



DoD INSTRUCTION 6200.03

PUBLIC HEALTH EMERGENCY MANAGEMENT (PHEM) WITHIN THE DoD

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Approved by:	James N. Stewart, Assistant Secretary of Defense for Manpower and Reserve Affairs, Performing the Duties of the Under Secretary of Defense for Personnel and Readiness

Purpose: In accordance with DoD Directive (DoDD) 5124.02, this issuance:

- Establishes policy, assigns responsibilities, and provides direction to ensure mission assurance and readiness for public health emergencies caused by all-hazards incidents.
- Defines a public health emergency within the DoD to include the occurrence or imminent threat of an illness or health condition that poses a high probability of a significant number of deaths, serious or long-term disabilities, widespread exposure to an infectious or toxic agent, overwhelmed health care resources, or severe degradation of mission capabilities.
- Provides DoD policy for management of public health emergencies, in accordance with DoD Instruction (DoDI) 6055.17, through integration with the DoD Emergency Management (EM) Program.
- Outlines the public health emergency health powers, roles, and responsibilities of the military installation commander, including the authority for restriction of movement.
- Details procedures for internal and external notifications of DoD-declared public health emergencies.
- Clarifies the PHEM roles and responsibilities of the medical treatment facility (MTF) commander or director, the public health emergency officer (PHEO), and the medical emergency manager (MEM).

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SECTION 1: GENERAL ISSUANCE INFORMATION

1.1. APPLICABILITY.

a. This issuance applies to:

(1) OSD, the Military Departments (including the Coast Guard at all times, including when it is a Service in the Department of Homeland Security (DHS) by agreement with that Department), the Office of the Chairman of the Joint Chiefs of Staff and the Joint Staff, the Combatant Commands (CCMDs), the Office of the Inspector General of the Department of Defense, the Defense Agencies, the DoD Field Activities, and all other organizational entities within the DoD (referred to collectively in this issuance as the “DoD Components”).

(2) The Service members, U.S. Government civilian employees, dependents of military or civilian personnel, contractors, and other individuals who are subject to DoD authority and are present on DoD installations and facilities worldwide.

b. This issuance does not impose additional regulatory requirements on the public.

1.2. POLICY. It is DoD policy that:

a. DoD installations, property, and other assets, as well as individuals working in or residing on DoD installations, facilities, field operations, and commands, will be protected pursuant to applicable legal authorities including:

(1) Sections 113, 3013, 5013, and 8013 of Title 10, United States Code (U.S.C.), which generally provide authority to conduct the affairs of the DoD authorized by the Constitution and laws of the United States.

(2) Section 2672 of Title 10, U.S.C., which authorizes the protection of buildings, grounds, and property under DoD jurisdiction, custody, or control as well as the persons on that property.

(3) Section 797 of Title 50, U.S.C., which provides penalties for violating any lawful regulation or order for protecting or securing property or places subject to DoD jurisdiction and administration or in DoD custody. The regulation or order may include ingress or egress or otherwise provide for safeguarding the same against destruction, loss, or injury, either by accident or by enemy or other subversive actions.

(4) Section 1382 of Title 18, U.S.C., which authorizes the regulation of entry onto DoD installations.

(5) Section 301 of Title 5, U.S.C., which authorizes regulations for the custody, use, and preservation of government property.

(6) Sections 243, 248, 249, and 264-272 of Title 42, U.S.C., and Parts 70 and 71 of Title 42, Code of Federal Regulations (CFR), which contain regulations for preventing the introduction, transmission, and spread of communicable diseases and hazardous substances from foreign countries into the United States, and from one State or possession into another. These references also authorize the Director of the Centers for Disease Control and Prevention (CDC), through delegated authority of the Secretary of the U.S. Department of Health and Human Services (HHS), to apprehend, detain, and conditionally release individuals with the quarantinable communicable diseases listed in Executive Order (E.O.) 13295, as amended by E.O. 13375 and E.O. 13674.

(7) Section 4 of E.O. 13527, which requires the establishment of mechanisms for the provision of medical countermeasures (MCM) to personnel performing mission-essential functions following a biological attack for continuity of operations.

(8) Any provision of Chapter 47 of Title 10, U.S.C., also known as the “Uniform Code of Military Justice” regarding a breaking or breach of medical quarantine.

b. In order to achieve the greatest public health benefit while maintaining operational effectiveness, DoD military installation commanders, referred to in this issuance as “military commanders,” may declare a DoD public health emergency and subsequently implement relevant emergency health powers, in accordance with the procedures in Section 3.

c. All public health emergencies will be managed in accordance with DoDI 6055.17 and this issuance.

d. Public health and medical preparedness efforts for chemical, biological, radiological, nuclear, and high-yield explosives (CBRNE) events will meet the standards and capability requirements provided in DoDI 3020.52. These actions will be integrated and synchronized with installation CBRNE preparedness activities to support effective and unified response operations.

e. To the extent practicable, military commanders will act in accordance with the applicable provisions of public health emergency declarations made by U.S. public health officials at the federal level and at the State, local, tribal, and territorial (SLTT) levels. Overseas military commanders will act in accordance with host nation (HN) and allied forces public health emergency declarations as applicable, practicable, and as otherwise defined in relevant agreements, including status-of-forces agreements, defense cooperation agreements, and base rights agreements.

f. DoD Components will cooperate closely with the federal and SLTT public health officials, as appropriate, to provide a unified response regarding public health emergencies.

g. Geographically proximate military commanders, PHEOs, and MEMs will coordinate and collaborate, to the maximum extent possible, to provide unified representation of the DoD to SLTT, other federal agencies’ regional offices, and HN EM planners and public health officials.

h. In the event of an all-hazards incident, the military commander ensures personnel at affected DoD installations will receive access to a pre-identified disaster mental health response

(DMHR) team and disaster mental health (DMH) services, to include rapid response teams, regional teams, and other shared resources as necessary.

i. DoD installations in the United States are authorized to serve as receipt, staging, and storage (RSS) sites for Strategic National Stockpile (SNS) assets that are being deployed to SLTT public health officials. DoD installations are also authorized to serve as closed points of dispensing (PODs) capable of distributing SNS assets to their DoD population (as defined in Military Department planning guidelines). DoD installations are prohibited from serving as open PODs for the general population.

j. In actual or potential public health emergencies, DoD laboratories that are members of, or participate in, the CDC-sponsored Laboratory Response Network (LRN) are authorized to provide diagnostic services pertaining to laboratory specimens of non-DoD health care beneficiaries referred for analysis, consistent with designated LRN tests, other procedures, agreements, and the mission of the LRN, pursuant to the authority of Section 1074(c) of Title 10, U.S.C., and in accordance with DoDI 6025.23.

(1) The authority to perform laboratory diagnostic services for non-DoD health care beneficiaries will be used very sparingly and will not result in a laboratory incurring significant incremental costs or limitation of its laboratory operations.

(2) Laboratory diagnostic services for non-DoD health care beneficiaries that would result in significant incremental costs will be conducted in accordance with DoDD 3025.18.

k. PHEO, alternate public health emergency officer (APHEO), MEM, and alternate medical emergency manager (AMEM) designees, as described in this issuance, must be afforded adequate training and work time to perform all assigned PHEM duties, including preparing and responding to public health emergencies and all-hazards incidents.

l. The policy changes delineated in this issuance were developed during the transition of roles and responsibilities, which were historically assigned to the medical components of the Services, to the Defense Health Agency (DHA). Nothing in this issuance is intended to supersede future transfers to the DHA of responsibility for health care delivery.

1.3. INFORMATION COLLECTIONS. The budget estimates, referred to in Paragraph 2.9.h. of this issuance, do not require licensing with a report control symbol in accordance with Paragraph 10 of Volume 1 of DoD Manual 8910.01.

SECTION 2: RESPONSIBILITIES

2.1. UNDER SECRETARY OF DEFENSE FOR PERSONNEL AND READINESS (USD(P&R)). The USD(P&R) provides criteria, guidance, and instruction to incorporate PHEM requirements into appropriate DoD policy, program, and budget documents.

2.2. ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS (ASD(HA)). Under the authority, direction, and control of the USD(P&R) and in accordance with DoDD 5136.01, the ASD(HA):

- a. Oversees the policy, program planning and execution, and allocation and use of public health, medical, and veterinary resources for activities within the DoD related to public health emergencies. These activities will be coordinated with other applicable officials such as the Assistant Secretary of Defense for Nuclear, Chemical, and Biological Defense Programs; Assistant Secretary of Defense for Manpower and Reserve Affairs; Assistant Secretary of Defense for Homeland Defense and Global Security (ASD(HD&GS)); and the Assistant Secretary of Defense for Special Operations and Low-Intensity Conflict (ASD(SO/LIC)).
- b. Collaborates with federal and other applicable entities to implement this issuance.
- c. Issues any necessary DoD public health, medical, veterinary, and mental health guidance to implement this issuance.
- d. Issues any necessary guidance regarding the protection of humans and animals from environmental health threats.
- e. Develops additional policy and updates guidance regarding restriction of movement (human or animal quarantine, isolation, and conditional release) within the DoD as appropriate and in consultation, when necessary, with the:
 - (1) Under Secretary of Defense for Policy (USD(P)) and the ASD(HD&GS).
 - (2) Joint Staff Surgeon.
 - (3) Surgeons General (SGs) of the Military Departments.
 - (4) Medical Officer of the Marine Corps.
 - (5) SG of the United States.
 - (6) Director, Coast Guard Health, Safety, and Work-Life.
 - (7) Director, DHA.
 - (8) Appropriate joint force commanders.

(9) HHS Assistant Secretary for Preparedness and Response.

(10) Director of the CDC.

f. Coordinates DoD efforts to review public health emergency of international concern (PHEIC) declarations from the World Health Organization (WHO) in collaboration with the ASD(HD&GS), the ASD(SO/LIC), the SGs of the Military Departments, the Joint Staff Surgeon, and appropriate CCMD(s), to:

(1) Determine the scope and applicability of the PHEIC declaration to DoD personnel and other beneficiaries, including individuals working on DoD installations or in DoD facilities, field operations and/or commands, and individuals residing on DoD installations.

(2) Evaluate the impact of the PHEIC on DoD missions, personnel, and other beneficiaries.

(3) Develop appropriate force health protection (FHP) guidance to achieve the greatest public health benefit while minimizing disruptions to DoD missions and deployments.

g. Reviews notifications of DoD-declared public health emergencies to:

(1) Identify circumstances suggesting a potential PHEIC. The ASD(HA) provides approval, as appropriate, to the National Military Command Center (NMCC)/Global Situational Awareness Facility (GSAF) to notify the HHS Secretary's Operations Center (SOC) of the potential PHEIC, pursuant to the WHO International Health Regulations (IHR) (see Paragraph 3.3.).

(2) Ensure notification of DoD public health emergency declarations are made to the ASD(HD&GS) and the ASD(SO/LIC).

h. Grants exceptions to this issuance consistent with law.

2.3. DIRECTOR, DHA. In addition to the responsibilities in Paragraph 2.8., under the authority, direction, and control of the USD(P&R), through the ASD(HA), and in accordance with DoDD 5136.13, the Director, DHA:

a. Supports the Secretaries of the Military Departments PHEM responsibilities and activities as outlined in this issuance.

b. Provides technical support to the SGs of the Military Departments, geographic Combatant Commanders (GCCs); appropriate joint force commanders; DoD agencies and other DoD Components, and the Director, Coast Guard Health, Safety, and Work-Life on coordination of PHEM as necessary.

c. Ensures that standardized public health and medical training and education programs associated with implementation of this issuance are regularly offered.

d. Designates a PHEO and a MEM at the Defense Health Headquarters for effective integration of PHEM activities within the DHA. The Director, DHA, may designate APHEOs and AMEMs, as required, to support the PHEO and MEM mission responsibilities.

2.4. UNDER SECRETARY OF DEFENSE FOR ACQUISITION AND SUSTAINMENT.

The Under Secretary of Defense for Acquisition and Sustainment provides criteria, guidance, and instruction to incorporate PHEM requirements into relevant DoD EM program elements.

2.5. ASSISTANT SECRETARY OF DEFENSE FOR SUSTAINMENT. Under the authority, direction, and control of the Under Secretary of Defense for Acquisition and Sustainment, the Assistant Secretary of Defense for Sustainment advocates for resources and supports planning, programming, and budgeting processes to meet the PHEM requirements of the DoD EM Program.

