HEADQUARTERS, US NORTHERN COMMAND
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USNORTHCOM CONPLAN 3591-09
USNORTHCOM RESPONSE TO PANDEMIC INFLUENZA

References:

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1. Situation

a. General

(1) Background on Pandemic Influenza

(a) The threat of future Pandemic Influenza (PI) has serious national security implications for the United States. Because humans have little or no immunity to a new virus, a pandemic can occur with substantially higher sickness and mortality rates than normal influenza. Three human pandemics have occurred in the 20th century, each resulting in illness in approximately 30% of the world population and death in 0.2% to 2% of those infected. Using this historical information and current models of disease transmission, it is projected that a modern pandemic could lead to the deaths of 200,000 to 2 million Americans.

(b) Human influenza virus" usually refers to those subtypes that spread widely among humans. There are only four known A subtypes of influenza viruses (H1N1, H1N2, H3N2, and H7N2) currently circulating among humans. It is likely that some genetic parts of current human influenza A viruses originally came from birds. Influenza A viruses are constantly changing, and other strains might adapt over time to infect and spread among humans.

(c) The risk from avian influenza is generally low to most people, because the viruses do not usually infect humans. H5N1 is one of the few avian influenza viruses to have crossed the species barrier to infect humans, and it is the most deadly of those that have crossed the barrier.

(d) The current avian influenza outbreak, associated with the H5N1 virus, has spread through Asia, Europe and Africa. It has been identified in 387 people since 2003 – resulting in death for more than half (63%) of them. Almost all of those infected have contracted the disease directly from birds. There has been no sustained human-to-human spread of H5N1 influenza as of the date of this plan. Most cases of H5N1 influenza infection in humans have resulted from contact with infected poultry (e.g., domesticated chicken, ducks, and turkeys) or surfaces contaminated with secretion/excretions from infected birds.

(e) So far, the spread of H5N1 virus from person to person has been limited and has not continued beyond one person. Nonetheless, because all influenza viruses have the ability to change, scientists are concerned that the H5N1 virus one day may be able to infect humans and spread easily from one person to another.

(f) In the current outbreaks in Asia, Europe, and Africa, more than half of those infected with the H5N1 virus have died. Most cases have occurred in previously healthy children and young adults. However, it is possible that the only cases currently being reported are those in the most severely ill people, and that the full range of illness caused by the H5N1 virus has not yet been defined.

(g) Influenza viruses with pandemic potential are novel or new influenza viruses with the following characteristics: (1) The virus is easily spread among humans; (2) It spreads globally in a short period of time; and (3) A majority of the human population is susceptible to infection and severe disease. According to the World Health Organization (WHO), it is only a matter of time before a mutation occurs from H5N1, or another strain, that allows efficient human-to-human transmission. At this point, the influenza virus becomes a disease of humans and has the potential to become a pandemic influenza.

(h) Currently developed influenza vaccine cannot be depended upon to immunize against the next pandemic strain and an effective vaccine could take at least six months to develop.

(i) A pandemic differs from most natural or manmade disasters in nearly every respect. The impact of a severe pandemic is more comparable to a global war or a long term environment than an isolated disaster such as a hurricane, earthquake or an act of terrorism. It will affect all communities. Exact consequences are difficult to predict in advance because the biological characteristics of the virus are not known. Similarly, the role of the Federal government in a pandemic response will differ based on the pandemic's morbidity and mortality rates.

(j) The secondary effects of PI have significant health, economic, and security ramifications, including the potential for large-scale social unrest due to fear of infection or concerns about services and safety among individuals and their families.

(k) For further background on PI, see refs: k., l.and jj.

(2) Potential Impact of PI on the Department of Defense (DOD).

(b)(2)

US Northern Command (USNORTHCOM)

support of civil authorities during PI must be accomplished using forces and capabilities not allocated for the Nation's defense.

(a) Environment. USNORTHCOM's response in support of civil authorities during a pandemic will not be the same as its response in a geographically limited emergency or disaster. USNORTHCOM's response takes into consideration that a pandemic is an environment, not an event. This environment, which may last up to 18 - 24 months, will have significant operational consequences. (b)(2) The following are environmental planning facts taken from Concept Plan (CONPLAN) 3551:

1 USNORTHCOM's defense support of civil authorities (DSCA) mission, in support of natural disasters and other emergencies and contingencies, will remain in effect. Response to requested support will be within capabilities and may not be to the level currently expected.

2 Unless otherwise directed, USNORTHCOM will continue to follow the formal request for assistance (RFA) process, as described in the National Response Framework (NRF), DOD Implementation Plan (DIP), and respond to Secretary of Defense approved RFAs. These RFAs may be turned into mission assignments for execution.

3 Outside the continental United States (OCONUS) operational commitments will continue at current levels through the next several years.

(b)(2)

4 There will be no increase in overall DOD force structure, as a result of implementing this plan. The military draft will not be invoked.

(b)(2)

b RC and some NG will continue to be subject to contingency mobilization. Other RC and NG members should not be recalled due to the critical nature of their civilian occupations (e.g., first responders, health and medical professionals, transportation industry, critical infrastructure sustainment). Current policy states: that the Federalization of NG members will not be pursued. However, if an unforeseen event occurs that may require Federalization then the call up must be balanced with state requirements. (b)(2)

c President of the US (POTUS)/Secretary of Defense (SecDef) guidance will determine the scope of USNORTHCOM involvement in PI operations.

(b)(2)

a State-to-state assistance (e.g., Emergency Management Assistance Compact (EMAC)) may be limited in application due to the impact of the pandemic environment across many states.

(b)(2)

d Competing demands for low-density units (e.g., medical, mortuary) will decrease the range of options.

e High death rate during the pandemic waves may cause delays in burial and overburden morgues.

6 Title 10 support will be requested by the primary Federal agency

a Department of State (DOS) / United States Agency for International Development (USAID) will request support from DOD to provide foreign humanitarian assistance (FHA) support to the international community.

b. Department of Homeland Security (DHS) will request support from USNORTHCOM as it coordinates the domestic Federal response to PI.

c. Department of Health and Human Services (HHS) as the primary Federal agency will request support from USNORTHCOM as it executes its responsibility of overall coordination of the public health and medical emergency response during a pandemic.

(b)(2)

8. A strain specific vaccine will not be developed for at least four to six months after the beginning of a pandemic

(b)(2)

9. Following development of an effective vaccine, quantities and methods of distribution will initially be insufficient to meet demand.

10. Containing the spread of a novel influenza virus is not likely once an efficient human-to-human transmission has occurred and the outbreak has extended beyond a geographically circumscribed area.

(b)(2)

13. Infected persons (foreign nationals) entering the US legally or illegally may not be automatically deported and may be isolated or quarantined as circumstances require to protect the health and safety of the public.

(b)(2)

(b)(2)

16. Military movements (e.g., Joint Reception, Staging, Onward Movement, Integration (JRSOI); basing; over flight; etc) as well as support to coalition operations may be restricted by other countries.

(b)(2)

(b) Personnel. Significant portions of the overall USNORTHCOM key population (i.e., DOD Joint Forces, civilian components, family members, DOD beneficiaries and contractors) will contract influenza over the lifespan of the pandemic. Due to the nature of PI,

(b)(2)

Available NG assets may already be committed to the states' needs. Additionally, NG and Reserve personnel may be uniquely qualified civilians needed by the civil sector to provide health care, critical infrastructure capacity, and law enforcement.

(c) Transportation. The anticipated reduction in transportation capacity will affect DOD acquisition/distribution. Civil aviation support to strategic deployment will be reduced, interstate transport of material and equipment to aerial ports or seaports of debarkation (APOD/SPOD) will decrease, access to goods OCONUS will be reduced and DOD assets will be requested to offset private sector shortfalls (e.g., ports, transport, security, medical, etc). Additionally, movement restrictions designed to slow the spread of a pandemic will impact operations.

(d) Communications. Communications equipment requires preventive maintenance and updates in order to maintain effectiveness. As personnel get sick, some of these maintenance and update actions may not be completed and (b)(2)

(3) DOD Support. A PI will be so overwhelming that local, state and non-military Federal responders will have difficulty managing the situation. DOD has a history of supporting civil authorities in the wake of catastrophic events with specialized skills and capabilities. When employed in support of (ISO) a primary agency, these assets can rapidly stabilize and improve the situation until civil authorities can meet the needs of their populace. (b)(2) Protecting the Nation, by conducting Homeland Defense and enabling force projection will remain the first priority. Providing support to civil authorities (b)(2) will be provided only within capabilities and in response to approved mission assignments.

(4) USNORTHCOM. USNORTHCOM anticipates and conducts Homeland Defense (HD) and Civil Support operations within the assigned AOR to defend, protect and secure the United States and its interests. When directed by the POTUS or the SecDef, USNORTHCOM executes its civil support mission. At times, this is fulfilled by responding to RFA in accordance with (IAW) the NRF (ref. eee.) and DOD policy and guidance (see ref. w.). Additionally, Commander USNORTHCOM (CDRUSNORTHCOM) has been designated the supported commander for planning and drafting the DOD Global Concept Plan to Synchronize Planning for Pandemic Influenza. When designated by the SecDef, CDRUSNORTHCOM is the supported commander for operations in a PI environment within the USNORTHCOM AOR.

(5) National Response Framework (NRF). The NRF is a guide to how the Nation conducts all-hazards response. It is built upon scalable, flexible, and adaptable coordinating structures to align key roles and responsibilities across the Nation. It describes specific authorities and best practices for managing incidents that range from the serious but purely local, to large-scale terrorist attacks or catastrophic natural disasters. It provides the coordinating structure for support provided under the Robert T. Stafford Disaster Relief and Emergency Assistance Act (PL 93-288) (Title 42 USC Section 5121, et, seq.) and the Economy Act (Title 31 USC Section 1535). The Stafford Act and the

Economy Act are the major pieces of legislation that govern the Federal response, which includes DOD actions.

(a) The NRF is applicable to all Federal departments and agencies that have primary jurisdiction for or participate in operations requiring a coordinated Federal response. It identifies how Federal departments and agencies will respond to state, tribal, and/or local requests for assistance (RFAs). A basic premise is that incidents are generally handled at the lowest jurisdictional level possible. The NRF is coordinated and managed by the Federal Emergency Management Agency (FEMA). The overall coordination of Federal incident management activities is executed through the Secretary of Homeland Security.

(b) The majority of health-related Federal responses to PI are covered under the Biological Incident Annex of the NRF. DOD-specific functions related to PI response in this annex are in support of emergency support function (ESF) #8, Public Health and Medical Services. It is anticipated that DOD response will extend beyond health and medical services, and will encompass substantially increased roles identified in the NRF, such as response under the Catastrophic Incident Annex which includes distinct and necessary support for ESFs 6, 8, 9, 10 and 15. Additionally, DOD is a supporting agency in all other ESFs and may be requested to support in those areas if primary agencies are overwhelmed.

(c) National Disaster Medical System (NDMS). Although NDMS plays a significant role in disasters and emergencies, the pandemic environment will minimize the effectiveness and limit the normal role of NDMS due to the widespread nature of the pandemic, as well as anticipated restrictions on travel and movement.

(6) National Strategy. The President's National Strategy for Pandemic Influenza frames how the US response to PI will be accomplished. The pillars of the National Strategy include:

(a) Preparedness and Communication

(b) Surveillance and Detection

(c) Response and Containment

(7) National Strategy for Pandemic Influenza Implementation Plan (NIP). The NIP expands on the National Strategy and synchronizes objectives in items 6a, 6b and 6c above with the intent of (1) stopping, slowing, or otherwise

limiting the spread of a pandemic to the United States, (2) limiting the domestic spread of a pandemic and mitigating disease, suffering, and death, and (3) sustaining infrastructure and mitigating impact to the economy and the functioning of society. The plan also provides guidance for the following areas:

(a) US Government planning

(b) US Government response

(c) International efforts

(d) Transportation and borders

(e) Protecting human health

(f) Protecting animal health

(g) Law enforcement, public safety, and security

(h) Institutional considerations

(8) US Government (USG) Stages. USG Stages are trigger points that reflect geography driven decision points tied to when potential Federal responses will take effect:

(a) Stage 0 - New domestic animal outbreak in at-risk country

(b) Stage 1 - Suspected human outbreak from animals overseas

(c) Stage 2 - Confirmed human outbreak overseas

(d) Stage 3 - Widespread human outbreaks at multiple locations overseas

(e) Stage 4 - First human case in North America

(f) Stage 5 - Spread throughout the United States

(g) Stage 6 - Recovery and preparation for subsequent waves

(9) CONPLAN 3551. CONPLAN 3551, "DOD Global Pandemic Influenza Concept Plan", identifies six phases that delineate when DOD actions will occur in response to a PI. The six phases that will be utilized are: (0) Shape, (1)

Prevent, (2) Contain, (3) Interdict, (4) Stabilize, and (5) Recover. CONPLAN 3591 follows this phasing construct. The phase descriptions will be discussed in detail in paragraph c of the base plan.

(10) SecDef Guidance. The SecDef and OSD outlined why DOD will take action by establishing clear mission parameters that preserve combat capabilities and readiness, save lives and reduce human suffering.

(a) Protect US interests at home and abroad

(b) Assist in supporting domestic infrastructures

(b)(2)

(11) DOD Implementation Plan for Pandemic Influenza (DIP). The DIP for PI defines what DOD will accomplish with regard to the tasks in the NIP. CONPLAN 3551 (ref. eee.) assigns roles and responsibilities for these tasks and where they will execute them.

(12) CJCS PLANORD 141224ZNOV05 (ref. zz.) directs USNORTHCOM to conduct execution-level planning for response to PI. The plan addresses FHP and civil support operations in the USNORTHCOM AO, as well as support to foreign humanitarian assistance (FHA) operations in the USNORTHCOM area of responsibility (AOR).

b. Area of Concern

(1) Area of Responsibility (AOR). USNORTHCOM's geographic AOR for the conduct of normal operations includes North America, the Gulf of Mexico, the Straits of Florida; the Caribbean region inclusive of the US Virgin Islands, British Virgin Islands, Puerto Rico, the Bahamas, and Turks and Caicos Islands; the Atlantic Ocean and the Arctic Ocean from 169° W, east to 045° W, south to 21° N, west to 064° W, south to 17° 30' N, west to 068° W, north to 20° 30' N, west to 073° 30' W, west along the northern Cuban territorial waters to 23° N/084° W, southwest to the Yucatan peninsula at 21° N/086° 45' W, south from Mexico at 092° W to 8° N, west to 112° W, northwest to 50° N/142° W, west to 170° E, north to 53° N, northeast to 65° 30' N/169° W, and north to 90° N

(2) Area of Interest (AOI). The AOI for USNORTHCOM is its assigned air, land, and maritime areas including all of the United States, its territories, and possessions, approaches to the AOR, and any foreign territory worldwide

where events may indicate the presence of PI that could cause adverse impacts on the United States.

(3) Operational Area (OA). The USNORTHCOM OA for PI, applicable to this CONPLAN, is the 48 contiguous states, Alaska, the District of Columbia, Puerto Rico, the US Virgin Islands, and any possession of the United States within the USNORTHCOM AOR. Although the countries of Mexico and Canada are within the USNORTHCOM AOR, the focus of operations in this CONPLAN is on operations within the identified joint operations areas (JOAs). DOD support required in other countries within the normal AOR will be addressed through established theater security cooperation (TSC) arrangements or as requested through the Department of State (DOS) or United States Agency for International Development (USAID).

(4) Regional Joint Operations Area (RJOA). Primary RJOAs for PI operations will be identified within the 48 contiguous United States (to include the District of Columbia), Alaska, Puerto Rico, and the US Virgin Islands. USNORTHCOM will designate appropriate RJOAs for air, land, and maritime operations within the USNORTHCOM OA for the execution of PI operations. (b)(2) It is anticipated that RJOAs will be established to align with the regional structure established by the primary agencies. Although not the initial focus of this plan, supplemental JOAs may be established if required for PI operations involving partner nations within the USNORTHCOM AOR.

c. Deterrent Options. Traditional deterrent options against a virus do not directly apply. However, force health protection measures and following guidelines published at www.panflu.gov can provide some deterrent options. Each level of command will have and establish different force health protection measures. Some general deterrent options would include:

(1) Annual/Seasonal flu shots

(2) Washing hands frequently

(3) Cough etiquette

(4) Social distancing

d. Enemy/Threat. Estimate of Enemy Capabilities. The primary threat for this CONPLAN is the emergence of an influenza or novel new virus with effects similar to the 1918 pandemic. These effects will have negative impacts on DOD

readiness (including training, manning, equipping and deploying forces) potentially allowing opportunistic adversarial aggression. Currently, the H5Nl Avian Influenza virus is identified by the World Health Organization (WHO) as the leading candidate to cause the next worldwide pandemic event. Early detection of a virus with sustained human-to-human transmissibility will be the key to an effective response.

(1) The primary threat to DOD during a pandemic is the high transmissibility and rapid onset of severe morbidity resulting in large numbers of people becoming sick or absent simultaneously. The current H5N1 virus has a morbidity rate of 63%. (b)(2)

(2) Impact of the primary threat may cause political, social, and economic instability, (b)(2) Countries with more advanced and robust health care systems may be better able to mitigate many of the pandemic effects.

