5.12. Assist with removal and/or disposal of hazardous waste associated with the public health emergency or disease of operational significance. (T-2)

1.4.6.6. Direct Force Support Squadron to:

1.4.6.6.1. Determine requirements for water, emergency subsistence (which may include meals-ready-to-eat (MRE)), and meals for people with special dietary needs to support ROM that may be implemented during a public health emergency or disease of operational significance. (T-2)

1.4.6.6.2. Ensure sufficient stocks exist to work through the incident and/or re-supply food and water for the installation can be accomplished, as required, in the aftermath of a biological incident. Stocks sufficient to support two disease incubation periods may be required (see **Paragraph 2.5.1**). (T-1)

1.4.6.6.3. Ensure water surveillance/testing plans and food monitoring programs have been accomplished for installation threats IAW AFI 48-116, *Food Safety Program*, and AFI 48-144, *Drinking Water Surveillance Program*. (T-1)

1.4.6.6.4. Develop plans to handle and process contaminated remains IAW AFI 34-242, *Mortuary Affairs Program*, to include utilization of temporary storage/interment options as directed. (T-1)

1.4.7. Operations Group/Support Squadron Commander will:

1.4.7.1. Ensure adequate protection of aircrew and other mission-essential personnel during public health emergencies or diseases of operational significance. (T-2)

1.4.7.2. Coordinate with MTF/CC for medical countermeasures, aircrew personal protective equipment (PPE), and post-exposure medical screening. (T-2)

1.4.7.3. Provide guidance to aircrew for in-flight disease recognition and response to aircrew members and passengers with symptoms of the disease. (T-2)

1.4.7.4. Outline installation processes to maintain mission readiness for intelligence functions and services during a public health emergency or disease of operational significance for a sustained period of six to eight weeks in the context of manning shortfalls. Address the impact of absenteeism and social distancing, and the potential impact on mission critical personnel. (T-2)

1.4.7.5. Outline the installation processes for collecting, developing, and submitting Spot Intelligence Reports and Intelligence Information Reports at the highest possible priority to combatant commands and the Defense Intelligence Agency as soon as possible after a significant biological incident. (T-2)

1.4.7.6. Outline the installation process, IAW existing guidance, for disseminating intelligence reports and products received from combatant commands and the DOD Intelligence Community concerning the public health emergency or disease of

operational significance, to non-DOD agencies, allies, HNs, state and local governments, and tribal authorities. (T-1)

Chapter 2

PLANNING FACTORS

2.1. General. The more prepared an installation is prior to a biological incident, the greater the commander's ability to mitigate effects of a biological attack, public health emergency, or disease of operational significance. Preparatory actions consist of a broad range of tasks and activities necessary to build and sustain operational capabilities prior to, during, and following such incidents. Preparedness is a continuous process that involves all functional communities and personnel at every level to identify threats, assess vulnerabilities, and prepare their personnel and equipment to execute the measures required to respond effectively. Actions taken (or not taken) prior to a biological incident can affect options available to commanders for responding to and recovering from the incident. Diseases of operational significance may require an integrated response from multiple organizations across the base as well as local, state, federal, international, and/or HN authorities. Functional assignments to carry out the tasks described in this chapter may vary from installation to installation, and commanders will assign roles and responsibilities appropriate to their installation. **Note:** ARC units and GSUs may not have the resident capability or personnel to prepare for or respond to a public health emergency or disease of operational significance. This will ultimately limit a commander's ability to implement some of the provisions of this manual. (T-1)

2.2. Baseline Assumptions. Installation commanders should consider the following when planning for a public health emergency or disease of operational significance, and coordinating the installation's response to contain the disease.

2.2.1. Initially, a disease caused by an attack may be indistinguishable from a naturally-occurring outbreak. In addition, due to varying incubation periods of biological organisms, exposure may precede the onset of illness by days or weeks. Biological toxins are an exception because symptoms will generally manifest within hours of exposure. Several days may pass before medical authorities suspect an intentional or deliberate cause.

2.2.2. Assume all outbreaks are contagious until the causative agent and mode of transmission are identified. Initial response should provide protection against all potential modes of transmission until the causative agent and mode are identified.

2.2.3. Treatment in place is the DOD policy for highly-contagious patients and aeromedical evacuation will likely not be permitted for transporting contagious casualties. In addition, transportation of contaminated human remains (CHR), both domestically and repatriation from deployed locations, will require approval from the SecDef or higher authorities. See *USTRANSCOM Policy for Patient Movement of Contaminated Contagious or Potentially Exposed Casualties*.

2.2.4. The ability to execute installation MEFs will be degraded due to significant absenteeism caused by a public health emergency or disease of operational significance.

2.2.5. The ability to conduct installation MEFs will be degraded due to limitations on freedom of movement due to partner nation restrictions.

2.2.6. U.S. civil authorities' ability to maintain MEFs will be degraded due to significant absenteeism.

2.2.7. All AORs will not be affected simultaneously or to the same degree.

2.2.8. Identification of a contagious outbreak may initially occur at a civilian medical facility or department of health or human hygiene (or similar local or state agency) giving DOD some warning of the PI&ID outbreak before significant operational impacts occur and allowing commencement of mitigation measures.

2.2.9. FHP activities can limit/delay the spread of disease.

2.2.10. Medical resources (military, domestic, and foreign) will be overwhelmed, and medical countermeasures will not be immediately available or 100% effective.

2.2.11. ARC units and GSUs will have MOUs or MOAs with appropriate civilian public health agencies to identify, coordinate, and prepare for disease containment and identification of biological pathogens to adequately address the requirements of this manual.

2.3. Public Awareness. Public trust and cooperation during a biological incident are critical due to the nature of diseases of operational significance. A healthy, well-informed populace is better prepared and can respond more effectively. In preparation for and during all phases of an outbreak, installation personnel should be made aware of possible biological threats, their effects, recognition of disease symptoms, and expected installation responses. Healthy practices (e.g., diet and exercise) and protective/preventative actions (e.g., hand washing or coughing into one's sleeve) should be encouraged, especially during the Prepare phase, so they become routine. Frequency and scope of public awareness campaigns should increase commensurate with threat.

2.3.1. During the Prepare phase, standardized messaging (e.g., incident fact sheets, Straight Talk Line messages, installation/unit internet-based updates, e-mail messages to a distribution list, and/or inputs for command information channels) should be developed to be quickly disseminated to the installation population in the event of a public health emergency or disease of operational significance. See AFI 35-101, *Public Affairs Responsibilities and Management*, for additional information. (T-1)

2.3.2. A Straight Talk Line and/or a media center should be stood up for use during an outbreak. The Straight Talk Line could be a receive-only phone line, providing the installation population with an authoritative POC for current and accurate information about the status of an incident and the installation commander's actions. The media center, which could be set up as a Joint Information Bureau, should be in a location easily accessed by both internal and external media sources.

2.3.3. In the prepare phase, community involvement is critical in the planning and preparation of plans, messaging, and response aspects. Joint interaction must be conducted with local health departments, MTFs, and Law Enforcement Agencies.

2.4. Threat/Hazard Assessment. Intelligence / Office of Special Investigations must provide functional organizations (e.g., Security Forces, Medical, and Civil Engineering) with an understanding of the biological threat and likely delivery methods. (T-1)

2.5. Installation Resources. As part of the DCP development process, the first step in assessing an installation's capability to effectively contain a disease is to conduct a detailed inventory of existing response resources including equipment, personnel, and training. Non-mission essential manpower and designated augmentation forces may need to be reallocated to support the anticipated additional burden on certain functional communities such as medical/public health,

force support, and security forces. In addition, the installation should analyze what resources are made available under support agreements with local communities and/or HNs. An installation can augment its resources through cooperation with local or regional agencies, other Air Force and DOD resources, or the HN. These additional support elements might include emergency medical services, public health offices, law enforcement agencies, environmental agencies, communications capabilities, transportation support, laboratory facilities for confirmative analysis, and contracted response and remediation companies. Using this inventory, each functional area should determine its ability to respond effectively to a public health emergency or disease of operational significance.

