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This manual implements Air Force Policy Directive (AFPD) 48-1, *Aerospace & Operational Medicine Enterprise (AOME)* **and is consistent with** Department of Defense Instruction (DoDI) 6200.03, *Public Health Emergency Management (PHEM) Within the DoD*, Department of Defense Directive (DoDD) 6490.02E, *Comprehensive Health Surveillance*, DoDD 6200.04, *Force Health Protection*. It explains the procedures for surveillance, prevention, control, and reporting of diseases and conditions of public health and military significance. Unless otherwise directed, Department of Air Force (DAF) medical personnel follow the methods for controlling and preventing disease as described in the Centers for Disease Control and Prevention (CDC) publication, *Morbidity and Mortality Weekly Report* (MMWR), *Recommendations and Reports* and its supplements and the American Public Health Association publication, *Control of Communicable Diseases Manual*. Where applicable, the most recent guidelines from these publications are used as the standard. This publication applies to all the civilian employees and uniformed members of the United States Space Force, Regular Air Force, the Air Force Reserve (AFR), and the Air National Guard (ANG). **Note:** AFR and ANG will be collectively referred to as Air Reserve Component (ARC) within a DAF Medical Treatment Facility (MTF) or similar unit responsible for public health activities. Due to ARC limitations, certain sections may not apply. Local Aerospace Medicine Council (AMC) will make final determination and document in the AMC minutes.

This manual requires the collection and or maintenance of information protected by the Privacy Act of 1974 authorized by *Title 10 United States Code*, Section 55, Automated Medical and Dental Care. The applicable System of Records Notice(s) is F044 AF SG R, *Reporting of Medical Conditions of Public Health and Military Significance* (June 16, 2003, 68 FR 35646) available at:

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Defense Health Agency guidance, when developed and within its scope of authority within DAF MTFs, will supersede if it conflicts with guidance in this document. The use of the name or mark of any specific manufacturer, commercial product, commodity, or service in this publication does not imply endorsement by the DAF.

SUMMARY OF CHANGES

This re-write of DAFMAN 48-105, *Public Health Surveillance*, has been substantially revised and should be reviewed in its entirety. Changes include: reclassification of this document from AFMAN to DAFMAN; updated roles and responsibilities; updated Lead in Blood chapter to include adding Defense Health Agency guidance; updated Tuberculosis prevention and control guidance and updated Rabies Prevention Program guidance.

Chapter 1

ROLES AND RESPONSIBILITIES

1.1. Department of the Air Force Surgeon General (DAF/SG) will:

1.1.1. Provide policy guidance on the surveillance, prevention, control, treatment, reporting of public health and military significant diseases and conditions.

1.1.2. Ensure compliance with Department of Defense (DoD) directives and instructions and serves as the executive agent for the DoD Respiratory Pathogen Surveillance Program.

1.2. Air Force Medical Readiness Agency (AFMRA) will:

1.2.1. Develop and establish DAF policies and guidance for the surveillance, prevention, control, treatment, reporting of public health and military significant diseases and conditions.

1.2.2. Represent DAF/SG for surveillance, prevention, and control of diseases and conditions of public health and military significance, or delegate representation for DAF/SG involvement, including collaborative research, to other DoD or Federal agencies and organizations.

1.2.3. Review periodic reports of various disease surveillance, prevention, and control programs and recommend improvement to DAF/SG.

1.2.4. Utilize evidence-based information and population health data to assist Major Commands (MAJCOMs), Field Commands (FLDCOMs) and MTFs in optimizing population health through effective and efficient healthcare delivery and disease detection, prevention, treatment, and control.

1.2.5. Coordinate with Defense Health Agency (DHA) to ensure equities are represented.

1.2.6. Oversee DAF Medical Entomology Program IAW AFI 48-102, *Medical Entomology Program.*

1.3. Air Reserve Component (ARC) Surgeons General will:

1.3.1. Coordinate with AFMRA to provide their components' policies and guidance for surveillance, prevention, control, treatment, and reporting of public health and military significant diseases and conditions.

1.3.2. Ensure ARC medical units report cases of *Armed Forces Reportable Medical Events* acquired while the member is on active military status to ANG Surgeon General, AFR Command Surgeon General, state/local health officials, and to the Defense Centers for Public Health – Dayton (DCPH-D).

1.4. MAJCOM, FLDCOM, Combatant Commands, and Air Forces Forward Surgeons General:

1.4.1. Provide and execute specific command policy and guidance to fixed and deployed MTFs for surveilling, preventing, controlling, treating, and reporting of public health and military operational significant diseases and conditions in accordance with DoD, DHA, and DAF policies following CDC and the Advisory Committee on Immunization Practices (ACIP) recommendations.

1.4.2. Ensure DAF medical components transmit reports on exposures, diseases, injuries, and fatalities involving deployed personnel during disease outbreaks, public health emergencies, and pandemic events. After deployments, ensure DAF medical components forward copies of lessons learned and after-action reports to the Joint Lessons Learned Information System at **https://www.jllis.mil/apps/index.cfm** and the National Center for Medical Intelligence (NCMI) under the "Contact" link at **https://www.ncmi.dodiis.mil/**

1.4.3. Provide operational guidance and oversight to MTFs during disease outbreaks, public health emergencies, and/or biological incidents of operational significance.

1.5. USAFSAM/PH will:

1.5.1. Develop training on prevention, investigation, control, reporting requirements and applied epidemiology of public health and military significant diseases and conditions.

1.5.2. Conduct training on prevention, investigation, control, reporting requirements and applied epidemiology of public health and military significant diseases and conditions.

1.6. DCPH-D will:

1.6.1. Plan and program for appropriate resources to examine, analyze, and respond to, as necessary, public health and military significant diseases and conditions.

1.6.2. Execute the DAF Medical Entomology Program.

1.6.2.1. Provide consultation and recommendations for vector surveillance, pest management and control, vector-borne and zoonotic disease investigation and response, and personal protection as outlined in AFI 48-102.

1.6.2.2. Offer identification and laboratory analysis services to support surveillance, prevention, control, and management of medically important pests. Provide field support upon request.

1.6.3. Execute the Food Operational Response and Technology Laboratory in accordance with DAFI 48-116, *Food Protection Program*.

1.6.4. Provide consultative support for the Food Protection Program as outlined in AFMAN 10-246, *Food and Water Protection Program* and DAFI 48-116.

1.6.5. Identify sentinel bases for etiology-based respiratory pathogen surveillance in collaboration with Army, Navy, DoD-GEIS, and CDC points of contact. Sentinel sites are available online at the USAFSAM website: **https://hpws.afrl.af.mil/epi-consult/index.cfm**

1.6.6. Provide viral collection materials to sentinel sites. Provide viral collection materials to non-sentinel sites upon request.

1.6.7. Conduct the following public health activities, as defined at Title 32 C.F.R. 219.102, under the public health authority of DAF/SG or AFMRA (or execute the following public health activities on behalf of DAF/SG or AFMRA):

1.6.7.1. Provide worldwide consultation services to DoD components in public health surveillance, epidemiology, preventive medicine, and outbreak response.

1.6.7.2. Conduct comprehensive health surveillance for the DAF by managing, monitoring, and analyzing the available integrated surveillance data and other DAF-specific data (e.g., Air Force Disease Reporting System internet (AFDRSi)) capturing disease, risk factors, and other significant health events. Report relevant and actionable findings and trends to appropriate DoD authorities.