2.6. ASD(HD&GS). Under the authority, direction, and control of the USD(P) and in accordance with DoDD 5111.1 and DoDD 5111.13, the ASD(HD&GS):

a. Coordinates with the ASD(HA) on PHEM policy and guidance to ensure integration and consistency with policies and programs related to homeland defense; national preparedness; national or global security; combatting weapons of mass destruction; defense support of civil authorities; chemical, biological, radiological, or nuclear defense; mission assurance; and defense continuity.

b. Provides the ASD(HA) assistance when a public health emergency occurs within the DoD that affects DoD operations; national or global security; or involves the National Security Council, other federal departments or agencies, HNs, or other non-DoD parties.

2.7. ASD(SO/LIC). Under the authority, direction, and control of the USD(P) and in accordance with DoDD 5111.10, the ASD(SO/LIC):

a. Oversees humanitarian assistance, disaster relief, and global health policy.

b. Oversees program planning and execution, and allocation and use of resources for activities that the DoD conducts related to humanitarian assistance, disaster relief, and global health, including international public health emergencies.

2.8. DOD COMPONENT HEADS. The DoD Component heads:

a. Implement this issuance and any supporting PHEM guidance of the ASD(HA).

b. Ensure that the headquarters (HQ), installation, and DoD-leased facility EM programs identify appropriate public health and medical subject matter experts (SMEs) to advise on public health and medical issues pertaining to the DoD EM Program. DoD Component heads without public health and medical resources will ensure that appropriate SMEs are identified (e.g.,

PHEOs and/or MEMs at nearby DoD installations or local civilian public health officials) to consult on public health emergency preparedness and response planning activities.

c. Authorize installations and DoD-leased facilities to enter into support agreements with other DoD Components, SLTT public health officials, mental health providers, or other EM resources to support effective public health emergency preparedness planning and response efforts in accordance with DoDI 4000.19.

d. Provide written approval and authorization for DoD installations and DoD-leased facilities in the United States to make agreements with SLTT public health officials to serve as closed PODs for SNS assets when requested, and inform the CCMD Surgeon and other relevant officials at the United States Northern Command or United States Indo-Pacific Command, as appropriate. Encourage installations and DoD-leased facilities to participate in applicable SLTT public health emergency planning efforts by serving as closed PODs capable of dispensing SNS medical materiel to their DoD population.

2.9. SECRETARIES OF THE MILITARY DEPARTMENTS. In addition to the responsibilities in Paragraph 2.8, the Secretaries of the Military Departments:

a. Designate a PHEO and a MEM at the HQ level for effective integration of all PHEM activities. The Secretaries may designate APHEOs and AMEMs, as required, to support the PHEO and MEM mission responsibilities.

b. Ensure execution of PHEM program requirements across all installations, entities, and activities.

c. Authorize designation of additional individuals at other levels of their organizational structure to facilitate coordinated PHEM planning among PHEOs and MEMs with SLTT governments, other DoD Components, other federal agencies' offices within the United States, and HNs.

d. Develop and maintain intra- and inter-Service collaborative networks of installation and/or command PHEOs. Consistent with the DoD EM Program, these networks will coordinate locally and regionally with other federal agencies and in concert with geographic CCMD in order to provide unified representation of the DoD to SLTT authorities, other federal agencies' regional offices, and HN emergency planners and public health officials.

e. Ensure military commanders develop and maintain collaborative relationships with SLTT authorities, other DoD Components, other federal agencies' regional offices, and HN authorities to meet mutual aid and support requirements of public health emergencies and formally document such agreements.

f. Ensure military commanders provide a public health, medical, and veterinary response capable of effectively responding to a public health emergency within DoD in accordance with this issuance, DoDI 3020.52, and DoDI 6055.17. Military commanders will ensure the following functions are available through installation resources, regional assets, or civilian or HN providers:

- (1) Patient decontamination.
 - (2) First-responder and first-receiver care.
 - (3) Mass casualty response.
 - (4) Triage.
 - (5) Patient movement.
 - (6) Distribution and employment of medical supplies.
 - (7) Distribution and administration of pharmaceuticals (e.g., MCM such as antibiotics, antivirals, and vaccines).
 - (8) Provision of alternate treatment facilities.
 - (9) Health surveillance, including occupational and environmental health surveillance and medical surveillance subcomponents.
 - (10) Psychological support.
 - (11) Health risk communications and assessment.
 - (12) Veterinary patient management and zoonotic disease surveillance.
- g. Ensure military commanders are prepared to establish, at their discretion, a health protection framework (referred to in this issuance as the health protection condition (HPCON) level) during an all-hazards emergency to communicate specific health protection measures to the affected population, including individuals working in, residing on, or visiting the installation. The HPCON framework can include any authorized FHP measures that may be applicable to the emergency and should be coordinated with other affected installations to ensure consistent messaging across installations and Services.
- h. Develop budget estimates and submit program objective memorandum requirements that cover program establishment; equipment; tactics, techniques, and procedures; training; exercises; assessments; and sustaining activities to make it possible to execute the responsibilities prescribed in this issuance.
- i. Ensure that required PHEM resources and capabilities are identified and developed (e.g., mass notification and recall, command and control elements).
- j. Provide written approval and authorization to military installations in the United States to make agreements with SLTT public health officials to serve as RSS sites and closed PODs for SNS assets when requested, and inform the CCMD Surgeon and other relevant officials at the United States Northern Command or United States Indo-Pacific Command, as appropriate.

(1) Maintain comprehensive and up-to-date lists of installations that have signed agreements with SLTT SNS coordinators to serve as RSS sites.

(2) Encourage military commanders to participate in the CDC's Cities Readiness Initiative and other applicable SLTT public health emergency planning by serving as closed PODs capable of dispensing SNS medical materiel to their DoD populations.

k. Ensure military commanders of DoD installations meet the requirement outlined in Section 4 of E.O. 13527 in accordance with Service guidance on mass prophylaxis planning and ensuring access to MCM for mission-essential personnel.

l. Ensure that appropriate standards for credentialing and certification for MEMs are established at the Service-level, and issue policy and guidance to implement the standards.

m. Ensure military commanders of DoD installations in HNs oversee execution of PHEM requirements in accordance with status-of-forces agreements, other applicable U.S. government and HN agreements, Department of State (DoS) and geographic CCMD guidance, and applicable HN standards.

2.10. GCCS. In addition to the responsibilities in Paragraph 2.8., the GCCs:

a. Designate a PHEO at the HQ level to ensure effective integration of all PHEM activities with the DoD EM Program. The GCC may also designate APHEOs, as required, to support the PHEO mission responsibilities.

b. Designate additional individuals as needed at other levels of their organizational structure (e.g., local, regional, and theater) to facilitate coordinated PHEM planning among PHEOs and MEMs (within their area of operations) and with SLTT governments and other federal agencies' regional offices within the United States and with HNs.

c. Ensure unity of effort in the implementation of PHEM at DoD installations within the CCMD area of responsibility and compliance with status-of-forces agreements, other applicable U.S. Government and HN agreements, DoS guidance, and applicable HN standards.

d. In collaboration with the appropriate chief of mission (COM), engage each HN's public health officials regarding respective roles for reporting and notification of potential PHEICs within the HN's territory in accordance with the WHO IHR notification requirements.

2.11. CHIEF, NATIONAL GUARD BUREAU. The Chief, National Guard Bureau:

a. Serves as the principal advisor to the Secretary of Defense, through the Chairman of the Joint Chiefs of Staff, on matters involving non-federalized National Guard and has the specific responsibility to address matters relating to the Army National Guard, the Air National Guard of the United States, Air National Guard, and the Air National Guard of the United States.

b. Serves as the channel of communications for matters pertaining to the use of National Guard personnel and resources between DoD Components and the States, to include planning for and responding to public health emergencies.

c. In coordination with the Adjutants General of the States, and consistent with State and local EM plans, ensures National Guard units not collocated on active duty military installations communicate identified health threats to the DoD installation PHEO in their catchment area.

SECTION 3: DOD PUBLIC HEALTH EMERGENCY DECLARATIONS AND EMERGENCY HEALTH POWERS

3.1. DECLARATION OF A PUBLIC HEALTH EMERGENCY.

a. Public health emergencies can appear and progress rapidly, leading to widespread health, social, and economic consequences. Their causes can be diverse, and they may result from natural disasters, industrial accidents, or intentional CBRNE events, including the release of a novel or reintroduced infectious agent, biological toxin, zoonotic disease, or radiological agent. They may also result from a cyberattack on critical infrastructure with cascading consequences that endanger the public's health.

b. Military commanders must be prepared to make timely decisions to protect lives, property, and infrastructure and enable DoD installations and/or military commands to sustain mission-critical operations and essential services.

(1) Military commanders should expect a level of uncertainty during the decision-making process, especially during early stages of a public health emergency.

(2) The PHEO and staff judge advocate (SJA) or command judge advocate (CJA) should be prepared to provide relevant guidance relating to the military commander on authorized actions, powers, and limits of authority.

(3) Efforts that strengthen lines of communication with civilian decision makers at the community level will greatly enhance the response's effectiveness.

c. Circumstances suggesting a public health emergency should be evaluated according to the Public Health Emergency Decision Algorithm (see Figure 1). Situations that may be public health emergencies include the occurrence or the imminent threat of an illness or health condition with a high probability of any of the following:

(1) A significant number of deaths.

(2) A significant number of serious or long-term disabilities.

(3) Widespread exposure to an infectious or toxic agent that poses a significant risk of substantial future harm.

(4) Health care needs that exceed available resources.

(5) Severe degradation of mission capabilities or normal operations.

d. The military commander will direct the PHEO to determine the existence of cases suggesting a public health emergency affecting the installation's population, ensure that sources of the health hazard (e.g., infection or contamination) are investigated, define the distribution of the illness or health condition, and recommend implementation of proper mitigation and/or control measures. Appropriate actions by the PHEO may include:

(1) Initiating actions to collect and analyze data on the health hazard causing the public health emergency, particularly when the source or hazard is unknown or novel, in coordination with applicable installation units.

(2) Evaluating the health threat as a potential PHEIC (see Paragraph 3.4.). A public health emergency may require notification to the WHO as a potential PHEIC pursuant to the WHO IHR through the procedures outlined in Paragraph 3.3. Some diseases, such as smallpox or severe acute respiratory syndrome, require immediate notification to the WHO.

(3) Ensuring identification, interviewing, and tracking of all individuals or groups suspected to have been exposed to the health hazard to characterize the source and spread of the health hazard and estimate the impact on critical and mission essential personnel.

(4) Advising the military commander on appropriate health protection measures for personnel; the examination, closing, evacuation, or decontamination of a facility; or the decontamination or destruction of any material contributing to the public health emergency.

(5) Sharing information gathered during the investigation of a potential public health emergency with federal and SLTT public health and public safety officials to the extent necessary to protect public health and safety and for reporting potential PHEICs, pursuant to the WHO IHR. Shared information may include personally identifiable health information in accordance with DoD 6025.18-R.

(6) Notifying, directly or through applicable DoD channels, the appropriate defense criminal investigative organization concerning information indicating a possible terrorist incident or other crime. Notifications to other law enforcement authorities (e.g., Federal Bureau of Investigation, SLTT police) are as made as necessary. Without compromising efforts to preserve life and minimize risk to health, the PHEO should seek to cooperate with law enforcement efforts to prevent terrorist or other adversary attacks, ameliorate their effects, and to apprehend and prosecute their perpetrators.

e. Public health emergencies may be declared in the United States by the Secretary of HHS at a national level (pursuant to Section 247d of Title 42, U.S.C.) and by SLTT government authorities in their respective jurisdictions according to applicable SLTT law.