(3) Key security concerns that would arise from the political, social, and economic instabilities as discussed above include opportunistic aggression, opportunities for violent extremists to acquire weapons of mass destruction (WMD), reduced partner capacity during and after a PI, instability resulting from a humanitarian disaster, and decreased distribution and production of essential commodities. The prevalence of PI coupled with instability may result in reduced security capabilities, providing an opportunity for international military conflict, increased terrorist activity, internal unrest, political and/or economic collapse, humanitarian crises, and dramatic social change.

(4) Enemy Center of Gravity (COG). Once the virus is capable of efficient and sustained human-to-human transmission its strengths, or COG, will be the geographic speed at which it can spread and the lethality/efficacy of the virus. A PI will produce cascading effects due to the large number of simultaneous absences over extended periods of time on a global scale. A virus capable of generating these effects must possess a unique set of characteristics and circumvent mitigation strategies which seek to influence these characteristics. This will affect the scale and impact of the PI.

(a) Critical Capabilities. The ability to efficiently reproduce within a host, mutate quickly, and efficiently transmit from human-to-human is the key requisites for the occurrence of PI. The degree of transmissibility is dependent upon a number of key factors such as virus mutation which enables transmission of new viral strain among humans, proximity and behavior of hosts (e.g., travel between population centers), and survivability outside a host on surfaces.

(b) Critical Requirements. A critical requirement of the virus is the ability to mutate and propagate between hosts. Efficient human-to-human transmission requires respiratory spread, but spread can also occur via surfaces (e.g., doorknobs, desktops) where the virus can survive from hours to days. Additionally, the impact of illness is severe enough to incapacitate hosts or generate psychological impact among a population (generating societal impact due to absenteeism, fear, and panic). Furthermore, the infected host must survive long enough to shed virus and infect others. Finally, vulnerable populations include those that are inadequately trained on preventive health measures allowing for disease spread.

(c) Critical Vulnerabilities. The virus must be transmitted to a non-immune host and is susceptible to transmission blocking measures, various forms of environmental disinfection, and the development of effective immune response by vaccine or natural infection. The virus is also possibly susceptible to pre- and post-exposure prophylaxis and treatment with antiviral medication. Additionally, targeted layered containment (including social distancing, use of personal protective equipment (PPE), non-exposure, hand washing, containment, and other non-pharmaceutical interventions) can impede human-to-human transmission.

e. Friendly

(1) Centers of Gravity.

(a) Strategic Center of Gravity. The strategic center of gravity during a pandemic is the stability of political, social, economic, and military structures and capabilities.

(b)(2)

(b) Operational Center of Gravity.

(b)(2)

1. Critical Capabilities:

a. Force Health Protection. FHP in a sustained contagious environment enables USNORTHCOM and forces assigned to execute missions for the defense of the Nation and support of civil agencies.

b. DOD transportation. The ability of the transportation infrastructure to support movement of forces and other assets in response to changes in priority as required, despite systemic disruptions during a PI environment.

c. Projection of forces. USNORTHCOM mission accomplishment requires the ability to properly position forces in the USNORTHCOM AOR with the required numbers, skills, and materiel in support of RJTFs.

d. Situational Awareness. Maintaining a common operating picture and protecting the capability to exchange/share information and capabilities with interagency, state, local and tribal partners.

2. Critical Requirements:

a. Maintain the confidence of USNORTHCOM personnel in the command's ability to respond effectively to PI.

b. Protect and maintain the military's infrastructure and capabilities. This includes sewer, water, energy, academics, trash, medical and security (SWEAT-MS). This will enable distribution of medical supplies, health care, food and commodities to areas of need, allowing continued delivery of essential goods and services on installations, bases, posts, and ships.

3. Critical Vulnerabilities:

a. Degradation of unit readiness may cause units to become non-mission capable due to the impact of the virus. Non-mission capable readiness could be caused by the lack of a PI vaccine, lack of anti-virals, lack of education on hygiene, and social distancing. This is germane to active duty, NG and RC forces and DOD civilian personnel and contractors. Second and third order effects may also cause degradation in unit readiness.

b. Degradation of unit readiness may also occur as a result of NG and RC personnel who hold key civilian jobs that require their critical skill sets during the emergency. This factor will be considered in the decision process to federalize NG and RC units providing the exemption authority for key civilian personnel.

(2) Friendly Elements.

(a) US Department of Defense

1. Office of the Secretary of Defense (OSD). OSD is the principal staff element of the Secretary of Defense in the exercise of policy development, planning, resource management, fiscal, and program evaluation responsibilities.

2. The Assistant Secretary of Defense for Health Affairs (ASD(HA)). ASD (HA) serves as the principal medical advisor to the SecDef. ASD(HA) disseminates policy and guidance in order to provide health service support to Service members during military operations. ASD (HA) establishes FHP guidelines, including prioritization and distribution of vaccines and anti-viral medications which is executed by the Services in cooperation with the combatant commands. DOD components will ensure operational considerations are integrated with FHP tasks and measures.

3. The Assistant Secretary of Defense for Homeland Defense and Americas' Security Affairs (ASD (HD&ASA)). The ASD (HD&ASA) was designated by Deputy Secretary of Defense as the overall lead for coordinating the departmental PI effort, and provides policy oversight for CS/DSCA missions. US military forces will support OSD-approved requests for support and provide capabilities to respond to the consequences of a PI situation in the US, its territories and possessions.

(b) Chairman of the Joint Chiefs of Staff (CJCS). The CJCS communicates SecDef guidance to the combatant commanders, Services, and DOD Agencies. On SecDef's behalf, the Joint Director of Military Support (JDOMS) coordinates DOD support through ASD(HD&ASA) to the primary or coordinating agency, issues orders directing the employment of military assets, and directs the transfer of military personnel and resources to CDRUSNORTHCOM and other supporting commands.

1. Military Services. Services will recommend installations to serve as Base Support Installations (BSIs) and when directed, provide designated installations as BSI's to support HD and operations. BSIs provide

USNORTHCOM and subordinate commanders specified, integrated resource support for the DOD response effort. Additional tasks are annotated in Annex C, Appendix 31 of this Plan.

a. When directed, Services will provide unit data including summaries of forces, facilities and assets to Commander, USJFCOM (CDRUSJFCOM) to recommend sourcing of PI response forces.

b. Additionally, under imminently serious conditions, when time does not permit approval from higher authority, military commanders or responsible DOD civilians who control DOD assets may provide those assets in response to requests from civil authorities to save lives, prevent human suffering, and mitigate great property damage under Immediate Response Authority.

c. When directed by the POTUS or when approved by the SecDef, and through the appropriate Service component commanders, the military Services provide forces, facilities and assets to CDRUSNORTHCOM for the DOD response actions.

2. FHP Responsibilities. IAW CONPLAN 3551, Military Services and DOD agencies will work in cooperation with USNORTHCOM to ensure timely and effective FHP measures are regionally synchronized and implemented in preparation for or during operations in the USNORTHCOM AO, and that actions of installation commanders under Immediate Response Authority do not jeopardize the readiness of the force for operations in the USNORTHCOM OA or OCONUS operational commitments. FHP reporting procedures and information processing channels are through the Services and for USNORTHCOM via the USNORTHCOM Service components.

3. Service Reserve Components. Each Service will establish guidelines for the recall of Federal Reserve personnel IAW policy guidance from the Assistant Secretary of Defense for Reserve Affairs (ASD (RA)) regarding call-up of reserves for emergency response during PI.

(c) Unified Commands.

1. Commander, US Africa Command (CDRUSAFRICOM). When directed by the SecDef, CDRUSAFRICOM is a supporting Combatant Commander to CDRUSNORTHCOM for PI operations in the USNORTHCOM AO.

2. Commander, US Central Command (CDRUSCENTCOM). When directed by the SecDef, CDRUSCENTCOM is a supporting Combatant Commander to CDRUSNORTHCOM for PI operations in the USNORTHCOM AO.

3. Commander, US European Command (CDRUSEUCOM). When directed by the SecDef, CDRUSEUCOM is a supporting Combatant Commander to CDRUSNORTHCOM for PI operations in the USNORTHCOM AO.

4. Commander, US Pacific Command (CDRUSPACOM). When directed by the SecDef, CDRUSPACOM is a supporting Combatant Commander to CDRUSNORTHCOM for PI operations in the USNORTHCOM AO.

5. Commander, US Southern Command (CDRUSSOUTHCOM). When directed by the SecDef, CDRUSSOUTHCOM is a supporting Combatant Commander to CDRUSNORTHCOM for PI operations in the USNORTHCOM AO.

6. Commander, US Special Operations Command (CDRUSSOCOM). When directed by the SecDef, CDRUSSOCOM is a supporting Combatant Commander to CDRUSNORTHCOM for PI operations in the USNORTHCOM OA and managing FHP and deployment of strategic, high priority assets to ensure Continuity of Operations (COOP).

7. Commander, US Joint Forces Command (CDRUSJFCOM). When directed by the SecDef, CDRUSJFCOM supports CDRUSNORTHCOM and serves as the joint force provider for PI operations. CDRUSJFCOM provides military forces to construct RJTFs with balanced capabilities for preparation and execution in assisting civil authorities within the USNORTHCOM OA prior to and during a PI. Annex C, Appendix 31 contains a complete list of assigned tasks.

8. Commander, US Strategic Command (CDRUSSTRATCOM). When directed by the SecDef, CDRUSSTRATCOM supports CDRUSNORTHCOM by conducting space operations, space control support and Nuclear Weapons Control during PI operations in the USNORTHCOM OA and managing FHP and deployment of strategic, high priority assets to ensure COOP. USSTRATCOM, through the Center for Combating Weapons of Mass Destruction (SCC-WMD), will provide situational awareness and planning support upon request. Situational awareness support includes the biological (BIO) common operational picture (see Annex K). Annex C, Appendix 31 contains a complete list of assigned tasks.

9. Commander, US Transportation Command (CDRUSTRANSCOM). When directed by the SecDef, CDRUSTRANSCOM

provides deployment and redeployment common-user air, land, and sea transportation for forces engaged in PI operations; and provides aero-medical evacuation and air refueling support as required. Additionally, USTRANSCOM is designated as DOD's distribution process owner, charged to integrate strategic and theater distribution. When requested by a Federal agency and approved by SecDef, USTRANSCOM may provide transportation support to non-DOD organizations, such as movement of critical capabilities or commodities, or evacuation of personnel. Annex C, Appendix 31 contains a complete list of assigned tasks.

10. Commander, North American Aerospace Defense Command (CDRNORAD). When directed by the SecDef in coordination with the Canadian Minister of Defense, CDRNORAD will coordinate aerospace defense operations with CDRUSNORTHCOM in support of PI operations in the USNORTHCOM AOR and manage FHP and deployment of strategic, high priority assets to ensure COOP.

(d) USNORTHCOM Component Commands.

1. Commander, Army North (CDRUSARNORTH). When approved by the SecDef and directed by USJFCOM in support of CDRUSNORTHCOM, CDRARNORTH employs military resources and forces to ensure continuity of defense of the homeland and conducts PI mitigation operations within the USNORTHCOM OA or RJOA, as directed. (b)(2) CDRARNORTH has been designated the standing Joint Force Land Component Commander (JFLCC). Annex C, Appendix 31 contains a complete list of assigned tasks.

2. Commander, US Fleet Forces Command (COMUSFLTFORCOM). When approved by the SecDef and directed by USJFCOM in support of CDRUSNORTHCOM, COMUSFLTFORCOM employs military resources and forces to ensure continuity of defense of the homeland and conducts PI mitigation operations within the USNORTHCOM OA or RJOA, as directed. (b)(2) Annex C, Appendix 31 contains a complete list of assigned tasks.

3. Commander, Marine Forces North (COMMARFORNORTH). When approved by the SecDef and directed by USJFCOM in support of CDRUSNORTHCOM, COMMARFORNORTH coordinates the employment of USMC resources and forces to ensure continuity of defense of the homeland and conducts PI mitigation within the USNORTHCOM OA or RJOA, as directed.

4. Commander, Air Forces North (CDRAFNORTH). When approved by the SecDef and with forces provided by USJFCOM in support of CDRUSNORTHCOM, CDRAFNORTH employs military resources and forces to ensure continuity of defense of the homeland and conducts PI mitigation operations within the USNORTHCOM OA or RJOA, as directed. Annex C, Appendix 31 contains a complete list of assigned tasks.

(e) CDRUSNORTHCOM. CDRUSNORTHCOM is the Combatant Commander (CCDR) and Supported Commander for operations in the USNORTHCOM AOR, and the principal executor of this PI plan. CDRUSNORTHCOM will be the joint force commander (JFC) for PI operations. As the JFC, he will coordinate and execute all PI operations within the USNORTHCOM OA and provide C2 of all RJTFs and operational forces assigned to USNORTHCOM. The NORAD-USNORTHCOM Command Center (N2C2) coordinates all operations within the AOR to include all PI activities reported on within JOA(s). Current guidance and plans for HD and CS/DSCA must address conducting operations in a PI environment.

(f) USNORTHCOM Subordinate Commands.

1. USNORTHCOM Joint Force Land Component Commander (JFLCC). CDRARNORTH has been designated as the standing JFLCC. The JFLCC will command and control the 5 Regional Joint Task Forces (RJTF) assigned by USNORTHCOM. The headquarters elements of the 5 RJTF are composed an RFF headquarters element assigned to Region A, (b)(2) assigned to Region B, An RFF headquarters element assigned to Region C, (b)(2) assigned to Region D, and Fleet Forces Command who has designated assigned to Region E.

a. JFLCC is tasked to support USNORTHCOM efforts to ensure the uninterrupted flow of essential services and supplies to DOD forces within the USNORTHCOM OA.

b. The JFLCC will ensure the accomplishment of all mission assignments that have been vetted through the RFA process per the NRF and assigned to DOD forces for execution.

c. The JFLCC will assist the RJTF Commanders in developing their tactical level planning to include the base plan with all required Annexes and Appendices, the Joint Manning Documents and establishing JRSOI guidance and procedures.

(b)(2)

e. The JFLCC will provide guidance to the RJTF Commanders in developing Tactical level plans to mitigate the effects of a Pandemic within the USNORTHCOM OA.

f. JFLCC will develop implementation guidance for FHP measures per Annex Q of this plan IOT ensure FHP efforts are synchronized across the JOA.

g. Additional tasks for the JFLCC are contained in Annex C Appendix 31 of this plan.

2. USNORTHCOM Joint Force Air Component Commander (JFACC). CDRAFNORTH has been designated the standing JFACC excluding the JTF-AK JOA, Space Coordination Authority (SCA), Collections Operations Management (COM), Airspace Control Authority (ACA) and Area Air Defense Commander (AADC) for those areas within the USNORTHCOM AOR not under the direction of the NORAD-designated ACA/AADC.

a. Plan, prepare and O/O execute CS and HD missions within the AFNORTH OA.

b. Provide capability to plan, direct, coordinate and control assigned/attached Joint air forces operations.

c. Initiate pre-deployment, deployment and post-deployment Force Health Protection and medical surveillance measures.

d. Provide intelligence information and assessments to decision makers at all levels of command.

(b)(2)

f. BPT conduct PI operations in support of USNORTHCOM.

3. USNORTHCOM Joint Force Maritime Component Commander (JFMCC). COMUSFLTFORCOM has been designated the standing JFMCC excluding the JTF-AK JOA.

a. Plan, prepare and O/O execute CS and HD missions within the CDRFFC OA.

b. Provide capability to plan, direct, coordinate and control assigned/attached joint maritime forces operations.

c. Initiate pre-deployment, deployment and post-deployment force health protection and medical surveillance measures.

d. Provide intelligence information and assessments to decision makers at all levels of command.

e. BPT conduct PI operations in support of USNORTHCOM.

4. USNORTHCOM Regional Joint Task Forces established for PI response. The current template for DOD PI response envisions the five regional RJTFs as outlined in Para 1 above. Each of the five regions is created by merging two of the ten current FEMA regions into one larger area (See Fig. 5-1, "Proposed USNORTHCOM PI Response C2 RJTF,"). Below are some but not all tasks assigned to the RJTFs: (A complete lists of assigned tasks are listed in Annex C, Appendix 31 of this plan)

a. RJTFs will be established by USNORTHCOM using assigned and attached forces (See paragraph 1 above).

b. RJTFs will develop tactical level plans using all references and phases IOT Command and Control assigned Title 10 Forces, Defend the Homeland, IAW the NRF execute all properly tasked mission assignments, assist in mitigating the effects of a Pandemic on DOD forces, ensure key resources and critical infrastructure is maintained, assist DOD in accomplishment of the DOD mission, and assist the Federal government in efforts to mitigate the impact of a Pandemic on the Nation's economy and citizens.

c. On order the RJTF Commanders will execute their plans.

d. RJTF Commanders will receive Execute Orders (EXORDs) to stand up their RJTFs and implement approved RFAs /mission assignments.

e. RJTF commanders primarily execute their mission using attached Title 10 Forces, and exercise operational control (OPCON) over those

forces to conduct approved PI operations within their USNORTHCOM-assigned RJOAs.

f. The RJTF Commander will also exercise C2 of Title 10 forces under OPCON of any dual status state-level Joint Task Force (JTF) which may be established in their RJOA.

g. As necessary, RJTFs will coordinate to improve unity of effort with the regional entities listed below:

1. Installation commanders for coordination of all responses proposed or executed whether through deliberate planning or immediate response.

2. JFHQ-S/State activities. USNORTHCOM, through OSD, the Joint Staff and NGB, will coordinate plans and operations with the states to streamline unity of effort. If joint force headquarters – states (JFHQ-Ss) are functional, it is possible that the state NGs will coordinate their activities through those headquarters rather than a JTF.

