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Medical

***PANDEMIC INFLUENZA MEDICAL
RESPONSE PLAN FOR DEPLOYED
OPERATIONS***

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

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This instruction implements AFD 48-1, *Aerospace Medicine Program* and contains the guidance that AFSOC Operations Support Medical (OSM) Flights will use to plan for a deployment to areas with an increased risk of Pandemic Influenza (PI). Currently, these are areas in which Avian Influenza (AI) H5N1 strains are circulating in animal populations with occasional human infections. Since these areas do not have U.S. Military Treatment Facility (MTF) support, the plan identifies the surveillance, medical preparedness and response steps necessary for the care and evaluation of AFSOC Special Operations Group (SOG) personnel and those that fall under their medical responsibility during the deployment. This plan does not apply to, nor supersede, applicable installation PI preparation plans OSM flights are subjected to while in garrison. This instruction does not apply to the Air National Guard (ANG) and the Air Force Reserve Command (AFRC). Ensure that all records created as a result of processes prescribed in this publication are maintained in accordance with AFMAN 37-123 (will convert to AFMAN 33-363), *Management of Records*, and disposed of in accordance with the Air Force Records Disposition Schedule (RDS) located at <https://afrims.amc.af.mil/>. Refer recommended changes and questions about this publication to the Office of Primary Responsibility (OPR) using the AF Form 847, *Recommendation for Change of Publication*, route AF Form 847s from the field through the appropriate functional's chain of command.

SUMMARY OF CHANGES

This instruction has been changed to reflect AFI 33-360, *Publications and Forms Management*, and AFI 90-20, *The Air Force Inspection System*, tier identification and waiver requirements (T-0, above AF authority-waiver is pub OPR; T-1, strong risk of mission or program failure-waiver MAJCOM/CC & pubs approving official; T-2, may degrade mission or program effectiveness or efficiency-waiver MAJCOM/CC; T-3, may limit mission or program effectiveness or efficiency-waiver Wing/DRU/FOA/CC). A margin (I) indicates newly revised material.

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Section A—Overview of Pandemic Influenza Considerations.

1. Introduction.

1.1. When influenza pandemics occur, they have the potential to cause substantially higher morbidity and mortality than annual seasonal influenza epidemics. Whereas seasonal epidemics have the greatest impact on elderly and medically high-risk groups, pandemics are likely to cause high levels of morbidity and mortality in all populations. The potential is great for a rapid, worldwide spread of PI once the influenza virus mutates to a strain capable of efficient human to human transmission. When this occurs, an influenza pandemic will likely have a significant impact on military operations. To mitigate the resulting morbidity and mortality, many international and U.S. agencies, including DoD, have prepared and published extensive PI preparedness plans. Across the various plans, an overarching purpose is to prepare populations.

1.2. U.S. military PI plans have been directed and are being developed by all installations/MTFs. Additionally, Combatant Commands (COCOM) have been directed to develop PI preparation plans. However, AFSOC OSM flights deploy to areas that may belong to a COCOM other than U.S. Special Operations Command (SOCOM) and their missions may rapidly evolve or develop; further, these missions often are located in countries considered by medical experts as being at higher risk for the origin for an influenza pandemic. To address these unique PI considerations, AFSOC medical units need specific instructions to prepare properly.

1.3. To help facilitate the preparation of PI preparedness plans, a checklist has been developed that lists many of the more important items the OSM should consider. The checklist can be found at Attachment 2, “Pandemic Influenza Action Plan Checklist for AFSOC OSM Units”. (T-1).

2. Influenza Virus/Infection Characteristics.

2.1. Virus Characteristics.

2.1.1. The influenza virus is a ribonucleic acid (RNA) virus that exists in various strains; influenza A strains infect both animals and humans. The virus mutates rapidly and because of this characteristic can cause both seasonal epidemics and pandemics in humans. Pandemics occur when a majority of humans do not have protective antibodies against a circulating viral strain. In the past, these pandemics have arisen when animal (specifically birds) influenza strains mutated to a type that was capable of effective human to human transmission. When this has occurred in previous pandemics, significant human mortality and morbidity has occurred.

2.1.2. Human pandemic influenza strains can, through a process known as genetic shift, arise from different animal influenza strains. Currently, the strain thought to be a highly likely candidate for the next PI human strain is H5N1. This strain is currently causing epizootics in wild and domestic birds and has caused sporadic human disease and death as well. Experts believe if this strain mutates to a form that is easily transmitted from human to human, it will become the next pandemic influenza strain.