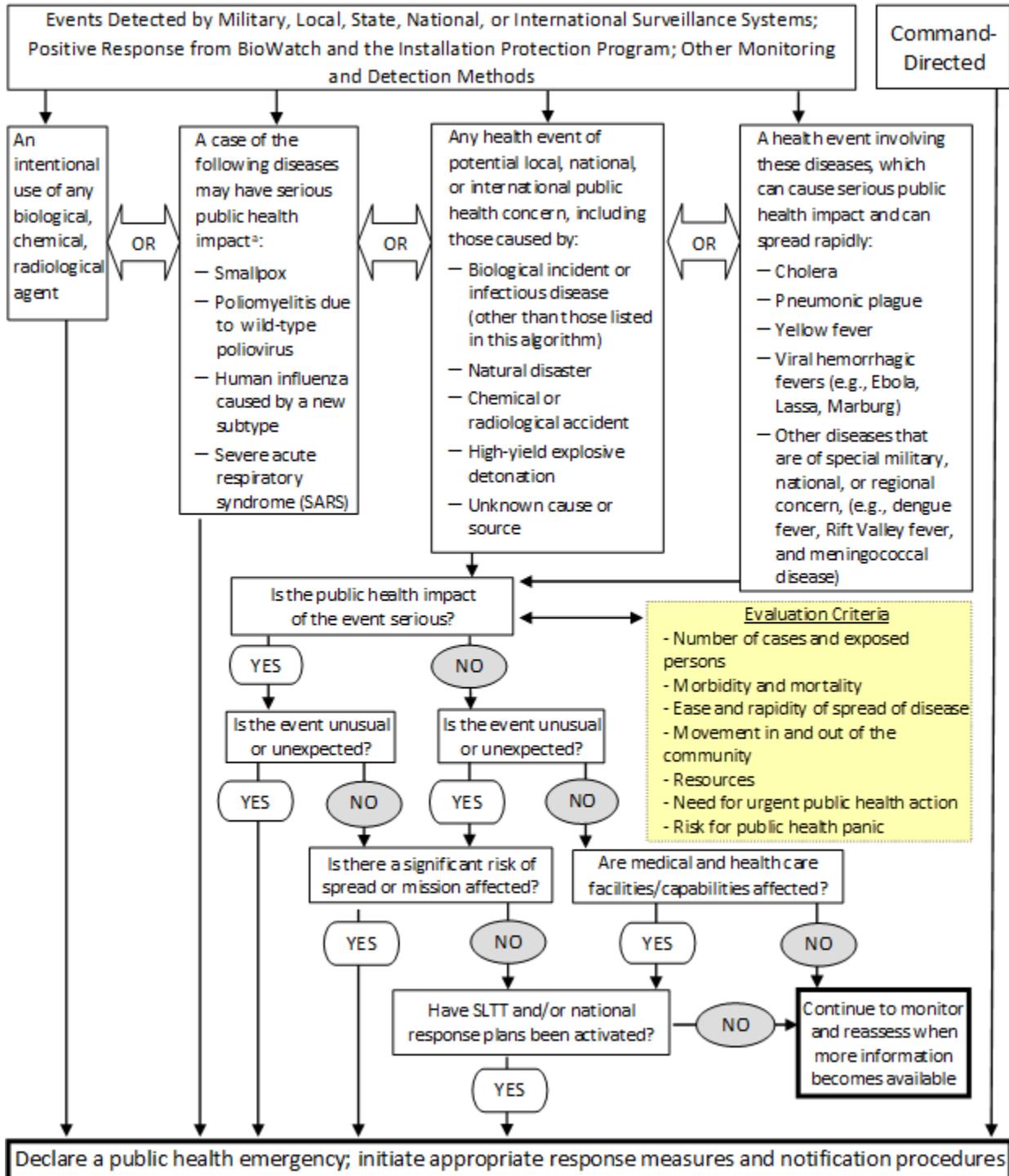
(1) In these circumstances, the PHEO will assist the military commander in determining the impact of the emergency on the installation and what actions are necessary and practicable for the installation to act with the relevant declaration(s) (see Paragraph 1.2.e.).

(2) Military commanders whose installations fall in the jurisdiction of an SLTT public health emergency declaration may declare a public health emergency on the installation to facilitate coordination with civilian authorities.

(3) In situations where there are potential conflicts with SLTT declarations, the military commander and PHEO will consult their SJA/CJA for guidance, particularly in cases where the installation has concurrent federal and State jurisdiction. SLTT public health laws vary between jurisdictions, and the SJA/CJA may be required to provide a legal opinion on the installation's

legal obligations to comply with the SLTT requirement. When possible, efforts should be made to resolve issues with SLTT authorities before legal action is required.

Figure 1. Public Health Emergency Decision Algorithm



² As per WHO case definitions

This algorithm is adapted from the WHO International Health Regulations (2005), Annex 2

f. When the military commander and PHEO determine that a public health emergency declaration is necessary to respond to a suspected or confirmed incident, the military commander will complete a written declaration within the scope of their authority with the support and guidance of the SJA/CJA and in consultation with the public affairs office (PAO). The declaration must outline the situation and relevant actions that will be taken (see Figure 2).

Figure 2. Suggested Template for Written Declaration of a Public Health Emergency

{LETTERHEAD}	{DATE}
MEMORANDUM FOR ALL SUBORDINATE COMMANDS AND TENANT UNITS	
SUBJECT: Declaration of a Public Health Emergency on {Installation Name}	
<p>I have been notified by my Public Health Emergency Officer (PHEO) of a possible public health situation on our installation involving {agent/disease name or description of the qualifying incident} that requires immediate action. Based on the PHEO's recommendations and the results of a preliminary investigation, I am declaring a public health emergency in accordance with DoD Instruction (DoDI) 6200.03, "Public Health Emergency Management (PHEM) Within the DoD," and {applicable Service Instruction}. This declaration will terminate automatically 30 days from the date of this memorandum unless it is renewed and re-reported or terminated sooner by me or a senior commander in the chain of command.</p>	
<p>The installation PHEO {and public health personnel} are hereby directed to identify, confirm, and control this public health emergency utilizing all the necessary means outlined in DoDI 6200.03 and {applicable Service Instruction}. To implement my direction, the PHEO may issue guidance that affects installation personnel and property, and other individuals working, residing, or visiting this installation (e.g., steps to protect personnel health, closing base facilities, restricting movement, or implementing quarantine for select individuals). We will establish the Health Protection Condition (HPCON) level framework that will provide specific actions specific to this emergency that each person should take to protect his or her health.</p>	
<p>The installation command and the PHEO will coordinate activities and share information with {list which of the following are applicable to the current situation: federal, State, local, tribal, territorial, and/or host nation. For overseas commands, replace "Federal, State, and local" with "host nation"} officials responsible for public health and public safety to ensure our response is appropriate for the public health emergency. Shared information may include personally identifiable health information only to the extent necessary to protect the public health and safety.</p>	
<p>Any person who refuses to obey or otherwise violates an order during this declared public health emergency may be detained. Those not subject to military law may be detained until civil authorities can respond. Violators of procedures, protocols, provisions, or orders issued in conjunction with this public health emergency may be charged with a crime under the Uniform Code of Military Justice and under Section 271 of Title 42, United States Code (U.S.C.). Pursuant to Section 271 of Title 42, U.S.C., violators are subject to a fine up to \$1,000 or imprisonment for not more than one year, or both.</p>	
{Installation Commander Signature Block}	

g. A declaration of a public health emergency within the DoD will be immediately reported through the chain of command to the Secretary of Defense (see Paragraph 3.3.).

h. The declaration will be communicated within 12 hours to all installation personnel, including those individuals in tenant organizations and commands, and individuals residing on the installation, with the support of the PAO. Appropriate risk communications (e.g., HPCON) will be developed and distributed to installation personnel, Military Health System (MHS) beneficiaries, and guests on the installation to inform all individuals of the situation, actions that will be taken, and where to get more information. If installation services are curtailed, guidance should be provided on other service availability, especially in the case of restrictions on medical care. The PHEO, MTF commander or director, MEM, PAO, and other relevant personnel will coordinate on the development and distribution of these communications.

i. Public health emergency declarations within the DoD will terminate automatically in 30 days, unless renewed and re-reported, or may be terminated sooner by the military commander who made the declaration, any senior commander in the chain of command, the Secretary of the Military Department concerned, or the Secretary of Defense.

j. For zoonotic diseases, PHEO activities and procedures will be conducted in coordination with other public health and veterinary activities.

k. In coordinating with the Coast Guard, DoD Components should note that the Coast Guard has designated the Director, Coast Guard Health, Safety, and Work-Life (or designee) to serve as the PHEO and MEM for the Coast Guard and does not have APHEOs or AMEMs.

l. In areas outside the United States, declarations of a public health emergency may be limited to U.S. personnel and subject to the requirements of applicable treaties, agreements, and other arrangements with foreign governments and allied forces, particularly in the case of non-U.S. installations and field activities (see Paragraph 3.5.).

3.2. EMERGENCY HEALTH POWERS AND RESTRICTION OF MOVEMENT.

a. Applicability.

(1) When a military commander declares a DoD public health emergency within the scope of their authority due to a suspected or confirmed incident, the military commander is authorized to take relevant emergency actions to respond to the situation to achieve the greatest public health benefit while maintaining operational effectiveness.

(2) To the extent necessary for protecting or securing DoD property or places and associated Service members, emergency health powers may include persons other than Service members who are present on a DoD installation or other areas under DoD control, including:

(a) Reserve Component installations not collocated with active duty installations.

(b) DoD civilian personnel, contractors, beneficiaries, and other persons within the scope of the military commander's authority.

b. Military Commander Emergency Health Powers. Military commander emergency health powers include:

(1) Directing Service members to submit to medical examinations or testing as necessary for diagnosis or treatment. Persons other than Service members may be required as a condition of exemption or release from restrictions of movement to submit to a physical examination or testing, as necessary, to diagnose and prevent the transmission of a communicable disease and enhance public health and safety. Qualified clinical personnel will perform examinations and testing.

(2) Collecting specimens and performing tests on any property or on any animal or disease vector, living or deceased, as reasonable and necessary for emergency response.

(3) Using facilities, materials, and services for purposes of communications, transportation, occupancy (e.g., emergency shelters or quarantine/isolation), fuel, food, clothing, health care, and other purposes, and controlling or restricting the distribution of commodities as reasonable and necessary for emergency response.

(4) Taking measures as reasonable and necessary, pursuant to applicable law, to obtain and control the use and distribution of needed health care supplies.

(5) Closing, directing the evacuation of, or decontaminating any asset or facility that endangers public health; decontaminating or destroying any material that endangers public health; or asserting control over any animal or disease vector that endangers public health, including quarantine and isolation of animals on the installation.

(6) Controlling evacuation routes on, and ingress and egress to and from, the affected DoD installation or military command.

(7) Taking measures to safely contain and dispose of infectious or contaminated waste as may be reasonable and necessary for emergency response.

(8) Restricting movement to prevent the introduction, transmission, and spread of communicable diseases or any other hazardous substances that pose a threat to public health and safety as outlined in Paragraph 3.2.c.

c. Restriction of Movement.

(1) Quarantine, isolation, and conditional release are types of restriction of movement that can be imposed in certain circumstances by a military commander for individuals within the scope of the commander's authority.

(a) In the case of Service members, restrictions of movement, including isolation, quarantine, conditional release, or any other measure necessary to prevent or limit transmitting a communicable disease and enhance public safety may be implemented.

(b) In the case of persons under the commander's authority other than Service members, restrictions of movement may include isolation or limiting ingress and egress to, from,

or on a DoD installation or military command. Coordination with civilian public health officials, including the CDC, SLTT, and HN public health agencies, may be required.

(2) In the United States, restriction of movement should be considered in coordination with the local CDC quarantine officer and SLTT public health. These agencies have public health authorities that may be applicable when the military commander's authority is limited.

(a) Authority for restriction of movement may vary between civilian public health officials depending on the situation and scope of applicable law. Civilian public health officials may provide vocal authorization for the military commander to restrict the movement of individuals not within the military commander's scope of authority until a formal written order is issued by the CDC or SLTT public health official.

(b) In accordance with Parts 70 and 71 of Title 42, CFR, the Director of the CDC may take public health measures or a combination of measures the Director deems reasonably necessary to prevent the spread of disease, particularly when involving movement across State lines or international travel.

(c) Within the borders of their own jurisdictions, SLTT public health officials may have authority for restriction of movement and can quarantine or isolate individuals under applicable State, tribal, or territorial law.

(3) Quarantine or isolation will be accomplished through the least restrictive means available, consistent with protection of public health.

(4) Conditional release is a less restrictive alternative to quarantine and is authorized for persons who may have been exposed to a communicable disease or hazardous substances and require continued health monitoring and supervision but have been assessed and determined to be asymptomatic and present a low risk to public health.

(a) Conditional release is a subjective option and is not appropriate under all circumstances. The PHEO should advise the military commander on the appropriateness of conditional release after consultation with the chain of command and relevant DoD and civilian public health and medical officials.

(b) Persons under conditional release orders may return to their living quarters but must comply with the terms of the orders, including regular monitoring visits, travel restrictions, and limited contact with other persons as directed. Additional conditions may be required dependent upon the circumstances of the exposure. Violations of conditional release may result in more restrictive measures and charges under applicable law.