1.6.7.3. Support the DHA, Public Health Division in the standardization of laboratory data and information for surveillance, including identifying emerging pathogens and common sources of disease outbreaks.

1.6.7.4. Manage the DoD Respiratory Pathogen Surveillance Program; coordinate with Service representatives, the DHA/Armed Forces Health Surveillance Division (AFHSD)/Air Force Satellite Cell, and with DHA/AFHSD/DoD Global Emerging Infections Surveillance (DoD-GEIS) program office.

1.6.7.4.1. Analyze and report positive test results to appropriate personnel at MTFs for notification and follow-up.

1.6.7.4.2. Generate regular reports during the influenza season and an annual report at the end of each influenza season. Provide these reports to sentinel sites, AFMRA, MAJCOMs, FLDCOMs, DoD-GEIS, Service, and Office of the Assistant Secretary of Defense for Health Affairs points of contact.

1.6.7.4.3. Coordinate findings in viral identification and typing with the CDC for consideration in national influenza vaccine selection.

1.6.7.5. Provide clinical reference lab and diagnostic services for DoD components, including performing requested DAF accessions screening.

1.6.7.6. Provide consultative support for tuberculosis (TB), including guidance on TB risk assessment and prevention of TB transmission.

1.6.7.7. Provide on-site epidemiological response support to DAF activities upon request and notify MAJCOM/FLDCOM medical leadership when assistance is required or requested. To request on-site support, the MTF Commander or Director, Aeromedical Commander (or equivalent), Chief of Medical Staff (SGH), or Chief of Aerospace Medicine (SGP) should send the request directly to the USAFSAM Commander, Public Health Department Chair, or Epidemiology Consult Service Division Chief.

1.6.7.8. Provide guidance to installations on foodborne/waterborne illness outbreak investigation and response, as well as in-house or contract laboratory analytical services to installations for pathogen detection in food samples implicated during an outbreak investigation.

1.7. Air Education and Training Command and Air Force Training Centers will:

1.7.1. Collect, analyze, and disseminate information on significant events and mortality from the training populations, and participate in DoD efforts to reduce morbidity and mortality in training populations.

1.7.2. Maintain information systems to track health events in the training populations and program for appropriate resources to examine, analyze, and respond to diseases and conditions that affect the health of those involved in training.

1.7.3. Perform population-based febrile respiratory illness surveillance at DAF Basic Military Training. The Naval Health Research Center in San Diego, California, manages this population-based component of the DoD Respiratory Pathogen Surveillance Program.

1.8. Installation Responsibilities.

1.8.1. Installation commanders will ensure all units and tenants comply with requirements for preventing and controlling diseases, injuries, and other reportable medical events in accordance with DoDD 6200.04. **(T-1)**

1.8.2. **Unit/Squadron Commander will:**

1.8.2.1. Ensure unit personnel report to the MTF, Reserve Medical Unit, and/or Guard Medical Unit for screening, immunizations, and medical appointments, as required by DoDD 6200.04. **(T-1)**

1.8.2.2. Ensure that unit personnel processing to and arriving from overseas locations (e.g., permanent change of station, deployment, and/or temporary duty) or planning overseas travel (to include leisure travel) contact the MTF for a determination of which health assessments, screenings, immunizations, and medical exams are recommended or required. **(T-1)** ARC medical units may not have the staffing or the ability to address leisure travel reviews for its service members or their families.

1.8.2.3. Ensure unit personnel complete appropriate routine screenings, immunizations, and medical exams as required by CDC, DoD, and DAF guidance in accordance with DoDD 6200.04. **(T-0)**

1.8.2.4. Ensure that non-pharmaceutical public health countermeasures (e.g., sanitation measures, insect repellent, mosquito netting) are issued at home station to include training (as health threat driven), and for deployment. **(T-1)** Ensure unit personnel obtain required Force Health Protection Prescription Products (FHPPP) (e.g., malaria prophylaxis) and direct personnel to comply with recommendations for use. **(T-1)**

1.8.3. **Base Civil Engineer will:** collaborate with Bioenvironmental Engineering and Public Health to ensure the base has a safe water supply, effective sanitation infrastructure (e.g., proper sewage and trash disposal), effective disease vector and reservoir control (e.g., insects, rodents), proper site selection, and any other environmental safeguards necessary to reduce illnesses or injuries on the base, taking into consideration operational priorities and resources. **(T-2)**

1.8.4. **Medical Treatment Facility Commander or Director will:**

1.8.4.1. Provide for the surveillance and control of diseases, injuries, and conditions that adversely impact the health of the base population. Recommend and take actions to prevent or reduce their impact in accordance with DoDD 6490.02E, *Comprehensive Health Surveillance*. (Applies to ARC/ANG GMUs) **(T- 0)**

1.8.4.2. Ensure collection, surveillance, prevention, detection, treatment, and public health activities adhere to CDC, DoD, and DAF guidelines and applicable federal, state/local, or host nation requirements. **(T-0)** Ensure these activities are integrated with Infection Prevention and Control and Population Health functions as required by AFI 44-108, *Infection Prevention and Control Program* and AFI 44-173, *Population Health*, respectively. (Applies to ARC/ANG GMUs) **(T-1)**

1.8.4.3. Appoint, in writing, physician(s) as clinical consultants for TB and human immunodeficiency virus (HIV). **(T-2)** Appoint additional physician(s) as clinical consultants for other communicable disease control measures based on real or potential health threats. (Applies to ARC/ANG GMUs) **(T-2)**

1.8.4.4. Ensure FHPPP (e.g., malaria prophylaxis or Pyridostigmine Bromide tablets) are appropriately prescribed to individual personnel by a credentialed and privileged healthcare provider as required by each Combatant Command. **(T-1)** Ensure the MTF dispenses FHPPP to individuals with a legal prescription, appropriate education, and documentation in the DoD Electronic Health Record (EHR) and Aeromedical Services Information Management System (ASIMS). (Applies to ARC/ANG GMUs) **(T-1)**

1.8.4.5. Maintain TB screening and immunization functions and ensure complete documentation in ASIMS, or currently approved tracking system. (Applies to ARC/ANG GMUs) **(T-1)**

1.8.4.6. Ensure collection and surveillance of communicable, environmental, and other reportable medical events in accordance with *Armed Forces Reportable Medical Events Guidelines & Case Definitions* as posted by the AFHSD (see **Attachment 1** for Universal Resource Locator (URL)) and ensure reporting to DCPH-D via AFDRSi, MAJCOM/FLDCOM Public Health, and state/local or host nation officials, as appropriate. (Applies to ARC/ANG GMUs) **(T-0)**

1.8.4.7. Ensure contracts for healthcare employees, volunteers, and students clearly specify appropriate prophylaxis and vaccination requirements, and delineate the support provided by the contractor/providing entity and the MTF. **(T-2)**

1.8.4.8. Ensure that healthcare providers and clinical laboratory personnel notify Public Health of patients with reportable diseases and other unusual diseases/conditions. **(T-1)**

1.8.4.9. Ensure reportable medical events diagnosed at clinical visits are correctly coded, using the International Classification of Diseases (ICDs), and entered into current information systems. **(T-1) Note**: ICD codes for reportable events are listed in the *Armed Forces Medical Events Guidelines and Case Definitions* document (see **Attachment 1** for (URL)).