2.2. Influenza Infection Characteristics.

2.2.1. The influenza incubation period ranges from 4 – 10 days and a human to human PI outbreak is expected to infect approximately 35% of all age groups. Past PI mortality rates have been approximately 5% but higher in certain populations (e.g., the 1918 pandemic caused much higher mortality in young, healthy adults).

2.2.2. The influenza pandemic may occur in several different waves, each wave lasting several weeks. Once infected, individuals may shed virus and be contagious one to two days prior to manifesting any signs or symptoms of disease. Military units in close quarters could experience between 20%- 50% of their force being infected in a very short period of time during a pandemic.

3. PI Assumptions. In order to plan and prepare for pandemic influenza, certain assumptions are necessary. Below are assumptions that especially pertain to AFSOC and are listed in the ASD(HA)'s 25 Jan 2006 memorandum, "Department of Defense Influenza Pandemic Preparation and Response Health Policy Guidance". The policy is found at: <http://www.vaccines.mil/documents/886PandemicFluPolicy.pdf>

3.1. Pandemic influenza assumptions.

3.1.1. An influenza pandemic could occur in any season and could affect a substantial portion of the world population.

3.1.2. Most US military personnel would be susceptible to the illness.

3.1.3. Once an influenza pandemic is introduced into the United States or other country, it could spread quickly to all parts of the country.

3.1.4. A pandemic in a country could be expected to have significant morbidity and mortality. For example, PI in the US could result in 20-35% of the population becoming ill, 3% being hospitalized, and 1% dying.

3.2. Antiviral drug assumptions. Should pandemic influenza occur before vaccine is available, use of antiviral drugs may reduce the impact on military units.

3.3. Vaccine assumptions.

3.3.1. The Department of Defense (DOD) will use the same vaccine formulation as the US civilian population.

3.3.2. The time between identification of a new strain and vaccine availability may be six to nine months.

3.4. Operational assumptions.

3.4.1. It is possible that medical response to an influenza pandemic will be required while military forces are simultaneously engaged in armed conflict.

3.4.2. Should an influenza pandemic affect US forces during field operations, the number of ill, dying, and dead personnel would have a significant impact on force strength, perhaps causing curtailment of the operations. Opposing forces would be similarly affected.

3.4.3. It is possible that entire aircrews could become ill simultaneously in flight.

3.4.4. Curtailing passenger air transportation completely might temporarily delay movement of influenza from one region to another, but the disease would probably arrive eventually.

3.4.5. Restriction of movement between affected and unaffected areas may be helpful.

3.4.6. In most instances, it would be best not to utilize air evacuation to transport patients with PI. However, if the patient must be moved, infection control procedures must be utilized.

4. Pandemic Influenza Progression.

4.1. An influenza pandemic is expected to evolve in six phases. These phases have been identified and described by the World Health Organization (WHO) and U.S. Department of Health and Human Services (DHHS). The predominant pandemic phase may vary by location and currently the world is in PI Phase 3. Responsibility for the declaration and notification of the identification of a progression of PI phases from Phase 3 to 6 will be as follows: Secretary, HHS, will notify the Secretary of Defense and the Assistant Secretary of Defense for Health Affairs who will, in turn, notify the Joint Staff and the Surgeons General. Unit commanders will be informed via command channels, augmented by reports in the news media.

4.2. During each phase, DOD units and departments are expected to perform various PI preparatory tasks and procedures. These tasks may be found in the ASD(HA)'s 25 Jan 2006 "*Department of Defense Influenza Pandemic Preparation and Response Health Policy Guidance*".

5. Operational Priorities. Because current supplies of PI personal protective equipment (PPE) and antiviral medications are either in short supply or not yet developed, ASD(HA) has set priorities for distribution. A partial listing of the priorities includes the following:

5.1. **Maintaining the health and operational capability of the fighting force.** This is accomplished through preventive methods and appropriate medical treatment.

5.2. **Air Operations.** If crews have not been immunized, then antiviral drugs should be considered, or, if not available, consideration should be given to canceling flights from heavily affected areas. Air crew members without previously documented use of antiviral medications will require a 24 hour ground test period and follow-up before use in flight. Before use of antiviral medications, local Flight Surgeons must gain approval from the OSM Flight Commander and HQ AFSOC/SG or SGP. **(T-1)**.

Section B—Pre-deployment PI Preparation.