(c) Regular monitoring may be accomplished through in-person encounters, telephone or video calls, or other suitable electronic methods through the incubation period of the communicable disease, or as determined by medical authorities. The written notice of the conditional release will detail how monitoring will be accomplished, designated monitors, and timeframe for monitoring encounters.

(d) For personnel residing off-installation, the PHEO will coordinate with federal, SLTT, or HN public health officials. Conditional release may require approval by applicable civilian public health officials.

(5) The needs of persons quarantined or isolated will be addressed in a systematic and competent fashion.

(a) Places of quarantine will be maintained in a safe and hygienic manner, designed to minimize transmission of infection or contamination or other harm to other persons under quarantine. Adequate food, clothing, medical care, and other necessities will be provided.

(b) Isolating individuals or groups serves to prevent the transmission and spread of a communicable disease or any other hazardous substances that pose a threat to public health and safety. Isolation measures may be implemented in health care facilities, living quarters, or other buildings on a DoD installation or military command. Isolation measures do not lessen the responsibilities of the MHS to provide medical care to infected or affected persons to the standard of care feasible given resources available (see Section 5).

(6) In accordance with DoDD 5400.11 and DoD 6025.18-R, personally identifiable information, including protected health information, will be used and disclosed only as necessary to safeguard public health and safety.

(7) Quarantine or isolation of any persons will be terminated when no longer necessary to protect public health.

(8) The PHEO will, as soon as practicable, ensure that every person subject to quarantine, isolation, or conditional release is provided written notice of the reason for the order and a plan of examination, testing, and treatment designed to resolve the reason for the restriction of movement. Figures 3 and 4 are suggested templates to be adapted based on the circumstances of the public health emergency and with appropriate consultation by the SJA/CJA. The notice of conditional release can be adapted from the notice of quarantine.

(9) The PHEO will provide an opportunity to any person subject to quarantine, isolation, or conditional release who contests the reason for restriction of movement to present information supporting an exemption or release from quarantine. Where possible, technological resources will be used to support communications and limit the necessity for in-person encounters. The military commander or designee (who has not been previously involved in any medical determination concerning the person) will review such information. The reviewing official will exercise independent judgment and promptly render a written decision on the need for quarantine or isolation for the person.

(10) A person subject to quarantine or isolation will:

(a) Obey the restrictions and orders established by the military commander.

(b) Remain in assigned quarters.

(c) Not put themselves in contact with any persons except as specified in the notice of quarantine.

(11) No person may, without authorization, enter quarantine or isolation premises. A person who, by reason of unauthorized entry, poses a danger to public health and becomes subject to quarantine.

Figure 3. Suggested Template for Written Notice of Quarantine

{LETTERHEAD}	{DATE}
MEMORANDUM FOR INDIVIDUALS SUBJECT TO QUARANTINE	
FROM: {Installation Commander}	
SUBJECT: Notice of Quarantine	
<p>In response to a declared public health emergency on {installation name}, this is a formal notice that as the installation commander, I am ordering your quarantine. I am providing you with the following directions and information regarding the quarantine.</p>	
<p>{Name, identifying information or other description of the individual, group of individuals or geographic location subject to the order. Brief statement of the facts warranting the quarantine.}</p>	
<p>{Symptoms of the subject disease and a course of treatment. Instructions on the disinfecting or disposal of any personal property. Precautions to prevent the spread of the subject disease.}</p>	
<p>{Conditions for termination of the order. Specified duration of quarantine. The place or area of quarantine. Rules for the quarantine. Requirements for contact with non-quarantined individuals.}</p>	
<p>Any individual subject to quarantine has the right to contest the reason for quarantine. Information supporting an exemption or release can be provided to me or one of my designated representatives. I (or a designated representative) will review the information provided, in consultation with public health, medical, and legal personnel, for a final determination on the need for quarantine. The total time from submission to response will not exceed 24 hours.</p>	
<p>Procedures for the declaration of a public health emergency, quarantine, and the actions prescribed above are found in Department of Defense Instruction 6200.03, "Public Health Emergency Management (PHEM) Within the DoD," and {applicable Service Instruction}. It is DoD and {Military Service} policy that military installations, property, and personnel and other individuals working or residing on military installations will be protected under applicable legal authorities against communicable diseases associated with biological warfare or terrorism or other public health emergency. Violators of procedures, protocols, provisions, or orders detailed in this memorandum may be charged with a crime under Section 271 of Title 42, United States Code, and subject to punishment of a fine up to \$1,000 or imprisonment for not more than one year, or both.</p>	
<p>A wide range of professionals are working hard to bring this situation to a resolution that supports your health and the safety of the general public.</p>	
<p>{Installation Commander Signature Block}</p>	
<p>Attachment: Declaration of Public Health Emergency</p>	

Figure 4. Suggested Template for Written Notice of Isolation

{LETTERHEAD}	{DATE}
MEMORANDUM FOR INDIVIDUALS SUBJECT TO ISOLATION	
FROM: {Installation Commander}	
SUBJECT: Notice of Isolation	
<p>Due to your diagnosis of {specify communicable disease of concern}, this is a formal notice that as the installation commander, I am ordering your isolation. I am providing you with the following directions and information regarding the isolation.</p>	
<p>{Name, identifying information or other description of the individual, group of individuals or geographic location subject to the order. Brief statement of the facts warranting the isolation.}</p>	
<p>{Symptoms of the subject disease and a course of treatment. Instructions on the disinfecting or disposal of any personal property. Precautions to prevent the spread of the subject disease.}</p>	
<p>{Conditions for termination of the order. Specified duration of isolation. The place or area of isolation. Rules/requirements for the isolation, such as no unapproved contact with non-isolation or protocols for individuals entering isolation premises.}</p>	
<p>Any individual subject to isolation has the right to contest the reason for isolation. Information supporting an exemption or release can be provided to me or one of my designated representatives. I (or a designated representative) will review the information provided, in consultation with public health, medical, and legal personnel, for a final determination on the need for isolation. The total time from submission to response will not exceed 24 hours.</p>	
<p>Procedures for the declaration of isolation and the actions prescribed above are found in Department of Defense Instruction 6200.03, "Public Health Emergency Management (PHEM) Within the DoD," and {applicable Service Instruction}. It is DoD and {Military Service} policy that military installations, property, and personnel and other individuals working or residing on military installations will be protected under applicable legal authorities against communicable diseases of public health concern.</p>	
<p>Violators of procedures, protocols, provisions, or orders detailed in this memorandum may be charged with a crime under Section 271 of Title 42, United States Code, and subject to punishment of a fine up to \$1,000 or imprisonment for not more than one year, or both.</p>	
<p>A wide range of professionals are working hard to ensure you receive the highest quality medical care and are released from isolation as soon as possible. These actions are necessary to safeguard the health of your loved ones and ensure the safety of the general public.</p>	
{Installation Commander Signature Block}	
Attachment: Declaration of Public Health Emergency	

(12) Submission to vaccination, treatment, or diagnostic testing may be a requirement to return to work or gain access to a DoD installation or facility or as a condition of exemption or release from restriction of movement to prevent transmitting a communicable disease and to protect public health and safety.

(a) Qualified clinical personnel will perform these procedures consistent with appropriate medical standards, including appropriate exemption criteria.

(b) Service members may be required to participate in certain FHP measures, including mandatory vaccination, treatment, or diagnostic testing, subject to the applicable laws and regulations described in DoDI 6200.02.

(c) Persons other than Service members may be required to submit to vaccination, treatment, or diagnostic testing as necessary as a condition of access to a DoD installation or facility. During a declared DoD public health emergency, the provisions in DoDI 6205.4 regarding voluntary vaccination for non-Service members do not supersede the requirements in Paragraph 3.2.c.(12).

(13) Security and enforcement measures should be appropriate to the circumstances.

(14) Individuals and groups subject to quarantine will be advised that violators may be charged with a crime pursuant to law (including Section 797 of Title 50, U.S.C.; Section 1382 of Title 18, U.S.C.; or Parts 70 or 71 of Title 42, CFR) and subject to punishment of a fine up to \$1,000 or imprisonment for not more than 1 year, or both.

(a) In the case of Service members, these sanctions are in addition to applicable military law authorities, to the extent allowed by law.

(b) Those individuals or groups not subject to military law and who refuse to obey or otherwise violate an order issued in accordance with this issuance may be detained by the military commander until appropriate civil authorities can respond. The military commander will coordinate with civil authorities to ensure the response is appropriate for the public health emergency.

(15) Any fatalities associated with quarantined or isolated individuals will be addressed to prevent contamination and dissemination of the hazardous agent. The PHEO will recommend measures for reasonable and necessary testing and safe disposition of human remains after appropriate consultation with chain of command, local SLTT public health officials, and the coroner's office. The CDC, the Central Joint Mortuary Affairs Office, and the Office of the Armed Forces Medical Examiner will provide guidance regarding the testing and safe disposition of human remains in accordance with DoDI 1300.18.

3.3. NOTIFICATION PROCEDURES.

a. A declaration of a DoD public health emergency as defined by this issuance, will be immediately reported by the military commander through the chain of command to the Secretary of Defense.

b. The PHEO will initiate the reporting of a public health emergency declaration, with the military commander's approval, through the chain of command to:

(1) The respective Military Department SGs and the Service Public Health Center and, if the military commander is under the command of a GCC, to the Joint Staff Surgeon.

(2) SLTT public health agencies or HN health officials as applicable.

c. Reporting will follow the process described in Figures 5 and 6. Figure 6 is an expansion of the right side of Figure 5 for CCMD and overseas notifications. Figure 7 provides additional guidance on interpreting these diagrams.

(1) Every DoD Component identified in Figures 5 and 6 will ensure each of the component's specified reporting relationships is established and operational.

(2) The NMCC/GSAF is the designated DoD point of notification to the HHS SOC for potential PHEICs. The HHS SOC serves as the U.S. Government's National Focal Point (NFP) for notifications under the WHO IHR.

(3) Circumstances suggesting a public health emergency from non-DoD sources will be reported using the process described in Chairman of the Joint Chiefs of Staff Manual 3150.05D.

(4) There will be circumstances where it may be necessary to deviate from this outlined process to provide the notification to additional agencies and components, with authorization from appropriate authorities.

d. Notifications for public health emergency declarations by Coast Guard military commanders will occur in accordance with Coast Guard and DHS procedures and as follows:

(1) The Coast Guard will interface with the process outlined in Figure 5 through notifications made to the Armed Forces Health Surveillance Branch (AFHSB), which will relay information as described in Figure 7, item 5.

(2) The Coast Guard will notify the PHEO for collocated DoD installations.

(3) When under the authority of the Navy, the Coast Guard will execute public health emergency notification procedures as specified by Navy policy and directives.

(4) The Coast Guard will have additional notification procedures through internal processes and under DHS requirements.