1.8.4.10. Ensure adequate resources and training are provided for surveillance, prevention, and control of public health and military significant diseases and conditions. **(T-1) Note**: Public Health personnel should have the appropriate mobile capability (e.g., laptop, tablet) to perform real-time epidemiologic data collection during emergency events such as disease outbreaks or disaster investigations in-garrison and in the deployed environment.

1.8.4.11. Ensure providers are aware of the current clinical management guidelines when treating patients. (Applies to ARC/ANG GMUs) **(T-1)**

1.8.4.12. Ensure compliance with the requirements of the DoD Respiratory Pathogen Surveillance Program. (Applies to ARC/ANG GMUs) **(T-0)**

1.8.4.13. Ensure MTF implements an effective Lead in Blood Program that follows current CDC and DHA guidelines in accordance with applicable state/local regulations (see **Chapter 2** for Lead in Blood Program). **(T-0)**

1.8.4.14. Ensure MTF implements an effective TB Detection and Control Program that follows current CDC guidelines (see **Chapter 3** for Tuberculosis Detection and Control Program). (Applies to ARC/ANG GMUs) **(T-1)**

1.8.4.15. Ensure MTF complies with Rabies Prevention Program requirements in accordance with applicable state/local regulations and AFI 48-131, *Veterinary Health Services* (see **Chapter 4** for Rabies Prevention Program). **(T-0)** The Rabies Prevention Program must follow current CDC guidelines. **(T-0)**

1.8.4.16. Ensure MTF offers travel medicine services to military personnel and TRICARE beneficiaries in accordance with the Travel Medicine User Guide, located at **https://www.milsuite.mil/book/community/spaces/usafphamilymatters** under the Force Health Management tab. **(T-1)**

1.8.4.17. Assess risk/evaluate need for antivenom and coordinate with medical logistics IAW AFMAN 41-209, *Medical Logistics Support*, to have antivenom available to mitigate risk.

1.8.5. **Chief of Medical Staff (SGH) and Chief of Aerospace Medicine (SGP) will:**

1.8.5.1. Assist Public Health in developing local MTF instructions and procedures to implement the surveillance and control of diseases, injuries, and conditions that adversely impact the health of the base population. **(T-2)**

1.8.5.2. Provide clinical guidance to the MTF medical professional staff for prevention, control, surveillance, treatment, and reporting of public health and military significant diseases and conditions. **(T-2)**

1.8.5.3. At training installations, oversee trainee population health. **(T-2)** Collaborate with unit commanders at wing and installation forums to prevent and control diseases and injuries in the trainee population. **(T-2)**

1.8.5.4. The SGH or equivalent will ensure that all credentialed medical staff are briefed annually on reportable medical events, the Rabies Prevention Program (e.g., local risk and current prophylaxis requirement), Lead in Blood Program and occupational illness and injury trends. **(T-2)**

1.8.5.5. All medical staff require annual TB education per CDC guidance, bloodborne pathogens training IAW Occupational Safety and Health Administration standards 29, Code of Federal Regulation 1910.1030, and foodborne illness training IAW DAFI 48-116, 2.9.15. **(T-0)**

1.8.5.6. Ensure the PCM team tracks required follow-up appointments, laboratory tests, and completion of all treatment protocols using ASIMS Patient Management module. **(T-1)**

1.8.6. **Public Health will:**

1.8.6.1. Conduct community or location-specific public health surveillance, which includes chemical, biological, radiological, and nuclear terrorism and syndromic surveillance as directed by DoDI 6200.03 and DoDD 6490.02E. **(T-0)** Provide information to the MTF Commander or Director and medical staff as necessary. **(T-1)** For more information of CBRN surveillance, visit the Armed Forces Health Division website at: **https://health.mil/Military-Health-Topics/Health-Readiness/AFHSD**

1.8.6.2. Conduct and manage epidemiological surveillance, contact interviews, and serve as a non-clinical consultant on disease prevention, education, and control programs. **(T-1)** In the event of a suspected or declared public health emergency, these activities (including reporting) shall be conducted in coordination with the Public Health Emergency Officer (PHEO) and state/local or host nation health officials, as appropriate. **(T- 1) Note:** In the event of outbreaks in training populations, Public Health should coordinate with a preventive medicine physician, if available.

1.8.6.3. Inform the MTF Commander or Director, providers, the PHEO, MAJCOM/FLDCOM Public Health, DCPH-D, and, if deployed, the Joint Task Force/Theater Surgeon of the incidence, prevalence, modes of transmission, and recommended control measures for public health and military significant diseases and conditions, as necessary. **(T-2)**

1.8.6.4. Review MTF surveillance data and conduct investigations as appropriate. **(T-1)**

1.8.6.4.1. Ensure appropriate syndromic surveillance is being conducted to assess public health threats through Electronic Surveillance System for the Early Notification of Community-based Epidemics (ESSENCE) or other established surveillance systems as required by DoDD 6490.02E. **(T-0)** Each MTF will have at least two active ESSENCE account holders. **(T-1)**

1.8.6.4.2. Conduct special surveillance not specified by this directive, as appropriate. **(T-2)** Conditions not identified as reportable in the *Armed Forces Reportable Medical Events Guidelines and Case Definitions* (See **Attachment 1** for URL) may require special surveillance activities when the local risk is significant. **(T- 2) Note**: When initiating special surveillance activities, institutional review board evaluation is usually not needed (see DoDI 3216.02_AFI40-402, *Protection of Human Subjects and Adherence to the Ethical Standards in Air Force Supported Research*), but ethical principles (e.g., equal protections and due process) still apply to participant selection and interaction. If ethical questions cannot be resolved within the MTF, ethical consultation is available in accordance with DoDI 6025.27, *Medical Ethics in the Military Health System*.

1.8.6.4.3. Provide health surveillance, disease, and injury prevention (including immunization recommendations and screening) for recruits and training populations based on the unique population risk characteristics (e.g., age, challenging physical activities, and close living quarters) in accordance with national recommendations, DoD, and DAF policies. **(T-1)**

1.8.6.4.4. Perform active and passive surveillance to detect, track, and trend the incidence of reportable diseases/conditions of public health significance at a frequency determined by the Aerospace Medicine Council. **(T-2)**

1.8.6.4.5. Perform daily retrieval of all communicable diseases results in the EHR (e.g., MHS GENESIS Discern Portal) to ensure positive cases are reported to providers, state/local health/host nation officials, and AFDRSi, as required.