5. Commander, Joint Task Force Civil Support (CDRJTF-CS). JTF Civil Support (JTF-CS) (b)(2) in the event of a weapon of mass destruction terrorist attack on the homeland during a PI, but will be prepared to serve as the headquarters element of a JTF, in response to a natural or manmade disaster during a Pandemic as required by the JFLCC.

(b)(2)

When approved by the SecDef, and directed by the JFLCC, CDRJTF-CS may be tasked with deploying C2 military resources and forces to assist Federal, state, local, and tribal authorities for PI response within the USNORTHCOM AO. Annex C, Appendix 31 contains a complete list of assigned tasks.

6. Commander, Joint Task Force Alaska (CDRJTF-AK). When approved by the SecDef and directed by CDRUSNORTHCOM, CDRJTF-AK accepts operational control of military resources and forces, and conducts PI mitigation operations within the Alaska JOA. JTF-AK will conduct PI operations in the Alaskan JOA during a PI on a non-interference basis with

execution of core operational plans and missions in the PACOM AOR. JTF-AK will C2 in their JOA. JTF-AK will coordinate with Region E Joint Field Office (JFO-E) and RJTF E, to ensure seamless integration of response operations within their geographic area. Annex C, Appendix 31 contains a complete list of assigned tasks.

7. Commander, Joint Force Headquarters National Capital Region (CDRJFHQ-NCR). JFHQ-NCR will maintain its present roles and command relationships in the NCR during a PI. When approved by the SecDef and directed by CDRUSNORTHCOM, CDRJFHQ-NCR will transition to Commander, Joint Task Force National Capital Region (CDRJTF-NCR) and support PI response, accept operational and tactical control of military resources and forces, and conduct mitigation operations within the National Capitol Region (NCR) JOA. JTF-NCR will coordinate with JFO-B and RJTF B to ensure seamless integration of response operations within their geographic area. Annex C, Appendix 31 contains a complete list of assigned tasks.

8. Commander, Joint Task Force - North (CDRJTF-N). JTF-N provides DOD support to our nation's Federal law enforcement agencies in the interdiction of suspected transnational threats within and along approaches to the CONUS. JTF-N has direct liaison authorized (DIRLAUTH) with RJTFs in order to coordinate border security operations during PI. Any expansion of JTF-N current mission will be amplified in the EXORD for this plan (when published). Annex C, Appendix 31 contains a complete list of assigned tasks.

9. USNORTHCOM Standing Joint Force Headquarters (NC/SJFHQ). NC/SJFHQ provides CDRUSNORTHCOM with the scalable capability to form the core of a Joint Task Force or augment multiple organizations in order to anticipate and conduct HD and CS missions anywhere in the AOR during crisis operations. Annex C, Appendix 31 contains a complete list of assigned tasks.

10. Defense Coordinating Officer (DCO). DCOs and their defense coordinating elements (DCEs) are assigned to US Army North (USARNORTH) and if required OPCON to USNORTHCOM with an execute order (EXORD) to deploy in support of a lead or primary agency. In the event of a PI within the US, it is anticipated that multiple joint field offices (JFOs) will activate in multiple regions along with multiple regional JTF's (RJTFs). The number of JFOs established (regional, state and local) will dictate the placement and location of the DCO/E who may begin coordination at the regional response coordination center (RRCC) and the initial operating facility (IOF) before the JFO is established. Once in place the DCO serves as the DOD's single point of contact within the JFO. While in the JFO, DCOs

coordinate and process applicable requests for DOD assistance, they may recommend resources to fulfill those requests, monitor status of request completion, provide an LNO capability between the JFO and RJTF and provide feedback to the lead or primary agency. DCOs will also provide C2 of DOD forces and assets until the arrival of a RJTF, which will assume OPCON of all DOD resources within the region.

11. Regional Emergency Preparedness Liaison Officers (REPLOs). Each Service selects trains and equips Reserve officers in the grades of O5/O6 to serve as REPLOs. They also select enlisted personnel to serve in support assignments. REPLOs are Service assets and may be activated and employed by their Services. During a PI and once activated, REPLOs are OPCON to the Service component commander. Those REPLOs requested and allocated to USNORTHCOM are TACON to the DCO. REPLOs can be activated to perform duty with the RJTF and the RJTF CDR, but they will be OPCON to Services.

12. State Emergency Preparedness Liaison Officers (SEPLO). SEPLOs act to develop state situational awareness, recommend and obtain needed resources to conduct operations, advise state civil authorities on military issues, and provide SITREPS to the established chain of command. During a PI, all Service's SEPLOs are TACON to the DCOs in their Federal PI regions and may be attached to the RJTF or the RJTF CDR. but they will be OPCON to Services.

13. Joint Regional Medical Planner (JRMP). The JRMP is assigned to USNORTHCOM in OPCON status to DCO/DCE during event. The JRMP assists in processing all requests for DOD medical services, serving as the DOD liaison to ESF#8 primary agency, and as staff medical advisor to the DCO. During a PI the JRMP may be used as the primary medical advisor to the RJTF prior to a medical officer filling the medical officer billet within the RJTF. Once a medical officer is assigned to the RJTF he will coordinate with the JRMP.

(g) Other Supporting DOD Agencies. These agencies may provide the following resources and/or capabilities during a pandemic, as follows:

1. Defense Intelligence Agency (DIA). DIA's National Center for Medical Intelligence (NCMI). NCMI provides all-source global intelligence assessments of the threat of pandemic influenza to US global strategic interests. In the event of a pandemic, NCMI will provide finished intelligence on the spread of the disease, associated morbidity and mortality, and risk to the USNORTHCOM AOR as the pandemic progresses.

2. Defense Information Systems Agency (DISA). DISA is a combat support agency responsible for planning, engineering, acquiring, fielding, and supporting global net-centric solutions to serve the needs of the POTUS, Vice President, the SecDef, and other DOD Components, under all conditions of peace and war.

3. Defense Logistics Agency (DLA). DLA coordinates with USNORTHCOM and Service components for medical, antiviral, PPE, subsistence, clothing, individual equipment, petroleum, construction materials, personal demand items, medical materials and repair parts support. DLA provides integrated material management and supply support for all DLA managed material. DLA provides property and hazardous material (HAZMAT) disposal services.

4. Defense Contract Management Agency (DCMA). DCMA will deploy contingency contract administration services (CCAS) to the Area of Operations (AO) to administer civil augmentation programs (e.g., Army Logistics Civil Augmentation Program (LOGCAP) and the Air Forces civil augmentation program (AFCAP)) external support contracts and weapons system support contracts with place of performance in theater.

5. National Geospatial-Intelligence Agency (NGA). NGA provides imagery, imagery intelligence, and geospatial products ISO PI operations for DOD, primary agencies, coordinating agencies, and supporting organizations.

6. Defense Threat Reduction Agency (DTRA). DTRA leverages the Biological Warfare Proliferation Prevention Program to strengthen state capabilities for surveillance, early detection and rapid response to animal and human pandemic influenza.

7. Defense Commissary Agency (DeCA). DeCA will support the local installation-level preparedness and response plan for PI.

8. Other DOD Entities. Other DOD organizations may be tasked to support the DOD response to PI. At a minimum, all entities will develop and exercise COOP plans.

a. National Guard Bureau (NGB). The NGB coordinates with the JFHQ - State during the execution of PI operations to assist local, state, and tribal authorities and also assists in ensuring FHP of those forces while under the command and control of the Governor. NGB assists USNORTHCOM in synchronizing and integrating Federal and non-Federal

military operations including CS to avoid duplication and achieve unity of effort. NGB will assist the states, Territories, and District of Columbia with manning, training and equipping their respective forces, as required. Annex C, Appendix 31 contains a complete list of assigned tasks.

b. Joint Force Headquarters - State (JFHQ-State). JFHQ - State provides command and control of all NG forces within the state or territory for the Governor, or in the case of the District of Columbia, the Secretary of the Army and can function as a joint Service headquarters for national-level response efforts. JFHQ - State is responsible for fielding a task force or JTF that can assume tactical control of deployed military units within the state. JFHQ-State is responsible for providing joint reception, staging, onward movement, and integration (JRSOI) of all inbound military forces; and is the conduit between the Governor's Emergency Operation Center, the deployed JTF - State, and NGB when deployed forces are under the Governor's control. JFHQ - State provides the state's common operating picture to NGB and other state and Federal departments and agencies as required. JFHQ-State will provide LNOs to the RJTF CDR as required or requested to ensure unity of effort and coordination.

c. Joint Task Force State (JTF - State). JTF - State provides command and control of deployed NG forces which are under the control of the Governor and ensures unity of effort of NG forces deployed in support of civil authorities, and facilitates the flow of information between the JFHQ - State and the deployed units. The size and complexity of the emergency response determines the JTF - State structure; JTF - State commanders are trained for the potential of dual- status Command should it be in the best interest of operations, requested by CDRUSNORTHCOM and agreed to by the Governor and POTUS, to execute this C2 option for a wide spread emergency within his AOR.

d. In accordance with law, and when appropriate, NG forces may be federalized into a Title 10 USC active duty status under the C2 of CDRUSNORTHCOM. Authority to place the NG into Federal status is contained in applicable statutory authority. Some NG personnel hold key civilian jobs that may require their critical skill set during the emergency. This factor is normally considered during the decision process to federalize NG units and normally an exemption authority is granted for key civilian personnel.

(h) Federal Agencies. Various Federal statutory authorities and policies provide the basis for Federal actions and activities in the context of domestic incident management. This includes response to a PI. PI response

will not alter the existing authorities of individual Federal departments and agencies.

1. Department of Homeland Security (DHS). The Secretary of DHS is the principal Federal official (PFO) for domestic incident management. The Secretary is responsible for coordinating Federal operations within the United States to prepare for, respond to, and recover from terrorist attacks, major disasters, and other emergencies. The Secretary may delegate this responsibility and appoint a representative to serve as PFO on-site during a disaster, emergency, incident, or event. DHS uses the NRF and National Incident Management System (NIMS) structure to coordinate the Federal response. As part of DHS, FEMA plans, coordinates, and conducts Federal disaster response and recovery efforts with local, state, and tribal authorities (See Annex V for other Federal government departments and agencies). DHS has pre-appointed a National PFO and regional PFOs to lead their response in the five Federal PI regions.

2. Department of Health and Human Services (HHS). IAW the NRF, the Secretary of HHS will be the primary agency coordinating the overall public health and medical response efforts across all Federal departments and agencies under ESF#8. These responsibilities include coordination of all Federal medical support to communities, provision of guidance on infection control and treatment strategies to state and local governments and the public, maintenance, prioritization and distribution of countermeasures in the Strategic National Stockpile, ongoing epidemiologic assessment, modeling of the spread of PI and research into the influenza virus and novel countermeasures, among others. Given that health and medical considerations will be important drivers for decision making in a pandemic, from transportation decisions to continuity decisions within the Federal government, it will be essential for the Secretary of HHS to work in close coordination and collaboration with the Secretary of Homeland Security to ensure DOD and USNORTHCOM are incorporated in support of the national response. The Secretary of HHS will serve as the principal Federal spokesperson for PI issues.

3. Department of Transportation (DOT). During a pandemic, transportation will be a significant factor in preparation and response. DOT will provide the expertise and the interface to Federal, state and commercial transportation capabilities.

4. US Department of Agriculture (USDA). USDA is the primary agency for execution of ESF #11, Agriculture and Natural Resources. Prior to a human pandemic, USDA will serve as primary agency for avian influenza

related activities, some of which will be aimed at preventing or slowing virus mutation.

5. Department of State (DOS). The Secretary of State is responsible for the coordination of the international preparation and response, including persuading other nations to join our efforts to contain or slow the spread of the PI virus, helping to limit the adverse impacts on trade and commerce, coordinating our efforts to assist other nations that are impacted by the PI, and interdiction with all official and non-official American citizens (AMCITs) overseas. Current DOS policy for AMCITs is to remain in place during a pandemic.

(b)(2)

6. Other Federal Departments. DHS coordinates overall non-medical support and response actions across all other Federal departments and agencies in support of the NRF's ESF framework. Those agencies retain jurisdiction over their sector-specific responsibilities, as well as supporting activities outside of the NRF that are in their areas of responsibility.

7. Operating Locations.

a. FEMA Headquarters/Regions. Assigned REPLOs and support personnel will perform duty at FEMA Headquarters and/or FEMA Regional locations. REPLOs are Service assets and may be activated and employed by their Services. During a PI and once activated, REPLOs are OPCON to the Service component commander. Those REPLOs requested and allocated to USNORTHCOM are TACON to the DCO. REPLOs can be activated to perform duty with the RJTF and maybe used as LNOs for the RJTF CDR, but they will be OPCON to Services. REPLOs perform duty at the FEMA regional response coordination center (RRCC) to advise FEMA, and provide situation reports (SITREPS) to the established chain of command which will include the RJTF HQ Element. In the case of PI, REPLOs may be located by the PI Regions designated by DHS, which will assist in operations and unity of command.

b. State locations. SEPLOs and support personnel perform duty in the Governor's (state) Emergency Operation Center (EOC), the JFHQ-State joint operations center (JOC), or the JTF-State Headquarters.

c. Joint Field Office (JFO) locations. The JFO is the multi-agency coordination center established in or near the incident site for coordinating incident-related prevention, preparedness, response, and recovery actions under the NRF. During a pandemic, JFOs will be established for multi-

agency coordination with associated PFOs, Federal coordinating officers (FCOs) and NRF ESFs activated as necessary. The five Regional JFOs, A-E, are currently planned for the following locations:

Region A: Boston, MA

Region B: Atlanta, GA

Region C: Chicago, IL

Region D: Denton, TX

Region E: Bothell, WA

The five alternate Regional JFOs are currently planned for the following locations:

Region A: New York, NY

Region B: Philadelphia, PA

Region C: Denver, CO

Region D: Kansas City, MO

Region E: Oakland, CA

f. Assumptions:

(1) USNORTHCOM's Homeland Defense mission will remain first priority.

(2) A critical priority will be to sustain the health and safety of DOD key population in order to accomplish all DOD missions.

(3) Protection of the Nation's critical infrastructure and key resources will be required to accomplish force projection.

(4) Support of essential government functions will be as requested and performed within capabilities.

(5) Authorities will remain the same, consistent with existing laws of the US Government, including as primary considerations, the Posse Comitatus

Act (PCA) and DODD 5525.5. Title 10 DOD forces do not have the authority to provide law enforcement in support of movement restrictions or enforcement of civil law, unless the POTUS asserts his authorities under the Constitution and directs Title 10 DOD employment in accordance with the "Insurrection Act," or another exception to the PCA applies. Intelligence oversight laws, policies, and regulations apply.

g. Legal Considerations:

(1) Significant Legal Issues. Significant legal issues could arise during the conduct of operations in response to PI. The PCA and DODD 5525.5 prohibit the use of DOD forces for direct law enforcement unless an exception to the PCA exists. DOD forces cannot enforce isolation, quarantine and containment operations or otherwise enforce the law during civil unrest situations unless the POTUS asserts his authorities under the Constitution, and directs DOD employment in accordance with existing law and regulations. NOTE: NG units in Title 32 / state active duty status are not subject to the PCA.

(2) Standing rules for the use of force (SRUF) will apply to Title 10 forces while providing support to civil authorities during a pandemic and conducting land homeland defense operations, in accordance with CJCSI 3121.01B (see ref. oo.). RJTF CDRs may request either more/less stringent guidelines on SRUF through the chain of command.

(3) Standing rules of engagement (SROE) will apply to Title 10 forces if the President directs NORTHCOM to conduct air and or maritime homeland defense missions as part of a response to PI.

(4) Command and Control. Title 10 commanders not appointed as dual-status commanders cannot exercise command and control over NG forces in Title 32 / SAD status. NG commanders in Title 32 / state active duty status not appointed as dual-status commanders cannot exercise command and control over Title 10 forces. Three methods of achieving unity of effort between Federal and state military forces are: 1) conduct of operations within the NIMS, 2) the establishment of coordinating authority through a memorandum of agreement and 3) the use of dual-status commanders pursuant to either 32 USC. 325 or 315 (see Appendix 4, Annex E).

(5) Other Legal Considerations that factor into PI planning.

1. The Federal Government has legal authority to prioritize distribution of vaccines and anti-virals (see ref. g.).

2. State and local governments have the primary authority to impose medical screening, restrictions on movement and assembly, isolation and/or quarantine restrictions within their political jurisdictions. The Federal government's authority to impose restrictions on movement and assembly of persons, and to issue isolation and/or quarantine restrictions, is normally limited to those cases involving movement of persons into the territorial boundaries of the United States and movement of persons between states.

3. Defense Production Act authorizes the Federal government to require manufacturers to give priority for goods and services necessary or appropriate to promote the national defense.

4. DODD 6200.04 FHP. This Directive establishes policy and assigns responsibility for implementing FHP measures, on behalf of all military Service members during active and Reserve military Service, encompassing the full spectrum of missions, responsibilities, and actions of the DOD components in establishing, sustaining, restoring, and improving the health of their forces. FHP Measures will be further discussed in Annex Q of this Plan.

2. Mission. When directed by the President or Secretary of Defense, CDRUSNORTHCOM conducts operations in response to an influenza pandemic within designated operational areas (OAs) to mitigate the impact on our Nation's welfare.