2.5.1. Basic Needs. Due to the nature of diseases of operational significance, re-supply of basic needs from local or intra-theater sources may not be readily available. If a public health emergency is declared and/or ROM is established, the base population will need basic supplies sufficient to sustain a minimum of two disease incubation periods. The actual duration will be disease-specific; however, for planning purposes the recommended duration is thirty days.

2.5.1.1. Plan for/acquire essential life-supporting services and supplies such as potable water, emergency subsistence, sanitation, and first-response medical care for the base populace, as well as quarantine and isolation support.

2.5.1.2. Because evacuation of biologically-contagious individuals may not be advisable or feasible, consider their basic needs as well.

2.5.1.3. Normal distribution, re-supply, and refuse plans may be interrupted by the public health emergency or disease of operational significance. All plans and mutual aid agreements (MAA) should be reviewed and contingencies established. In addition, a remote area to off-load supplies should be considered.

2.5.2. Special Needs. Personnel classified as having special needs due to a medical condition or religious belief may require special care. Examples include altered immune states, pregnancy, behavioral casualties, diabetics, or religious dietary restrictions.

2.5.2.1. Consider retired military personnel, dependents, and other local populations that routinely seek resources or medical care from the installation.

2.5.2.2. Vaccination plans must also take into account special needs, as some individuals are not able to tolerate vaccination or medical treatment.

2.5.2.3. Coordinate with appropriate personnel in the local community as they may have considered some of these same populations in their planning efforts.

2.6. Detection and Identification. The ability to detect and identify a biological incident will significantly affect when an installation can initiate response and recovery actions, and how effectively those actions minimize casualties. During the Prepare phase, installations should ensure their plans and procedures for placement and monitoring of biological collection equipment is up to date. They should also ensure there are sufficient supplies to support execution of the plans. Installation Civil Engineering and the MTF have responsibility for installation detection and identification. In addition, the Installation PHEO will maintain situational awareness of all installation medical surveillance activities. Public health will ensure

medical surveillance is accomplished IAW AFI 48-105, *Surveillance, Prevention, and Control of Diseases and Conditions of Public Health or Military Significance*. (T-1)

2.7. Alert, Notification, and Reporting. Alert, notification, and reporting refers to the official processes, protocols, and procedures for public health emergencies found in DODI 6200.03; AFI 10-206; AFI 10-2519; and Air Force Tactics, Techniques, and Procedures (AFTTP) 3-2.56, *Multi-Service Tactics, Techniques, and Procedures for Chemical, Biological, Radiological, and Nuclear Contamination Avoidance*, for CBRN Warning and Reporting System (CBRNWRS) procedures including utilization of Joint Warning and Reporting Network software. In addition to standard operational reporting requirements, the occurrence of a biological incident may create additional medical reporting requirements. For example, the discovery of a case of smallpox or other public health emergency on a military installation would require the PHEO to notify local civilian public health officials or others in the medical chain of command and the Centers for Disease Control and Prevention (CDC). Responses to outbreaks suspected of being deliberate in origin require consideration of special law enforcement procedures (e.g., establishing and maintaining chain of custody for all clinical or environmental samples submitted and transported for laboratory testing). All alert, notification, and reporting actions should take into account operations security considerations and DOD release authority to non-military outlets. Since reporting occurs during all phases of an outbreak, the following guidelines should be considered at all times. See [Paragraph 1.2.4.4](#) and [3.4.11](#) for additional reporting guidance.

2.7.1. IAW AFI 10-206, the command post should submit Synchronous Report/Voice Report within 15 minutes from the incident; and initial Asynchronous Report/Record Copy within one hour of discovery.

2.7.2. Reporting in the U.S. and its territories should be done IAW established procedures consistent with the Air Force Incident Management System.

2.7.3. In addition to AFI 10-206 reporting requirements, units in the U.S. and its territories will report suspected or confirmed biological attacks through the North American Aerospace Defense Command (NORAD) Warning and Reporting System (reference NORAD Command Instruction 10-22, *Nuclear Biological Chemical Warning and Reporting System*). (T-1)

2.7.4. Outside the Continental United States (OCONUS) reporting will be accomplished IAW AFI 10-206 and applicable theater directives/operations plans. OCONUS CBRNWRS reports will be submitted IAW AFTTP 3-2.56. (T-1)

2.8. Individual Protection. Installations must consider equipment requirements for functional communities involved in execution of disease containment procedures. Each functional community will conduct appropriate training on equipment use during the Prepare phase. See AFI 10-2501 for additional information on individual protection requirements. (T-1)

2.9. Integrated Defense. Existing integrated defense activities can assist in preventing or mitigating the effects following a biological attack or naturally-occurring outbreaks. Certain integrated defense capabilities (e.g., sample collectors and laboratory identification) can be utilized to protect an installation within its physical perimeter. Whereas other integrated defense capabilities (e.g., intelligence and law enforcement actions) can help to extend an installation's security zone beyond its physical perimeter to provide advance warning of a biological incident. All integrated defense measures must be conducted IAW appropriate laws and regulations. (T-1)

2.10. Restriction of Movement. ROM involves limiting the movement of people to prevent or reduce person-to-person transmission of diseases of operational significance. AFI 10-2519 contains guidance regarding emergency health powers that govern the use of ROM.

2.10.1. ROM may include actions such as social distancing, quarantine, and isolation, among others.

2.10.1.1. Social distancing is a community-based strategy to increase the physical space between people to prevent person-to-person spread of an infectious disease (e.g., physical separation, cancellation of public events, closure of schools and daycare facilities, employing a minimum manning policy, telework).

2.10.1.2. Quarantine may be a voluntary or mandatory ROM placed upon individuals or groups reasonably believed to have been exposed to a communicable disease. Absent extraordinary circumstances and specific orders to the contrary, active duty military enforcement of quarantine should be conducted on military installations only. (See CDC, *Public Health Guidance for Community-Level Preparedness and Response to Severe Acute Respiratory Syndrome Version 2, Supplement D: Community Containment Measures, Including Non-Hospital Isolation and Quarantine*). Advance planning, particularly with respect to providing support to and coordinating with civilian authorities is critical. All quarantine activities must comply with applicable laws and regulations. (T-1) Consult the servicing Staff Judge Advocate (SJA) early in the planning process to ensure compliance. See AFI 10-2519 for further guidance.

2.10.1.3. Isolation differs from quarantine in that it removes obviously ill personnel (i.e., those displaying symptoms of disease) from the general population. Adequate facilities must be identified and plans developed to provide medical care and meet basic needs of personnel in isolation. All isolation activities must comply with applicable laws and regulations. (T-1) Consult the servicing SJA early in the planning process to ensure compliance.

2.10.2. ROM and travel restrictions could obligate U.S. government funds (e.g., per diem, permanent change of station delays, temporary duty delays, and “stop movement” orders). Such costs and obligations should be considered but not override the primary goal of preventing the spread of the disease.

2.10.3. The base population should be trained during Phase 0 (See [Figure 2.1](#)) to implement ROM techniques when instructed and as required.

2.10.4. Appropriate facilities to be utilized for quarantine and isolation should be pre-identified to ensure they meet environmental and infection control standards. Another consideration is proximity to medical facilities for monitoring and care. The facilities and environmental considerations may vary depending upon the causative agent, means of transmission, and the number of potentially-exposed personnel.

2.10.5. Procedures to ensure appropriate medical personnel have the capabilities and training necessary to implement monitoring procedures of personnel in quarantine and/or isolation need to be in place prior to implementation of ROM procedures. In addition, it is critical the installation ensure availability of resources to execute ROM monitoring procedures. **Note:** The resources and procedures vary for passive and active monitoring of personnel. For example, passive monitoring may require appropriate medical personnel to man phone banks

to receive periodic updates from quarantined personnel. Active monitoring may require appropriate medical personnel to conduct visits with personnel placed in a quarantine facility.