1.8.6.5. Evaluate the risk of vector-borne and zoonotic disease in the local geographical area and, if indicated, develop a vector surveillance plan in accordance with AFI 48-102. **(T- 2)** Vector surveillance plan resources can be located at: **https://www.milsuite.mil/book/community/spaces/usafphamilymatters/medical-entomology/content?filterID=contentstatus%5Bpublished%5D~category%5Bentomology%5D**

1.8.6.6. Collaborate with the local military installations as well as state/local or host nation public health officials. **(T-2)** Maintain awareness of local epidemiological activities, including local surveillance, prevention, and control capabilities. **(T-2)**

1.8.6.7. Complete disease-specific case investigation forms as mandated by federal/state/local or host nation health officials. **(T-0)**

1.8.6.7.1. Transmit all DAF reportable medical events to DCPH-D via the AFDRSi website (referred to as Medical Event Reports in AFDRSi), **https://drsi.health.mil/AFDRSi/** **(T-1)**

1.8.6.7.1.1. *Armed Forces Medical Events Guidelines and Case Definitions* for reportable and urgently reportable medical events are available at the following AFHSD website: **https://health.mil/Military-Health-Topics/Health-Readiness/AFHSD/Reports-and-Publications.**

1.8.6.7.1.2. Report urgently reportable medical events within 24 hours as required by AFDRSi. **(T-1)** Report all other reportable medical events as soon as possible, but no later than 7 calendar days or once confirmatory lab results are available. **(T-1)**

1.8.6.7.2. Report disease information as required by their state, local, and/or host nation public health officials. **(T-0)**

1.8.6.8. Review test results provided by the laboratory and other electronic data sources to ensure timely identification and investigation of reportable and communicable infections, including public health and military significant diseases and conditions not identified in the *Armed Forces Medical Events Guidelines and Case Definitions* (See **Attachment 1** for URL) (e.g., Lead in Blood Program as outlined in **Chapter 2**). **(T-1)**

1.8.6.9. Disseminate information derived from public health surveillance in a timely manner to healthcare providers and appropriate MTF committees (e.g., Aerospace Medicine Council, Population Health Working Group, Professional Staff, Occupational and Environmental Health Working Group, and Infection Prevention and Control Function) regarding incidence or prevalence of diseases and conditions that are affecting, or potentially affecting, the installation's personnel. **(T-2)**

1.8.6.10. At sentinel respiratory pathogen surveillance sites, provide the Primary Care Manager (PCM) team with program instructions and updates, including the case definition for influenza-like illness or other current circulating respiratory illnesses. **(T-2)** Coordinate with the PCM teams and MTF laboratory to ensure questionnaires and respiratory samples for influenza or other current circulating respiratory illnesses are sent to DCPH-D using the prescribed mechanism. **(T-2)**

1.8.6.11. Interview individuals with communicable infections that require contact tracing following current CDC guidelines (see **Chapter 3** for specifics on Tuberculosis Detection and Control). **(T-1)**

1.8.6.12. Refer contacts of patients with reportable diseases and diseases/conditions of public health and military significance, if eligible, for medical care and counseling within the MTF; refer non-TRICARE beneficiaries to the health department in their area of residence. **(T-1)**

1.8.6.13. Perform disease outbreak investigations and work with the SGP, PHEO and/or alternate PHEO to advise the MTF Commander or Director on the management and control of disease outbreaks. **(T-2)**

1.8.6.14. Coordinate travel medicine services for military personnel and MTF-enrolled TRICARE beneficiaries in accordance with the Travel Medicine User Guide, located at **https://www.milsuite.mil/book/community/spaces/usafphamilymatters/travel-medicine**. Infectious disease physicians, preventive medicine physicians, or travel medicine clinics may replace or augment Public Health in providing this service. **(T-1)**

1.8.6.15. To request on-site support from DCPH-D, recommend the MTF Commander or Director, Aeromedical Commander (or equivalent), SGH, or SGP send the request directly to the USAFSAM Commander, Public Health Department Chair, or Epidemiology Consult Service Division Chief. Notify MAJCOM/FLDCOM medical leadership when this assistance is required or requested. Additional responsibilities are outlined in **Chapter 2**, **Chapter 3**, and **Chapter 4**.

1.8.7. **Clinical Laboratory Active Component will:**

1.8.7.1. Notify providers, Public Health, and state/local or host nation health officials of reportable diseases/conditions meeting laboratory criteria for diagnosis as listed in the *Armed Forces Reportable Medical Events Guidelines and Case Definitions* (see **Attachment 1** for URL) as required by DoDD 6200.04. **(T-0)** Notify Public Health of any unusual pattern of laboratory testing results or significant increase in the incidence of a disease. **(T-1)**

1.8.7.2. Participate in the CDC Laboratory Response Network for Bioterrorism and Chemical Terrorism. **(T-1)** Report identification of potential offensive biological and chemical agents as directed by CDC-DoD notification protocols in accordance with DoDI 6200.03. **(T-0)** Facilitate the process for forwarding clinical, environmental, and food specimens (e.g., unusual pathogens, antibiotic-resistant strains, chemical and radiological exposures), where appropriate or required, to DoD or civilian reference labs. **(T-1)**

1.8.7.3. During epidemiological and outbreak investigations, coordinate with Public Health on appropriate sample collection protocols, test availability, and result reporting. **(T-2)**

1.8.7.4. For respiratory pathogen surveillance, sentinel MTFs will send respiratory specimens to DCPH-D as directed by DHA. **(T-0)**

1.8.8. **MTF Information Management Officer will:** Maintain systems to support reporting and surveillance activities, including training population and immunization tracking databases. **(T-2)**

1.8.9. **Medical and Dental Providers will:**

1.8.9.1. Counsel individuals on communicable diseases, risk factor reduction, and early recognition of symptoms. **(T-1)**

1.8.9.2. Report to Public Health:

1.8.9.2.1. Within 24 hours, with reportable diseases/conditions determined to be urgently reportable as listed in the *Armed Forces Reportable Medical Events Guidelines and Case Definitions* (see **Attachment 1** for URL), any unusual disease activity, disease clusters or indications of a possible outbreak as required by DoDI 6200.03. **(T-0)**

1.8.9.2.2. With all non-urgent reportable diseases/conditions. Report as soon as possible, but no later than 7 calendar days after identification. **(T-1)**

1.8.9.2.3. With diseases that require contact tracing, or those required by state/local, or host nation directives. **(T-0)**

1.8.9.2.4. With diseases/conditions with public health impact and military significance. **(T-1)**

1.8.9.3. Use case definitions and ICD Codes for reportable events outlined in the *Armed Forces Reportable Medical Events Guidelines and Case Definitions* (see **Attachment 1** for URL). **(T-1)** If a case definition is not available in the Armed Forces Guidelines, use CDC guidelines and case definitions. **(T-1)**

1.8.9.4. Ensure appropriate disease reporting through chain of command, Infection Preventionist, SGH, and PHEO as required by local policy. **(T-3)**

1.8.9.5. At sentinel respiratory pathogen surveillance sites, identify patients meeting the case definition for influenza or other current circulating respiratory illnesses, collect respiratory specimens, and ensure the completion of the prescribed questionnaire IAW the DoD Respiratory Pathogen Surveillance Program. **(T-1)**

1.8.9.6. Prescribe pre- and post-exposure prophylaxis, including vaccines, as directed by DoD, DAF, or Combatant Command policies following CDC or the ACIP recommendations. **(T-0)**

1.8.9.7. Screen, treat, and follow-up with personnel with actual or potential communicable infections as directed by CDC, DoD, and DAF and any applicable guidelines or policies, considering the local epidemiology and high-risk groups (such as basic military trainees), as necessary. **(T-1)**

1.8.9.8. The PCM team will document all patient interventions, including attempts to contact member, in the EHR. **(T-1)**

1.8.9.9. The PCM team tracks required follow-up appointments, laboratory tests, and completion of all treatment protocols. **(T-1) Note**: This paragraph also applies to the tracking of patients receiving non-Food and Drug Administration approved blood products.