3. Execution:

a. Concept of Operations. The concept of operations for PI flows from the National Strategic objectives which include: "To minimize the impact of PI on our Nation's welfare; preserve the fundamental freedoms, security, health and stability of the Nation." The DOD Global CONPLAN to Synchronize Planning for Pandemic Influenza outlines four objectives: protection of key population, DOD critical infrastructure and capabilities; sustain mission assurance; support USG PI response efforts; and effective communication

(1) Commander's Intent:

(a) End State:

1. The pandemic is over, or PI is no longer considered a threat within the AOR. POTUS or SecDef direct DOD to return to normal operations and Phase 5 (recover phase) is complete.

2. Military forces have been relieved by proper authorities and have been transferred to their respective commands for redeployment.

3. CDRUSNORTHCOM relinquishes OPCON over deployed forces upon notification of their redeployment.

(b) Strategic Objectives:

1. Defend the Homeland. This takes precedence over all other objectives.

2. Sustain the Health and Safety of DOD key population. When excess military capacity is available, DOD may assist in providing for the health of others and for the continuation of essential services, minimizing devastating impacts within USNORTHCOM's OA.

3. Protect the Nation's Essential Infrastructure. During a pandemic, it is recognized that health concerns might affect the ability to sustain the Nation's critical infrastructure. It is important that this fact is recognized and that preparations are made to sustain that infrastructure within the USNORTHCOM OA. Essential infrastructure protection requirements will be provided by the primary agencies under which they are assigned.

4. Support Essential Government Functions. Government is necessary to ensure the rule of law is upheld and that the effects of PI are mitigated. (b)(2)

(c) Desired Effects. Maintain defense of the homeland while limiting the long-term impact of a PI in order to preserve the fundamental freedoms, security, health, and safety of our nation.

(2) General. For this CONPLAN lines of operation and the phases established by the USG and WHO influence operations by phase.

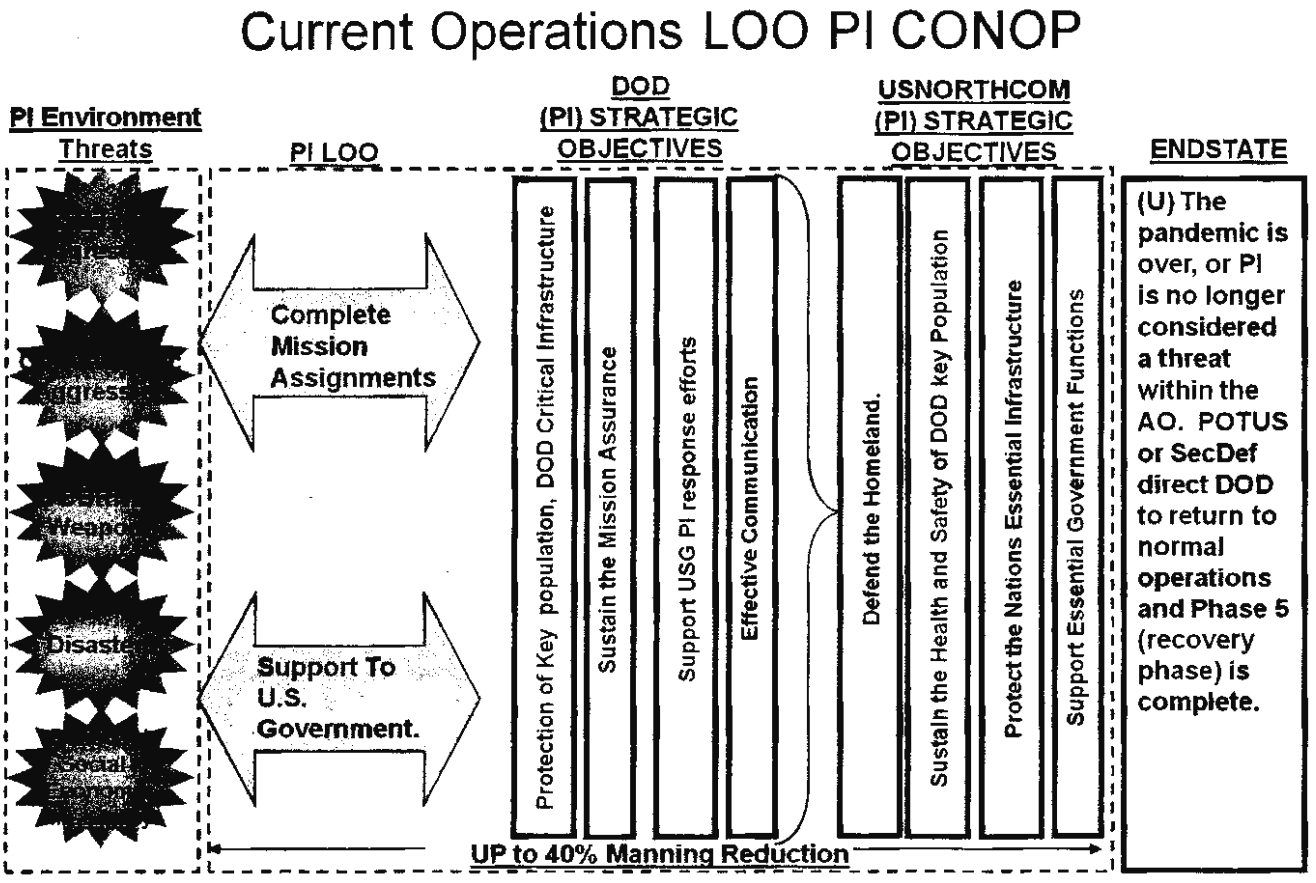


Figure 3-1. USNORTHCOM Lines of Effort

(a) USNORTHCOM Lines of Operations. To support the commander's strategic objectives, USNORTHCOM has developed lines of operations along which to focus and operate should the need arise. Specific actions identified under the various lines of operations below may support multiple lines of operations outlined in Annex C. Two main lines of operations and supporting activities along these lines may include:

1. Complete Mission Assignments (Main Effort):

a. Synchronize and coordinate efforts

b. Monitor and analyze PI effects

c. Enhance force health protection

d. Provide strategic communication

e. Ensure continuity of operations

2. Support to US Government (Supporting Effort):

a. Synchronize and coordinate efforts

b. Monitor and analyze PI effects

c. Provide strategic communication

(b) CONPLAN Phasing. This is a six phased CONPLAN driven by operational requirements, the virulence of the influenza virus, and the spread of the virus geographically. A comparison of USNORTHCOM Phases with World Health Organization Phases and US Government Stages is helpful:

USNORTHCOM Response to PI Phases (Response, Virus and Geography Driven)		Federal Government Response Stages (Geography Driven)		WHO Phases (Virus Driven)	
0	No new influenza subtypes have been detected in humans.	0	New domestic animal outbreak in at-risk country.	1	No new influenza virus subtypes have been detected in humans. An influenza virus subtype that has caused human infection may be present in animals. If present in animals, the risk of human disease is considered to be low.
				2	No new influenza virus subtypes have been detected in humans. However, a circulating animal influenza virus subtype poses a substantial risk of human disease.
1	Receipt of information of human infections with a new viral subtype, but no human-to-human spread, or at most rare instances of spread to a close contact.	1	Suspected human outbreak from animals overseas	3	Human infection(s) with a new subtype, but no human-to-human spread, or at most rare instances of spread to a close contact.
2	Receipt of information of small cluster(s) with limited human-to-human transmission, but the spread is highly localized suggesting the virus is not well adapted to humans.	2	Confirmed human outbreak overseas	4	Small cluster(s) with limited human-to-human transmission but spread is highly localized, suggesting that the virus is not well adapted to humans.
3	Indications and warnings identify large cluster(s) of human-to-human transmission(s) in an affected region.			5	Larger cluster(s) but human-to-human spread still localized, suggesting that the virus is becoming increasingly better adapted to humans, but may not yet be fully transmissible (substantial PI risk).
4	Receipt of information of a highly lethal pandemic influenza virus is spreading globally from human-to-human signaling a breach in containment and failing interdiction efforts.	3	Widespread human outbreaks at multiple locations overseas	6	PI phase, increased and sustained transmission in general population
		4	First human case in North America		
		5	Spread throughout the United States		
5	Receipt of information that case incident is decreasing, indicating the slowing of the pandemic wave. Reconstitution of DOD assets and conditions established to return to a previous phase.	6	Recovery and preparation for subsequent waves		

Figure 3-2. Phase Comparison

1. WHO Phases are categorized by the ease of virus transmission in animals and in humans, as well as the frequency of occurrence in both:

Phase 1: Low risk of human cases

Phase 2: Higher risk of human cases

Phase 3: No or very limited human-to-human transmission

Phase 4: Evidence of increased human-to-human transmission

Phase 5: Evidence of significant human-to-human transmission

Phase 6: Efficient and sustained human-to-human transmission

2. Federal Government Response Stages. The USG characterizes the stages of an outbreak in terms of the immediate and specific threat a pandemic virus poses to the American population. The following stages provide a framework for USG actions:

Stage 1: Suspected outbreak overseas

Stage 2: Confirmed outbreak overseas

Stage 3: Spread in multiple regions

Stage 4: First case(s) in North America

Stage 5: Spread in United States

Stage 6: Recovery

3. USNORTHCOM Phases. USNORTHCOM's phasing follows the DOD Global Concept Plan to Synchronize Planning for Pandemic Influenza; it also integrates the additional consideration of operational requirements. This plan follows a six-phased construct: Shape, Prevent, Contain, Interdict, Stabilize, and Recover (as shown in Figure 3-2, above). See Annex C for further specifics.

a. Shape Phase (0). This phase occurs in an inter-pandemic period (WHO phase 1 and 2 conditions) and is a continuous phase incorporating adaptive planning, routine surveillance and engagement activities to assure and solidify collaborative relationships, shape perceptions, and influence behavior in order to be prepared for a new influenza viral subtype. This phase includes education and training for the USNORTHCOM population, interagency, and international partners. Success in this phase is defined as: USNORTHCOM is prepared for the onset of a new viral sub-type; and USNORTHCOM forces are intact. (b)(2) This phase ends upon receipt of information of human infection(s) with a new

influenza viral sub-type but no human-to-human spread, or at most rare instances of spread to a close contact (similar to WHO phase 3 conditions). .

b. Prevent Phase (1). This phase begins upon receipt of information of human infection(s) with a new influenza viral sub-type but no human-to-human spread, or at most, rare instances of spread to a close contact (similar to WHO phase 3 conditions). During this phase USNORTHCOM will support USG efforts to prevent or limit the spread of the virus. Success in this phase is defined as: the identification of a new influenza viral sub-type and limiting the spread of the virus in geography and numbers; and USNORTHCOM forces remain intact.

(b)(2)

This phase ends upon receipt of information of small cluster(s) with limited human-to-human transmissions but the spread is highly localized suggesting the virus is not well adapted to humans (similar to WHO phase 4 conditions).

c. Contain Phase (2). This phase begins upon receipt of information of small cluster(s) with limited human-to-human transmission but the spread is highly localized suggesting the virus is not well adapted to humans (similar to WHO phase 4 conditions). During this phase USNORTHCOM components will take measures to protect the USNORTHCOM population in the localized region(s) while maintaining the freedom of action to conduct assigned missions. As directed, USNORTHCOM components will support USG efforts to contain the new virus within a limited area in order to prevent a pandemic and gain time for implementation of additional pandemic preparedness measures. Success in this phase is defined as: a. USNORTHCOM population protected from human-to-human transmission; b. Virus spread delayed or halted in affected geographic areas; and c. Impact to USNORTHCOM mission risk mitigated through the use of protective measures to allow forces to retain freedom of action.

(b)(2)

This phase ends when indications and warnings identify large clusters of human-to-human transmission (similar to WHO phase 5 conditions) or when the outbreak is contained with no additional cases in an (the) identified region(s).

d. Interdiction Phase (3). This phase begins when indications and warnings identify large clusters of human-to-human transmission in (the) affected region(s) (similar to WHO phase 5 conditions). During this phase USNORTHCOM components will take broader measures to protect the USNORTHCOM population while maintaining the freedom of action to conduct assigned missions. As directed, USNORTHCOM components will support USG efforts to delay or halt a PI wave. Success in this phase is defined as: a. USNORTHCOM population protected from human-to-human transmission; b. Virus spread delayed or halted in affected geographic areas; and c. Impact to USNORTHCOM mission risk mitigated through the use of protective measures to allow forces to retain freedom of action. (b)(2) This phase ends upon receipt of information that highly lethal, influenza virus is spreading efficiently from human-to-human signaling a failure of containment and interdiction actions within a region(s) (similar to WHO phase 6 conditions) or when the outbreak is contained with no additional cases in the identified region(s).

e. Stabilize Phase (4). This phase begins upon receipt of information the PI virus is spreading globally from human-to-human signaling a failure of containment and interdiction actions (similar to WHO phase 6 conditions). During this phase USNORTHCOM components will protect the USNORTHCOM population, maintain freedom of action to conduct assigned missions and within capabilities, as directed, support USG in mitigating the pandemic effects in order to ensure governments and communities are capable of maintaining social order, maintain critical infrastructure, and to minimize human suffering. Success in this phase is defined as: effective employment of COOP to offset degraded USNORTHCOM capabilities that support USG efforts. (b)(2) This phase ends upon receipt of information that case incidence is decreasing, indicating the slowing of the pandemic wave and conditions begin to allow reestablishment of governments functions without USNORTHCOM support.

f. Recover Phase (5). This phase begins upon receipt of information that case incidence is decreasing, indicating the slowing of the pandemic wave. During this phase USNORTHCOM conducts force reconstitution operations and as directed will support USG efforts to re-establish normal support conditions with key partners. Success in this phase is defined as: USNORTHCOM forces and assets regenerated to pre-pandemic

levels. (b)(2) This phase ends when normal support relations are in place, USNORTHCOM PI response forces are reconstituted and reset, and conditions allow for a return to the inter-pandemic conditions or back to a previous phase.

(b)(2)

(1) General Tasks

(a) Develop a plan in coordination with interagency and intergovernmental partners

(b)(2)

(c) Monitor global infections to identify a possible influenza pandemic

(d) Train and rehearse

(b)(2)

(g) Pre-position key capabilities

(b)(2)

(i) Set priority of support and designate Base Support Installations

(b)(2)

(k) Support USG containment efforts

(b)(2)

(m) Support USG mitigation efforts

(n) Prepare for next wave

(b)(2)

(p) Reconstitute USNORTHCOM forces

(2) Shape Phase Tasks

(a) Develop plan in coordination with interagency and intergovernmental partners

(b)(2)

(c) N-NC/J7 will coordinate planning and conduct biennial exercises as per CONPLAN 3551

(d) N-NC/J7 will coordinate planning and conduct of PI events as per the Commander's Training Guidance (CTG) in the current Joint Training Plan (JTP).

(3) Prevent Phase Tasks

(a) Monitor global infections to identify influenza pandemic

(b)(2)

(c) Train and rehearse

(4) Contain Phase Tasks

(b)(2)

(c) Pre-position key capabilities (see annexes C and D)

(5) Interdiction Phase Tasks

(a) Enhance FHP for USNORTHCOM population

(b) Set priority of support

(b)(2)

(d) Support USG containment efforts

(6) Stabilize Phase Tasks

(b)(2)

(b) Support USG mitigation efforts

(7) Recover Phase Tasks

(a) Prepare for next wave

(b)(2)

(c) Reconstitute USNORTHCOM forces

c. Coordinating Instructions

(1) This document is effective for planning upon receipt and for execution upon notification. Subordinate and component plans are due NLT 90 days following approval of this plan.

(2) DIRLAUTH among subordinate units, Service forces conducting immediate response operations and Title 32/state active duty forces, as well as other Federal forces conducting PI operations in the USNORTHCOM AO is authorized.

(3) Administrative, logistical, medical, and communications support for deployed forces remain a Combatant Command Service Component responsibility.

(4) All Service casualties will be reported via both operational and Service chains of command.

(5) Service and functional components will capture costs during all phases of the PI response for ultimate reimbursement from the primary agency.

(6) CDRUSNORTHCOM shall be the coordinating authority for any USNORTHCOM members (military and civilian) conducting PI operations in the USNORTHCOM AO. Such forces, with the exception of US Transportation Command (USTRANSCOM) forces not assigned to the NORTHCOM Deployment

and Distribution Operations Center (NDDOC) shall become OPCON to CDRUSNORTHCOM upon arrival at duty location for PI.

(7) Any Service forces responding under Immediate Response Authority must notify the N2C2 at the time they notify the National Military Command Center (NMCC) IAW DepSecDef 25 Apr 05 guidance on, "Reporting Immediate Response Requests from Civil Authorities."

(8) All PI operations will be provided on a reimbursable basis unless the operation was ordered by the POTUS or reimbursement is waived by the SecDef. Immediate response should be provided to civil authorities on a cost-reimbursable basis, if possible.

(9) Installation support provided initially by memorandum of agreement/memorandum of understanding or under DODD 2000.18, Installation CBRNE CM response, will be completed or will be incorporated into the USNORTHCOM-led response as OPCON to the established C2 organization and incorporated via the BSI and JRSOI process. RJTF Commanders will make recommendations for the nomination of a BSI to the JFLCC.

(10) All forces arriving in the USNORTHCOM OA will be received via the JRSOI process. Establishing JRSOI will be an initial priority of all designated RJTF command elements supporting the PI operation.

(11) Services are responsible for coordinating FHP actions (e.g., movement restrictions, appropriate staffing of medical facilities, isolation) with USNORTHCOM to ensure minimal impact to operations in the AO. Assigned personnel will fall under the FHP actions of the RJTF Commander.