6. Medical Surveillance.

6.1. The goal of pre-deployment medical surveillance is to provide a comprehensive assessment of the potential of a pandemic influenza in the AOR or deployment location. This is done in order to provide an updated regional threat to the mission commander and SOF forces for mission planning.

6.2. Regional threats will include the status of H5N1 in human as well as animal populations and more broadly, human seasonal influenza infection trends. Coordinate medical

intelligence with other DOD medical units deployed in contiguous areas of operations (AORs). OSM personnel should include a variety of intelligence sources such as: Armed Forces Medical Intelligence Center, World Health Organization, Centers for Disease Control and Prevention, Center for Infectious Disease Research and Policy, and PandemicFlu.gov.

7. Medical preparedness. PI preparedness steps should at least include the following:

7.1. Medical equipment, supplies, and medications. Planning should include identifying and procuring supplies of PPE, antibiotics to treat secondary infections, PI vaccines when available (a H5N1 vaccine has been developed and is currently undergoing clinical trials), and antiviral chemoprophylaxis (currently, oseltamivir and zanamivir are FDA approved for use in the treatment of uncomplicated influenza A & B viral infections). If pre-exposure prophylactic medication is used, it is important to note that the PI virus may either already have or quickly will develop resistance to the medication after it is initiated. Even if effective, the medication may decrease but will not likely totally eliminate the risk of infection. It is important that personnel continue to practice good influenza hygiene measures in addition to taking chemoprophylaxis. Because of limited antiviral supplies and the potential long duration of prophylaxis necessary, this strategy should be limited to the minimum number of essential personnel. It is optimal for all forces to receive the first dose of prophylaxis at least 48 hours before exposure; however, this may not be possible with SOF operations. **(T-2).**

7.2. Education. Personnel must be educated on various aspects of PI to include recognition of disease, prevention and limiting spread, and virus characteristics. Ideally, education should be prepared in advance for each phase. Emphasis should be placed on personal hygiene: proper hand washing (warm water and soap for 15-20 sec) or hand sanitizer; covering coughs and sneezes. Personnel must avoid visiting animal/bird markets and poultry farms. **(T-2).**

7.3. Screening program. A screening process to be used during deployment to identify and separate influenza infected individuals from healthy individuals must be developed by the senior medic on site. The screening program will include current WHO case definitions for human H5N1 influenza infections. Currently, a suspected case of influenza would include a fever of at least 100.4 F (>38C) plus one of the following: sore throat, cough, or dyspnea. Additionally, during the past several years, humans infected with H5N1 infections have had abnormal chest radiographs and over half have had diarrhea. The official WHO case definitions include: Person under Investigation; Suspected H5N1 Case; Probable H5N1 Case; Confirmed H5N1 Case and are described fully at: http://www.who.int/csr/disease/avian_influenza/guidelines/case_definition2006_08_29/en/index.html

7.4. Laboratory. OSM medical personnel need to keep up with latest technology regarding influenza diagnostic tests. Rapid diagnostic tests have been developed that can detect influenza A and B viruses and can, in some of the tests, distinguish between the two. Additionally, a rapid test has been developed for use in certain U.S. laboratories that can detect influenza A, H5 infections. In many cases however, collection and shipment of influenza specimens may not be feasible under field conditions since specimens must be sent cooled or frozen and arrive at testing laboratory within a short period of time. Regardless of limitations above, OSM flights should identify the influenza testing capabilities of proximate

U.S. or host nation laboratory assets that would be used when influenza testing is required in deployed setting.

7.5. **Patient tracking.** A process to identify, track and report PI patients while deployed needs to be developed and implemented. OSMs must accomplish this and report results to HQ AFSOC/SG at least daily while deployed through medical situation reports (SITREPS) and operation reports (OPREPS) for those hospitalized.

Section C—Deployment PI Actions.

8. Medical Preparedness.

8.1. OSM flights will need to have immediate access to antiviral medications and other medical supplies and equipment necessary for PI prevention and/or treatment. The minimum items are listed in attachment 3, “Pandemic Influenza Medical Supplies”. (T-2).

8.2. Since antivirals may need to be given in an expedient manner in certain situations, it is essential that any approval for their use has either been done prior to the deployment or can be accomplished within 12 hours after the need has arisen during the deployment. OSM medical personnel must deploy with enough antiviral medications to treat at least 10 patients and prophylax the entire AFSOC population at risk (PAR). (T-2).

8.3. A vaccine to immunize troops against a pandemic influenza virus will not be able to be developed until the specific viral strain has been isolated. Once isolated, it will take a minimum of 6-9 months before a vaccine can be developed.