1.8.9.10. Additional responsibilities are listed in **Chapter 2**, **Chapter 3**, and **Chapter 4**.

1.9. Air Reserve Component Medical Units will: Report cases of *Armed Forces Reportable Medical Events* (see **Attachment 1** for URL) detected **while the member is on active military status** to Air National Guard Surgeon General or Headquarters Air Force Reserve Command Surgeon General, DCPH-D; and their respective state/local health authorities. **(T-0)** ARC Public Health will submit information to state/local health authorities as required. **(T-1)**

1.9.1. Transmit all DAF reportable medical events to DCPH-D via the AFDRSi website (referred to as Medical Event Reports in AFDRSi), **https://drsi.health.mil/AFDRSi/ (T-1)**

1.9.1.1. Armed Forces medical events guidelines and case definitions for reportable and urgently reportable medical events are available at the following AFHSD website: **https://health.mil/Military-Health-Topics/Health-Readiness/AFHSD/Reports-and-Publications.**

1.9.1.2. Report urgently reportable medical events within 24 hours as required by AFDRSi. **(T-0)** Report all other reportable medical events as soon as possible, but no later than 7 calendar days or once confirmatory lab results are available. **(T-1)**

1.9.2. Report disease information as required by their state/local, and/or host nation Public Health officials. **(T-0)**

1.9.3. Evaluate the risk of vector-borne and zoonotic disease in the local geographical area and, if indicated, develop a vector surveillance plan in accordance with AFI 48-102. **(T- 2)** Vector surveillance plan resources can be located at: **https://www.milsuite.mil/book/community/spaces/usafphamilymatters/medical-entomology/content?filterID=contentstatus%5Bpublished%5D~category%5Bentomology%5D**

1.9.4. Collaborate with the local military installations as well as state/local or host nation public health officials. **(T-2)** Maintain awareness of local epidemiological activities, including local surveillance, prevention, and control capabilities. **(T-2)**

Chapter 2

LEAD IN BLOOD PROGRAM

2.1. Overview. The objective of this program is to identify children living on and off base who are at risk for environmental lead exposure in accordance with state/local/host nation, CDC, and DHA guidance.

2.2. MTF Commander or Director will: ensure MTFs implement an effective Lead in Blood program in accordance with state/local/host nation regulations for screening, investigation, treatment, and follow-up. **(T-0)**

2.3. Chief of Medical Staff (SGH) will: coordinate with Public Health to ensure the development of a local risk assessment questionnaire for targeted lead screening. **(T-1)** Use the local health jurisdiction's questionnaire, if available. **Note**: This questionnaire supplements the CDC's standard lead exposure screening questions and reflects the community-specific lead exposure risk, including high-risk parental occupations. CDC guidance for a lead questionnaire is located at: **https://www.cdc.gov/nceh/lead/prevention/testing-children-for-lead-poisoning.htm**

2.4. Medical Providers will:

2.4.1. Ensure parents receive educational materials about prevention, sources, and risk of childhood lead exposure. **(T-2)**

2.4.2. Conduct universal childhood blood lead level (BLL) testing when required by state/local/host nation regulations. **(T-0)** Otherwise, medical providers will conduct targeted or risk-based screening following current CDC and DHA guidelines. **(T-1)**

2.4.3. Conduct targeted screening through a local risk assessment questionnaire beginning at 9-12 months of age and periodically between ages 24 months to 6 years, as directed by state/local/host nation guidance. **(T-0)** Ensure results of questionnaires are recorded in the EHR. **(T-1)**

2.4.3.1. Consider BLL testing for children under the age of 6 with one or more lead exposure risk factors. Use CDC guidelines for instructions on BLL sampling technique, treatment, and follow-up of a BLL at or above the current CDC's blood lead reference value. **(T-0)**

2.4.3.2. Refer all children with venous BLLs above the current CDC reference value to Public Health even if no mandatory reporting exists. **(T-1)**

2.4.4. Promptly notify the child's parent or guardian of elevated BLL results IAW DHA Clinical Practice Guidelines.

2.4.4.1. A first attempt at notification should occur no more than 24 hours after the BLL result is available to the provider.

2.4.4.2. All notifications by phone should be followed by a written correspondence by letter and MHS approved messaging services.

2.4.4.3. Notifications should be sent for all lead in blood test data for children and for adults regardless of BLL.

2.5. Public Health will:

2.5.1. Initiate an environmental investigation for any confirmed pediatric venous BLLs above the current CDC reference value regardless of the age of the individual. **(T-0)** Coordinate with Bioenvironmental Engineering or the local Public Health department for lead sampling of the facility based on epidemiological data following current CDC and Occupational Safety and Health Administration guidelines. **(T-0) Note:** Ensure Bioenvironmental Engineering will review the local lease agreement prior to initiating any sampling in privatized housing areas to determine if the base or state has jurisdiction. **(T-0)**

2.5.1.1. Report new cases of elevated venous blood test results (i.e., above the current CDC reference value) once per child 6 years and under to DCPH-D using AFDRSi. Follow-up test results for the same case should not be reported again. **(T-1)**

2.5.1.2. Promptly provide findings from the environmental investigation to the patient's medical provider and within AFDRSi. **(T-1)**

2.5.1.3. Track and follow-up on all elevated BLL results IAW the current CDC guidelines. **(T-3)**

2.5.2. Report all BLLs to the state/local/host nation according to formal reporting guidance. **(T-0)**

2.6. DCPH-D will:

2.6.1. Provide surveillance and report significant findings or unusual trends on blood lead results to AFMRA and AFHSD. (T-2)

2.6.2. Submit an annual calendar year summary of the Lead in Blood Program. (T-2)

Chapter 3

TUBERCULOSIS (TB) DETECTION AND CONTROL PROGRAM

3.1. Overview. The objective of this program is to align the DAF TB program with the national program to eliminate TB. The Air Force Medical Service follows current CDC guidelines for TB prevention and control. The following guidance is intended to cover areas where CDC guidance is vague or does not exist.

3.1.1. The DAF TB screening program will be a targeted program based on environmental and operational mission requirements.

3.1.2. The TB testing program for DAF personnel will be limited to individuals with high-risk TB exposure histories and/or those with clinical indications for testing.

3.1.3. TB screening for recruits and new accessions will be based on current clinical recommendations and guidance from trainee health medical leadership. **Note:** Dependents can be screened and/or tested based on clinical recommendation.

3.2. MTF Commanders or Directors will:

3.2.1. Ensure MTFs and ARC Medical Units implement an effective TB control program following current CDC guidelines. **(T-0)**

3.2.2. Ensure a written plan for the prevention of transmission and treatment of TB for the MTF and ARC Medical Unit is included in the MTF infection control plan and is completed and reviewed annually. **(T-1)**

3.2.2.1. The plan will include a multi-disciplinary healthcare team (e.g., SGH, Infection Control, Public Health, and Bioenvironmental Engineering) evaluation following CDC guidelines. **(T-0)**

3.2.2.2. The plan will also include appropriate respiratory protection for potentially exposed healthcare workers, effective engineering controls, education (including risk factors, signs, and symptoms), counseling and evaluation of healthcare workers, and identification and treatment of individuals with active disease or latent tuberculosis infection (LTBI). **(T- 3)**

3.3. Public Health will:

3.3.1. Coordinate with the Infection Prevention and Control Function and Bioenvironmental Engineering to ensure compliance with relevant Occupational Safety and Health Administration guidelines for the control of occupational exposure to TB. **(T-3)**

3.3.2. Implement MTF infection control plan to prevent transmission and treatment of TB, if necessary. **(T-3)** Reviews plan annually recommending risk-based procedures for screening, control, and protection against TB following current CDC guidelines. **(T-0)** Coordinates the review with Infection Prevention and Control Function and Bioenvironmental Engineering. **(T-3)**