4. Administration and Logistics

a. Concept of Support. The concept of logistics for PI operations, to include deployment, sustainment, and combat service support (CSS) efforts will be flexible and tailored to support the mission requirements. At the tactical level, PI support will be provided, to the extent possible, using the designated BSI (or multiple installations) as the hub supporting RJTF operations. See Annex D for more detail.

b. Logistics. Service component commands will coordinate through their respective Service channels (with assistance from DLA) for the provision of administrative, logistics, medical, and communication support for forces employed in PI operations. Designated BSIs, and the BSI's owning Service, will provide common logistics services and supplies. Each Service remains

responsible for providing Service-unique logistics support to their forces deployed for pandemic operations. The RJTF is responsible to integrate logistics support provided from Service channels and commercial sources. In all cases, delivery will be pushed as far down the supply chain as feasible, to the nearest retail distribution point, typically at the designated BSI.

(1) Local Acquisition of Supplies and Services. The RJTF may either modify existing BSI service contracts, or leverage local or regional contract capability to meet logistics requirements. Efforts must be directed at leveraging the existing infrastructure, contracts, and support relationships with non-DOD vendors through innovative information sharing, business practices, contracting, and operating procedures.

(2) Mobility and Transportation. (See Annex D)

(a) CDRUSTRANSCOM will provide required lift. CDRUSNORTHCOM, as the supported Combatant Commander, will validate movement requirements via time-phased force and deployment data. If demand exceeds lift capacity CDRUSNORTHCOM will coordinate with CDRUSTRANSCOM and the applicable coordinating Federal agencies in situations requiring prioritization between competing DOD and interagency requirements.

(b) CDRUSNORTHCOM will coordinate with the cooperating agency and CDRUSTRANSCOM, to control the movement of personnel, material, and equipment into the BSI and AO. When required, USNORTHCOM/J4 will activate the USNORTHCOM Deployment and Distribution Operations Center (NDDOC) to synchronize and facilitate movement of personnel, material, and equipment into, within, and out of the AO. The NDDOC will be augmented by USTRANSCOM subject matter experts and will be OPCON to USNORTHCOM.

(3) Civil Engineering. (See Appendix 6 to Annex D).

(4) Environmental Considerations. Significant environmental actions are not expected in support of USNORTHCOM PI operations. Actions undertaken by USNORTHCOM response forces are considered emergency actions, where national security and protection of life or property are at stake and make it necessary to take immediate actions without preparing the normal environmental planning documents required.

(5) Environmental Responsibilities. USNORTHCOM is in support of a Primary Agency. Environmental responsibilities remain with the Primary Agency. However, this does not release USNORTHCOM from responsibility to

plan and conduct operations in a manner responsive to environmental considerations. Commanders are responsible to employ environmental practices that minimize adverse impacts to human health and the environment. All USNORTHCOM forces employed in PI operations must be knowledgeable on their responsibilities for protection of our environment. They must develop strategies for all phases of operations to avoid, reduce or eliminate negative impacts on the environment. Emergency exemptions are required for disposal of contaminated and hazardous material. Close coordination with local, state, and Federal agencies during operations is needed to avoid negative environmental consequences. USNORTHCOM's goal is compliance with all applicable laws to the maximum extent possible.

(6) Environmental Conditions and Transfer to Civil Authorities. Documenting conditions and actions as soon as possible before, during, and after operations facilitates resolution and closure of environmental issues. Accomplish an environmental review of USNORTHCOM operations to identify possible environmental issues before a negative impact occurs. Close liaison with the applicable DOD Regional Environmental Coordinator (REC) will aid in ultimate resolution of environmental issues with local, state, and Federal agencies. Environmental impacts are addressed as soon as possible once operations have stabilized. USNORTHCOM forces must direct efforts to properly identify, contain, document, and transfer environmental issues to civil authorities as soon as possible.

c. Personnel. RJTF Commanders will develop and submit a Joint Manning Document (JMD) to USNORTHCOM for validation as soon as possible following command assignment. The JMD will be broken out by phases and will be used to source required units, personnel and equipment. The JMD will comply with the format and process established in CJCSI 1301.01C (see ref. ll). The JMD will be used to develop a Request for Forces (RFF) and placed in the sourcing process per ref ll. Upon SecDef direction, CDRUSJFCOM in coordination with USPACOM and Service components will source USNORTHCOM validated requirements and notify the RJTF Commander of individual augmentee/Unit information and arrival dates. The designated RJTF headquarters (HQ) will be responsible for coordinating the Joint Reception Center (JRC), maintaining accountability of deployed USNORTHCOM personnel, and reporting personnel information to USNORTHCOM via the Joint Personnel Status (JPERSTAT) report IAW CJCSM 3150.13 (see Annex E for personnel guidance and Annex R for report requirements).

d. Public Affairs. The media will play an important role in reporting and shaping public opinion concerning PI operations. Any USNORTHCOM response must take into account possible media repercussions. The JFO JIC

will provide information to the media. The Office of the Assistance Secretary of Defense (Public Affairs) is the DOD focal point for all media inquiries concerning DOD PI operations. Delegation of release authority to the USNORTHCOM Public Affairs Office, and in turn to the appropriate C2 HQ, is allowed ISO this plan (see Annex F).

e. Medical Services. During PI operations, medical and public health needs will be significant factors. The National Disaster Medical System (NDMS), which includes DOD coordination with participating non-Federal fixed hospitals and DOD provided patient evacuation, will provide Federal-level medical response when applicable and able. A pandemic environment will reduce the effectiveness of NDMS. Therefore, NDMS will not be used for movement of influenza patients and will be of limited functionality in the event of a mass casualty event requiring patient movement/regulation from an area impacted by another disaster. Other DOD medical capabilities external to NDMS should be requested if it is determined necessary to augment or sustain the NDMS/local response in order to save lives and minimize human suffering. The time sensitive nature of the requirements necessitates early and rapid interagency coordination to be effective. Restrictions on the use of military medical stockpiles and on the military immunizing civilians may need to be addressed in mission planning (see Annex Q). JFHQ-State accessing Strategic National Stockpile resources through respective state health departments is encouraged.

f. Funding Requirements and Tracking. Funding of DOD units participating in PI operations ISO other government agencies will normally be authorized under the Stafford Act and conducted IAW law and within the established Federal acquisition regulation; DOD Directives, policy, and guidance; and the NRF. Each USNORTHCOM component is responsible for capturing and reporting incremental costs to the Service Agency Comptroller. If the Stafford Act is not invoked as the statutory authority for DOD support, the Economy Act will be the deferred authority for DOD to render support. Standard interagency billing procedures will be followed.

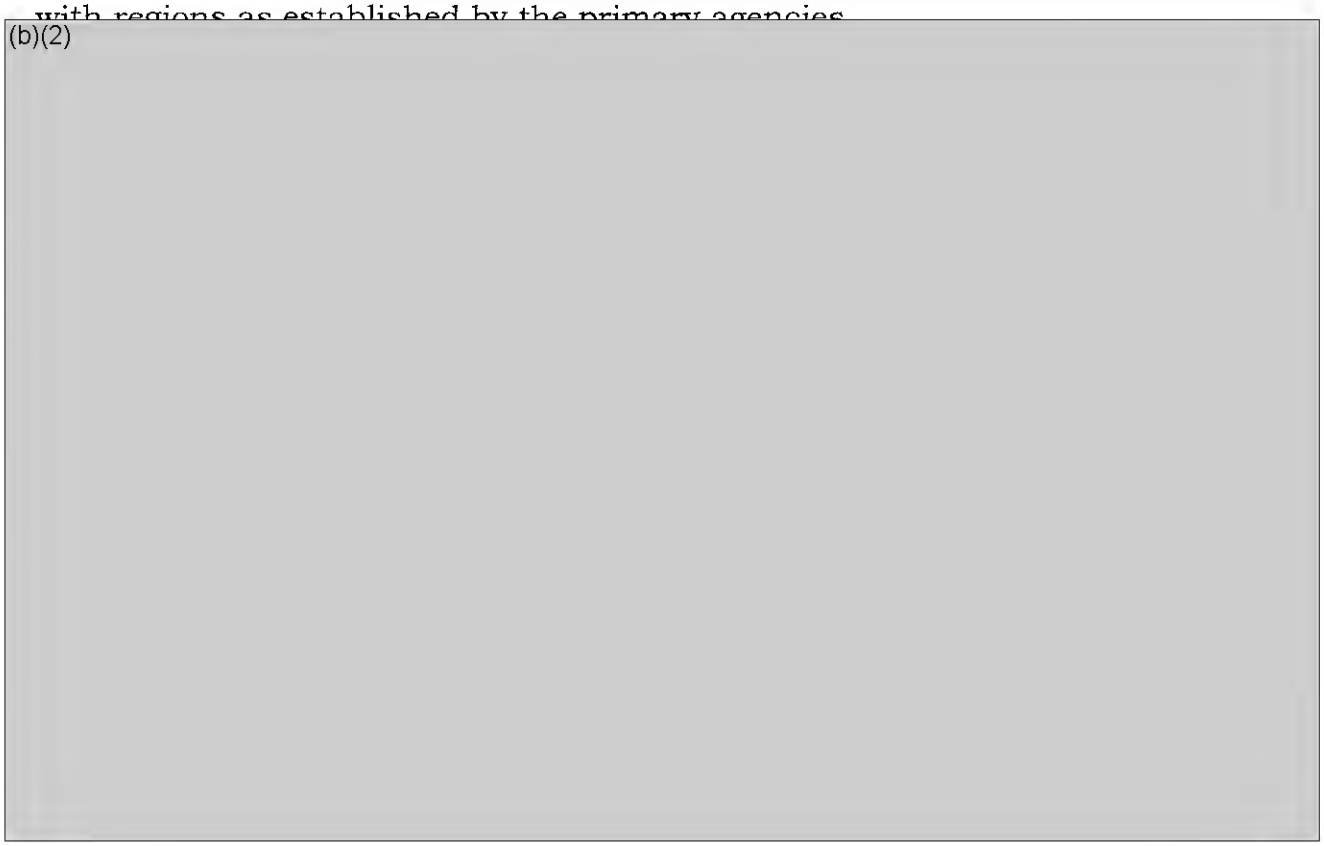
5. Command and Control

a. Command. CDRUSNORTHCOM is responsible for synchronizing planning for DOD efforts in support of the US government response to pandemic influenza, and will do so in coordination with other combatant commands, the Services, and, as directed, appropriate US government. Additionally, USNORTHCOM (b)(2) is the lead planning agent for DOD support to PI operations in the US territories of Puerto Rico and Virgin Islands. C2 for Federal PI response forces (b)(2) for the mission

will be aligned with primary agency structures. CDRUSNORTHCOM will be the Joint Force Commander. The JFC will establish 5 RJTFs, aligned with PI Regions established by the primary agencies. These RJTFs will command all DOD Title 10 PI response operations within their respective RJOAs, which will consist of 7-13 states per region. As necessary, the RJTF commander may deploy their forces to states within the region and coordinate with Services through USNORTHCOM for BSI/JRSOI and installation support.

b. Regional Construct. Figure 5-1 depicts a potential PI C2 RJTF construct. The figure depicts USNORTHCOM's alignment of RJTFs with PI response as identified by the primary agency. Aligning in this fashion requires the establishment and resourcing of five RJTFs, in addition to existing subordinate commands and component organizations in support of PI operations. If regions are not identified in this way, USNORTHCOM will align with regions as established by the primary agencies.

(b)(2)



(1) Command Relationships. The POTUS, SecDef and CJCS have designated CDRUSNORTHCOM as the supported Combatant Commander for PI operations in the USNORTHCOM AOR. CDRUSNORTHCOM will plan and execute Federal military PI operations within the USNORTHCOM OA. USNORTHCOM PI response forces will always remain under C2 of military commanders and will always be ISO civil authorities unless otherwise directed

by the POTUS (see Annex J). Figure 5-2 depicts the proposed PI C2 relationships, which are dependent on how the primary agency establishes regions. The figure depicts the day-to-day posture for planning and coordination, and is not intended to represent any particular operation.

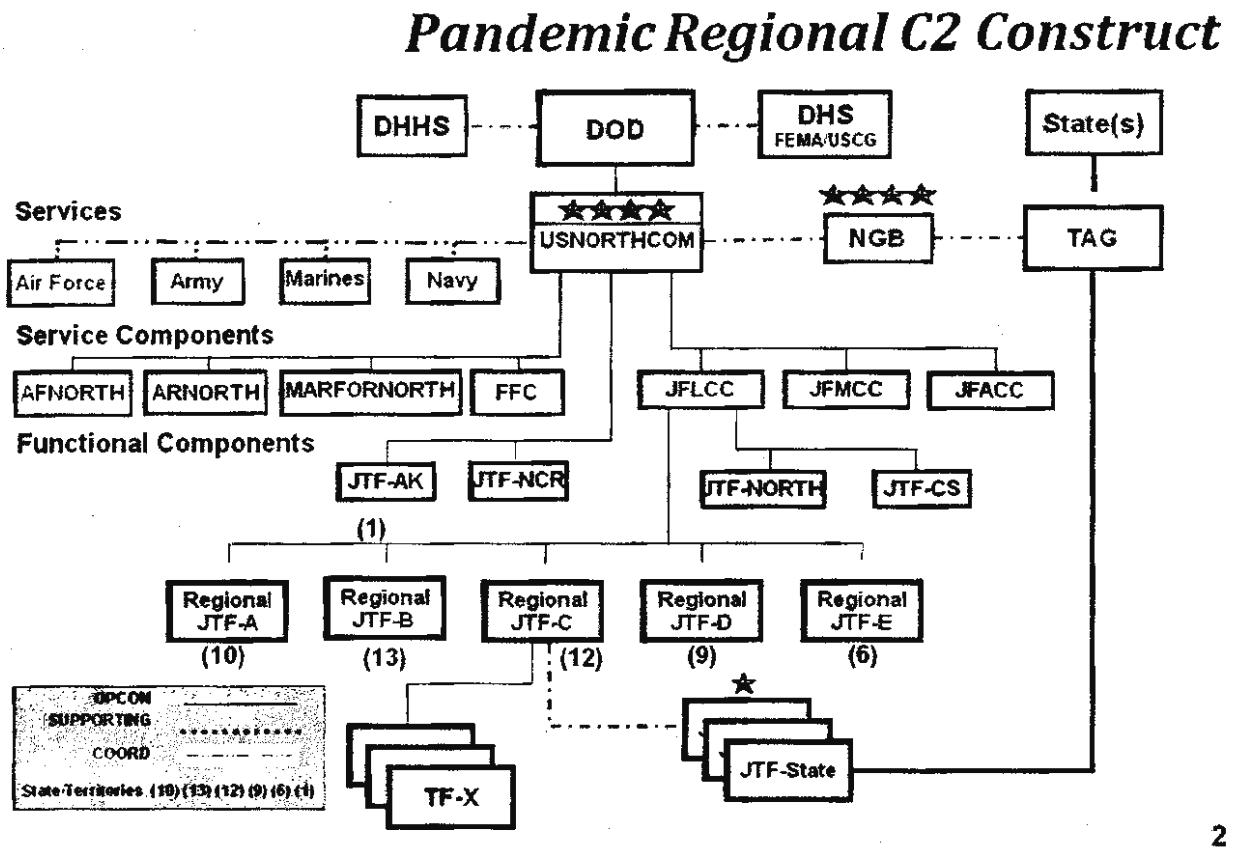


Figure 5-2 USNORTHCOM PI Response C2 Relationships

(a) Component Commanders/ Supporting Component Commanders

1. CDRARNORTH

2. CDRAFNORTH

3. COMMARFORNORTH

4. COMUSFLTFORCOM

(b) Functional Components

1. JFLCC

2. JFACC

3. JFMCC

(c) Assigned Headquarters

1. CDRJTF-CS

2. CDRJTF-N

(d) Subordinate OPCON Commands/Commanders

1. CDRJFHQ-NCR

2. CDRJTF-AK

(e) Defense Coordinating Officer. The DCOs are normally co-located with the JFOs. In a PI environment requirements may dictate the placement of DCOs within a state or region to process RFAs over large geographic areas. DCOs will validate RFAs provided by the FCOs within established JFO operating locations.

(f) National Guard Bureau (NGB). NGB is the primary channel of communication from USNORTHCOM elements to the Joint Force Headquarters in each state or Territory (JFHQ-State(s). However, if needed CDRUSNORTHCOM can coordinate directly with the state Adjutant Generals.

(2) Command Posts

(a) NORAD-USNORTHCOM Command Center (N2C2). The N2C2, USNORTHCOM's primary incident awareness center, is situated in Building 2 on Peterson Air Force Base, Colorado. The N2C2 monitors and coordinates domestic event activities, initiates activation messages and drafts the Commander's estimate. The NORAD and USNORTHCOM battle staffs operate under three core operational centers, current operations, future operations and future plans. The core centers plan and conduct current and future operations, establish appropriate C2, and oversee the execution of operations orders.

(b) Joint Force Land Component Commander (JFLCC). The JFLCC will command all RJTFs for pandemic operations and lead USNORTHCOM PI operations in support of primary agencies. The JFLCC will be established at Ft Sam Houston, TX and in the vicinity of USARNORTH.

(c) Joint Force Air Component Commander (JFACC). The JFACC will command and control air operations in support of USNORTHCOM PI operations. The JFACC is established at Tyndall Air Force Base, FL.