9. Medical Surveillance. The OSM must continue an on-going surveillance program in the AOR. The goal of surveillance will be to maintain an updated regional threat to the mission commander and SOF forces for mission planning. The specific purpose of influenza surveillance while deployed is to know what the pandemic influenza threat is to deployed forces on a continuous basis. Regional threat will include the status of H5N1 in human as well as animal populations and human seasonal influenza infection trends in the AOR. Coordinate medical intelligence with other DOD medical units deployed in the AOR.

10. Operational Medical Decisions.

10.1. If there is a significant PI risk in the AOR, the OSM medical commander will decide if personnel need to start prophylactic antiviral chemoprophylaxis. If the decision is yes, before prophylaxis is started, the OSM medical commander will receive concurrence from AFSOC/SG. If conditions warrant additional medical resources or personnel, the OSM medical commander will elevate requirements for these additional resources. Factors that may indicate a significant PI risk include: (T-2).

10.1.1. Operations are being conducted in the immediate area where H5N1 is currently circulating among animal populations and causing human infections.

10.1.2. Previous year surveillance revealed high risk of H5N1 in animal or humans in the AOR.

10.2. If the PI situation in the AOR deteriorates while SOF are deployed (i.e., the PI situation progresses from phase 3 to phase 4 or 5) and personnel have not been prophylaxed,

post-exposure prophylaxis must be begun immediately. The prophylaxis should be given to the entire SOF PAR.

11. Medical Response. Limiting influenza exposure/infection and prompt patient isolation once infected are important actions to mitigate results of an influenza outbreak. SOF operations may still continue even in the beginning stages of an influenza pandemic; in light of this, the above actions become even more important.

12. Medical Reporting.

12.1. If the PI risk is determined to be significant for that deployment, OSM daily situation reports will include the following information with regard to the PI risk:

12.1.1. Status of H5N1 (or other strain) infections in local animal/human populations;

12.1.2. Roster of personnel given pre-exposure prophylaxis doses; and

12.1.3. Total number of pre-exposure doses given.

12.1.4. If there are influenza patients, a listing of all ill persons with names, dates infected, locations and dates recovered/died will be included.

12.2. Reports. OSMs will submit all reports in accordance with applicable COCOM and other DoD/Joint directives. At a minimum, reporting will be to HQ AFSOC/SG and HQ AFSOC Battlestaff Director via daily SITREPs.

13. PI Phases 4-5 OSM Actions.

13.1. WHO PI Phase 4 means that clusters of limited human-to-human transmission occur but the virus may not yet be highly adapted to humans, while phase 5 means the virus is becoming increasingly better adapted to humans and there is a substantial pandemic risk.

13.2. If a deployment is occurring in an area that has been declared to be in a phase 4 or 5 condition, OSM personnel must be cognizant of that fact and, in addition to steps outlined above, take the following additional following actions when deployed.

13.2.1. An area set up to screen patients suspected of having PI; those patients found to be infected with PI will be masked and isolated. (T-2).

13.2.2. A casualty collection point and treatment facility set up to receive and treat patients in place. PI infected patients, unless their medical condition demands movement, will be treated in place and not transported. In light of this, OSM personnel must deploy with adequate ventilatory support and Advanced Cardiac Life Support medications. (T-2).

Section D—Redeployment PI Procedures.

14. Medical Surveillance. Complete after action reports that include all aspects of the deployed medical situation with regard to pandemic influenza need to be completed within 3 duty days after redeployment.

15. Medical Preparedness. Resupply of all medications and supplies used during the deployment should be accomplished as soon as possible after redeployment in order to be ready for another deployment.

Section E—Summary

16. Preparation. Preparation for the next pandemic influenza is occurring on many different fronts, including COCOMs and military installations. Whenever expected, OSM flights should follow applicable installation/COCOM preparation plans; however, during OSM deployments, many of these plans will either not apply or will not cover situations OSM personnel may encounter. This document is meant to address some of those issues.