3.3.3. Conduct risk assessment and symptom screening of individuals, including re-deployers and beneficiaries returning from high-risk TB endemic locations, and countries to determine the frequency of TB testing, as well as those who have been in recent close contact with transient, refugee, or migrant populations from TB endemic locations and countrie**s**. **(T-1)** Follow local city, county, and/or state recommendations if their guidance requires more frequent testing or inclusion of other individuals. **(T-0)**

3.3.4. Perform the initial LTBI patient interview following current CDC guidelines, document in the EHR, and refers patient to PCM. **(T-0)**

3.3.5. Perform contact tracing following current CDC guidelines and ensure the proper screening, and treatment as indicated, for individuals who may have become infected from persons with active TB disease. **(T-0)**

3.3.6. Monitor local TB risk and provide prevention and educational messages for the installation population. **(T-3)**

3.3.7. Reports active TB cases within 24 hours (or next duty day) to DCPH-D via AFDRSi. **(T-1)**

3.4. Primary Care Management (PCM) team will:

3.4.1. Evaluate all individuals with non-negative TB tests. Non-negative tests include:

3.4.1.1. Tuberculin skin test (TST) indurations greater than or equal to 5mm.

3.4.1.2. Indeterminate or positive blood assays for *M. tuberculosis* Interferon-Gamma Release Assay (IGRA).

3.4.2. Record positive reactions, initial and follow-up care on DAF Form 2453, *Tuberculosis Detection and Control Data.* Place DAF Form 2453 in the patient's medical record upon completion of medical treatment. **(T-1)** PCM will document all patient interventions, including attempts to contact member, in the EHR. **(T-1)**

3.4.3. Evaluate patients for active disease.

3.4.4. Provide clinical management and follow-up of patients with LTBI or active TB following CDC guidelines. **(T-0)**

3.4.5. Ensure all patients with LTBI or active TB are referred to Public Health for contact tracing, education, and reporting. **(T-3)**

3.4.5.1. If active TB is suspected, immediately alert the Infection Preventionist, SGH, SGP, and Public Health to ensure that appropriate precautionary infection control measures are applied.

3.4.5.2. ARC providers in collaboration with ARC Public Health equivalent will refer patients for initial LTBI patient interview and contact investigation following current CDC guidelines to respective RegDAF servicing MTF or state/local Public Health departments or private practice physicians. **(T-2)**

3.4.5.3. ARC Public Health equivalent will obtain medical documentation on the status of patients requiring X-Ray clearance and LTBI treatment determination from start to completion, deferment, and exemption. **(T-2)**

3.4.6. Ensure recent converters who do not have active TB but are on flying status, have flying status handled by following the current USAF Medical Standards Directory. **(T-1)**

3.4.6.1. If the services of the flyer are critical, (e.g., in a combat zone or for alert force manning and unable to be in Duty Not Involving/Including Flying status for three days) and active TB has been ruled out; LTBI treatment can be delayed for up to 18 months with the approval of the base SGP. **(T-1)**

3.4.6.2. SGP will document approval in the EHR. **(T-1)**

3.4.6.3. During this time, the flight surgeon will continue to monitor the flyer closely until his/her/their services are no longer critical, and treatment can be initiated.

3.5. Trained Immunization Clinic personnel or Trained Clinicians will:

3.5.1. Perform, read, and record Purified Protein Derivative skin tests. **(T-3)**

3.5.2. Follow current CDC guidance on testing procedures and interpretation of tests. **(T-0)** If TST induration is greater than or equal to 5mm, refer the patient to Public Health. **(T-2)**

3.6. Tuberculosis Testing Program.

3.6.1. The DAF TB testing program is a targeted program. DAF personnel (including deployers and other forward-based personnel) are only to be tested when they have individual high-risk TB exposure histories and/or are employees with clinical indications for testing as per local Aerospace Medicine Council recommendation.

3.6.2. Persons with LTBI who are at risk for developing active TB disease fall into two categories: those who have been recently infected and those with clinical conditions that increase the risk of progression from LTBI to TB disease.

3.6.2.1. Recent infection should be suspected in close contacts of a person with active TB, persons who have immigrated from or visited areas of the world with high rates of TB, residents or employees of congregate settings (homeless shelters, correctional facilities, and nursing homes), healthcare workers caring for patients who are at increased risk of TB, and children exposed to adults who are at increased risk for TB.

3.6.2.2. Clinical conditions that increase the risk of progression from LTBI to TB disease include HIV infection, persons who are receiving immunosuppressive therapy such as tumor necrosis factor–alpha (TNF-α) antagonists (e.g., infliximab, etanercept, or other), chronic systemic corticosteroids equivalent to ≥15 mg of prednisone per day for one month or longer, or immune suppressive drug therapy following organ transplantation, diabetes mellitus, chronic renal failure or hemodialysis, gastrectomy, jejunal bypass, history of cancer of the head, neck, or lung, silicosis, low body weight (10% below ideal), and younger than 5 years of age.

3.7. Testing Methods for Tuberculosis.

3.7.1. The Mantoux TST uses Intermediate-strength Purified Protein Derivative that is an intradermal injection. Most people who have been infected with TB will have a T-cell mediated delayed-type hypersensitivity reaction at the injection site, peaking at 48-72 hours after the injection. The TST is the preferred test in children younger than 2 years of age.

3.7.1.1. The TST may be administered either on the same day as live virus vaccines or must be performed four to six weeks after the administration of live virus vaccine. The TST must be delayed at least four weeks *after* smallpox vaccine administration, unless operational or clinical circumstances require administration of TST on the same day.

3.7.1.2. Measure TST reactions in millimeters of induration (not erythema) and record the results in ASIMS and the EHR. Do not delete the results of previous TB tests from ASIMS.

3.7.1.3. Refer all individuals with TST indurations greater than or equal to 5 mm to Public Health. If active TB is suspected, alert the Infection Preventionist, the PCM team, SGH, SGP, and Public Health to ensure that appropriate precautionary infection control measures are applied.

3.7.2. IGRAs – Detect the presence of *M. tuberculosis* infection by measuring the immune response to TB proteins in a blood sample.

3.7.2.1. An IGRA is the preferred test in persons who may be unlikely to return for TST reading and/or persons who have received bacille Calmette-Guerin vaccination.

3.7.2.2. For situations and special considerations in whether an IGRA or a TST is preferred, reference **"**Updated Guidelines for Using Interferon Gamma Release Assays to Detect *Mycobacterium tuberculosis* Infection --- United States, 2010" (cdc.gov)

3.7.2.3. IGRAs can be used in all circumstances in which the TST is used, including contact investigations, evaluation of recent immigrants who have had bacille Calmette-Guerin vaccination, TB screening of healthcare workers and others undergoing serial evaluation for *M. tuberculosis* infection.