2.10.6. Distribution of required resources to meet medical care and basic needs of personnel placed in ROM must also be planned during steady-state operations (i.e., Phase 0). The standard distribution of base supplies or MREs may vary depending upon the situation, the causative agent, and the phase.

2.11. Decontamination. Many variables determine the type of decontamination required, if required at all. Exposure to air or weathering may be sufficient as many biological agents die quickly in the environment. Commanders must also prepare for resilient, lingering agents and consider resources/supplies needed for a long-term decontamination response. Additionally, procedures for the temporary or permanent disposition of equipment and material that cannot be decontaminated must be addressed during planning.

2.11.1. Plans for decontamination should include procedures and consumable supplies, including a plan for distribution and re-supply.

2.11.2. In most cases, people exposed to biological agents will not require processing through emergency personnel decontamination stations or contamination control areas (CCA) prior to entering the MTF.

2.11.3. Based on guidance provided by the MAJCOM/theater, the installation should maintain decontamination supplies, and operational decontamination procedures should be trained and exercised regularly.

2.11.4. Refer to U.S. Army Public Health Command (USAPHC) Technical Guide 195, *Safety and Health Guidance for Mortuary Affairs Operations: Infectious Materials and CBRN Handling*, and Joint Publication (JP) 4-06, *Mortuary Affairs in Joint Operations*, for guidance on CHR.

2.12. Medical Intervention and Treatment. Medical intervention and/or treatment can prevent or reduce the impact of infection. Preparatory actions ensure supplies are available for immediate distribution to personnel.

2.12.1. The number and type (military, DOD civilians, contractors, dependents) of personnel that may require medical intervention or treatment in the event of a public health emergency or outbreak of a disease of operational significance is an important value to calculate to ensure adequate planning. Estimates should include where these personnel will receive prophylaxis (i.e., on the installation versus through private care providers) and take into account planning factors such as relevant threats and possible delivery means, as well as expected quantities of supplies from the SNS.

2.12.2. Prioritize personnel to receive vaccines or prophylaxis if time or quantity is limited based on individual susceptibility and/or mission criticality. This list will differ from one installation to another and must account for the needs of the entire base population.

2.12.3. Distribution plans should include alternate locations for distributing prophylaxis and performing vaccinations. In high-threat environments, consider pre-distributing prophylaxis to personnel based on individual susceptibility and/or mission criticality.

2.12.4. Consider conducting prophylaxis sensitivity checks of mission critical personnel to pre-determine adverse reactions.

2.12.5. Stockpile medical treatment supplies IAW Home Station Medical Response allowance standards and MAJCOM guidance, or plan for rapid resupply of vaccines, prophylaxis, antivirals, and other essential supplies/equipment to support medical intervention.

2.13. Mortuary Affairs. Special precautions must be taken to ensure personnel handling remains are adequately protected and can perform their mission safely. Many contaminated remains can be packaged appropriately and handlers can wear simple protective ensembles to ensure their safety from blood and body fluids. Current procedural guidelines discuss means of decontaminating exterior surfaces to reduce the hazards as much as possible. However, due to the lack of published standards and possible internalized hazard, human remains cannot be certified as "safe" at this time.

2.13.1. Review tactics, techniques, and procedures for the identification and segregation of CHR.

2.13.2. Air Force guidance for the handling of CHR is outlined in AFI 34-242. This AFI, which is derived from JP 4-06, provides guidance for mortuary affairs in contingency operations and the prescribed processes for mortuary collection points, temporary storage or interment, and handling CHR.

2.13.3. Transportation of CHR, including air transportation within CONUS and repatriation from OCONUS, may require approval from SecDef or higher authorities.

2.13.4. Relationships between the installation and local community medical examiner should be established prior to a public health emergency or disease of operational significance. Roles and responsibilities should be clarified, as appropriate.

2.14. Transportation. Implementation of installation disease containment guidance will pose unique transportation requirements, especially to move personnel and supplies within the installation and to transport specimens and samples off the installation. Further, because of ROM measures and the potential to contaminate vehicles when transporting contagious passengers, it is important to develop transportation plans in advance and to dedicate specific vehicles for unique transportation requirements as needed.

2.14.1. Personnel movement plans should address normal base mission requirements with social distancing/FHP restrictions. They should also ensure safe movement of personnel between supporting and supported facilities (e.g., SFS-augmentees guard mount location and mass prophylaxis area, MTF and isolation facilities).

2.14.2. Material movement plans should be developed for transportation of contaminated waste and specimens/samples to off-site laboratories. Ensure plans detail chain-of-custody requirements.

2.14.3. Transportation plans should include guidelines on the level of approval necessary for transport of particular items (e.g., transport of CHR and/or contaminated/contagious casualties may require approval from SecDef or higher authorities).

2.14.4. Develop transportation plans to reduce traffic/parking congestion around mass prophylaxis sites.

2.15. Legal Considerations. Responding to and containing a biological incident requires some legal actions that differ from standard incident response and should be accounted for in pre-

incident planning. Support by active duty military units and personnel to civilian law enforcement agencies is limited by the *Posse Comitatus* Act. Active duty military members are generally not permitted to perform any law enforcement functions off military installations, even if conducted in conjunction with or at the request of civilian law enforcement. This prohibition does not apply to ANG units and personnel serving in state active duty, and may not apply to Title 32 status. Commanders should consult with their servicing legal office for advice on any support requests from civilian law enforcement or when conducting any operations off of a military installation.

2.15.1. See AFI 31-115, *Security Forces Investigations Program*, and consult with local Security Forces for guidance on crime scene security and processing.

2.15.2. Identify and review statutes and other regulatory provisions that may impact the ability to enforce ROM and respond to civilian authorities during a public health emergency or an outbreak of a disease of operational significance. Commanders must be advised of their legal options to manage assigned installation personnel, including military personnel, DOD civilians, contractors, dependents, HN/third country personnel, coalition/allied forces, and other personnel that may be on or off the installation (T-1). Refer to AFI 10-2519 for additional guidance.

2.16. Mutual Aid or Host Nation Resources. The installation should analyze what resources are made available under support agreements with local communities and/or HNs. An installation can augment its resources through cooperation with local or regional agencies, other Air Force and DOD resources, or the HN. These additional support elements might include emergency medical services, public health offices, law enforcement agencies, environmental agencies, communications capabilities, transportation support, laboratory facilities for confirmative analysis, and contracted response and remediation companies.

2.17. OCONUS Installations. HN ownership and control of overseas installations may prevent commanders from unilaterally implementing many of the provisions of this manual. Ultimately, U.S. prerogatives and control at overseas locations may require adjustment to accommodate the sovereign interests of the HN, except as otherwise defined in applicable international agreements, such as SOFA, defense cooperation agreements, and base rights agreements.

2.18. Manpower and Augmentation. Mission-nonessential manpower and designated augmentation forces may need to be reallocated to support the anticipated additional burden on certain functional communities such as medical/public health, force support, and security forces. Whenever feasible, pre-identify and train augmentation forces to ensure they are prepared to support in the event of a public health emergency or disease of operational significance.

2.19. Medical Surveillance. Medical surveillance is the ongoing, systematic collection of health data to trigger early implementation of FHP practices. Effective surveillance, when coordinated with local public health efforts (e.g., county, state, and HN) can identify a biological outbreak. Preparatory actions include:

2.19.1. Reviewing local/regional disease trends.

2.19.2. Establishing a medical baseline for diseases endemic to your AOR.

2.19.3. Regularly monitoring disease surveillance reporting mechanisms for the installation and/or community.

2.19.4. Developing plans and procedures to conduct rapid, widespread contact tracing and/or epidemiological investigations. Contact tracing and epidemiological investigation allows the correct portion of the population to be identified for prophylaxis and/or treatment.