(d) RJTF HQ. The RJTF HQ will command all attached or assigned Title 10 forces and HQs in their respective regions and be in the vicinity of regional response centers for the primary agency wherever possible. RJTF Commanders will designate primary and alternate Command Post locations during the CONPLAN Development process.

(e) State JTF HQ. A state JTF HQ will be established as required for PI response operations in each state. JFHQ-State joint operations centers or state emergency operations centers may serve as state JTF command posts.

(3) Succession of Command. As specified in the UCP, if there is a vacancy in the office of the CDRUSNORTHCOM, or a temporary absence or disability, the Deputy Commander, USNORTHCOM shall act as the Combatant Commander and perform the duties of the Combatant Commander until a successor is appointed, or the absence or disability ceases.

(a) If a Deputy Commander has not been designated, or is absent or disabled, interim command shall pass to the next senior officer present for duty and eligible to exercise command regardless of Service affiliation.

b. Communications and Computer Systems. See Annex K

VICTOR E. RENUART
General, USAF
Commander

Annexes:

A – Task Organization (Not Used)
B – Intelligence (Note: Classified Appendixes – attached separately)
C – Operations
D – Logistics
E – Personnel
F – Public Affairs
G – Civil Affairs – Not Used
H – Meteorological and Oceanographic Operations – Not Used
J – Command Relationships (Not Used)
K – Command, Control, Communications and Computer Systems
L – Environmental Considerations – Not Used (See Base Plan para 4b(3)-(5)
M – Geospatial Information and Services – Not Used
N – Space Operations – Not Used
O – (Classified Annex – Not Used)
P – Host-Nation Support – Not used
Q – Health Services
R – Reports
S – Special Technical Operations – Not Used
T – Consequence Management – Not Used
U – Notional CP Decision Guide – Not Used
V – Interagency Coordination
W – Contingency Contractors and Contracting – Not Used
X – Execution Checklist – Not Used
Y – Strategic Communications
Z – Distribution (TBP)

HEADQUARTERS, US NORTHERN COMMAND
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13 August 2009

ANNEX B TO USNORTHCOM PANDEMIC INFLUENZA PLAN 3591-09
INTELLIGENCE

References: See base plan.

a. Dynamic Threat Assessment for CONPLAN 3551, DTA-MA2-20080930, 30 September 2008

1. Situation

a. Characteristics of the Area. The area of responsibility (AOR) for this plan is the 48 contiguous states and the District of Columbia, Alaska, Canada, Mexico, Cuba, the Bahamas, Puerto Rico, US Virgin Islands, British Virgin Islands, the Gulf of Mexico, the Caribbean Sea, the Atlantic Ocean and other islands (except Greenland), as outlined in the Unified Command Plan (UCP). When directed by the President or Secretary of Defense (SecDef), CDRUSNORTHCOM conducts operations in response to an influenza pandemic within designated joint operation area (JOAs) to mitigate the impact on our nation's welfare. Specific JOAs and consequences of a pandemic are difficult to predict in advance because the biological characteristics of the virus are not known. Similarly, the role of the federal government in a pandemic response will differ based on the pandemic's morbidity and mortality rates. In addition, the Department of Defense (DOD)'s efforts to assist in mitigating the impact of a pandemic will depend greatly on local, state, tribal and federal capabilities in the specific areas of the outbreak. Per the Defense Intelligence Agency's (DIA) Dynamic Threat Assessment (DTA) for CONPLAN 3551 (Concept Plan to Synchronize DOD Pandemic Influenza Planning), 30 September 2008, it is unlikely any country could detect cases early enough to contain a highly transmissible influenza. At best, countries may be able to take actions to delay entry of the virus across their borders. Political and social instability and substantial economic loss are probable secondary and tertiary effects of an influenza pandemic. The degree to which countries can mitigate morbidity and mortality during the pandemic and can reintegrate recovering individuals into society is assumed to have a considerable impact on the outcome. Countries with more advanced and robust health care systems will be better able to mitigate many of the secondary and tertiary effects of a pandemic.

b. Enemy

(1) The primary threat for this concept plan (CONPLAN) is the emergence of an influenza pandemic with effects similar to the 1918 pandemic. (b)(2) Currently, the H5N1 Avian Influenza virus is identified by the World Health Organization (WHO) as the leading candidate to cause the next worldwide PI event. Early detection of a virus with sustained human-to-human transmissibility will be key to responding.

(2) The primary threat to DOD and allied forces during a pandemic is the high transmissibility and rapid onset of severe morbidity resulting in large numbers of people becoming sick or absent simultaneously. (b)(2)

(3) An influenza pandemic will likely threaten economic, political and social stability of states and regions. A pandemic could directly threaten global economic security; prove a catalyst for regime instability; stir social, religious, and cultural tensions; and reduce governmental capacity to meet internal and external security challenges. (b)(2) Countries with more advanced and robust health care systems will be better able to mitigate many of the pandemic effects. Refer to DTA for detailed information on health impacts, secondary and tertiary effects, international response and cooperation, countermeasures, effects on selected countries and country-specific medical and veterinary capabilities.

(4) Key security concerns that would arise from the political, social and economic instabilities as discussed above include opportunistic aggression, opportunities for violent extremists to acquire weapons of mass destruction (WMD), reduced partner capacity during and after a PI, instability resulting from a humanitarian disaster, and decreased distribution and production of essential commodities. (b)(2)

(b)(2)

c. Friendly. Effective intelligence support to CDRUSNORTHCOM, staff and components in a PI environment depends on efficient and accurate information exchange between the intelligence community (IC) and medical organizations. This interaction leverages mutual capabilities to provide information key to defending the homeland, sustaining the health and safety of the populace, protecting the nation's essential infrastructure, and supporting essential government functions.

d. Legal Considerations. Any activities of DOD Intelligence components will comply with federal laws and policy, as specified in Executive Order 12333, "United States Intelligence Activities", and DOD Directive 5240.1, "Procedures Governing the Activities of DOD Intelligence Components that Affect United States Persons", unless otherwise approved by SecDef.

2. Mission. When directed by the President or SecDef, CDRUSNORTHCOM conducts operations in response to an influenza pandemic within designated JOA to mitigate the impact on our Nation's welfare. Intelligence components will provide indications and warning (I&W) and analyses to maintain defense of the homeland while limiting the long-term impact of a pandemic to preserve fundamental freedoms, security, health and safety of our nation.

3. Execution

a. Concept of Intelligence Operations

(1) The timely dissemination of medical related intelligence information will allow NORTHCOM commanders and subordinate commands to effectively mitigate a PI crisis. The bulk of the information will be derived from medical community reporting, with the intelligence aspects of the threat addressed by DIA's National Center for Medical Intelligence (NCMI). NCMI in coordination with the medical community (World Health Organization, Centers for Disease Control and Prevention) will report the potential advance of highly pathogenic avian influenza (HPAI) or other potential pandemic strains from overseas locations to the USNORTHCOM AOR. Situational awareness of the PI spread allows the NORTHCOM's Joint Intelligence Operations Center (JIOC-N) and DOD IC to monitor potential secondary and tertiary impacts of PI, with focus on political, military, economic, social, infrastructure and information (PMESII) effects. Accurate assessments on secondary and tertiary impacts provide important context to ongoing activities of both state and non-state actors and are important for USG decision-making. JIOC-N will primarily monitor secondary and tertiary impacts of PI with emphasis on potential for regional

instability to provide I&W of threats possibly requiring homeland defense actions.

(2) Once the virus is detected within CONUS, Department of Health and Human Services (HHS) will be the primary conduit for medical threat information within CONUS to USNORTHCOM. Medical threat information will include environment and population data on affected locations, the severity of outbreaks, and actions undertaken by nations and aid organizations to prevent and/or contain HPAI.

(3) The medical operations cell (MOC) is the USNORTHCOM point of entry for medical threat information, and will advise the NORAD-USNORTHCOM Command Center (N2C2) on developing situation for the purposes of planning and force health protection. JIOC-N is primarily responsible for providing indications and warning of geo-political or developing threat situations which could further challenge the security of the homeland.

(b)(2)

(4) After a pandemic virus has entered the US, USNORTHCOM will rely principally on those non-intelligence reporting agencies with charter and mission to provide medical threat information to the DOD and civilian communities. HHS will then be the primary information provider to USNORTHCOM for virus characteristics, spread and outbreak modeling within the US.

(5) The coordinated exchange of information among medical organizations in conjunction with traditional Intelligence Community (IC) activities are essential to analyzing PI effects and impacts, and enhancing force health protection. The effectiveness of DOD will be dependent on precise situational awareness of the viral threat outside US borders for early detection, preparation and I&W, as well as identification of health threats to DOD forces employed to support USG mitigation efforts.

b. Tasks. USNORTHCOM Intelligence and Surveillance tasks by phase are as follows.

(1) Phase 0 Tasks.

(a) Assure mission readiness to continue key USNORTHCOM intelligence functions during a pandemic.

(b) Develop and maintain interagency and international partner relationships in order to open communication pathways to share PI information.

(2) Phase 1 Tasks.

(a) Review and update if necessary, priority intelligence requirements (PIR) which address USNORTHCOM unique intelligence concerns.

(b) Ensure USNORTHCOM intelligence requirements are addressed in NCMI and DOD medical surveillance organizations' collection requirements. Ensure USNORTHCOM is addressed on all resultant products.

(c) Synchronize USNORTHCOM intelligence requirements with appropriate Canadian intelligence organizations. Ensure USNORTHCOM is addressed on all resultant products.

(d) In coordination with NCMI, assess validity of intelligence and surveillance information and assess its application to USNORTHCOM AOR.

(e) In coordination with USNORTHCOM MOC, provide early warning of detection of cases of human infection from a viral subtype(s) of pandemic concern.

(f) Track global disease spread of novel viral subtype(s) of pandemic concern in coordination with NCMI and MOC.

(g) Enhance established DOD, interagency and international relationships and communication pathways to share PI information.

(h) Disseminate information to USNORTHCOM subordinate commands using web-based tools at the UNCLASSIFIED and SECRET classification levels.

(3) Phase 2 Tasks.

(b)(2)

(b) Provide early warning of detection of cases of human infection from a viral subtype(s) of pandemic concern.

(c) Enhance established DOD, interagency and international relationships and communication pathways to share PI information.

(d) Track global disease spread of novel viral subtype(s) of pandemic concern in coordination with NCMI and MOC, and monitor progression for possible sustained human to human transmission.

(e) Synchronize USNORTHCOM intelligence requirements with appropriate Canadian intelligence organizations. Ensure USNORTHCOM is addressed on all resultant products.

(f) Continue tasks from previous phases as appropriate.

(4) Phase 3 Tasks.

(a) Continue and strengthen intelligence and surveillance activities in support of response operations.

(b) On order, assist the primary or coordinating authority through coordination with federal and state law enforcement in order to:

1 Identify threats to seize medical supplies or disrupting HPAI/PI relief efforts.

2 Identify targeting of DOD relief efforts for violent attack or disruption.

(b)(2)

(c) Track global disease spread of viral subtype(s) of pandemic concern in coordination with NCMI and MOC.

(d) Strengthen and maintain DOD, interagency and international relationships and communication pathways to share PI information.

(b)(2)

(f) Monitor secondary and tertiary effects of PI on state and non-state actors.

(b)(2)

(b)(2)

(h) Continue tasks from previous phases as appropriate.

(5) Phase 4 Tasks.

(a) Track global disease spread of viral subtype(s) of pandemic concern in coordination with NCMI and MOC, and monitor for emergence of follow on waves and disease mutation.

(b) When directed, provide environmental data which can affect relief recovery efforts.

(c) Track global disease spread of viral subtype(s) of pandemic concern.

(d) Maintain interagency and international relationships and communication pathways to share PI information.

(e) Assure mission readiness to key USNORTHCOM intelligence functions during a pandemic.

(f) Monitor secondary and tertiary effects of PI on state and non-state actors.

(g) Continue tasks from previous phases as appropriate.

(6) Phase 5 Tasks.

(a) Provide intelligence support for recovery operations.

(b) Continue tasks from previous phases as appropriate.

(b)(2)

(b)(2)

(4) Phase 3

(b)(2)

(5) Phase 4

(b)(2)

(b)(2)

(6) Phase 5

(b)(2)

(b)(2)

Early detection of indicators of sustained human-to-human transmission of a deadly influenza virus will rely on I&W from all intelligence disciplines, the interagency and international partners.

(1) Other Collection Activities. Medical reporting will utilize existing international, regional and DOD medical reporting systems to track the spread of the pandemic and determine the success of treatment and preventive actions. See basic plan for further information.

(2) Coordinating Instructions.

(a) Refer to National Intelligence Support Plan (NISP) in support of CONPLAN 3591 upon publication.

(b) Review DIA/NCMI DI-1812-1399-08 Warning Assessment for Pandemic influenza, 10 April 2008 for PI indicators.

(c) Review the DIA DTA (Dynamic Threat Assessment for CONPLAN 3551, 30 September 2008).

f. Processing and Evaluation. DIA/NCMI will be the primary organization for processing medical intelligence and evaluating the validity of the information. JIOC-N will be responsible for processing information pertaining to USNORTHCOM's traditional I&W problems, as well as information specific to USNORTHCOM's pandemic-related CCIRs. This information is primarily pertaining to secondary and tertiary effects, which could lead to execution of command branch plans. USNORTHCOM J2 and JIOC-N, in collaboration with DOD IC will evaluate the validity of information; coordinate with the NORAD-USNORTHCOM Command Center to ensure satisfaction of CCIRs.

g. Analysis and Production. All agencies and organizations responsible for intelligence production will perform those tasks with the objective of providing I&W of emergence of PI and assessing key second and third order effects, with focus on political, military and social effects.

(1) Imagery Analysis and Reporting. USNORTHCOM is responsible for ensuring the conduct of first and second phase exploitation of imagery and its dissemination by the appropriate agencies. All reporting units will provide first phase exploitation results in the initial phase interpretation report (IPIR) and second phase exploitation results in the supplemental phase interpretation report (SPIR). Reporting units will provide these reports to the USNORTHCOM, Service component commands, US Country Teams and the national intelligence community.

(b)(2)

(2) Signals Intelligence (SIGINT) Analysis and Reporting. US Cryptologic Service Elements supporting USNORTHCOM will provide information derived from SIGINT assets to supported commanders in the most timely, direct and secure manner possible.

(3) Human Intelligence (HUMINT) and Counterintelligence (CI) Analysis and Reporting. USNORTHCOM validates and tasks HUMINT and CI collection requirements to theater assets and forward to DIA those requirements that theater assets cannot satisfy. USNORTHCOM also coordinates with other National and Federal Agencies.

(4) All Source Intelligence Analysis and Production. DIA, through NCMI, is the responsible analytical center (RAC) for medical intelligence analysis and production concerning a pandemic, in collaboration with

USNORTHCOM and DOD IC. NCMI will provide global medical intelligence assessments on the spread of a PI and the latest information on the nature of the threat, current mutative state, affected personnel, and casualty information. NCMI will provide foreign medical capability to plan for, report, identify and treat a PI outbreak. USNORTHCOM in collaboration with DOD Component organizations, is the RAC for assessing key second and third order impacts, with focus on political, military and social effects of the pandemic on AOR countries.

(5) General Reporting. All Agencies and commands participating in the collection effort will report information pertinent to the PIRs using established reporting procedures. When information is time sensitive, provide advance notification directly to deploying commanders, to be determined by USNORTHCOM. Reporting will be in accordance with (IAW) CJCSM 3150.01, Joint Reporting Structure General Instructions and the US Message Traffic Formats.

(a) Standing Requirements. Assigned and attached units will report information pertinent to PIRs relating to PI.

(b) Intelligence Reports. Assigned and attached units will submit information of intelligence value as soon as possible and pass critical information via the most expeditious means available. SIGINT reporting will be via established means and procedures. Any agency may specify other one-time or special reports, but should minimize such requests. Following are the principal reports for use:

1 Spot Intelligence Report (SPIREP). Subordinate and supporting commands and agencies should prepare and submit a SPIREP to USNORTHCOM as soon as possible after the occurrence of a significant incident. There is no prescribed format for this report.

2 Intelligence Information Report (IIR). Subordinate and supporting commands and agencies should electronically prepare and submit all IIRs directly to DIA, with information copies to USNORTHCOM and associated organizations.

3 Intelligence Summary (INTSUM). As necessary, JIOC-N will publish daily INTSUMS, to summarize intelligence reporting for the previous 24-hours. This product will generally be produced for situational awareness and synchronization when USNORTHCOM is providing assistance to civil authorities. Significant geo-political developments or emerging threat situations due to a pandemic will be included in NORAD-USNORTHCOM's

Operational Intelligence Watch (OIW) Watchnotes, a product routinely produced on a daily basis.

4 Daily Intelligence Summary (DISUM). RJTFs will produce a DISUM summarizing significant all-source intelligence produced during the previous 24-hour period. The RJTF will commence DISUM reporting upon receipt of JCS Alert/Warning Order.

h. Dissemination and Integration. As the RAC, DIA/NCMI is responsible for dissemination of medical intelligence products concerning the emergence of a pandemic virus OCONUS, in collaboration with combatant commands and DOD IC. USNORTHCOM, in collaboration with DOD IC, is responsible for dissemination of products assessing key second and third order impacts of the pandemic on AOR countries. All reporting units will disseminate intelligence products to DOD organizations IAW existing guidance and to non-DOD agencies based on guidance developed with respect to specific mission requirements. Dissemination to Host Nation will be IAW existing guidance through the Embassy Country Team and the USNORTHCOM Foreign Disclosure Officer. USNORTHCOM will produce and coordinate changes to this guidance in the event of bilateral operations.