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Command Surgeon

Attachment 1

GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION

References

ASD(HA) Memorandum, 25 January 2006, “*Department of Defense Influenza Pandemic Preparation and Response Health Policy Guidance*”

CDRUSEUCOM CONPLAN 4690-06 Draft, 31 March 2006, “*USEUCOM Preparation and Response for Pandemic Influenza*”

DHHS, November 2005, “*HHS Pandemic Influenza Plan*”

DoD, 21 March 2006 Memorandum, “*Interim Guidance for Protecting DoD Personnel Involved in Avian Influenza Disease Eradication Activities*”

Homeland Security Council, May 2006, “*National Strategy for Pandemic Influenza, Implementation Plan*”

Homeland Security Council, November 2005, “*National Strategy for Pandemic Influenza*”

USD(P&R) Memorandum, 10 January 2006, “*Policy for Release of Tamiflu (Oseltamivir) Antiviral Stockpile During an Influenza Pandemic*”

USPACOMINST 0507.1, 24 August 2005, “*Pandemic Influenza (PI) Preparation Response and Planning Guidance*”

WHO, 29 August 2006, “*Case definitions for human infections with influenza A(H5N1) virus*”, located at:

http://www.who.int/csr/disease/avian_influenza/guidelines/case_definition2006_08_29/en/index.html

Abbreviations and Acronyms

AI—Avian Influenza

AFPD—Air Force Policy Directive

AFSOC—Air Force Special Operations Command

AFSOF—Air Force Special Operations Forces

AOR—Area of Responsibility

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

CC—Commander

COCOM—Combatant Commands

CONPLAN—Contingency Plan

CDRUSEUCOM—Commander, US European Command

DOD—Department of Defense

DHHS—US Department of Health and Human Services

MTF—Military Treatment Facility
OSM—Operations Support Medical
OPREPS—Operation Reports
PAR—Population at Risk
PI—Pandemic Influenza
PPE—Personal Protective Equipment
RNA—Ribonucleic acid
SOG—Special Operations Group
SG—Surgeon General
SITREPS—Situation Reports
SOF—Special Operations Forces
USD(P&R)—Undersecretary of Defense for Personnel and Readiness
USPACOMINST—US Pacific Command Instruction
USSOCOM—US Special Operations Command
WHO—World Health Organization

Attachment 2

PANDEMIC INFLUENZA (PI) ACTION PLAN CHECKLIST FOR AFSOC OSM UNITS

Because of mission needs, AFSOC OSM flights must be prepared to deal with PI situations that occur in their AOR. This checklist is intended as an aid to be used by the AFSOC OSM flights in order to develop PI contingency plans that they will use while at home station and when deployed.

The World Health Organization and CDC have established pandemic planning guidelines and the Assistant Secretary of Defense for Health Affairs and the Combatant Commands have established additional military specific requirements. This checklist is a distillate of many international, national, state, military, and commercial health care plans and checklists.

Pandemic response plans are essential preparative actions. They should provide guidance for appropriate, effective, and graded responses throughout the various phases of a pandemic. However, the plans must also be flexible. Although extensive international studies have recently revealed a great deal of new information about influenza, the actual transmission and disease characteristics of the next influenza pandemic viral strain are conjectural. Limitations to this knowledge require that assumptions be made based on characteristics of seasonal influenza. These assumptions may be accurate, but it is to be expected that they will be revised over time as more is learned about influenza. Therefore, expect recommendations of civilian and military authorities to change frequently prior to and during a pandemic. Those changes will require revisions in federal plans that will, in turn, drive changes in base plans.

Pandemic influenza plans must be thoroughly tested. Activities related to the routine epidemics from seasonal influenza such as mass immunizations, quarters authorizations, staff absenteeism, and increased patient loads may provide opportunities to test specific details of the plan. However, the scenario of seasonal influenza is unlikely to adequately test the actual capabilities and limitations of the base response plan. It is recommended that pandemic plans be tested to the point of failure in order to determine what changes are necessary.

Planning and Coordination	Completed	In Progress	Not Started
One person is identified as the OSM's PI response coordinator. This individual will be responsible for the OSM's pandemic influenza preparation planning and ensure that various tasks on this checklist are being addressed. The person will also be responsible for collaborating with various other pandemic influenza planning groups.			
The OSM has developed a PI preparation plan. Accountabilities, responsibilities and resources for key stakeholders are delineated in the plan.			