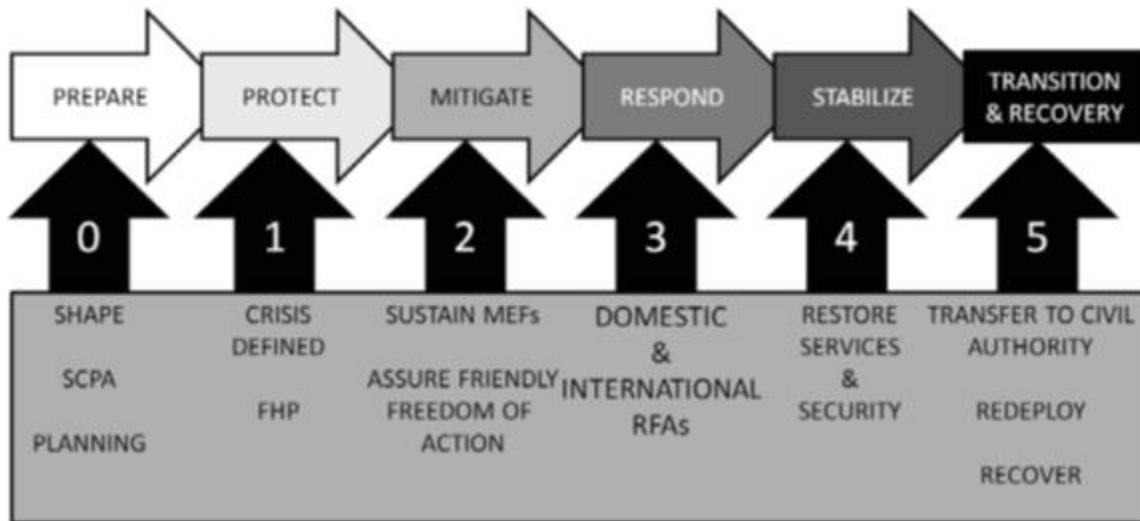
2.19.5. Effective surveillance must be coupled with timely dissemination of actionable data to higher authorities, both military and civilian.

2.20. Public Health Emergency. Upon declaration of a public health emergency by the Installation Commander and the implementation of ROM IAW AFI 10-2519, the Installation Commander must establish rules enforcing ROM measures and should consider the following (T-1):

2.20.1. Use the minimum force necessary to restrain personnel from unauthorized entry or departure from a quarantine area and for enforcing ROM IAW AFI 31-118, *Security Forces Standards and Procedures*. Those individuals or groups not subject to military law and who refuse to obey or otherwise violate an order under this manual may be detained by the military commander until appropriate civil authorities can respond. The military commander shall coordinate with civil authorities to ensure the response is appropriate for the public health emergency. (T-1) See AFI 10-2519 for further guidance.

2.20.2. Planning should take into account local, state, federal, and any applicable HN laws as well as international agreements and SOFAs. Commanders of installations in foreign nations may not have the authority to order quarantine or other ROM of non-U.S. military personnel due to HN sovereignty and jurisdiction over the installation. In these cases, immediate consultation with the servicing legal office and local authorities to request they impose ROM is necessary to protect U.S. military personnel, civilians accompanying the force, and HN personnel.

2.21. PI&ID Operational Phases. There will not be a single phase for DOD execution during a PI&ID incident. Through the GCP PI&ID 3551-13, the DOD has defined six operational phases—Prepare, Protect, Mitigate, Respond, Stabilize, and Transition and Recovery (See [Figure 2.1](#)). Each GCC will determine the operational phase of its AOR based on AOR-specific data, in coordination with the Joint Staff and OSD, and upon approval of the SecDef. Moving from phase to phase will be accomplished based on specific indicators and will imply expenditure of resources and obligating capabilities, as determined in GCC regional plans.

Figure 2.1. Six-Phase Model.

2.21.1. Phase 0 — Prepare. DOD develops synchronized plans for PI&ID, and integrates planning efforts with the interagency community and partner nations. DOD conducts integrated Security Cooperation and Partnership Activities (SCPA) to better prepare partner nations to detect, report, and respond to PI&ID outbreaks. Activities executed during this phase are considered steady-state operations and will be executed as part of GCCs Theater Campaign Plans, and supported by Services and Selected Defense Agencies. These activities will continue through all phases.

2.21.2. Phase 1 — Protect. Upon identification of a potential or actual disease outbreak of operational significance, DOD takes decisive action to protect DOD forces from becoming infected. The focus is the protection of U.S. Forces, DOD civilians, and DOD contractors performing critical roles, dependents and beneficiaries, as well as the associated resources necessary to maintain readiness. Additionally, DOD will work with the interagency and partner nations, to ensure DOD freedom of movement, and to coordinate communication strategies.

2.21.3. Phase 2 — Mitigate. DOD will mitigate the effects of an operationally significant disease outbreak on mission assurance and its forces. The focus of this phase is the protection of MEFs. Additionally, DOD will continue to work with the interagency and partner nations, to ensure DOD freedom of movement, and to coordinate communication strategies.

2.21.4. Phase 3 — Respond. DOD will provide assistance to civil authorities (domestic and/or international). The focus of this phase is providing support to civil authorities. Additionally, DOD will continue to work with the interagency and partner nations, to ensure DOD freedom of movement, and to coordinate communication strategies.

2.21.5. Phase 4 — Stabilize. DOD will complete requests for assistance and scale down response operations when military and civil authorities (domestic and/or international) decide appropriate. The focus of this phase is completion of assistance and preparation for transition.

2.21.6. Phase 5 — Transition and Recover. DOD will redeploy remaining civil support response forces, reconstitute the force, and make any preparations required for follow-on

waves of the pandemic. The focus of this phase is transition from civil support operations, reconstitution of the force, and preparing for subsequent pandemic waves.

Chapter 3

CONTENT FOR INSTALLATION DISEASE CONTAINMENT GUIDANCE

3.1. General. As directed by AFI 10-2519, installations must develop disease containment guidance either as a stand-alone DCP or incorporated in the IEMP 10-2 that allows the installation to effectively prepare for, respond to, and recover from public health emergencies or diseases of operational significance. (T-0, DOD GCP PI&ID 3551-13) This chapter outlines content to ensure the installation plan developed provides detailed procedures, information, and guidance to protect installation personnel and critical resources. Installation disease containment guidance supports sustainment of critical mission operations during public health emergencies or diseases of operational significance. The plan should be maintained in an executable state and updated during routine updates to the IEMP 10-2 or the MCRP, or sooner as threats to the installation change. When available, lessons learned from exercises and real-world incidents should be incorporated into the plan.

3.2. Plan Components. AFMAN 10-401 Volume 2, *Planning Formats and Guidance*, specifies components to a plan, but only three are necessary for disease containment guidance: the table of contents, the basic plan, and the attachments (annexes, appendices, and/or tabs).

3.3. The Basic Plan. It is *recommended* disease containment guidance follow the format below. However, the plan is *required* to contain, at a minimum, the following nine content areas: references, tasked organizations, situation, threat, key assumptions, mission, execution, administration and logistics, and C2. (T-0, DOD GCP PI&ID 3551-13) Installation planners may use discretion in the ordering of information and may add additional information as required. If developing a stand-alone DCP, keep the basic plan brief, incorporating detailed information within the annexes. Where applicable, *reference other installation plans* (e.g., Integrated Defense Plan (IDP), IEMP 10-2, or MCRP) rather than restating the information.