(1) For dissemination of classified imagery and imagery products use the DODIIS connected via the Joint Worldwide Intelligence Communications System (JWICS). Request for Information (RFI) management and dissemination will be via COLISEUM on JWICS or SIPRNet, or on NIPRNet via the JIOC-N web-based submission form in accordance with established procedures. Note that unclassified imagery support for Humanitarian Assistance/Disaster Relief (HA/DR) or civil support operations should be disseminated via NIPRNET.

(a) Primary dissemination of imagery and imagery products derived from NTM will be via Image Product Library (IPL) software on JWICS, with email as a secondary method, and on SIPRNet via the JIOC-N SIPRNET INTELINK web site. Unclassified imagery products will be disseminated via NIPRNet using the USNORTHCOM/JIOC-N Operations Portal, and via the Department of Homeland Security's HSIN Portal.

(b) Dissemination of RFIs and text responses will be via JIOC-N INTELINK web sites on JWICS, SIPRNet, and NIPRNet, as appropriate to the classification of the material, with a contingency method of distribution via record message traffic over the AUTODIN circuits. Users should have access to the automated message handling system (AMHS/M3).

(c) All database queries for combatant commands and national databases will be on NIPRNET, SIPRNET and JWICS.

(2) Primary dissemination of classified information will be through Intelink and Intelink-S. Primary dissemination of unclassified information will be through NIPRNET. CD-ROM and hard copy dissemination will be as per customer request.

(3) Timely intelligence reports and assessments will be produced at the lowest classification level possible with the intent of sharing as much intelligence on emergence of pandemic virus as possible with interagency and international partners and first responders. Classified products will also be reviewed for releasability to foreign nations.

(4) Request for Information (RFI) management and dissemination will be via COLISEUM in accordance with established procedures.

(5) Information will be classified according to source and content. Sensitive medical reporting with potential to cause damage to national security should be brought before an original classification authority prior to release. Refer to Defense Intelligence Management Document, Information Security Program, DIAR 50-2, 15 July 1993. Chapter 2 and Appendix A to Chapter 2 provide specific information on classification policy and guidelines.

//Signed//
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13 Aug 2009

ANNEX C TO USNORTHCOM PANDEMIC INFLUENZA RESPONSE CONPLAN 3591 OPERATIONS

References: See base plan.

1. Situation

a. General. This annex describes and provides guidance for the USNORTHCOM preparations for and response to a pandemic influenza (PI). It elaborates on the USNORTHCOM preparations and response using a six phase construct, the decisions to be made with regards to resource protection efforts and response, and outlines tasks by phase.

b. Area of Concern

(1) Area of Responsibility (AOR) USNORTHCOM's geographic AOR for the conduct of normal operations includes North America, the Gulf of Mexico, the Straits of Florida; the Caribbean region inclusive of the U.S. Virgin Islands, British Virgin Islands, Puerto Rico, the Bahamas, and Turks and Caicos Islands; the Atlantic Ocean and the Arctic Ocean from 169° W, east to 045° W, south to 21° N, west to 064° W, south to 17° 30' N, west to 068° W, north to 20° 30' N, west to 073° 30' W, west along the northern Cuban territorial waters to 23° N/084° W, southwest to the Yucatan peninsula at 21° N/086° 45' W, south from Mexico at 092° W to 8° N, west to 112° W, northwest to 50° N/142° W, west to 170° E, north to 53° N, northeast to 65° 30' N/169° W, and north to 90° N.

(2) Area of Interest (AOI) The AOI for USNORTHCOM is its assigned air, land, and sea areas including all of the United States, its territories, and possessions, approaches to the AOR, and any foreign territory worldwide where events may indicate the presence of PI that could cause adverse impacts on the United States.

(3) Area of Operations (AO) The USNORTHCOM AO for PI, applicable to this CONPLAN, is the 48 contiguous States, Alaska, the District of Columbia, the Commonwealth of Puerto Rico, the US Virgin Islands, and any possession of the United States within the USNORTHCOM AOR. Although the countries of Mexico and Canada are within the USNORTHCOM AOR, the focus of operations in this CONPLAN is on operations within the identified AO. DOD support required in other countries within the normal AOR will be addressed through established Theater Security Cooperation (TSC) arrangements or as requested

through the Department of State (DOS) or United States Agency for International Development (USAID).

(4) Regional Construct Figure C-1 depicts a potential PI command and control (C2) regional joint task force (JTF) construct. The figure depicts USNORTHCOM's desire to align RJTFs with regions identified primary agency.

(b)(2)

c. Deterrent Options. See base plan.

d. Enemy Capabilities. See base plan.

e. Friendly Capabilities. See base plan.

f. Assumptions. See base plan.

e. Legal Considerations. See base plan.

2. Mission. See base plan.

3. Execution

a. Concept of Operations. USNORTHCOM's phasing follows the CONPLAN 3551, six-phased construct: shape, prevent, contain, interdict, stabilize, and recovery. This CONPLAN supports the national strategic objective to minimize the impact of PI on our nation's welfare; preserve the fundamental freedoms, security, health, and stability of the nation. This plan supports the four strategic objectives via two main lines of operation: (1) completing mission assignments and (2) support to US Government.

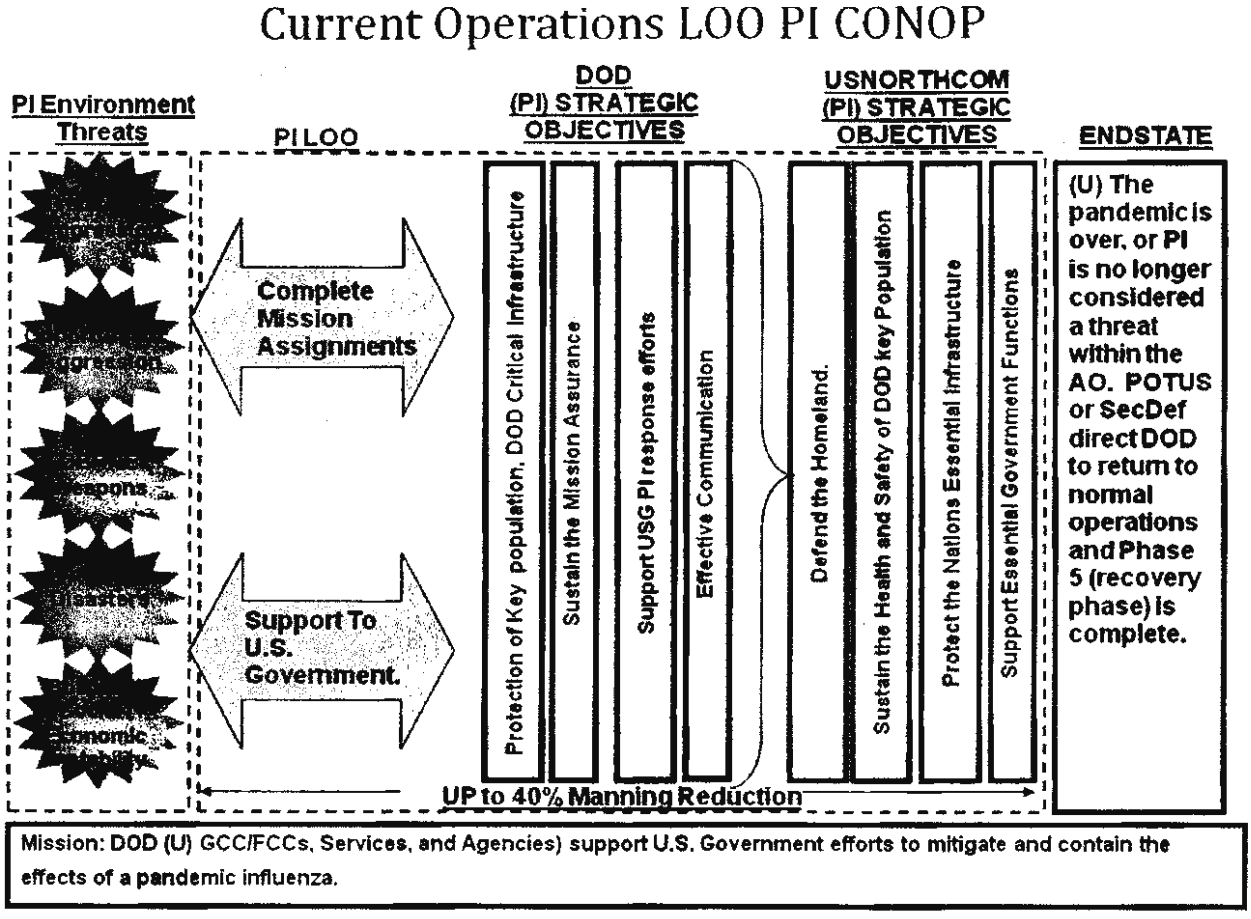


Figure 3-1. USNORTHCOM Lines of Effort

(1) Commander's Intent - Maintain defense of the homeland while limiting the long-term impact of a pandemic in order to preserve the fundamental freedoms, security, health, and safety of our nation.

(a) End State - The pandemic is over, or PI is no longer considered a threat within the AO. POTUS or SecDef direct DOD to return to normal operations and Phase 5 (recovery phase) is complete.

1. Military forces have been relieved by proper authorities and have been transferred to their respective commands for redeployment.

2. CDRUSNORTHCOM relinquishes (b)(2) over deployed forces upon notification of their redeployment.

(b) Strategic Objectives

1. Defend the Homeland. Takes precedence over all other objectives.

2. Sustain the Health and Safety of the Populace. When excess military capacity is available, DOD may assist in providing for the health of others and for the continuation of essential services, minimizing devastating impacts within USNORTHCOM's AO.

3. Protect the Nation's Essential Infrastructure. During a pandemic, it is recognized that health concerns might affect the ability to sustain the nation's critical infrastructure. It is important that this fact is recognized and that preparations are made to sustain that infrastructure within the USNORTHCOM AO. Infrastructure protection requirements will be provided by the primary agencies under which they are assigned.

4. Support Essential Government Functions. Support of essential government functions are necessary to ensure the rule of law is upheld and that the effects of PI are mitigated. It may be necessary for USNORTHCOM to protect and support essential government services within its AO.

(2) General. USNORTHCOM's phasing follows the DOD Global Concept Plan to synchronize planning for PI. This plan follows a six-phased construct: shape, prevent, contain, interdict, stabilize, and recover (as shown in Figure 3-2, in the base plan).

(a) USNORTHCOM Decision Support Template (DST)

Figure C-2, USNORTHCOM Decision Support Template

(b) (b)(2) potential USNORTHCOM decisions

1. Phase 1: (b)(2)

2. Phase 1 through Phase 5: (b)(2)

3. Phase 2: (b)(2)

4. Phase 2: (b)(2)

(b)(2)

5. Phase 2 through Phase 3:

(b)(2)

6. Phase 2 through Phase 3:

(b)(2)

7. Phase 3 through Phase 4:

(b)(2)

8. Phase 5:

(b)(2)

(c) Phases and Phase Objectives.

1. For the purpose of this CONPLAN, the USNORTHCOM objectives have been rendered into a set of phase objectives or desired end states for each of the DOD PI Phases. The individual USNORTHCOM phase objectives are illustrated in Figure C-3. The color phasing indicates the increasing and decreasing severity of the pandemic with red being the actual pandemic phase.

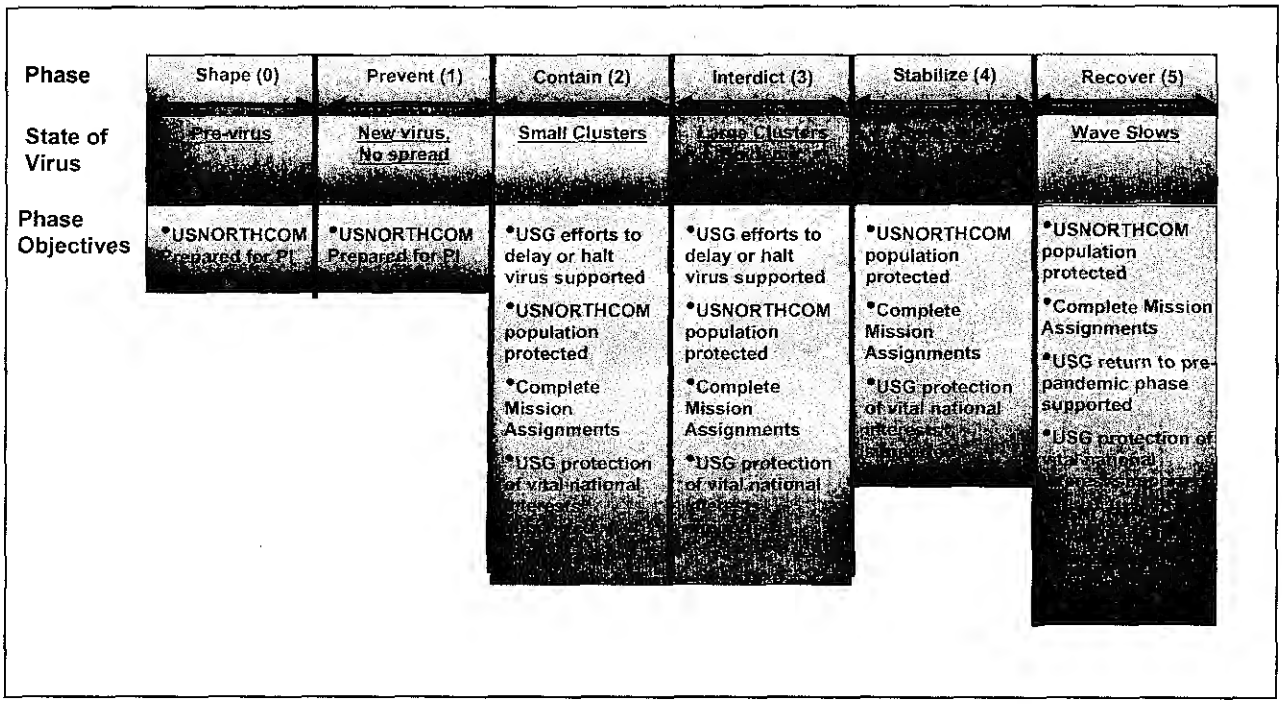


Figure C-3, USNORTHCOM PI Phases and Phase Objectives

(d) USNORTHCOM Phasing

1. Shape - Phase 0: This phase occurs in an inter-pandemic period (WHO phase 1 and 2 conditions) and is a continuous phase incorporating adaptive planning, routine surveillance and engagement activities to assure and solidify collaborative relationships, shape perceptions, and influence behavior in order to be prepared for a new influenza viral subtype. This phase includes education and training for the USNORTHCOM population, interagency, and international partners.

(b)(2)

b. This phase ends upon receipt of information of human infection(s) with a new influenza viral sub-type but no human-to-human spread, or at most rare instances of spread to a close contact (similar to WHO phase 3 conditions).

[redacted]
Objective 1 **USNORTHCOM Prepared for PI**
MOE: Increase/Decrease in percentage of PI plan elements synchronized
MOE: Increase/Decrease in number of PI related training/exercises conducted with mission partners

Figure C-4, Phase 0 - Objectives and MOEs

2. Prevent - Phase 1: This phase begins upon receipt of information of human infection(s) with a new influenza viral sub-type but no human-to-human spread, or at most, rare instances of spread to a close contact (similar to WHO phase 3 conditions). During this phase USNORTHCOM will support USG efforts to prevent or limit the spread of the virus.

(b)(2)

b. This phase ends upon receipt of information of small cluster(s) with limited human-to-human transmissions but the spread is highly localized suggesting the virus is not well adapted to humans (similar to WHO phase 4 conditions).

(b)(2)

3. Contain - Phase 2: This phase begins upon receipt of information of small cluster(s) with limited human-to-human transmission but the spread is highly localized suggesting the virus is not well adapted to humans (similar to WHO phase 4 conditions). During this phase USNORTHCOM components will take measures to protect the USNORTHCOM population in the localized region(s) while maintaining the freedom of action to conduct assigned missions. As directed, USNORTHCOM components will support USG efforts to contain the new virus within a limited area in order to

prevent a pandemic and gain time for implementation of additional pandemic preparedness measures.

(b)(2)

b. This phase ends when indications and warnings identify large clusters of human-to-human transmission (similar to WHO phase 5 conditions) or when the outbreak is contained with no additional cases in an (the) identified region(s).

(b)(2)

4. Interdiction - Phase 3: This phase begins when indications and warnings identify large clusters of human-to-human transmission in (the) affected region(s) (similar to WHO phase 5 conditions). During this phase USNORTHCOM components will take broader measures to protect the USNORTHCOM population while maintaining the freedom of action to conduct assigned missions. As directed, USNORTHCOM components will support USG efforts to delay or halt a pandemic influenza wave.

(b)(2)

b. This phase ends upon receipt of information that highly lethal, influenza virus is spreading efficiently from human-to-human signaling a failure of containment and interdiction actions within a region(s) (similar to WHO phase 6 conditions) or when the outbreak is contained with no additional cases in the identified region(s).

(b)(2)

5. Stabilize - Phase 4: This phase begins upon receipt of information the pandemic influenza virus is spreading globally from human-to-human signaling a failure of containment and interdiction actions (similar to WHO phase 6 conditions). During this phase USNORTHCOM components will protect the USNORTHCOM population, maintain freedom of action to conduct assigned missions and within capabilities, as directed, support USG in mitigating the pandemic effects in order to ensure governments and communities are capable of maintaining social order, maintain critical infrastructure, and to minimize human suffering.