Figure 5. Notification Routing Procedures (Overview)

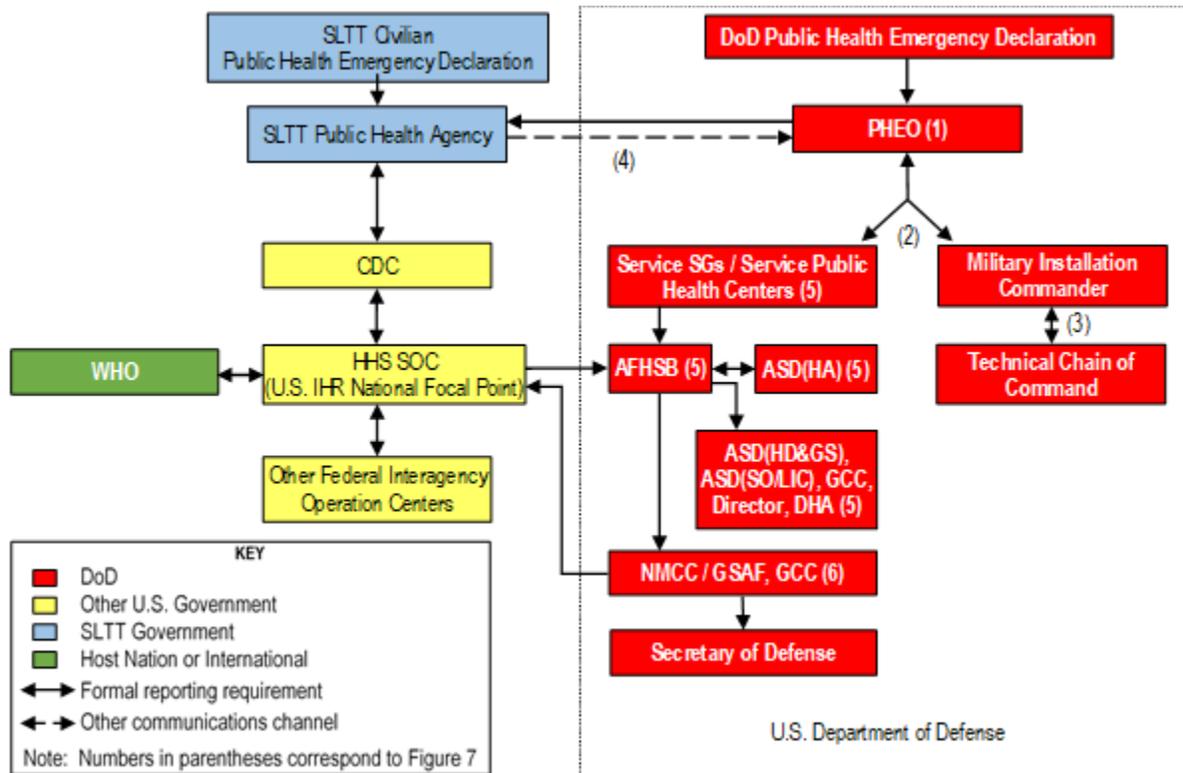


Figure 6. Notification Routing Procedures (Command and Overseas Notification)

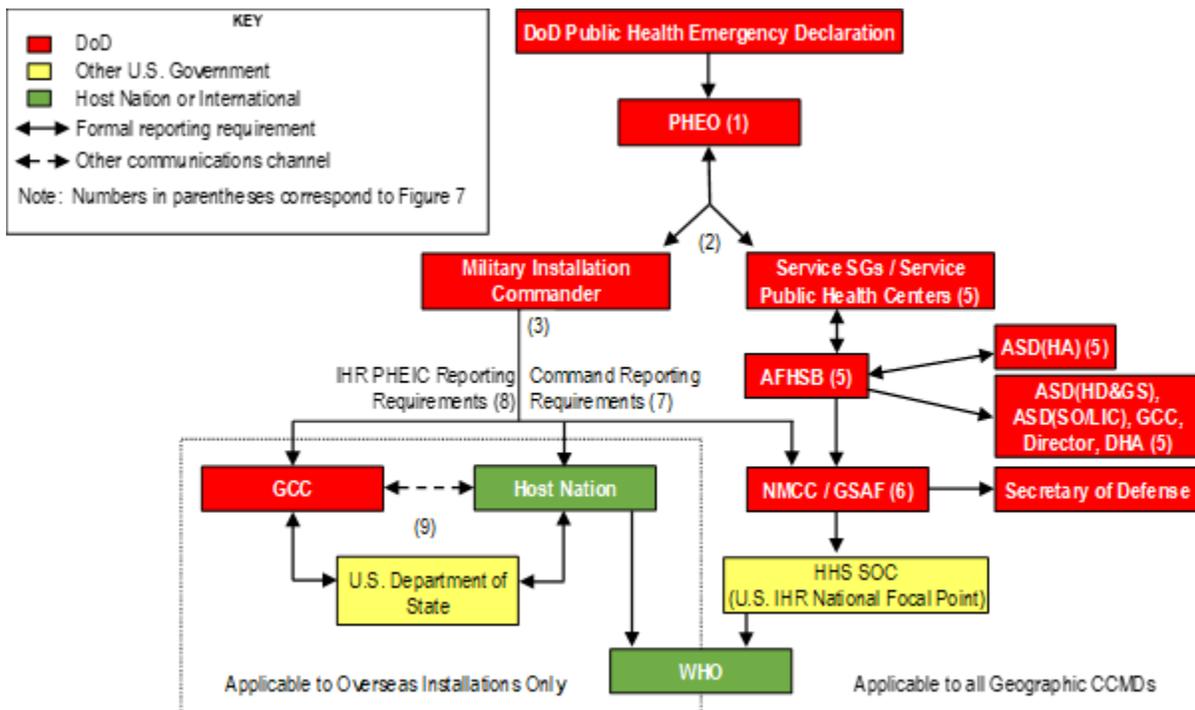


Figure 7. Explanatory Text for Figures 5 and 6

1. PHEOs will initiate notification procedures for a public health emergency declaration with approval by the military commander. For incidents that may be potential PHEICs, PHEOs will complete a report in accordance with Paragraph 3.4. of this issuance to be submitted through this same process. In some CCMDs, the Surgeon's office may perform duties similar to that of the PHEO.
2. The PHEO will provide the public health emergency declaration and relevant information, including potential PHEIC reporting, to the military commander for further reporting and to the appropriate Service SG and Service Public Health Center as appropriate.
3. Depending upon theater, operational, or regional policies, the military commander will notify the appropriate authorities within their technical chain of command. This may include the Service Major Command, the Service Chiefs, the CCMD, and the Service component, a joint task force, a subunified commander, or other entity as established.
4. The PHEO will notify appropriate SLTT public health officials of the DoD public health emergency declaration and accompanying response activities. In a civilian-declared public health emergency, SLTT officials may directly notify the PHEO or other installation point of contact depending on applicable agreements and communication plans.
5. The Military Department SGs and Service Public Health Centers will transmit notifications to the AFHSB for further dissemination. While AFHSB primary notification is to the ASD(HA) and to the NMCC/GSAF, other recipients of the notification will include ASD(HD&GS); ASD(SO/LIC); the Military Department SGs; GCC; the Director, DHA; and other DoD offices as required.
6. The NMCC/GSAF will notify the Secretary of Defense, CCMD, Military Services, and affected major commands of the public health emergency declaration as appropriate. The NMCC/GSAF will notify the HHS SOC/U.S. IHR NFP, upon ASD(HA) approval.
7. Command reporting follows CCMD tactics, techniques, and procedures and standard operating procedures (SOPs) established for line notification to the NMCC. Once joint task forces are operational, reporting will be in accordance with CCMD notification policy guidance.
8. PHEIC reporting policy under the WHO IHR is in accordance with determinations made by the relevant CCMD, COM, and HN.
9. Based upon discussions between the HN, GCC, and COM, potential PHEICs or events related to a declared PHEIC that involve U.S. Government affiliated personnel and dependents will be reported to the WHO via the U.S. IHR NFP and potentially by the HN IHR NFP.

3.4. REPORTING OF POTENTIAL PHEICs.

- a. Public health emergencies within the DoD will be assessed as potential PHEICs and reported accordingly through the notification procedures in Paragraph 3.3.

b. As part of the decision process for declaring a public health emergency, the PHEO will also evaluate the threat as a potential PHEIC. The determination of a potential PHEIC under the WHO IHR depends upon several factors.

(1) Due to the potential public health impact, these diseases must be reported immediately in accordance with the WHO IHR: smallpox, poliomyelitis due to wild-type virus, novel subtypes of human influenza, and severe acute respiratory syndrome. These diseases are the only ones that the WHO specifically identifies for immediate notification. Reporting is through the process outlined in Paragraph 3.3.

(2) Other disease and public health incidents, including those of unknown etiology, will be evaluated as potential PHEICs based upon the significance of the event. Two affirmative responses to any of the following four criteria indicate that PHEIC reporting is required:

- (a) Is the public health impact of this event serious?
- (b) Is the event unusual or unexpected?
- (c) Is there a significant risk of international spread?
- (d) Is there a significant risk of international trade or travel restrictions?

d. When reporting a potential PHEIC, the PHEO will provide detailed information on the threat by addressing each of the four PHEIC criteria, including the etiology of the threat, public health significance, affected population, and international impact.

e. Pursuant to the WHO IHR, the U.S. Government has 72 hours to formally notify the WHO of all events that may constitute a PHEIC within the United States as well as when the United States is in receipt of evidence of an international public health risk outside the United States.

(1) The DoD will review and route the PHEO's report of a potential PHEIC in accordance with the procedures in Paragraph 3.3. of this issuance and notify the HHS SOC of the potential PHEIC within 48 hours of submission of the PHEO's report to the appropriate Military Department SG and Service Public Health Center.

(2) The HHS SOC will inform WHO within 24 hours of notification of a potential PHEIC within the United States. The HHS SOC will also inform WHO, as far as practical, within 24 hours of receipt of evidence of a potential PHEIC outside the United States.

f. SLTT or HN public health officials may also report the potential PHEIC, however, this duplication does not relieve DoD of its reporting requirements.

g. As a signatory of the WHO IHR, the United States stated an exception to PHEIC reporting when notifications would undermine the ability of Military Services to effectively pursue national security interests. This exception does not apply to internal DoD reporting of potential PHEICs.

3.5. IMPLEMENTATION OUTSIDE THE UNITED STATES.

a. Many of the authorities cited in this issuance are inapplicable or cannot be implemented in an environment outside the United States without the cooperation of HN authorities, except to the extent as may be specified by governing international agreements.

b. HN ownership and control of installations outside the United States may prevent military commanders from unilaterally implementing many of the provisions of this issuance. Ultimately, U.S. authorities and control at locations outside the United States are subject to the sovereignty of the HN, except as otherwise defined in applicable international agreements, such as status-of-forces agreements, defense cooperation agreements, and base rights agreements.

c. A military commander's authority over personnel outside the United States is limited. This authority extends generally only to U.S. Service members, civilian employees of the U.S. Government, U.S. DoD contractor employees (when specified by agreements), and the dependents of these categories of personnel.

d. A military commander's authority and emergency health powers may be limited in scope as it pertains to HN personnel. Installations outside the United States will review their respective HN agreement and incorporate, by supplement to this issuance, the authority local military commanders possess as it pertains to HN personnel.

e. All installations located outside the United States will coordinate their responses to public health emergencies with the appropriate GCC. Coordination with the COM and DoS should be sought as appropriate.

SECTION 4: PHEM ROLES AND PROCEDURES

4.1. COMMAND RESPONSIBILITIES.

a. **Military Commander.** The military commander:

(1) Ensures that all units and tenant organizations comply with requirements of this issuance. No further delegation is authorized.

(2) Designates in writing a PHEO and an APHEO as defined in Paragraph 4.2. Additional APHEOs may be designated as necessary.

(a) When appropriately qualified personnel, as defined by the Service military medical department, do not exist at the installation level, military commanders may designate a PHEO as appropriate at a higher level in the Service organizational structure with the guidance of the Service HQ, as necessary. For DoD installations and military commands with widely geographically dispersed responsibilities, military commanders may designate a PHEO at an appropriate level within the organizational structure.

(b) In joint basing and tenant organization situations, the military commander will designate the PHEO and the APHEO(s).

1. On those installations where a joint medical center is a tenant, the commander of the joint medical center will make a qualified individual available to serve as PHEO for the host installation.

2. In some locations, it may be appropriate to designate a PHEO from one of the other tenant organizations, especially where a highly specialized skill set exists in another organization. APHEOs may be selected from Military Services different to that of the PHEO.

3. Joint basing and tenant organization agreements should reflect the requirement to provide a single coordinated response to any public health emergency.

4. When the designation of an appropriate PHEO is not forthcoming or causes local difficulties, the Service HQ PHEO should be consulted for adjudication; however, the final designation decision rests with the military commander.

(3) Ensures that the PHEO and APHEO(s) have adequate support and resources to accomplish their mission. Direct communication between the military commander and the PHEO will enhance preparedness for and response to public health emergencies.

(4) Ensures that FHP measures and PHEM are integrated into existing DoD installation and military command continuity, emergency preparedness, and response plans and agreements in accordance with DoDD 3020.26, DoDD 6200.04, DoDI 3020.52, and DoDI 6055.17.

(a) Ensures development of any necessary agreements with tenant medical, veterinary, and public health organizations for PHEM preparedness.

(b) Ensures appropriate public health, medical, and veterinary representation in the Emergency Management Working Group (EMWG) in accordance with DoDI 6055.17.

(c) Ensures that a public health emergency response exercise (e.g., disease containment plan (DCP) exercise or mass prophylaxis plan exercise) and a mass casualty exercise are conducted annually, either in conjunction with host installation or tenant command exercises or as stand-alone events.

(d) Ensures PHEO and MEM participation in installation and command exercises, as appropriate. After action reports should be completed promptly following exercises to identify corrective actions as well as to capture lessons learned in the appropriate Service-designated format.

(e) Ensures that medical and public health response activities to emergencies are managed in accordance with this issuance, DoDI 6055.17, and applicable Service instruction.