3.3.1. References. Attachment 1 lists applicable DOD, Joint, and Air Force guidance for executing disease containment guidance. Include installation-specific guidance, as well as any additional references required to execute the installation plan. (T-1)

3.3.2. Tasked Organizations. Identify installation-assigned or -attached organizations tasked to support the plan including tenants, GSUs, joint and coalition forces, and others supported or tasked as a result of the guidance. (T-1)

3.3.2.1. Supporting Forces. Identify military units or organizations outside the installation that support this plan. (T-1)

3.3.2.2. Supporting Organizations. Identify non-military organizations identified for support via MOA or MAA. (T-1)

3.3.3. Situation. Describe the most probable conditions for implementing this plan. Identify other plans that are likely to be implemented concurrently with this plan. (T-1)

3.3.4. Threat. Identify the biological threat(s) to the installation. Consider enemy and terrorist use of biological agents, as well as naturally-occurring outbreaks. Ensure a focus on endemic diseases that could be of operational concern due to contagiousness, high mortality, etc. **Note:** This portion of the plan may be classified; if it does, indicate the security precedence and handle IAW proper procedures. (T-1)

3.3.5. Key Assumptions. Outline major planning assumptions used in plan development. (T-1)

3.3.6. Mission. Outline the purpose and goals of installation disease containment guidance. Ensure the mission is synchronized with DOD GCP PI&ID and other applicable HHQ plans including AOR plans and GCC/Air Force component campaign plans. Include the mission of the installation and identify critical missions that must continue during a public health emergency or disease of operational significance. (T-1) Address the likelihood and circumstances that may require the installation to support sustainment of mission operations during an outbreak. (T-1) If assigned, attached, or transitioning forces must sustain mission operations, address their impacts in the plan. (T-1)

3.3.7. Execution. Identify the authority to execute the plan and the general process for implementation during steady-state (Phase 0) and contingency operations (Phases 1-5). (T-1) Highlight the major tasks each installation organization and/or functional community must perform to carry out the plan. (T-1)

3.3.7.1. Concept of Operations. Describe in general terms the process the installation will follow to prepare for and respond to a public health emergency or disease of operational significance (e.g., Develop an integrated PI&ID planning document, train the force, exercise the plan, and make modifications as necessary to keep the plan current and viable. (T-1) Ensure the DOD six-phase construct is followed throughout all steps of the process, See [Figure 2.1](#)). (T-1)

3.3.7.2. Desired Effects Priority List. Identify and outline a prioritized list of desired effects to achieve installation objectives. (T-1)

3.3.7.3. Limiting Factors. Identify factors that may significantly impact execution of the plan. Specify how often limiting factors (LIMFAC) will be reviewed and updated. (T-1) **Note:** Ensure inclusion of LIMFAC does not elevate the classification of the plan beyond *For Official Use Only* (FOUO); or if it does, indicate the security precedence and handle IAW proper procedures. (T-1)

3.3.8. Administration and Logistics. Identify how key installation organizations are to be supported and what support they must provide for themselves, or to others. In general terms, outline the sources for equipment and supplies required for execution and sustainment. (T-1) Address organic resources, those available via MOAs/MAAs and those available via other means (e.g., Time-Phased Force and Deployment Data). (T-1) Additionally, identify local support conditions that adversely affect plan implementation. (T-1) Resources required for plan execution but not currently available should be identified as LIMFAC (See [Paragraph 3.3.5.3](#)).

3.3.9. Command and Control. Identify command relationships both internal and external to the installation. (T-1)

3.3.9.1. List installation control centers used in the plan along with the individual or organization responsible for their operation. (T-1) **Note:** Ensure inclusion of installation control centers does not elevate the classification of the plan beyond FOUO; or if it does, indicate the security precedence and handle IAW proper procedures.

3.3.9.2. Consult installation COOP plan to understand alternate locations for critical missions, command succession plans, delegations of authority, and other provisions required for continuity of command. (T-1)

3.3.9.3. Outline methods of communications to be used. (T-1)

3.4. Annexes. Disease containment guidance will include, at a minimum, the following content. Installation planners may add additional annexes/appendices as required. (T-1)

Where applicable, annexes may reference other installation plans (e.g., IDP, IEMP 10-2, and MCRP) rather than restate the information. The following paragraphs outline proposed areas of focus for each annex/content area.

3.4.1. Annex A – Task Organization. This section should:

3.4.1.1. List all major elements directly subordinate to the headquarters including components and major subordinates, augmentation and supporting commands, and reserve component forces.

3.4.1.2. Outline the identified C2 structure.

3.4.1.3. Identify tasks that will be completed by an organization outside of the installation (e.g., HN, subordinate command).

3.4.2. Annex B – Intelligence. This section should identify the Commander's Critical Information Requirements (CCIR) during a public health emergency or disease of operational significance.

3.4.3. Annex C – Operations. This section should:

3.4.3.1. Identify the specific functions critical to operations when the installation is faced with a public health emergency or disease of operational significance.

3.4.3.2. Understand the processes to MEFs and services for a sustained period of six to eight weeks due to a public health emergency or disease of operational significance. Consider all tenant organizations' needs to make the return to normal operations as smooth as possible, and to prepare for further waves of the disease. Coordinate disease containment guidance with the installation COOP Plan. Limit redundancy between the two documents, but ensure references to each accurately reflect what is codified in the other.

3.4.3.3. Identify potential 2nd- and 3rd-order impacts of a public health emergency or disease of operational significance on the installation's ability to sustain operations, maintain installation support requirements, and provide FHP to the key population. Outline the installation's plan to mitigate these effects.

3.4.3.4. Establish overarching objectives and effects (to include key tasks and execution triggers by phase) for each response phase consistent with the DOD GCP PI&ID 3551-13. Ensure these take into account the CCIR.

3.4.3.5. Identify detection, sampling, and identification resources available on the installation, as well as resources available through MOAs/MAAs. Identify vulnerabilities in the detection and identification capabilities based on the installation-specific threat.

3.4.3.6. Identify steps to enhance bio-surveillance in response to an intelligence warning or actual incident. Tailor procedures for detector operations modes and sampling tempo IAW the force protection condition (FPCON), health protection condition (HPCON), trigger event, or the causative agent/disease.

3.4.3.7. Address individual protective equipment (IPE) and PPE requirements and the distribution plan for the installation. Follow guidance provided by the CDC on utilization of face masks and respirators. Consider prioritization of resources (e.g., organizations and functions, HN personnel) and unique requirements for transient forces.

3.4.3.8. Outline the methodology to be used when determining the appropriate shelter-in-place measures applicable to the public health emergency or disease of operational significance. Identify organizations tasked to support shelter operations, including roles and responsibilities, resources required, etc.

3.4.3.9. Outline procedures for conducting an investigation when the disease outbreak is suspected to be the result of a terrorist attack. Consult Office of Special Investigations for crime scene management and chain-of-custody requirements.

3.4.3.10. Consider possible FPCON/HPCON adjustments based on biological threats or incidents. Include procedures to report cases where the implementation of specific FP measures will adversely impact or significantly hamper accomplishment of assigned duties.

3.4.3.11. Identify the procedures that will be used to secure and control access into and out of quarantine/isolation facilities. Outline Rules for the Use of Force for enforcement of security requirements during response to biological incidents.

3.4.3.12. Specify procedures that will be used to provide security for transfer of laboratory samples/specimens, arrival of assets on the installation, and mass dispensing (i.e., Point of Dispensing) operations.

3.4.3.13. Identify anticipated installation-specific application of ROM (i.e., identify facilities for quarantine and isolation operations, lock down the installation and allow individuals to move freely within the fence, sector the installation and limit movement between sectors, HN limitations/restrictions).

3.4.3.13.1. Describe enforcement measures to be used for each type of ROM (e.g., social distancing will be self-monitored and isolation/quarantine will be monitored by designated individuals).

3.4.3.13.2. Where operationally feasible, establish policies for adopting flexible worksites (e.g., telecommuting) and flexible work hours (e.g., staggered shifts). Outline steps required for dispersion of mission essential personnel to alternate housing facilities/shelters.

3.4.3.13.3. Describe the procedure to implement social distancing measures to reduce risk of person-to-person transmission of disease (e.g., minimize personal contact with others). Identify non-essential installation facilities (e.g., schools, gymnasiums, and movie theaters) and prioritize them for closure or transition to quarantine/isolation facilities.