3.8. Indications for TB Screening and/or Testing.

3.8.1. Screen RegDAF and ARC members during initial processing at officer or enlisted accession centers or at their first duty station. **(T-1)**

3.8.2. Combatant Command may direct additional TB testing. When the Combatant Command defers to Service policy for TB testing, then the following applies: individuals who deployed to high-prevalence areas for 30 consecutive days or greater and who had direct and prolonged contact with the local population or had high-risk or known exposure to an active TB case should receive a TB test at 3 months (no later than 6 months) post-deployment. **(T-1)**

3.8.3. Conduct an individual baseline risk assessment, symptom screening of individuals, and baseline two-step TST or one IGRA for healthcare workers (including civilians, contractors, and volunteers) upon employment/volunteer service if there is no verifiable history of documented previous test. **(T-0)** A documented, initial TB test (baseline test) for DAF personnel is considered the first step of the two-step TST. **(T-0)** The second step should be completed within 1-3 weeks following date first test was read. **(T-0)**

3.8.4. In the absence of known exposure or evidence of ongoing TB transmission, healthcare personnel without LTBI should not undergo routine serial TB screening or testing at any interval after baseline (e.g., annually). **(T-0)** Healthcare facilities may consider using serial TB screening of certain groups who might be at increased occupational risk for TB exposure, following current CDC guidance. **(T-0)**

3.8.5. Perform baseline and subsequent TB testing for TRICARE beneficiaries following current CDC guidelines. **(T-1)**

3.8.5.1. Baseline TB testing and symptom evaluation is indicated for individuals who are PCSing to a high TB prevalence country and who have no verification of having been previously tested. **(T-1)** Testing and symptom evaluation should be completed prior to departure and 3 months after returning from the high TB prevalence country. **(T-1)**

3.8.5.2. Baseline TB testing and symptom evaluation is indicated prior to overseas travel if individuals anticipate prolonged contact with populations in settings at high-risk for transmission of infectious TB (e.g., hospital, prison, homeless shelters). **(T-1)** Perform annual testing for all individuals stationed in a high-prevalence overseas area and who have direct and prolonged contact with high-risk populations or have high-risk exposure. **(T-1)** Perform another TB test and symptom evaluation at 3 months (no later than 6 months) after returning from the high-risk setting/exposure.

3.8.6. Healthcare personnel with LTBI and no prior treatment will be offered, and strongly encouraged to complete, treatment with a recommended regimen, unless a contraindication exists. Healthcare personnel who do not complete LTBI treatment will be monitored with annual symptom evaluation to detect early evidence of TB disease and to reevaluate the risks and benefits of LTBI treatment.

Chapter 4

RABIES PREVENTION PROGRAM

4.1. Overview. The purpose of this chapter is to provide policies and procedures for rabies prevention and control across DAF installations. It is intended primarily for use by Public Health, MTF medical providers, and others with related responsibilities or interests. AFI 48-131, is the guiding document that provides specifics regarding rabies prevention and control in animals.

4.2. Reporting.

4.2.1. Military and TRICARE beneficiaries who are exposed to rabies or potentially exposed to rabies shall seek medical treatment from and report their animal exposure to a healthcare provider within 24 hours. Potential exposure events from an animal capable of spreading rabies include a bite or salivary contact with an open wound or mucous membrane. **Note:** Potential exposure to rabies virus includes any penetration of skin by the teeth of a potentially rabid animal; or contamination of scratches, open wounds, abrasions, breaks in skin integrity, or mucous membranes with saliva or other potentially infectious material (such as nervous tissue) from a potentially rabid animal. Inadvertent, seemingly inconsequential, or otherwise unrecognized bat contact will also be considered a potential rabies exposure event.

4.2.2. MTF medical providers shall initiate and complete all relevant portions of the DD Form 2341, *Report of Animal Bite – Potential Rabies Exposure*, for each patient with possible exposure to rabies and include the DD Form 2341 in the EHR documentation (to include patients evaluated/treated at off-base medical facilities). **(T-1)**

4.2.3. Individuals in deployed settings should be encouraged to report any possible rabies exposures on their Post-Deployment Health Assessment (DD Form 2796) as "animal bite" or in free-text sections of the forms.

4.3. Public Health will:

4.3.1. Monitor and communicate rabies risk in the local area to MTF providers. **(T-2) Note:** Public Health should routinely review MTF surveillance data (e.g., emergency room reports) and conduct investigations as appropriate.

4.3.2. Track animal bite cases, track completion of post-exposure prophylaxis, report initiation of post-exposure prophylaxis meeting the case definition in the DoD *Armed Forces Reportable Medical Events Guidelines and Case Definitions* in AFDRSi and as required by state/local Public Health officials, and report to the Aerospace Medicine Council, as necessary. **(T-2)**

4.3.3. The Public Health Officer (PHO) or PH Senior Enlisted Leader (SEL) (or SGP/senior flight surgeon when PHO/PH SEL are unavailable) will review all animal bite case reports in order to verify the appropriateness of case-specific risk assessment and document review in block 25 of DD Form 2341. As needed, the PHO/PH SEL, SGP/senior flight surgeon (or SGH), and the treating physician will meet to discuss cases when the appropriateness of risk assessment/post-exposure prophylaxis treatment decision is in question. (T-2)

4.4. Trained Immunization Clinic personnel or Trained Clinicians:

4.4.1. Ensure pre- and post-exposure prophylaxis are administered IAW the current CDC guidance and are documented in the patient immunization record. **(T-0)**

4.4.2. Notify individuals of required pre- and post-exposure prophylaxis and immunization schedule. **(T-2)**

4.4.3. Ensure that pre-exposure rabies prophylaxis will be made available to all personnel with occupational rabies exposure risk IAW AFI 48-131. Consult Public Health, as needed.

4.4.4. Ensure post-exposure rabies prophylaxis and human rabies immunoglobin are available at deployed locations.

4.5. MTF Medical Providers will:

4.5.1. Initiate and complete DD Form 2341 by signing block 26 of DD Form 2341, for each patient with possible exposure to rabies and ensure the completed DD Form 2341 is included in the EHR. **(T-2)**

4.5.2. Ensure patients who are exposed to rabies or potentially exposed to rabies are assessed (to include immune status and currency of tetanus vaccine following the current ACIP recommendations), treated (to include tracking patients for completion of rabies prophylaxis when necessary), and educated following current CDC guidelines. **(T-0)** PCM team will document all patient interventions, including attempts to contact member, in the EHR. **(T-0)** **Note:** The need for post-exposure prophylaxis is to be based on a case-specific risk assessment by the treating MTF provider. The treating MTF provider should contact the PHO or PH SEL for assistance in determining rabies risk from an animal bite/exposure.

4.5.3. Ensure measures are in place to complete the protocol without deviations when rabies prophylaxis is initiated. **(T-1)** **Note**: For the most current treatment requirements and rabies risk assessment reference **https://www.cdc.gov/rabies/resources/index.html**. Such measures include, but are not limited to, chain of command notification (military personnel), notification of local/state child protective services or equivalent agency (dependent minors), and documentation of provider counseling.