(5) Inside the United States, coordinates planning, preparedness, and response to public health emergencies with SLTT governments, other DoD Components, other federal agencies' regional offices, and forces operating under Title 32, U.S.C. (referred to in this issuance as "Title 32 forces") in accordance with DoDI 3020.52 and DoDI 6055.17. These efforts are to maintain effective communication channels with outside partners and to support the installation's internal preparedness and response activities.

(a) The military commander negotiates agreements with SLTT public health officials to serve as RSS sites for SNS materiel if the installation has suitable storage capability and sufficient capacity and if requested by SLTT public health officials. Support agreements are completed in accordance with DoDI 4000.19. Agreements will clarify responsibilities and must address situations when access to the installation is limited or restricted.

(b) The military commander negotiates agreements with SLTT public health officials to serve as closed PODs for an installation's population and is encouraged to do so as part of their preparedness activities when possible.

1. Agreements will specify the populations served by the POD (e.g., Service member, civilian, contractor, and beneficiary) and identify operational factors, including training and exercise requirements.

2. Preparedness planning should include bridging strategies for MCM and other medical materiel to cover the DoD population for up to 48 hours before resupply and assistance from the SNS is received.

3. DoD installations are to use local and military MCM assets as practicable before SNS assets, while ensuring priority access to MCM for mission essential personnel in accordance with Section 4 of E.O. 13527.

4. Installations that do not have closed POD agreements should be prepared to notify the installation's general population how to access MCM assets through the local

community when necessary with the assistance of the PAO and in coordination with SLTT public health officials.

(6) Outside the United States, exercises those emergency health powers granted in accordance with applicable international agreement, or otherwise within his or her inherent authority, in coordination with HN authorities.

(a) The PHEO will function as the military commander's primary public health advisor during an emergency regardless of HN actions.

(b) DoD installations located outside the United States must account for MCM materiel transit time/access when determining onsite asset requirements and should rely on onsite assets until other materiel becomes available.

(7) In response to a suspected or confirmed public health emergency and in consultation with his or her PHEO and SJA/CJA, declares a DoD public health emergency within the scope of the military commander's authority and implements relevant emergency health powers to achieve the greatest public health benefit while maintaining operational effectiveness. In widespread events, the number of incidents and/or the geographical extent of the incident(s) may warrant integration of response efforts at higher levels of command, e.g., Service or CCMD.

(8) Ensures that personnel accountability procedures are developed, assigned to appropriate personnel, and executed as necessary, in accordance with DoDI 3001.02. Accountability measures should account for the scope, severity, and unique circumstances of the public health emergency.

(9) Ensures an appropriate and measured local response to public health emergencies by directing the PHEO, MTF commander or director, and MEM to establish, as required, a temporary HPCON framework to provide stratified health protection measures for the overall installation population that are specific to the scope and severity of the current situation.

(a) The HPCON level should be synchronized with the installation force protection condition level, as detailed in Volume 2 of DoDI O-2000.16, and can include installation access, appropriate FHP measures, and limitation of non-critical activities.

(b) The determination to change the HPCON level will be made by the military commander in consultation with the PHEO and MTF commander or director.

(c) The HPCON framework is updated as necessary during the response to the public health emergency as new FHP guidance becomes available and will be discontinued at the termination of the public health emergency, unless renewed by the military commander for a specified period of time.

(10) Ensures that risk and crisis communications are executed by the PAO in coordination with the PHEO and all appropriate DoD installation and military command stakeholders. Public messaging should be disseminated widely throughout the installation community to ensure broad awareness of the HPCON level and recommended response actions.

(11) Ensures appropriate syndromic surveillance is conducted to assess threats to public health through the use of the Electronic Surveillance System for Early Notification of Community-based Epidemics (ESSENCE) or other established surveillance systems in accordance with DoDD 6490.02E.

(12) In carrying out activities under this issuance, cooperates with authorized law enforcement and other agencies investigating or responding to an actual or potential terrorist act, crime, or other relevant public health emergency. This includes reasonable steps to preserve potential evidence of criminal activity.

(13) Ensures DMH services are available through a DMHR team in response to an all-hazards incident by:

(a) Designating a licensed mental health provider (e.g., the Director of Psychological Health) as the DMHR team lead, who is trained in disaster mental health services, and who has overall responsibility for DMHR team training and service implementation, or identifying a pre-existing capability and entering into appropriate support agreements, as noted in Paragraph 4.1.a.(13)(c).

(b) Integrating DMH preparedness and response with other DoD installation and military command emergency response plans.

(c) Entering into agreements, as needed, with other installations, DoD Components, Reserve units, National Guard units, other federal departments or agencies, and civilian providers for DoD installations to ensure access to a DMHR team when the personnel and resources necessary to form a DMHR team are not present on a DoD installation.

(d) On installations where an MTF exists, the military commander may delegate the appropriate responsibilities in Paragraphs 4.1.a.(13)(a) to 4.1.a.(13)(c) to the MTF commander or director.

b. MTF Commander or Director. The MTF commander or director, as appropriate, (or, in the Coast Guard, Commandant (CG-11) or designee):

(1) Establishes a comprehensive MTF EM program that complies with DoDI 6055.17 and integrates all aspects of public health and medical emergency planning (e.g., mass medical care, medical logistics, DCP, and countermeasure acquisition and distribution). Ensures that installation MTF plans reflect the availability of capabilities noted in Paragraph 2.9.f.

(2) Designates in writing a MEM as defined in Paragraph 4.3. AMEMs may be designated as needed depending on capacity and facility needs.

(3) Ensures that the MEM has adequate support and resources to accomplish the mission.

(4) Authorizes licensed health care providers who are not credentialed or privileged, including non-DoD civilian health care providers offering assistance, to provide care within their facilities when necessary to respond to emergency requirements. Non-DoD civilian health care providers will maintain their licensure through their respective States (see Paragraph 5.3.).

(5) Authorizes medical support agreements with local health care providers to provide supplemental medical facilities, equipment, and other assistance as needed during emergencies.

(6) Directs MTF health care providers, medical examiners, pharmacists, laboratorians, and associated health care personnel under his or her authority to promptly report to the appropriate PHEO any circumstance suggesting a public health emergency to include diagnosed illnesses or health conditions; prescription rates, types, or trends; and presumptive or confirmed laboratory diagnostic results. These reports are in addition to reports required by otherwise applicable surveillance systems, including non-DoD systems, and as required by DoDD 6490.02E.

(7) Ensures each MTF identifies and designates all key response personnel (e.g., first responders and first receivers) and coordinates to ensure they have access to the installation during emergency conditions.

(8) Ensures all key response personnel are trained in the performance of the job functions they are assigned to during emergency conditions.

(9) Ensures that MTF EM is integrated into existing emergency preparedness and response plans (e.g., DCP and mass casualty plans) and agreements in accordance with DoDI 3020.52 and DoDI 6055.17. These plans will be coordinated with both medical and non-medical stakeholders, including the installation (or joint base) EM program, SLTT governments, other federal agencies' regional offices, Title 32 forces, and HN authorities, as applicable. These plans will be exercised regularly, in accordance with applicable Service instructions, and revised based on corrective action plans as necessary.

(10) Ensures appropriate syndromic surveillance is conducted to assess threats to public health through the use of ESSENCE or other established surveillance systems.

4.2. PHEO AND APHEO.

a. **Qualifications.** PHEOs and APHEOs:

(1) Are either Service members or DoD civilian medical employees. The PHEO must be a clinician (as defined by the Military Services in their respective implementing instructions). The APHEO is not required to be a clinician.

(2) Have a Master of Public Health (or equivalent) degree or 4 years of experience in public health, preventive medicine, or environmental health.

(3) Hold an active national security clearance at the SECRET level or above.

b. Requisite Training. To support effective preparedness, response, and recovery from public health emergencies affecting DoD personnel, installations, and properties, PHEOs and APHEOs must complete appropriate training.

(1) PHEM course requirements:

(a) **Basic Training:** Within 1 year of designation as a PHEO or APHEO, complete the initial level of the PHEM course offered by the Defense Medical Readiness Training Institute (DMRTI).

(b) **Sustainment Training:** Within 1 year of completing the 4th year of service as a PHEO or APHEO and after every subsequent 4 years in the role, complete the advanced level of the PHEM course provided by DMRTI.

(c) **Re-activation:** When returning to the role of PHEO or APHEO after 3 or more years in other duty assignments and within 1 year of returning to the role, complete the appropriate level of the PHEM course. Returning PHEOs and APHEOs will consult with their commands or Service PHEO resources to determine which PHEM course to complete.

(2) PHEOs and APHEOs must be familiar with systems involved in coordination, support, and integration with civilian authorities, including the National Incident Management System, Incident Command System, and the National Planning Frameworks, in accordance with DoDI 3020.52 and DoDI 6055.17.

(3) Public health and medical capabilities are critical components of CBRNE preparedness and response on DoD installations. PHEOs and APHEOs will comply with the knowledge requirements provided in DoDI 3020.52 on CBRNE capabilities within the DoD.

(4) Supplemental training may be required by the Military Services or CCMDs based on specific issues related to the PHEO or APHEO role, installation, or geographic location.

c. Responsibilities. PHEOs and APHEOs provide military commanders with guidance and recommendations on preparing for, declaring, responding to, mitigating, and recovering from public health emergencies. PHEO responsibilities fall into 10 major categories and include:

(1) Collaborating closely with the EM program manager and the MEM in preparing for, declaring, responding to, and recovering from a public health emergency.

(2) Maintaining situational awareness of public health and medical threats.

(3) Advising the military commander regarding the declaration of a public health emergency and the implementation of emergency health powers in accordance with relevant public health laws, regulations, and policies, in coordination with the SJA/CJA.

(4) Ensuring appropriate epidemiological investigations are conducted.

(5) Recommending appropriate diagnosis, treatment, and prophylaxis of affected individuals or groups and populations in consultation with appropriate clinical staff.

(6) Providing subject matter expertise to military commanders in the integration of public health and medical preparedness with other DoD installation or military command emergency response planning and exercises, including participating in annual exercises.

(7) Supporting preparedness for public health emergencies and medical surge capacity in collaboration with the MEM as appropriate, including providing subject matter expertise as needed on agreements with civilian public health and medical authorities.

(8) Assisting in public affairs risk communications, including dissemination of health protection measures detailed in the HPCON framework in coordination with the PAO.

(9) Advising the military commander on public health aspects of workplace and return to work issues during the emergency response and recovery phases.

(10) Coordinating with other DoD Components, civilian SLTT, other federal agency regional offices, Title 32 forces, and HN agencies and organizations in all responsibilities listed in Paragraphs 4.2.c.(1) through 4.2.c.(9) as necessary.

d. PHEO Procedures. PHEOs and APHEOs:

(1) Ensure collaboration and serve as a clearinghouse for health-related information during a public health emergency. The PHEO will work closely with other medical and non-medical personnel; SLTT governments; other federal agencies' regional offices; Title 32 forces; and HN authorities (as applicable) to identify, confirm, and control a public health emergency that may affect the DoD installation or military command.

(2) In the United States, coordinate through the chain of command, the local CDC quarantine officer, and SLTT public health officials in relation to actions taken in accordance with CDC quarantine authorities provided in Parts 70 and 71 of Title 42, CFR and SLTT quarantine authorities. Outside the United States, in addition to the chain of command, coordination will be with GCC, DoS, and appropriate HN public health officials.

(3) Provide accurate and relevant information to enable timely notification to affected individuals of a public health emergency, its termination, and actions taken to control or mitigate the emergency. Provision of information will be performed in coordination with the installation or military command's PAO and if applicable, a joint information center.

(4) Develop the HPCON framework, as directed by the commander, as a temporary risk communication tool for the specific health threat, in consultation with the MTF commander or director and MEM, based upon the scope and severity of the situation and provide guidance on appropriate actions individuals should take to protect themselves.

(a) Health measures in the HPCON framework will be clearly defined and specified in categories based on the impact of the health threat, specific precautions, and level of effort, beginning with simple precautions and escalating the level of effort in subsequent categories, based upon protective measures available to installation personnel (see Figure 8).

(b) Health precautions should utilize relevant FHP measures already identified when possible and appropriate, which can include personal protective equipment, individual behavioral actions, closure of installation facilities, MCM, and other protective measures to reduce the risk of the health threat.

(c) The PHEO updates the HPCON measures as necessary as the situation evolves using available guidance from DoD and appropriate civilian medical and public health sources.