- 3.4.3.13.4. Describe the process (i.e., when it is appropriate, the duration) to limit ingress and/or egress to the installation or limit access to certain sectors of the installation. Consider who will be permitted access to and from the installation or sector.
- 3.4.3.13.5. Outline procedures for initiating quarantine/isolation operations. Address isolation options for those not requiring hospitalization, including on-installation isolation and home isolation; a working quarantine plan for use when mission operations must continue; and plans for passengers and aircrew arriving or returning from areas of known disease outbreak at Aerial Ports of Embarkation, if directed.
- 3.4.3.13.6. Identify facilities and additional resources (i.e., utilities, transportation) required to initiate and execute quarantine and isolation operations.
- 3.4.3.13.7. Identify the procedures for subjecting individuals to quarantine/isolation; monitoring them, to include providing medicine and medical care; and removing them from quarantine/isolation.
- 3.4.3.13.8. Identify IPE/PPE requirements for occupants of quarantine/isolation facilities, as well as appropriate infection control measures (e.g., standard precautions, airborne precautions, contact precautions, droplet precautions).
- 3.4.3.13.9. Describe the procedures to distribute basic needs materials and services during quarantine and/or isolation.
- 3.4.3.13.9.1. Address requirements for health and resiliency of personnel during ROM such as, food and water (to include unique nutritional requirements for ill personnel), shelter, social/morale, and religious requirements.
- 3.4.3.13.9.2. Include sanitation/waste requirements to include laundry, bathing, and waste management. Identify procedures for handling/eliminating contaminated laundry and waste. Include both contract and non-contract options.
- 3.4.3.13.9.3. Identify processes to meet these needs if military beneficiaries are quarantined/isolated off-base or civilian employees are quarantined/isolated on-base.
- 3.4.3.14. Address legal requirements associated with public health emergencies and diseases of operational significance. Consult AFI 10-2519 for further guidance.
- 3.4.3.15. Ensure Chaplain Corps personnel provide direct and indirect religious support for military personnel, their families, and authorized DOD civilian personnel during diseases of operational significance. Utilize the Religious Support Team (RST) concept to provide required services and support.
- 3.4.3.15.1. Develop religious service curtailment plan to ensure continuity of spiritual care during public health emergencies and diseases of operational significance. Describe procedures to conduct liaison with civilian clergy, non-governmental agencies, faith-based organizations, and community-based organizations as applicable to the local situation to provide appropriate faith balance.

3.4.3.15.2. Identify how Chaplain Corps will be used in conjunction with Mental Health and others to reduce stress among the population IAW AFI 44-153, *Disaster Mental Health Response & Combat and Operational Stress Control*.

3.4.4. Annex D – Logistics. This section should:

3.4.4.1. Identify logistic requirements, both medical and non-medical, necessary to support steady-state (Phase 0) and contingency operations (Phases 1-5). Determine resources available on the installation, as well as critical supplies, goods, or services that require priority delivery from industry/suppliers. Shortages should be highlighted as LIMFAC.

3.4.4.2. Outline procedures for expeditious receipt, transport, and accountability of SNS assets and access to War Reserve Material supplies (e.g., MOU for SNS access).

3.4.4.3. Describe the procedures for transportation of medical items (e.g., laboratory samples), personnel—consider any special requirements for transport of exposed, symptomatic, and contagious personnel, and packaging and transport of Category A contaminated waste.

3.4.4.3.1. Outline necessary non-medical transportation (e.g., movement of sick personnel using other than medical assets (ambulances) to and from medical facilities, movement of supplies to support ROM measures).

3.4.4.3.2. Describe procedures to protect drivers during transport, and outline vehicle decontamination procedures required following transport.

3.4.4.3.3. Describe the procedures to maintain ability of transport infrastructure to respond to changes in priority caused by the public health emergency or disease of operational significance.

3.4.4.3.4. Describe the plan for coordinating transport to onward destinations for affected DOD and National Guard personnel and dependents to ensure movement to safer or more stable environments.

3.4.4.3.5. Include procedures for documentation of contaminated transportation resources. Consult AFTTP(I) 3-2.60, *Multi-Service Tactics, Techniques, and Procedures for Chemical, Biological, Radiological, and Nuclear Decontamination*.

3.4.5. Annex E – Personnel. This section should:

3.4.5.1. Outline adjustments required for installation human capital plans during a public health emergency or disease of operational significance. Consider compensation for non-essential and essential employees; normal and mandatory sick leave; family medical leave; installation telework policy, if appropriate; personnel procedures for social distancing; and procedures for processing grievances and providing counseling services.

3.4.5.2. Describe personnel accountability and tracking requirements.

3.4.5.3. Develop plans to augment manpower supporting critical mitigation tasks (e.g., security to include defending the base, enforcing quarantine, and crowd control; medical care and support to include monitoring personnel in quarantine/isolation, distribution of PPE and prophylaxis, and contact tracing).

3.4.5.4. Ensure other installation plans (e.g., IEMP 10-2, COOP, and IDP) include operational impacts of absenteeism, social distancing, and the possible scarcity of critical resources (e.g., antivirals, immunizations, food, and water) during a public health emergency or disease of operational significance.

3.4.5.5. Outline plans to address personnel reception and departure processing during a public health emergency or disease of operational significance.

3.4.5.6. Incorporate the mortuary affairs plan to describe procedures for handling remains to include temporary interment. Reference AFI 34-242 or other applicable documents rather than duplicating information.

3.4.6. Annex F – Public Affairs. This section should include PA products, including materials in languages other than English, and ensure adequate coverage of biological warfare related items within the installation Risk Communication Plan (see AFI 35-101). At a minimum, PA must ensure all messaging supports DOD PA objectives and addresses the requirements listed below. Medical Group communication requirements are contained in Annex Q.

3.4.6.1. Outline requirements and procedures to educate PA personnel on crisis communications fundamentals for public health emergencies and diseases of operational significance. Integrate PA into warning and notification, training, information management and control, and mental health measures.

3.4.6.2. Describe how the installation will ensure clear, effective, and coordinated communication with installation population before, during, and following a public health emergency or disease of operational significance. Identify relevant activities, associated themes, and relevant messages to build confidence that the installation is prepared to respond.

3.4.6.3. In coordination with key players, identify relevant activities, themes, and messages to provide external audiences with clear and concise information on the installation situation without providing too much information for exploitation. Ensure developed messages support DOD direction to “speak with one voice.”

3.4.7. Annex J – Command Relationships. This section should outline the methodology to ensure continued coordination with state, HN, tribal, and local organizations during public health emergencies and diseases of operational significance, to include:

3.4.7.1. Develop procedures to provide assistance to civil authorities, both foreign and domestic, and be prepared to do so as directed by AFI 10-801; DODI 2000.21, *Foreign Consequence Management (CM)*; and initiated by HHQ.

3.4.7.1.1. Be prepared to offset private sector shortfalls affecting DOD activities at ports, in transportation, or providing security, if approved by appropriate officials. Ensure the *Posse Comitatus* Act is not violated.

3.4.7.1.2. Be prepared to support local governments and utilities, as authorized by law and directed by appropriate authority, to ensure uninterrupted flow of essential services to the installation.

3.4.7.2. Develop procedures to ensure sharing of installation plans with other military installations within the surrounding community, to include sister Service installations.

3.4.7.3. Ensure integration of response capabilities (e.g., communications, unique equipment and/or personnel requirements).

3.4.7.4. Identify unique requirements associated with support of installation GSUs in preparation for and response to a public health emergency or disease of operational significance.

3.4.8. Annex K – Communications. This section will outline the plan to ensure the functionality of critical communications systems during a public health emergency or disease of operational significance.

3.4.8.1. Consider connectivity to HHQ, internal organizations, and external partners.

3.4.8.2. Identify installation communications capabilities to support social distancing measures such as telework and staggered work schedules.

3.4.9. Annex P – Host-Nation Support. Utilize this section to outline expectations related to the HN, address both providing support to them and receiving support from them.

3.4.9.1. Identify relevant HN considerations (e.g., agencies, assumptions, limitations, agreements).

3.4.9.2. Outline the HN agreements in place to support receipt and distribution of support during a public health emergency or disease of operational significance.

3.4.9.3. Ensure appropriate systems are in place to monitor the health of overseas military forces and for coordination with Department of State, allies, coalition, and HN public health communities to investigate and respond to a public health emergency or disease of operational significance on DOD installations, as well as those affiliated with the DOD.

3.4.10. Annex Q – Medical. This section will describe FHP procedures and mitigation efforts to ensure safety of installation population including:

3.4.10.1. Identify planning factors to estimate the number of installation personnel requiring medical intervention and/or treatment in the event of a biological incident. Develop guidance for allocating scarce installation medical resources, including mental health, during public health emergencies or diseases of operational significance.