Planning and Coordination	Completed	In Progress	Not Started
A. BACKGROUND STRUCTURE FOR DECISION MAKING:			
<p>All essential individuals are familiar with: <i>“Department of Defense Influenza Pandemic Preparation and Response Health Policy Guidance”</i>, 25 January 2006 http://www.vaccines.mil/documents/886/PandemicFluPolicy.pdf</p>			
<p>All OSM medical providers and planners (including MDs, PAs, IDMTs, MSCs and Public Health personnel) are familiar with national and HHS pandemic plans and where they can be located. http://www.pandemicflu.gov/plan/tab1.html</p> <p>The US state PI plans can be found: http://www.pandemicflu.gov/plan/stateplans.html</p>			
<p>Planning includes interfacing with local US military health authorities and where practical, local national health authorities to establish or confirm organizational structures, reporting procedures and requirements, points-of-contact. Identify the health authorities who will be involved in a PI situation and where practical, get to know them. Above considerations also apply when personnel deploy to other countries; in these situations, U.S. State Department personnel located at the country’s U.S. embassy or consulate need to be included in PI planning issues.</p>			

Planning and Coordination	Completed	In Progress	Not Started
Understand what the local US military Installation Commander’s authority and responsibilities are for declaring a public health emergency and activating the Base Pandemic Influenza Response Plan where applicable. AFI_10-2603, paragraph 2.3 Decision thresholds to implement Emergency Health Powers are established and can be found at: http://www.dtic.mil/whs/directives/corresponds/pdf/d62003_051203/d62003p.pdf http://www.e-publishing.af.mil/pubfiles/af/10/afi10-2603/afi10-2603.pdf			
Identify the local US military installation authorities responsible for executing the base pandemic plan, to include: PHEO, Legal, PHO, Force Protection, Public Affairs, BEE, Laboratory, Services Rep – including Mortuary Affairs, Wing Rep - for flying squadrons, Security Forces, Commander’s staff, and others as needed.			
A US military installation PI preparation working group should be established and if so, OSM personnel should become familiar with the working group and attend meetings as appropriate.			
Each organization has a plan that is annexed to the wing plan			
Planning and Coordination	Completed	In Progress	Not Started
B. OSM PI PLANS			
OSM has developed a unit PI plan.			
Plans are tested regularly with exercises. PI planning exercises are outlined in AFI 10-2603, Attachment 4, accessed at: http://www.e-publishing.af.mil/pubfiles/af/10/afi10-2603/afi10-2603.pdf			

1. Communications			
Contact roster for local US military and state department key decision making personnel, including phone numbers to include cell phone numbers, FAX numbers, and e-mail addresses are current.			
Military health contact names, titles, physical office addresses and other pertinent information is available.			
Contact information for local civilian and military health care facilities, emergency services, police, and laboratories with which you anticipate necessary communication and coordination throughout a pandemic is available. The list includes services provided/ sample testing capabilities/isolation capabilities/ constraints in the civilian hospitals, etc.			
Alternative communications tools (2-ways radios, beeper, cell phones, VPN, runners, commanders access television channel, etc.) are available.			
OSM personnel are aware of the basic tenets of risk communication. Advice on risk communication is found at: http://www.who.int/csr/resources/publications/WHO_CDS_2005_32/en/index.html			
2. Education Plan			
Education on infection control measures to prevent the spread of pandemic influenza is included in the OSM PI plan.			

3. Surveillance Plan			
<p>Responsibilities for monitoring public health advisories (WHO, DoD, AF, DoD, US) and informing command are assigned. The PI response coordinator is aware of where H5N1 and other potential PI virus strains are currently occurring in the world in both animal and human populations. This can be found at: http://gamapserver.who.int/mapLibrary/app/searchResults.aspx The coordinator is aware of the current state of PI status according to the WHO guidelines. This is found at: http://www.who.int/csr/disease/avian_influenza/phase/en/index.html</p>			
<p>While deployed, the OSM has established a system to monitor and review influenza activity in clinic patient populations (i.e., weekly or daily number of patients calling or presenting to the clinic with influenza-like illness). These data are sent to theater medical SOF command as well as HQ AFSOC/SG. A mechanism to report unusual cases of influenza-like illnesses and influenza to appropriate military medical commands has been established.</p>			
<p>While deployed and where applicable, laboratory systems are monitored for positive influenza results and are reported to Air Force Institute for Operational Health (AFIOH) per established protocols.</p>			

<p>An Armed Forces Medical Intelligence Center (AFMIC) account has been obtained to keep apprised of pandemic influenza threat, international events and helpful planning documents. AFMIC url is : http://www.afmic.detrick.army.mil</p>			
<p>4. Triage and Patient Processing</p>			
<p>Patient care management plans at various levels of local pandemic activity are developed. Included in the plan are the following possibilities:</p> <ul style="list-style-type: none"> • Temporarily canceling non-essential medical visits (e.g., annual physicals, elective procedures) • Designating separate blocks of time for non-influenza and influenza-related patient care. • Address “sick-at-home care” such as frequency of contact with patient and at what level, (nurse, tech, patient’s supervisor. • Address legal aspects of standard of care versus sufficient care during a contagious disease outbreak. 			
<p>Plans and criteria for the disposition/referral of patients following a medical evaluation (e.g., hospitalization, home health care services, self- or family-based care at home) have been discussed with local hospitals, health care agencies, and health departments.</p>			