(d) PHEOs are encouraged to collaborate on risk communications HPCON content with their counterparts at other affected DoD installations and SLTT public health officials to ensure consistency of messaging and unity of effort.

(5) Use all available resources to assist in determining if a public health emergency declaration is indicated and if a potential PHEIC should be reported.

(6) Maintain close contact and coordination with military veterinary authorities concerning relevant actions taken under this issuance.

Figure 8. Conceptual HPCON Framework

Situation	HPCON	Example Health Protection Measures
Normal baseline	0	Routine: Normal operations. Maintain standard precautions such as routine hand washing, cough on sleeve, good diet, exercise, vaccinations, education, routine health alerts, and regular preparedness activities
Report of unusual health risk or disease	A	Limited: Health Alert. Communicate risk and symptoms of health threat to installation; review plans and verify training, stocks, and posture; prepare to diagnose, isolate, and report new cases
Outbreak or heightened exposure risk	B	Moderate: Strict hygiene (no handshaking, wipe common-use items); if exposed, self-isolate (wear mask or remain home); avoid contaminated water/food or risk area; vector control if applicable
High morbidity epidemic or contamination	C	Substantial: Social distancing (limit or cancel in-person meetings, gatherings, temporary duty assignments); shelter in-place indoors; utilize respirators; mass distribution of MCM
High mortality epidemic or contamination	D	Severe: Restriction of movement (e.g., quarantine); mass evacuation; mass decontamination; subsist on secure food/water sources

(7) Maintain close contact and coordination with SLTT governments, other federal agencies' regional offices, Title 32 forces, and HN authorities concerning all actions taken under this issuance. Outside the United States, a PHEO will coordinate with appropriate HN officials and, if applicable, other allied forces public health officials. Consistent with the protection of DoD installations, facilities, assets, and personnel, a PHEO will facilitate the assumption of public health emergency responsibilities by civilian agencies with jurisdiction in relation to persons other than Service members and property not owned by the DoD.

(8) In the United States, provide SME support to the military commander, the EM program manager, MEM, and others in executing agreements with SLTT SNS coordinators regarding the receipt, distribution, and dispensing of SNS assets.

(9) In consultation with relevant officials and resources, support the military commander and the EM program manager on mass fatality management, particularly recommending measures for reasonable and necessary testing and safe disposition of human remains in CBRNE incidents (see Paragraph 3.2.c.(15)).

4.3. MEM AND AMEM.

a. **Qualifications.** MEMs and AMEMs:

- (1) Are either Service members or DoD civilian employees.
- (2) Hold an active national security clearance at the SECRET level or above.
- (3) Meet appropriate standards for credentialing and certification as identified by the respective Military Department.

b. Requisite Training. To support effective preparedness, response, and recovery from public health emergencies affecting DoD personnel, installations, and properties, MEMs and AMEMs must complete appropriate training.

- (1) PHEM course requirements:
 - (a) **Basic Training:** Within 1 year of designation as a MEM or AMEM, complete the initial level of the PHEM course offered by DMRTI.
 - (b) **Sustainment Training:** Within 1 year of completing the 4th year of service as a MEM or AMEM and after every subsequent 4 years in the role, complete the advanced level of the PHEM course provide by DMRTI.
 - (c) **Re-activation:** When returning to the role as a MEM or AMEM after 3 or more years in other duty assignments and within 1 year of returning to the role, complete the appropriate level of the PHEM course. Returning MEMs and AMEMs will consult with their commands or Service MEM resources to determine which PHEM course to complete.
- (2) MEMs and AMEMs must be familiar with systems involved in coordination, support, and integration with civilian authorities including the National Incident Management System, Incident Command System, and the National Planning Frameworks, in accordance with DoDI 3020.52 and DoDI 6055.17.
- (3) Public health and medical capabilities are critical components of CBRNE preparedness and response on DoD installations. MEMs and AMEMs will comply with the knowledge requirements provided in DoDI 3020.52 on CBRNE capabilities within the DoD.

(4) Supplemental training may be required by the Military Services or CCMDs based on specific considerations related to the MTF, installation, or geographic location.

c. Responsibilities. MEMs and AMEMs coordinate planning and preparedness, and support MTF commanders or directors in the execution of an all-hazards MTF EM program. MEMs have the primary responsibility for the overall implementation and management of the MTF EM program, to include related elements such as continuity of operations, when specified by Service-level guidance. MEM responsibilities include:

(1) Ensure MTF EM plan development and management activities are comprehensive and compliant with applicable DoD and Service-level requirements, including DoDI 6055.17, such that plans are functionally aligned and integrated as a nested component within the host installation, as applicable.

(2) Ensure that threat information, vulnerability assessments, and all mitigating actions are considered in executing MTF EM activities as defined in DoDI 6055.17.

(3) Support MTF EM program accreditation by ensuring compliance with EM standards set by the Joint Commission.

(4) Act as the MTF point of contact with the installation's EM program manager, and serve as an active participant in the installation EMWG. Serve on the Recovery Work Group when activated. Coordinate with appropriate installation agencies to determine the support requirements in installation plans for mass prophylaxis, disease containment, mass casualty, and public health emergency response. This support may include, as appropriate, public health aspects of mass care, special needs populations, patient evacuation, and shelter-in-place. MEMs at standalone MTFs will coordinate with their host installation's EM program on planning activities and how to participate in the host installation's EMWG and Recovery Work Group.

(5) Provide subject matter expertise in the integration of public health and medical capabilities into installation EM planning to reduce the impact on the health and well-being of the installation's population during an incident.

(6) Assist with installation exercise design and development to ensure medical capabilities and capacities are incorporated, exercised, and evaluated as appropriate, including participation in annual exercises.

(7) Support MTF commanders or directors in the coordination and integration of EM-related training and exercises. Determine exercise goals and objectives to fully test medical response capabilities as noted in response plans.

(8) Serve as the MTF lead for military/civilian coordination as it relates to EM. Act as the point of contact in the development of appropriate medical support agreements with civilian public health and medical authorities.

(9) Integrate the acquisition, delivery, and distribution procedures of all available public health and medical materiel caches, including relevant DoD and SNS assets, into MTF and installation response plans as appropriate.

(10) Serve as the primary advocate to ensure that appropriate resource needs are identified to execute mission requirements.

d. MEM Procedures. MEMs and AMEMs:

(1) Serve as the central points of contact for MTF emergency planning and for coordinating public health and medical support to installation, local, or regional emergency response requirements.

(2) Coordinate closely with functional SMEs through the MTF and installation emergency preparedness committees or working groups, the PHEO, and the EMWG to ensure plans are adequate, supportable, coordinated, and synchronized.

(3) In the United States, assist the military commander in the execution of agreements with SLTT SNS coordinators regarding the receipt, distribution, and dispensing of SNS assets with the assistance of the EM program manager and PHEO.

4.4. VETERINARY PERSONNEL. In accordance with DoDD 6400.04E, veterinary personnel:

a. Provide veterinary services, as defined in DoDD 6400.04E, and subject matter expertise for DoD installations or military commands for animal health matters related to PHEM.

b. Coordinate and integrate veterinary public health and veterinary medical planning (e.g., veterinary medical care, medical logistics, and countermeasure acquisition and distribution) with PHEM preparedness and response planning activities where appropriate.

c. Report to the appropriate PHEO any circumstance suggesting a public health emergency. This responsibility is in addition to reports required by otherwise applicable surveillance systems, including non-DoD systems.

d. Provide operational guidance and support as necessary during a suspected or confirmed public health emergency, which may include:

(1) Animal health and welfare to include identification of affected or susceptible animals as well as detection or control of animal disease using strategic vaccination and treatment.

(2) Animal health surveillance.

(3) Food safety and defense.

(4) Training.

(5) Laboratory diagnosis.

(6) Biosecurity, cleaning, and disinfection.

(7) Criteria for animal quarantine or isolation (to include consideration of pets if the owner is under restriction of movement orders).

(8) Animal euthanasia.

(9) Coordination with wildlife management and vector control personnel.

(10) Risk communication message content.

4.5. DMHR TEAMS.

a. DMHR teams are multidisciplinary. They include, at a minimum, individuals in each of the following areas:

(1) Mental health (e.g., a psychiatrist, psychologist, social worker, psychiatric nurse practitioner, a mental health technician, or licensed provider who is trained in acute mental health intervention).

(2) Spiritual support (e.g., a chaplain and a religious affairs enlisted member).

(3) Family support (e.g., a community readiness consultant).

b. DMHR teams are led by licensed mental health providers.

c. DMHR teams have the following responsibilities:

(1) Coordinate with family assistance centers on the installation and other agencies to arrange DMH services for family and community members impacted by an all-hazards incident.

(2) Establish SOPs, in accordance with recognized national practice guidelines, such as the National Institute of Mental Health Publication No. 02-5138, that include at a minimum:

(a) The composition and role of the team.

(b) A listing of the available, locally-trained resources with contact information, including employee assistance programs.

(c) A description of local conditions and any identified high-risk groups.

(d) A response plan for team activation.

(e) Plans for conducting DMH needs assessments and surveillance.

(f) Required initial/periodic training.

(3) Establish a plan for maintaining individual DMHR team member psychological health in accordance with recognized national practice guidelines, such as the Department of

Health and Human Services Publication No. ADM 90-0537. Ensure integration of the plan within the DMHR SOPs.

(4) Provide DMH services to include prevention, outreach, screening, triage, psychological first aid, education, and specialty referral(s) to individuals and groups who have had or may have had exposure to an all-hazards incident. These services are not medical services, and therefore do not involve medical or mental health record documentation.

(5) Train annually as part of the overall installation EM exercises in accordance with DoDI 6055.17.

(6) Train at least quarterly as a DMHR team, using evidence-based practices, to develop and maintain the competencies necessary to provide DMH services. Training will cover, at a minimum, prevention, outreach, screening, triage, psychological first aid, education, and referral services for individuals and groups who have had or may have had exposure to an all-hazards incident. Training will also cover command consultation and ethical issues during disasters.

(7) Identify and train primary and alternate DMHR team members for each role to ensure continuous access to DMH services. Regional and rapid response teams should involve any installation-level and other DoD or command-authorized local mental health, spiritual support, and family support resources to augment DMH services and to provide knowledge of local community characteristics and needs.

(8) Coordinate efforts with the EM program manager, PHEO, and MEM as appropriate, and integrate efforts of the DMHR team into the overall installation's emergency preparedness, response, and recovery activities.

SECTION 5: SURGE CAPABILITIES AND PROCEDURES FOR HEALTH CARE IN DOD PUBLIC HEALTH EMERGENCIES

5.1. GENERAL.

a. Public health emergencies of national significance, such as pandemic influenza, are likely to result in surge requirements that overwhelm the response capacity, capability, and resources of both medical facilities and health care providers. Under these conditions, situational standards of care will be adopted, and difficult decisions regarding the allocation of limited resources will be required. Within DoD, all levels of command and health care providers will incorporate these principles in developing their public health emergency response plans and in determining the allocation of limited medical resources.

b. The MHS will adopt the framework in this section for the delivery of medical care at MTFs during public health emergencies and will incorporate it into all aspects of planning for these emergencies.

c. The provisions of this section are intended to establish a standard of care appropriate to the circumstances of the public health emergency and differ from the standard of care ordinarily applicable in MTFs, absent a declaration of public health emergency.

5.2. PRIORITIZING DELIVERY OF MEDICAL CARE AND AUTHORIZING SITUATIONAL STANDARDS OF CARE DURING PUBLIC HEALTH EMERGENCIES INVOLVING MASS CASUALTIES.

a. The MHS direct care system has two primary objectives: to support the national security mission and to provide care for MHS-eligible beneficiaries with MTF primary care managers. MTF commanders or directors will fulfill both of these primary objectives, however during resource scarcity, critical mission requirements may necessitate a higher priority of national security missions over beneficiary care.

(1) **Supporting the Mission.** Under emergency conditions, the allocation of resources may not be based solely on medical necessity or risk, but also may be based on operational or other national security requirements, as directed by the President or Secretary of Defense. Some Service members, for example, may receive a higher level of care due to operational requirements, independent of their immediate medical risk.

(2) **Providing Beneficiary Care.** While other objectives of the direct care system may have lesser priority in terms of supporting the mission, this prioritization does not obviate the responsibility to continue to care for beneficiaries enrolled with MTF primary care managers. These beneficiaries have an understandable expectation of continued access to their primary care. Such expectation, however, does not create an entitlement for care at a specific MTF.

b. MTF commanders or directors are directed to make public health emergency plans to meet surge requirements related to the two primary missions.