3.4.10.2. Develop a mass prophylaxis plan IAW AFI 41-106. Include required stockpiles for vaccines and prophylaxes. Consider follow-on monitoring of effects to personnel following administration.

3.4.10.3. Outline detailed installation FHP measures, by phase, IAW AFI 10-2519, DOD GCP PI&ID 3551-13, and in coordination with existing authorities. Plan and coordinate FHP implementation with HHQ, other military bases in close proximity, and state, tribal, and local partners.

3.4.10.4. Identify PPE requirements for healthcare providers and patients in MTFs (as applicable), as well as home care providers. Consider protective equipment requirements for standard, contact, airborne, and droplet transmission routes. Outline procedures for the management of staff who become ill in the workplace and reference procedures for triage and management of biological casualties IAW AFTTP 3-42.32, *Home Station Medical Response to Chemical, Biological, Radiological, and Nuclear (CBRN) Incidents*.

3.4.10.5. Outline procedures and conditions for movement of patients, specifically those infected with the disease. Ensure this is IAW higher-level policy and guidance.

3.4.10.6. Describe how the installation will conduct medical surveillance in support of installation activities, facilities, and key population.

3.4.10.7. Outline the procedures for screening, isolating, and recommending quarantine options for personnel transiting and/or departing the installation, as applicable.

3.4.10.8. Outline medical communication requirements of a public health emergency or disease of operational significance. At a minimum address coordination of medical expertise with PA and other installation functional experts, as required, and:

3.4.10.8.1. Include plans to produce, coordinate, and disseminate materials to inform installation population on biological threats, possible mitigation actions, and recommended readiness activities. Ensure plans are designed to keep the installation population informed during all phases of a biological incident(s).

3.4.10.8.2. Support the installation's existing strategic communications methods (e.g., Straight Talk Line).

3.4.11. Annex R – Reports. This section will identify requirements and procedures for reporting public health emergencies or diseases of operational significance including:

3.4.11.1. Outline installation procedures for compiling, distributing, and submitting reports (i.e., OPREP-3 or SITREPs) to the National Military Command Center and Armed Forces Health Surveillance Center IAW the guidelines established by DOD GCP PI&ID 3551-13, Annex R. Specifically:

3.4.11.1.1. Provide OPREP-3 reports for significant incidents and outbreaks during Phases 0 and 1.

3.4.11.1.2. Provide weekly reports during Phase 2.

3.4.11.1.3. Provide daily reports during Phases 3, 4, and 5.

3.4.11.1.4. Provide medical reports as required.

3.4.11.1.5. Provide a courtesy copy of all reports to the NORAD-USNORTHCOM Command Center.

3.4.11.2. Develop pre-formatted or pre-addressed messages for OPREP-3 and CBRN WRS transmission. Consider messages to HHQ, lateral units, tenant units, local public health officials, and other audiences as appropriate. In addition, consider preparing agent-specific information for use in warning and notification messages in advance of an actual incident.

3.4.12. Annex V – Interagency. Use this section to outline the coordination required with HHQ, state, tribal, and local partners. Ensure coordination with private sector and other government organizations to promote efforts to ensure continuity of Defense Critical Assets and thus availability of sufficient military capability to execute the National Military Strategy during a public health emergency or disease of operational significance.

3.4.13. Annex W – Contingency Contracting. Use this section to address any expected shortfalls in supplies and planned contingency contract support that may be required during a

public health emergency or disease of operational significance. Include contract considerations for cleaning and decontamination of isolation and quarantine facilities, and special requirements for the packaging and transport of Category A contaminated waste.

3.4.14. Annex Y – Commanders Communication Strategy. Use this section to address the strategic communications that must occur during a public health emergency or disease of operational significance.

3.4.14.1. Develop baseline messages to build installation population awareness of endemic diseases and other disease threats that have the potential to cause a public health emergency or disease of operational significance.

3.4.14.2. Provide guidance for installation personnel, both military and non-military, to develop home preparedness plans and checklists.

3.4.14.2.1. Identify suggested resources installation personnel and their families should maintain to become as self-sufficient as possible.

3.4.14.2.2. Provide recommendations for parents that address how to handle the issue of closed child care facilities and schools.

3.4.14.3. Identify installation measures that reduce person-to-person contact including telecommuting, staggered scheduling, and limiting unnecessary social contact.

3.4.15. Annex Z – Distribution. Include the distribution breakout.

3.5. Other Recommended Items.

3.5.1. Disease-Specific Requirements. Based on installation-specific threat assessments, identify diseases endemic to your area of operations and/or those that are viable biological threats. Determine if any of these agents would drive disease-specific, transmission-based requirements based on their unique characteristics (e.g., contagiousness and infectivity). If so, develop Transmission-Based Appendices (e.g., contact, airborne, and droplet) to outline required procedures related to the agent/disease in question.

3.5.2. Disease Containment Execution Checklists. Include checklists developed for quick and effective installation response to biological incidents.

3.5.3. Memorandum of Agreement/Mutual Aid Agreement. Include MOAs and MAAs developed to provide reciprocal assistance to, and receive reciprocal assistance from, local authorities and organizations.

3.5.4. Essential Elements of Friendly Information (EEFI). Identify applicable EEFI, relating to the preparation for and response to a biological incident that may expose sensitive installation vulnerabilities, intelligence, capabilities, plans, and/or procedures.

3.5.5. Maps and Charts. Include applicable products for use in preparing for and responding to a biological incident.

MICHAEL R. SHOULTS, SES, USAF
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Attachment 1

GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION

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Abbreviations and Acronyms

AFI—Air Force Instruction

AFLLP—Air Force Lessons Learned Program

AFLP—Air Force Lesson Process

AFMAN—Air Force Manual

AFPD—Air Force Policy Directive

AFTTP—Air Force Tactics, Techniques, and Procedures

ANG—Air National Guard

AOR—Area of Responsibility

ASD—Assistant Secretary of Defense

AT—Antiterrorism

BSI—Base Support Installation

C2—Command and Control

CBRN—Chemical, Biological, Radiological, and Nuclear

CBRNWRS—Chemical, Biological, Radiological, and Nuclear Warning and Reporting System

CCA—Contamination Control Area

CCIR—Commander's Critical Information Requirements

CDC—Centers for Disease Control and Prevention

CHR—Contaminated Human Remains

CM—Consequence Management

CONUS—Continental United States
COOP—Continuity of Operations
CSAF—Chief of Staff of the Air Force
DCP—Disease Containment Plan
DOD—Department of Defense
DODD—Department of Defense Directive
DODI—Department of Defense Instruction
DRU—Direct Reporting Unit
DSCA—Defense Support of Civil Authorities
EEFI—Essential Elements of Friendly Information
EM—Emergency Management
EMWG—Emergency Management Working Group
FHP—Force Health Protection
FOA—Field Operating Agency
FOUO—For Official Use Only
FP—Force Protection
FPCON—Force Protection Condition
GCC—Geographic Combatant Command
GCP—Global Campaign Plan
GSU—Geographically Separated Unit
HAF—Headquarters Air Force
HHQ—Higher Headquarters
HN—Host Nation
HPCON—Health Protection Condition
IAW—In Accordance With
IDP—Integrated Defense Plan
IEMP—Installation Emergency Management Plan
IPE—Individual Protective Equipment
JP—Joint Publication
LIMFAC—Limiting Factors
MAA—Mutual Aid Agreement
MAJCOM—Major Command

MCRP—Medical Contingency Response Plan
MEF—Mission Essential Function
MOA—Memorandum of Agreement
MOU—Memorandum of Understanding
MRE—Meal-Ready-to-Eat
MTF—Medical Treatment Facility
MTF/CC—Medical Treatment Facility Commander
NORAD—North American Aerospace Defense Command
OCONUS—Outside the Continental United States
OPR—Office of Primary Responsibility
OPREP-3—Operational Incident Report
OSD—Office of the Secretary of Defense
PA—Public Affairs
PHEO—Public Health Emergency Officer
PI&ID—Pandemic Influenza and Infectious Disease
PIR—Priority Intelligence Requirements
POC—Point of Contact
PPE—Personal Protective Equipment
ROM—Restriction of Movement
RSS—Receiving, Staging, and Storage
RST—Religious Support Team
SAF—Secretary of the Air Force
SCPA—Security Cooperation and Partnership Activities
SecDef—Secretary of Defense
SFS—Security Forces Squadron
SITREP—Situation Report
SJA—Staff Judge Advocate
SNS—Strategic National Stockpile
SOFA—Status of Forces Agreements
USAPHC—U.S. Army Public Health Command
USNORTHCOM—United States Northern Command
USTRANSCOM—United States Transportation Command

Terms

Air Force Emergency Management (EM) Program—The single, integrated Air Force program implementing the mission, vision, strategic goals, and objectives along with the management framework of the Air Force EM program to prevent, prepare for, respond to, recover from, and mitigate the direct and indirect consequences of an emergency or attack. The Director of Civil Engineering, AF/A4C, manages the Air Force EM program.