4.5.4. Consult with Public Health for local rabies prevalence and most current rabies prophylaxis recommendations/guidelines. **(T-3)**

4.6. Rabies Advisory Board (RAB) will:

4.6.1. Consist of a DAF PHO or PH SEL and at least two MTF medical providers trained in rabies risk assessment or in preventive medicine (e.g., SGP, treating provider). **(T-2)**

4.6.2. Provide case-by-case medical consultation regarding rabies risk, prophylaxis, and prevention measures, in consultation with a US military veterinarian. **(T-2)** The RAB shall be chaired by an appropriately credentialed and privileged medical corps officer and should be convened as needed to review high-risk cases. **(T-2)**

4.7. Aerospace Medicine Council will:

4.7.1. Review all reported animal bite/exposure cases, post-exposure prophylaxis administration, regional prophylaxis supply, documentation, supporting surveillance efforts, and other zoonotic diseases at least annually, or at frequency informed by local risk. **(T-3)**

4.7.2. Annually invite representatives from the major agencies and organizations involved with rabies prevention and control across the military installation (e.g., Security Forces, US military veterinarian, local/state health officials) in order to review aspects of the Rabies Prevention Program. **(T-3)**

4.7.3. Convene on a frequency determined by local MTF leadership in an appropriate epidemiological context informed by rabies risk to review and make recommendations on the Rabies Prevention Program. **(T-3)**

ROBERT I. MILLER
Lieutenant General, USAF, MC, SFS
Surgeon General

Attachment 1

GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION

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DD Form 2341, *Report of Animal Bite—Potential Rabies Exposure*

Adopted Forms

DAF Form 847, *Recommendation for Change of Publication*

DD Form 2796, *Post-Deployment Health Assessment*

Abbreviations and Acronyms

ACIP—Advisory Committee on Immunization Practices

AFDRSi—Air Force Disease Reporting System internet

AFHSD—Armed Forces Health Surveillance Division

AFI—Air Force Instruction

AFMRA—Air Force Medical Readiness Agency

AFPD—Air Force Policy Directive

AFR—Air Force Reserve

ANG—Air National Guard

ARC—Air Reserve Component

ASIMS—Aeromedical Services Information Management System

BLLs—Blood Lead Levels

CDC—Centers for Disease Control and Prevention

DAFI—Department of the Air Force Instruction

DHA—Defense Health Agency

DoD—Department of Defense

DoDD—Department of Defense Directive

DoD-GEIS—DoD Global Emerging Infections Surveillance Program Office

DoDI—Department of Defense Instruction

EHR—Electronic Health Record

ESSENCE—Electronic Surveillance System for Early Notification of Community-based Epidemics

FHPPP—Force Health Protection Prescription Products

FLDCOM—Field Command

HIV—Human Immunodeficiency Virus

ICDs—International Classification of Diseases

IGRA—Interferon-Gamma Release Assay

LTBI—Latent Tuberculosis Infection

MAJCOMs—Major Commands

MMWR—Morbidity and Mortality Weekly Report

MTF—Medical Treatment Facility

NCMI—National Center for Medical Intelligence

OPR—Office of Primary Responsibility

PCM—Primary Care Manager

PCS—Permanent Change of Station

PHEO—Public Health Emergency Officer

PHO—Public Health Officer

RAB—Rabies Advisory Board

SG—Surgeon General

SGH—Chief of Medical Staff

SGP—Chief of Aerospace Medicine

TB—Tuberculosis

TST—Tuberculin Skin Test

URL—Universal Resource Locator

USAFSAM—United States Air Force School of Aerospace Medicine

USAFSAM/PH—United States Air Force School of Aerospace Medicine/Public Health and Preventive Medicine Department

Terms

Accessions—Service accessions include service members in recruit training, Officer Candidate School, service academy preparatory school, service academy, officer-indoctrination school, other officer accession programs, and officers that are directly commissioned.

Active surveillance—Requires direct action to collect disease information. For example, active surveillance includes: contacting physicians, hospitals, laboratories, or other health entities to actively search for disease cases.

Active Tuberculosis—a disease that is caused by *Mycobacterium tuberculosis* or other members of the *Mycobacterium tuberculosis* complex family in any part of the body and that is in an active state as determined by either:

1) A smear or culture taken from any source in the person's body tests positive for tuberculosis and the person has not completed the appropriate prescribed course of medication for active tuberculosis disease.
2) Radiographic, current clinical, or laboratory evidence is sufficient to support a medical diagnosis of tuberculosis for which treatment is indicated.

Air Reserve Component (ARC)—Reserve forces that include the Air National Guard and the Air Force Reserve Command.

Diseases and conditions of public health or military significance—These are diseases or health conditions that impact the health or readiness of DAF personnel, their dependents, or other eligible personnel and which have a potential for substantial mission degradation, widespread morbidity, or significant adverse sequelae or mortality.

Disease outbreak—The occurrence of cases of disease in excess of what would normally be expected in a defined community, geographical area or season. An outbreak may occur in a restricted geographical area or may extend over several countries. It may last for a few days or weeks, or for several years. A single case of a communicable disease long absent from a population, or caused by an agent (e.g., bacterium or virus) not previously recognized in that community or area, or the emergence of a previously unknown disease, may also constitute an outbreak and should be reported and investigated.

High—risk TB prevalence country/area - A country or geographical area with a high prevalence of TB. See NCMI site **https://www.ncmi.dodiis.mil/** for country risk profile.

Latent Tuberculosis Infection (LTBI)—The presence of *Mycobacterium tuberculosis* bacteria in the body as evidenced by a significant reaction to a Mantoux tuberculin skin test or positive interferon gamma release assay. A person with latent TB infection does not have an illness nor is he or she infectious.

Passive surveillance—The reliance on healthcare providers or laboratories to report cases of disease.

Population health—Refers to the health or health outcomes of a geographic population rather than the health or health outcomes of individuals.

Public 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 risks to health, thereby enabling timely interventions to prevent, treat, or control disease and injury. It includes occupational and environmental health surveillance and medical surveillance.

Public Health Emergency Officer (PHEO)—A senior health professions military officer or DoD civilian employee, designated by the Installation Commander, with experience in preventive medicine/emergency response who is responsible for advising the Installation Commander in the exercising of emergency health powers (as outlined in DoDI 6200.03 and AFI 10-2519, *Public Health Emergencies and Incidents of Public Health Concern*) in the event of a suspected or confirmed public health emergency or incident of public health concern.

Potential exposure to rabies—Any penetration of skin by the teeth of a potentially rabid animal; or contamination of scratches, open wounds, abrasions, breaks in skin integrity, or mucous membranes with saliva or other potentially infectious material (such as nervous tissue) from a potentially rabid animal.

Reportable medical event—Diseases or conditions that may represent an inherent, significant threat to public health and military operations. These events have the potential to affect large numbers of people, to be widely transmitted within a population, to have severe or life- threatening clinical manifestations, and to disrupt military training and deployment. Reportable medical events were chosen by consensus and recommendations from each of the Services about notifiable diseases from the Centers for Disease Control and Prevention (CDC), the Council of State and Territorial Epidemiologists (CSTE), and events that military public health experts have identified as representing significant military threats that deserve additional emphasis for surveillance.

Screening—A method for early detection of disease or health problem before an individual would normally seek medical care. Screening is usually administered to individuals without current symptoms, but who may be at high-risk for certain adverse health outcomes.

Sentinel sites—Installations selected to enhance the Department of Defense's global influenza surveillance program by identifying patients meeting the case definition for influenza, collecting respiratory specimens, and ensuring completion of the influenza questionnaire.

Syndromic surveillance—The surveillance of disease syndromes (groups of signs and symptoms), rather than specific, clinical, or laboratory-defined diseases. Surveillance of syndromes recorded at the time of patient visit, instead of specific diagnoses reported after laboratory or other diagnostic procedures, can greatly lessen the time it takes to determine that an outbreak is occurring (ESSENCE is an example of a syndromic surveillance system). At a minimum, this syndromic surveillance includes respiratory (influenza-like illness), gastrointestinal, febrile illness (fever), and dermatologic conditions.