(1) Determination of critical personnel, rather than blanket policies affecting all Service members in an area of responsibility, will help meet the two seemingly conflicting objectives affecting mission requirements and beneficiary care. This approach will require a critical analysis at local levels of what represents a critical role.

(2) MTF commanders or directors will make arrangements to ensure that the minimum level of care provided to all enrolled beneficiaries is, at the very least, comparable to local community standards in the context of the public health emergency.

(3) Such arrangements may include special work schedules; increased use of Reserve Component members, intermittent employees, re-employed annuitants, contractor personnel, and volunteers; and coordination with the TRICARE Managed Care Support Contractor.

(4) Planning to ensure the smooth transition of care for MTF-enrolled patients by non-DoD providers, to the extent that is necessary, must be accomplished well in advance of emergency conditions.

(5) To fully manage expectations and educate the beneficiary population on the emergency response plan relating to access to care, risk communication messages and products must clearly state where to receive care in the event of a public health emergency.

c. As in any mass casualty event, when the number of casualties exceeds the available capabilities to rapidly treat and evacuate, the adoption of situational community standards of care will be required.

(1) In U.S. settings, the situational standard of care, at the very least, should be comparable to local civilian community standards. In many settings, the standard of care may exceed that of the local civilian community.

(2) In HN settings, the situational standard of care will not necessarily mirror that of the HN but will be based on available assets and requirements consistent with preexisting DoD medical triage practice.

d. During a declared public health emergency, to the extent necessary to deal with mass casualties and without unnecessarily compromising the quality of care, the MTF commander or director may authorize situational standards of care, including but not limited to:

(1) The scope of practice of health care practitioners and supporting technical staff (e.g., medical technicians, hospital corpsmen) may be expanded beyond the scope for which the practitioner is ordinarily privileged or authorized to perform, consistent with the judgment of the MTF commander or director and the training, experience, and capability of the practitioners involved.

(2) SOPs or standard clinical guidelines for specialty referrals, confirmatory clinical testing, use of equipment, provider-to-patient ratios, and similar matters may be suspended.

(3) Standard procedures for documentation regarding health care options, discussions, and decisions may be altered.

(4) Establishment of alternate or supplemental care sites that do not meet normal facilities standards.

(5) Expanded use of telemedicine.

e. When resources are insufficient to meet the health care needs of beneficiaries in a public health emergency, the MHS will use the limited resources to achieve the greatest good for the greatest number. In this context, “good” is defined as lives saved and suffering alleviated.

(1) In an environment of insufficient resources, MTF commanders or directors will not require expenditure of resources if treatment likely would prove futile or if a disproportionate amount of assets would be expended for one individual at the cost of many other lives that otherwise could be saved.

(2) MTF commanders or directors are to ensure the most competent medical authority is available, at the lowest level of command possible, to make medical judgments of this nature.

f. Decisions involving triage for care and the allocation of medical supplies must take into account the values of personal rights and fairness to all. Critical mission requirements may require allocation of resources based on operational factors rather than medical risk.

(1) MTF commanders or directors must communicate regularly and clearly on the resource limitations that exist at their facilities to maximize the communities’ effective response to a public health emergency.

(2) MTFs will provide care to their enrolled populations as noted in Paragraphs 5.2.a. and 5.2.b. Other eligible beneficiaries are expected to seek care at the facilities where they routinely receive primary care.

(3) Access to MTF care will comply with the beneficiary group priority list at Part 199.17 of Title 32, CFR. However, availability of care is always subject to mission requirements directed by the President or Secretary of Defense as authorized by federal law.

g. MTF commanders or directors and health care providers throughout the DoD need to engage in ongoing planning and decision-making consistent with this general policy and responsive to changing local conditions.

(1) MTF commanders or directors must effectively communicate decisions regarding resource limitations to each other and the community before emergencies occur, as well as during emergencies when conditions change.

(2) A decision made in one area may not be appropriate for another due to conditions such as population demographics, susceptibility, capacity, and resources.

(3) Conditions affecting decisions include, but are not limited to, availability of health care providers and resources such as pharmaceuticals, ventilators, and hospital beds, all in the context of evolving disease characteristics on target and at-risk populations. A discussion of

planning challenges, including ethical issues, is included in the Mass Medical Care Community Planning Guide from the HHS Agency for Healthcare Research and Quality.

5.3. USE OF VOLUNTEERS TO SUPPLEMENT HEALTH CARE PERSONNEL.

a. Upon a declaration of public health emergency, the MTF commander or director may supplement the available staff of health care personnel with the use of volunteers.

b. The policies and procedures of DoDI 1100.21 and DoDI 5200.02 will apply to the use of volunteers under this section, except that:

(1) For purposes of credentialing and privileging, the MTF commander or director may accept information and documentation provided through HHS's Emergency System for Advance Registration of Volunteer Health Professionals (also known as "ESAR-VHP"), or other such documentation that the MTF commander or director determines reliable.

(2) There is no requirement for a criminal background check. However, volunteers without a criminal background check require close clinical supervision when they are caring for patients under the age of 18.

c. Volunteers under Paragraph 5.3. are considered employees of the DoD to the extent provided in DoDI 1100.21.

d. For purposes of licensure requirements, a current, valid license in a State (or other federal jurisdiction) is required.

(1) There is no requirement that the license be unrestricted, such as a license restricted to Federal Government practice, so long as the restriction does not indicate a lack of qualifications to provide the services covered by the volunteer agreement.

(2) There is no requirement for a license from the specific State (or other federal jurisdiction) where the DoD installation or treatment facility (including a temporary facility treating DoD personnel and health care beneficiaries and under DoD control) is located.

e. Temporary privileges for volunteers supplementing health care personnel in a DoD-declared public health emergency may be initiated only when the MTF's EM plan or installation EM plan has been activated and the MTF is unable to handle the immediate patient needs.

(1) These privileges allow non-staff practitioners to come to the aid of the MTF during a public health emergency.

(2) The MTF commander or director may grant temporary privileges, but there must be policy and procedure in place that addresses current accreditation requirements and temporary privileges.

(3) All temporary privileges will immediately terminate once the EM plan is no longer activated; however, the MTF may choose to terminate temporary privileges prior to that time.

GLOSSARY

G.1. ACRONYMS.

AFHSB	Armed Forces Health Surveillance Branch
AMEM	alternate medical emergency manager
APHEO	alternate public health emergency officer
ASD(HA)	Assistant Secretary of Defense for Health Affairs
ASD(HD&GS)	Assistant Secretary of Defense for Homeland Defense and Global Security
ASD(SO/LIC)	Assistant Secretary of Defense for Special Operations and Low-Intensity Conflict
CBRNE	chemical, biological, radiological, nuclear, and high-yield explosives
CCMD	Combatant Command
CDC	Centers for Disease Control and Prevention
CFR	Code of Federal Regulations
CJA	command judge advocate
COM	chief of mission
DCP	disease containment plan
DHA	Defense Health Agency
DHS	Department of Homeland Security
DMH	disaster mental health
DMHR	disaster mental health response
DMRTI	Defense Medical Readiness Training Institute
DoDD	DoD directive
DoDI	DoD instruction
DoS	Department of State
EM	emergency management
EMWG	Emergency Management Working Group
E.O.	Executive Order
ESAR-VHP	Emergency System for Advance Registration of Volunteer Health Professionals
ESSENCE	Electronic Surveillance System for Early Notification of Community-based Epidemics
FHP	force health protection
GCC	geographic Combatant Commander
GSAF	Global Situational Awareness Facility
HHS	Department of Health and Human Services
HN	host nation

HPCON	health protection condition
HQ	headquarters
IHR	International Health Regulations (2005)
LRN	Laboratory Response Network
MCM	medical countermeasures
MEM	medical emergency manager
MHS	Military Health System
MTF	medical treatment facility
NFP	National Focal Point
NMCC	National Military Command Center
PAO	public affairs office
PHEIC	public health emergency of international concern
PHEM	Public Health Emergency Management
PHEO	public health emergency officer
POD	point of dispensing
RSS	receipt, staging, and storage
SG	Surgeon General
SJA	staff judge advocate
SLTT	State, local, tribal, territorial
SME	subject matter expert
SNS	Strategic National Stockpile
SOC	Secretary's Operations Center
SOP	standard operating procedure
U.S.C.	United States Code
USD(P&R)	Under Secretary of Defense for Personnel and Readiness
USD(P)	Under Secretary of Defense for Policy
WHO	World Health Organization

G.2. DEFINITIONS. Unless otherwise noted, these terms and their definitions are for the purpose of this issuance.

all-hazards. Defined in Presidential Policy Directive 21.

COM. Defined in the DoD Dictionary of Military and Associated Terms.

Cities Readiness Initiative. A federally-funded, CDC-managed effort to prepare major cities and metropolitan areas to respond to a large-scale bioterrorist event by dispensing antibiotics and other medical supplies to the entire identified population within 48 hours of the decision to do so.

closed POD. A site intended for the dispensation of medications to a select or pre-defined population, not the general public.

communicable disease. An illness due to a specific infectious agent or its toxic products that arises through transmission of that agent or its products from an infected or affected individual, animal, or a reservoir to a susceptible host, either directly or indirectly through an intermediate animal host, vector, or the inanimate environment.

conditional release. Temporary supervision and monitoring of an individual or group, who may have been exposed to a quarantinable communicable disease to determine the risk of disease spread. Supervision is accomplished through in-person visits, telephone, or through electronic or Internet-based monitoring.

DMH. Provision of prevention, outreach, screening, triage, psychological first aid, education, and referral services to individuals and groups who have had or may have had exposure to an all-hazards incident.

DMHR team. Designated team that provides command consultation, prevention, outreach, screening, triage, psychological first aid, education, and referral services following an all-hazards incident.

ESSENCE. DoD's syndromic surveillance tool that monitors and provides alerts for rapid or unusual increases in the occurrence of infectious diseases and biological outbreaks.

HPCON level. A framework to inform an installation's population of specific health protection actions recommended in response to an identified health threat, stratified by the scope and severity of the health threat.

isolation. The separation of an individual or group infected or reasonably believed to be infected with a communicable disease from those who are healthy in such a place and manner to prevent the spread of the communicable disease.

LRN. Defined in DoDI 6440.03.

military commander. Defined in DoDI 5200.08.

MTF. Defined in the DoD Dictionary for Military and Associated Terms.

MTF commander or director. The commander or director of a facility established for the purpose of furnishing medical or dental care to eligible individuals.

open POD. A public site designed for dispensation of medications to the general population.

POD. A location where pharmaceuticals and other medications are distributed to the end user; these facilities may range from small clinics to large operations with multiple staging and operations areas; these facilities may also support a range of methods of distributing drugs and medications to the patients.

public health emergency. An occurrence or imminent threat of an illness or health condition that poses:

A high probability of a significant number of deaths in the affected population considering the severity and probability of the event;

A significant number of serious or long-term disabilities in the affected population considering the severity and probability of the event;

Widespread exposure to an infectious or toxic agent, including those of zoonotic origin, that poses a significant risk of substantial future harm to a large number of people in the affected population;

Health care needs that exceed available resources; or

Severe degradation of mission capabilities or normal operations.

PHEIC. An extraordinary public health event as declared by the Director of the WHO that constitutes a public health risk to other countries through the international spread of the health hazard and potentially requires a coordinated international response.

quarantinable disease. Any of the communicable diseases defined in E.O. 13295, as amended.

quarantine. The separation of an individual or group that has been exposed to a communicable disease, but is not yet ill, from others who have not been so exposed, in such manner and place to prevent the possible spread of the communicable disease.

restriction of movement. Limiting movement of an individual or group to prevent or diminish the transmission of a communicable disease, including limiting ingress and egress to, from, or on a military installation; isolation; quarantine; and conditional release.

RSS site. Sites with adequate warehouse space, cargo management, and logistics assets that accept SNS assets deployed to SLTT public health authorities for secure storage.

Service public health centers. Navy and Marine Corps Public Health Center, U.S. Air Force School of Aerospace Medicine, U.S. Army Public Health Center.

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

telemedicine. Defined in the DoD Dictionary of Military and Associated Terms.

terrorism. Defined in the DoD Dictionary of Military and Associated Terms.

TRICARE. Defined in DoDD 5136.13.

United States. Defined in the DoD Dictionary of Military and Associated Terms.

zoonotic disease. Diseases transmissible under natural conditions between vertebrate animals and humans.

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