Basic Needs—The minimum requirements to sustain personnel in emergency or crisis situation including food, water, clothing, and shelter.

Biological Agent—A microorganism (or toxin derived from it) that causes disease in personnel, plants, or animals or causes the deterioration of material. Pathogens are microorganisms (e.g., bacteria, viruses, rickettsia) that directly attack human, plant, or animal tissue and biological processes. Toxins are poisonous substances that are produced naturally (by bacteria, plants, fungi, snakes, insects, and other living organisms) but may also be produced synthetically. (JP 1-02, *Department of Defense Dictionary of Military and Associated Terms*)

CBRN Incident—Any occurrence, resulting from the use of CBRN weapons and devices; the emergence of secondary hazards arising from counterforce targeting; or the release of toxic industrial materials into the environment, involving the emergence of CBRN hazards. (JP 1-02)

Collective Protection—The protection provided to a group of individuals in a biological environment that permits reduction of IPE.

Communicable Disease—An illness due to a specific infectious agent or its toxic products that arises through transmission of that agent or its products from an infected and/or affected individual, animal, or a reservoir to a susceptible host, either directly or indirectly through an intermediate animal host, vector, or the inanimate environment. (DODI 6200.03)

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. (AFI 10-2519)

Contamination Control Area (CCA)—An area in which contaminated IPE is removed; people, equipment, and supplies are decontaminated to allow processing between a toxic environment and a toxic free area; the last area an individual can safely don IPE before moving into a contaminated area. (AFI 10-2501)

Disease of Operational Significance—An infectious disease (natural, accidental, or deliberate) likely to significantly impact the ability of the DOD to maintain mission assurance or likely to result in significant increases in request for DOD assistance. (*Joint Strategic Capabilities Plan (JSCP)*, 10 June 2011)

Essential Elements of Friendly Information (EEFI)—Key questions likely to be asked by adversary officials and intelligence systems about specific friendly intentions, capabilities, and activities, so they can obtain answers critical to their operational effectiveness. (JP 2-01)

Force Protection—Preventive measures taken to mitigate hostile actions against Department of Defense personnel (to include family members), resources, facilities, and critical information. Also called FP. (JP 3-0) [*The process of detecting threats and hazards to the Air Force and its mission, and applying measures to deter, pre-empt, negate or mitigate them based on an*

acceptable level of risk.] {Italicized words in brackets apply only to the Air Force and are offered for clarity.} (Annex 3-10, *Force Protection*)

Health Surveillance—The regular or repeated collection, analysis, and interpretation of health-related data and the dissemination of information to monitor the health of a population and to identify potential health risks, thereby enabling timely interventions to prevent, treat, reduce, or control disease and injury. It includes occupational and environmental health surveillance and medical surveillance subcomponents. (JP 1-02)

Individual Protective Equipment (IPE)—In chemical, biological, radiological, or nuclear operations, the personal clothing and equipment required to protect an individual from chemical, biological, and radiological hazards and some nuclear hazards. Also called IPE. (JP 1-02)

Integrated Defense—Integrated defense is the application of active and passive defense measures, employed across the legally-defined ground dimension of the operational environment, to mitigate potential risks and defeat adversary threats to Air Force operations. (AFPD 31-1, *Integrated Defense*)

Mutual Aid Agreement (MAA)—Written or oral agreement between and among agencies/organizations and/or jurisdictions that provides a mechanism to quickly obtain emergency assistance in the form of personnel, equipment, materials, and other associated services. The primary objective is to facilitate rapid, short-term deployment of emergency support prior to, during, and/or after an incident. (*National Incident Management System*)

Natural Disaster—An emergency situation posing significant danger to life and property that result from a natural cause. (JP 1-02)

Personal Protective Equipment (PPE)—The protective clothing and equipment provided to shield or isolate a person from the chemical, physical, and thermal hazards that can be encountered at a hazardous materials incident. See also Individual Protective Equipment. (JP 1-02)

Population at Risk—The strength in personnel of a given force structure in terms of which casualty rates are stated. (JP 1-02)

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 poses 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. (AFI 10-2519)

Religious Support Team (RST)—RST is a model of ministry, which can be employed at deployed locations and/or home stations. The installation chaplain/non-commissioned officer in charge ensures that members of their staff are prepared to perform as an RST. RSTs consist of various combinations of chaplains and chaplain assistants, depending on mission requirements; however, one of each is required at a minimum. The purpose of the RST is to provide for, support, and strengthen the spiritual and moral well-being of all members of the command to which they are assigned. (JP 1-05, *Religious Affairs in Joint Operations*)

Restriction of Movement (ROM)—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. An example is implementation of a “snow day,” in which offices, schools, and transportation systems are cancelled as for a major snowstorm.

Quarantine — The separation of an individual or group reasonably believed to have been exposed to a quarantinable communicable disease, but who are not yet ill, from others who have not been so exposed to prevent the possible spread of the quarantinable communicable disease. Quarantine may be voluntary or mandatory (42 CFR 70.1)

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 PPE while at work is required.

Isolation — The separation of an individual or group reasonably believed to be infected with a quarantinable communicable disease from those who are healthy to prevent the spread of the quarantinable communicable disease. (CFR 70.1)

Strategic National Stockpile (SNS)—A national repository of antibiotics, chemical antidotes, antitoxins, life support medications, intravenous administration fluids and sets, airway maintenance supplies, and medical/surgical items. The SNS is designed to supplement and re-supply State and local public health agencies in the event of a national emergency anywhere and at any time within the United States or its territories. (DODI 6200.03)

Vector—An organism, such as an insect, that transmits a disease-causing pathogen.

Attachment 2

**AIR FORCE REPORT FOR STRATEGIC NATIONAL STOCKPILE AND MASS
PROPHYLAXIS ACTIONS**

Table A2.1. Air Force Report for Strategic National Stockpile and Mass Prophylaxis Actions

Installation: _____	
PHEO: _____ (rank, name, office symbol, phone, e-mail)	
<u>Description of Public Health Emergency (complete with items 1 or 2 below):</u>	
(1) SNS Request – PULLED	
Amount and Description of Materials Needed:	
Agency Material Requested From:	
Did the Installation Commander include the request with the OPREP-3 PINNACLE report to the National Military Command Center?	
(2) SNS Request – PUSHED	
Amount and Description of Materials Receiving:	
Agency Providing Material:	
Is Material being Tracked in Defense Medical Logistics Standard Support (Cost Center 5233)?	
(3) Receiving, Staging, and Storage (RSS) Request	
Description of RSS Agreement:	
Amount and Description of Materials Storing:	
Agency / Community Supported:	
RSS Specific MOU/A signed by Installation Commander?	
<ol style="list-style-type: none"> 1. Only complete portion (1-3) pertaining to the request. 2. Completely answer all sections and send supplemental information as necessary. 3. See AFI 10-2519, Paragraph 5 for additional detail. 	