<p>Patient assessment, patient flow, and isolation of those with possible pandemic influenza procedures are developed.</p>			
<p>5. Infection Control Procedures</p>			
<p>OSM personnel can describe first line health defenses for protection against PI (cough etiquette, hand washing, other personal hygiene and social distancing measures).</p>			
<p>Infection control supplies (e.g., hand washing stations, alcohol-based hand sanitizers, soap, paper towels, facial tissues, disposal containers, etc.) are available for use in garrison and deployed settings.</p>			
<p>The plan includes designated locations and/or processes for handling patients with influenza symptoms that segregate ill patients from other patients awaiting care. Surgical masks, facial tissues, and other supplies for symptomatic patient use are available.</p>			
<p>Separate exam rooms are designated for the examination of patients with influenza-like-illnesses.</p>			
<p>Procedures are in place for OSM to secure an adequate supply of mass prophylaxis and countermeasures (vaccines, anti-virals, PPE). These items are expected to be taken when the unit deploys to an area where H5N1 or other potential PI viral strain is currently located. Currently, this consists of the following items:</p> <p style="padding-left: 40px;">Enough masks (N-95 equivalent and surgical masks) should be taken on deployments to use for all OSM personnel for 20 days.</p> <p style="padding-left: 40px;">Anti-virals currently include Tamiflu; enough Tamiflu should be taken to start and maintain prophylaxis of OSM PAR for 20 days.</p> <p>PPE: disposable gowns and gloves for OSM personnel for 20 days.</p>			

<p>Policies for transporting the ill or deceased are established. See AFMIC Note DI 1812-1105, 03 March 2006, “Bodies of Dead H5N1 Avian Influenza Patients Pose Minimal Risk for Virus Spread” at http://www.afmic.detrick.army.mil</p>			
<p>WHO and CDC recommendations for use and wear of surgical masks and respirators are reviewed. WHO site: www.who.int/csr/resources/publications/influenza/Mask%20Clarification10_11.pdf</p>			
<p>Protocols are established for quarantine, isolation, flexible work schedules, absenteeism, return to duty after illness, etc. Triggers for implementation and termination of the protocols are established.</p>			
<p>6. Vaccine and Antiviral Use Plan</p>			
<p>Current federal and/or US military recommendations for the use and availability of pandemic influenza vaccines and antiviral medications are known. Local US military installation Point of Dispensing (POD) plan for distribution of Strategic National Stockpile (SNS) assets is known. OSM personnel are familiar with DHHS vaccine distribution plan at: www.hhs.gov/pandemicflu/plan/sup6.html</p>			
<p>Estimates of the numbers of personnel who would be targeted and their priorities for receipt of pandemic influenza vaccine or antiviral prophylaxis has been developed for use before deploying to an area with H5N1 identified in animal/human populations in the local area. Mission essential individuals are identified.</p>			
<p>Assessment of Tamiflu, Relenza, and other antiviral requirements, stockpiles and processes for re-supply have been determined.</p>			

A mechanism to maintain a log of previously ill persons who have recovered and presumed immune to the current strain of infection is established.			
Tracking systems to evaluate efficacy and adverse effects of vaccines and antivirals have been developed.			
7. Occupational health plan			
Mission essential personnel contact roster is up-to-date and readily available.			
OSM personnel have access to AFCITA for administration and tracking pandemic influenza vaccinations.			
Protocols are established for disposition of symptomatic personnel before they report for duty. These protocols have been field tested in exercises in pre-pandemic settings.			
Contacts are established for US military Life Skills, mental health and faith-based resources that could provide counseling and other services during a PI situation.			
8. Medical Surge Capacity Plan			
Plans address management of staffing shortages due to illness in personnel or their family members.			
Staff member family-care plans address actions to take when community containment measures (e.g., “snow days,” school closures) are implemented.			
MOUs are established with local US military hospitals and clinics. These documents include local bed status coordination procedures.			
Estimates of consumable resource requirements (e.g., masks, gloves, hand hygiene products, medical supplies) are established. Reserve supplies sufficient for at least two weeks of operation is available.			

Primary and contingency plans address supply shortages. Procedures for acquisition of supplies through normal channels as well as alternate sources are addressed.			
9. H5N1 Surveillance in Animal Populations			
OSM personnel assess AFMIC/WHO and /or FAO sources for recent H5N1 activity in animal populations in deployed areas.			
Planning and Coordination	Completed	In Progress	Not Started
C. DECISION POINTS			
Thresholds for social distancing measures and/or restriction of movement are pre-determined. Example: Illness in 3% of the local population at risk (PAR) results in cancellation of non-essential meetings. National estimates include 35-40 % work and school absenteeism due to fear of disease and illness of individuals or their family members during the peak of the pandemic waves.			
Policies address protocols for individuals to stay home, come to work, and leave work when they are healthy and ill. Protocols for leave policies during the pandemic are established. Examples include: workers who are exposed, but not symptomatic; members exposed to pandemic influenza while on leave returning to work in an area currently free of disease; criteria for quarters authorizations.			
Alternate facilities for medical treatment of respiratory illnesses are determined. Adequate waiting and examination rooms, medical supplies, hand washing and toilet facilities, ventilation, and hazardous waste disposal are available. Thresholds for use of the alternate facility are established.			
Protocols to establish case definition are in place. These include how, when, and by whom the case definition is			

determined. Prepare to alter this periodically during the pandemic. Lab support will be insufficient to test everyone who is symptomatic. The case definition will need to be primarily syndromic during the pandemic waves.			
Procedures are available to estimate attack and death rates. A possible choice for the calculation is found at: http://www2.cdc.gov/od/fluid/default.htm			
Procedures and locations to monitor non-hospitalized individuals with upper respiratory infections are developed. Force Protection measures and thresholds for initiating and terminating the measures are established.			
Vaccination and treatment decision trees and practice guidelines are established. Plans for rationing scarce resources, e.g., antivirals, vaccines, and ventilators are written. Local legal counsel and ethics committee members are involved in decisions.			
Procedures for receiving and the treatment of individuals who become ill in-flight are established.			
Planning and Coordination	Complete	In Progress	Not Started
D. DOD REPORTING REQUIREMENTS			
Processes and contacts for DOD pandemic influenza reporting are established.			
Procedures to track and provide frequent epidemiologic data, e.g., number infected, hospitalized, and deaths are established. Casualty Affairs, Mortuary Affairs, Patient Administration, local medical examiner and funeral directors are aware of and will cooperate with MTF reporting requirements.			
Senior leader reporting requirements and limiting factors are established.			
Protocols are in place to send lab specimens and patient questionnaire to AFIOH promptly after collections. https://afiera.brooks.af.mil/pestilence/			

<p>Protocols for investigation of possible cases are established.</p>			
<p>Requirements to report deaths, hospitalizations, acute care and ICU bed availability, number of pandemic influenza cases, doses of vaccine and antiviral medications, ventilators and supplies available, and medical staff health status daily by 2400 ZULU through your chain of command are expected. (Format may be in the form of the MEDRED-C but the requirement will likely require civilian and military involvement nation-wide.) Local reporting protocols and mechanisms should be established that will include military members and dependents treated in civilian healthcare facilities.</p>			
<p>Plans for reconstitution of base and health care operations post-pandemic and between pandemic waves are established.</p>			

Attachment 3**PANDEMIC INFLUENZA MEDICAL SUPPLIES**

The following items will be procured as part of the PI medical supply package.

PPE: Deploy with enough equipment and supplies for up to 20 days.

N-95 masks (a minimum of 1 per healthcare worker per day),
Protective gowns (a minimum 1 per healthcare worker per day),
Goggles (1 per healthcare worker),
Gloves (1 per healthcare worker per patient visit), and
Surgical masks (1 for each screened patient);
Disinfectants (many different disinfectants are effective against influenza. The disinfectant used should be inexpensive and approved for use on aircraft surfaces and interiors)
Hand sanitizer – quantity sufficient for all OSM personnel to apply several times per day and before and after each patient encounter.
Biohazard bags - quantity sufficient for anticipated medical waste.

Chemoprophylaxis: Deploy with enough of the following medications to provide prophylaxis/treatment of OSM personnel and/or PAR for up to 20 days.

Antivirals

Tamiflu (Oseltamivir) In addition to prophylaxis, Tamiflu will be used to treat no less than 10 patients.

Relenza (Zanamivir) (this is optional but should be considered – Relenza is currently being stockpiled by USG for its neuraminidase activity but it is not as convenient to administer since it is an inhaler)

Antibiotics (broad spectrum to treat secondary pneumonias)