(b)(2)

b. This phase ends upon receipt of information that case incidence is decreasing, indicating the slowing of the pandemic wave and conditions begin to allow reestablishment of governments functions without USNORTHCOM support.

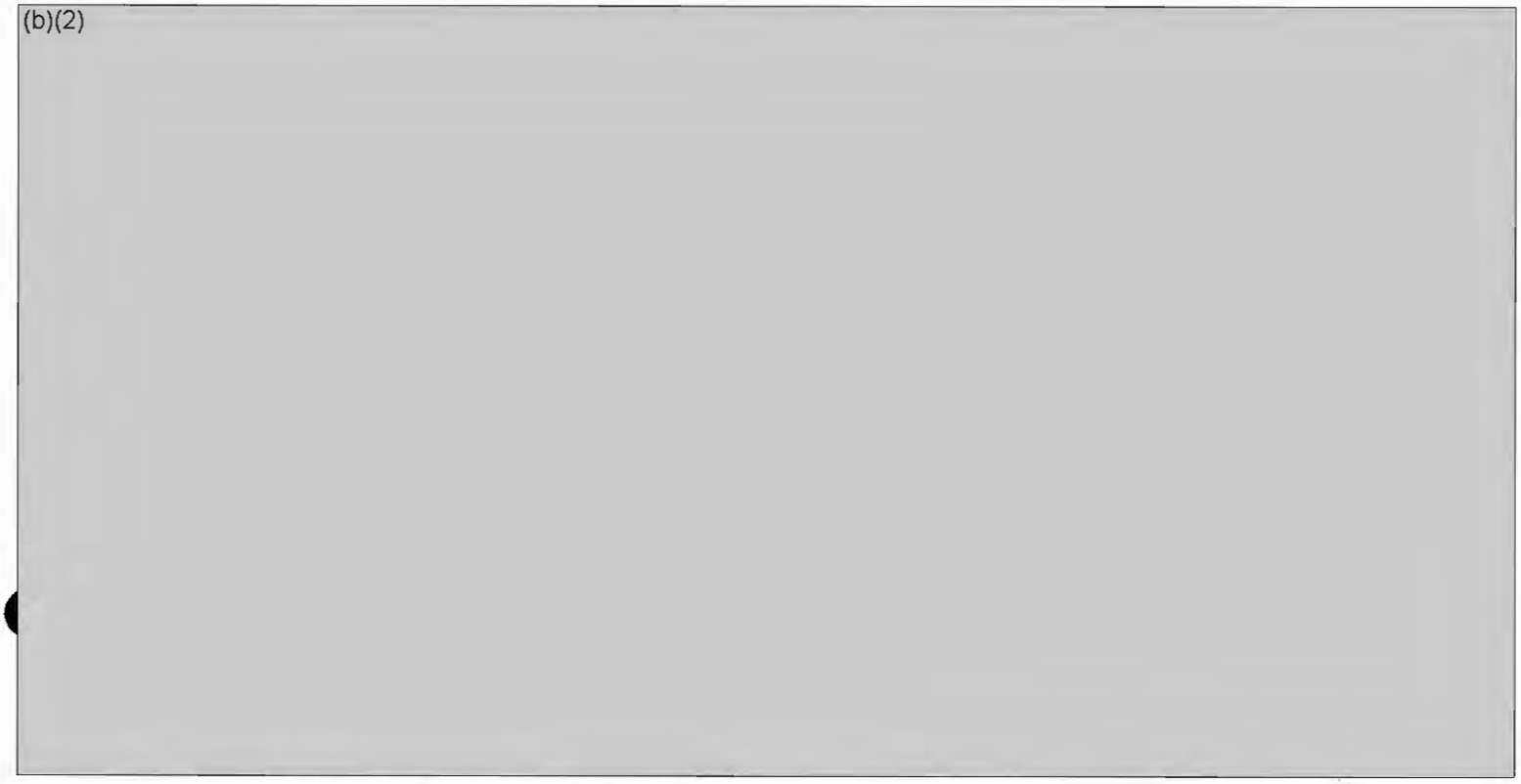
(b)(2)

6. Recovery - Phase 5: This phase begins upon receipt of information that case incidence is decreasing, indicating the slowing of the pandemic wave. During this phase USNORTHCOM conducts force reconstitution operations and as directed will support USG efforts to re-establish normal support conditions with key partners.

(b)(2)

b. This phase ends when normal support relations are in place, USNORTHCOM PI response forces are reconstituted and reset, and conditions allow for a return to the inter-pandemic conditions or back to a previous phase.

(b)(2)



(3) Tasks. See Appendix 31.

(4) Coordinating Instructions. See base plan.

4. Administration and Logistics. See base plan.

5. Command and Control. See base plan.

Appendixes
1 -- Nuclear Operations – Not Used
2 -- Combating Weapons of Mass Destruction- Not Used
3 -- Information Operations
4 -- Special Operations – Not Used
5 -- Personnel Recovery (PR) Operations – Not Used
6 -- Removed from JOPES
7-- Removed from JOPES
8 -- Rules for the Use of Force (RUF)

9 – Reconnaissance- Not Used
10 -- Air Base Operability – Not Used
11 -- Combat Camera
12 -- Noncombatant Evacuation Operations – Not Used
13 -- Explosive Ordnance Disposal – Not Used
14 -- Amphibious Operations – Not Used
15 -- Force Protection
16 -- Critical Infrastructure Protection
28 --USNORTHCOM Decision Support Template
31 – Master Task List

OFFICIAL

//Signed//
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APPENDIX 3 TO ANNEX C TO CONPLAN 3591
INFORMATION OPERATIONS

References:

a. Joint Pub 3-13, Joint Doctrine for Information Operations, 13 February 2006

b. Joint Pub 3-13.1, Joint Doctrine for Electronic Warfare, 25 January 2007

c. Joint Pub 3-53, Doctrine for Joint Psychological Operations, 5 September 2003

d. Joint Pub 3-13.3, Joint Doctrine for Operations Security, 29 June 2006

e. Joint Pub 3-13.4, Joint Doctrine for Military Deception, 13 July 2006

f. DODD 3600.01, Information Operations, 14 August 2006

g. CJCSI 3213.01B, Joint Operations Security, 17 December 2003

h. CJCSI 6510.01E, Information Assurance and Computer Network Defense, 15 August 2007

i. N-NC Policy Directive 10-102, Information Operations Policy, 2 February 2009

j. N-NC Instruction 10-100, Operations Security, 1 August 2003

1. Situation

a. General. See base plan

b. Enemy. See base plan

c. Friendly

(1) Information operations (IO) capabilities across the whole of the DOD must be considered during all phases of CONPLAN 3591. Combatant command, Service and DOD Agencies IO planners must ensure that all friendly IO objectives and capabilities are identified, de-conflicted, integrated, and synchronized to ensure optimal support to this plan.

(a) Augmenting Organizations. Special Assistants to the Commanders must be included in IO planning and approval. They include:

1 Public Affairs (PA). PA is the coordinating element for media relations, command information, community relations and single point of contact for US and foreign press. PA is the key participant in the Strategic Communications process, and PA must be cognizant of current and future IO in order to ensure deconfliction, synergy and optimal messaging effect. See Annex F.

2 Judge Advocate General (JA). The employment of IO capabilities must be subject to thorough legal review, especially if IO capabilities are utilized within the United States.

3 Interagency (IC). Significant coordination with various government agencies will be required for successful employment of IO capabilities in support of pandemic influenza (PI) mitigation. The IC can facilitate coordination among this complex set of organizations.

(b) Other Supported Commands, Supporting Commands, Services and DOD Agencies. Successful employment of IO in a PI scenario requires the integrated coordination of supported and supporting Commands, the Services, and DOD Agencies. The IO capabilities, plans, programs, and activities of other combatant commanders and agencies must be synchronized to provide the most efficient response to a global PI scenario.

1 USSTRATCOM. Commander, US Strategic Command (CDRUSSTRATCOM) is the supported commander for trans-regional IO.

2 USSOCOM. Commander, US Special Operations Command (CDRUSSOCOM) is the supporting commander for active duty forces and capabilities used for a Civil Affairs Information Support Element (CAISE). A CAISE can assist in the dissemination of life-saving messages and information, as approved by cognizant civil authorities.

3 Joint Information Operations Warfare Command (JIOWC). JIOWC will provide full spectrum IO planning support to operational commanders.

4 1st Information Operations (IO) Command. 1st IO Command provides tailored support to Army component commands.

5 Naval Network Warfare Command (NETWARCOM). NAVNETWARCOM provides tailored support to Navy component commands.

6 Air Force Information Warfare Center (AFIWC). AFIWC provides full-spectrum IO support to Air Force component commands.

7 Joint COMSEC Monitoring Activity (JCMA). JCMA provides communication security monitoring of USNORTHCOM Headquarters and its Service components as required.

8 Joint Warfare Analysis Center (JWAC). JWAC provides support to combatant commands and the OCONUS offensive IO mission.

9 Interagency OPSEC Support Staff (IOSS). IOSS provides combatant commands support in developing OPSEC programs.

10 Other combatant commands include US Transportation Command (USTRANSCOM), and US Joint Forces Command (USJFCOM). Their IO capability activities will contribute to the global PI mission and must be coordinated and synchronized to ensure unity of effort. In particular, USJFCOM is the supporting commander for reserve component forces and Combat Camera (COMCAM) capabilities.

d. Assumptions. See base plan.

2. Mission. See base plan.

3. Execution

a. Intent. Establish a planning framework for the employment of IO capabilities to mitigate and contain PI. Be prepared to (BPT) employ IO capabilities, within the bounds of established law and policy, in support of US Government efforts to mitigate and contain the effects of pandemic influenza.

(1) Examine effectiveness of IO capabilities, and their applicability in the context of established law and policy.

(2) Retain freedom of action in the information environment.

(3) Provide relevant IO capabilities as necessary to:

(a) Preserve the operational effectiveness of our forces.
(b) Sustain mission assignments for DOD missions.
(c) Respond quickly and effectively to requests from civil authorities when directed by the President or Secretary of Defense.

b. End State. DOD Components synchronize IO in order to mitigate the impact of PI on DOD forces and help ensure that DOD is capable of conducting assigned missions worldwide.

c. Strategic Objectives. See base plan.

d. Priority Effects List. See base plan.

e. Concept of Operations. This plan provides for the execution of IO in support of the strategic objectives and priority effects throughout the six phases in the base plan and Annex C, Operations. The base plan also identifies two lines of effort that group similar type tasks. Each of these lines of effort and the tasks associated with them are to be executed throughout the phases of this CONPLAN and assist in the completion of the Federal goals and DOD objectives.

A PI will present two main challenges once it achieves efficient, sustained human-to-human transmission. Those challenges will be the speed at which the virus can spread geographically, and its efficacy/lethality. IO planners must be prepared to rapidly synchronize effects and execute approved IO for various phases of this CONPLAN. Combatant commands and other organizations will not necessarily be in the same phase of execution, nor will operations follow strictly sequential phasing in a particular AOR. DOD components must seek to educate civil and military authorities about the IO capabilities well before any event and seek advocacy in employing these capabilities during a PI.

f. IO Objectives & Effects

(1) Phase 0- Shape Phase

(a) Required activities include adaptive planning and engagement activities to assure and solidify collaborative relationships, shape perceptions, and influence behaviors in foreign audiences in order to prepare for a new influenza viral subtype. Actions taken in this phase includes education and

training for the key population (to include DOD response forces), interagency, state, tribal, local, and international partners.

(2) Phase 1- Prevent Phase

(a) The priority of effort is to prepare for and respond to a potential PI, to include: training, organizing and equipping the force; educating key populations; continued planning; strategic communication; execution of NIP/DIP tasks. During this phase, USNORTHCOM will support USG efforts to prevent or limit the spread of the virus, as directed. IO efforts should focus on educating the key populations, supporting strategic communication, maintaining situational awareness and coordinating with interagency, state, tribal, local, and international partners.

(b) Required activities include: enhanced education and training for the key populations; refinement of plans; close coordination with host nations, interagency, and international partners; and support to strategic communication.

(3) Phase 2- Contain Phase

(a) The priority of effort is to protect USNORTHCOM population and maintain freedom of action to conduct assigned missions. Secondary effort is to support USG containment efforts, as directed. IO efforts should focus on maintaining situational awareness and coordinating with interagency, state, tribal, local, and international partners.

(b) Key activities will include supporting public information efforts as DOD components take measures to protect key populations in the localized region(s) and maintain freedom of action to conduct assigned missions. As directed, DOD IO activities will support USG efforts to contain the new virus within a limited area in order to prevent/inhibit a PI or gain time for implementation of additional PI preparedness measures.

(4) Phase 3- Interdict Phase

(a) The first objective is to take broader measures to preserve USNORTHCOM mission essential capabilities. The second objective is to support USG efforts to delay or halt a PI wave, as directed. IO efforts should focus on assisting in sychronizing DOD, interagency, state, tribal, local, and international partner planning, response, and communication. Additionally, traditional and emerging threats should also be addressed so that adversaries are not inclined to exploit a PI environment.

(b) Key activities will include assisting public communication as broader measures are implemented to protect the key populations, maintaining freedom of action in the information environment, and communicating deterrence messages to potential adversaries seeking to exploit the PI environment.

(5) Phase 4- Stabilize Phase

(a) Priority of effort is the protection of the USNORTHCOM population and maintaining freedom of action to execute assigned missions. Secondary effort is support of USG efforts to mitigate PI, as directed. IO efforts should focus on assisting in synchronizing DOD, interagency, state, tribal, local, and international partner planning, response, and communication. Traditional and emerging threats should be addressed so that adversaries are not inclined to exploit a PI environment.

(b) Key activities will include assisting public communication as DOD implements COOP measures through each PI wave, maintaining freedom of action in the information environment, and communicating deterrence messages to potential adversaries seeking to exploit the PI environment.

(6) Phase 5- Recovery Phase

(a) Priority of effort is continued protection of USNORTHCOM population to complete mission assignments, while redeploying and reconstituting the force. Secondary effort is to support, as directed, USG efforts to re-establish inter/pre-pandemic conditions. IO efforts should focus on assisting in synchronizing DOD, interagency, state, tribal, local, and international partner planning, response, and communication. Traditional and emerging threats should continue to be addressed so that adversaries are not inclined to exploit a PI environment.

(b) Key activities will include assisting public communication as USNORTHCOM operates and reconstitutes through each PI wave, maintaining freedom of action in the information environment, and communicating deterrence messages to potential adversaries seeking to exploit the PI environment.

g. Coordinating Instructions.

(1) Public Affairs Coordination. Public affairs coordination is essential throughout all phases of this plan.

(b)(2)

(2) Interagency Coordination. Interagency coordination is vital to the success of IO in support of pandemic influenza response operations. Interagency coordination will occur via the normal staff or adaptive headquarters processes.

(3) Strategic Communication. To be promulgated in accordance with Federal Government and DOD guidance. All IO capabilities will support a USNORTHCOM strategic communication effort, coordinated and synchronized with the National Strategic Communication effort.

(4) Operations Security (OPSEC). Per ref (j), OPSEC is concerned with identifying, controlling, and protecting sensitive-but-unclassified information. All USNORTHCOM personnel have a responsibility to avoid discussing sensitive but unclassified, and critical information with personnel not having a required need-to-know. All DOD organizations need to ensure OPSEC is integrated into all training, operations and plans. This should include awareness training and a review of approved critical information lists.

(b)(2)

4. Administration and Logistics. See Annexes D and E

5. Command and Control. See base plan and Annex C.

a. Component Commanders will execute coordinated and synchronized IO capability activities in support of Higher Headquarter pandemic influenza response operations.

b. Within USNORTHCOM components, IO capability activities are directed by the J3 with support from all directorates, as directed by the Joint Force Commander per Ref i.

Tabs
A – Military Deception – Not Used
B – Electronic Warfare (EW) –Not Used
C – Operations Security (OPSEC)- Not Used
D – Psychological Operations- Not Used
E – Physical Attack/Destruction – Not Used
F – Computer Network Attack – Not Used
G – Defensive Information Operations (D-IO) – Not Used

H – Computer Network Defense (CND) Operations- Not Used

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APPENDIX 8 TO ANNEX C TO USNORTHCOM CONPLAN 3591
RULES FOR THE USE OF FORCE

References:

a. CJCSI 3121.01B, Standing Rules of Engagement/ Standing Rules for the Use of Force (S), 13 June 2005

b. National Guard Rules for the Use of Force

c. Additional References see base plan

1. Purpose. To provide substantive guidance on the standing rules for the use of force (SRUF) during a pandemic influenza in support of civil support (CS) operations.

2. Situation

a. Enemy. See base plan

b. Friendly. See base plan

3. Mission. See base plan

4. General

a. Reference a applies to Title 10 Forces performing CS operations.

b. National Guard (NG) soldiers performing duty in a non-federalized duty status are governed by their state rules for the use of force (RUF).

c. Requests for SRUF augmentation or mission specific RUF for Title 10 forces will be staffed through normal operational channels to the CDRUSNORTHCOM.

(b)(2)

(b)(2) [redacted]

e. If the U.S. accepts foreign military support personnel, SRUF should be specified and coordinated through the Department of State (DOS) and Department of Justice (DOJ) prior to the receipt of foreign military personnel support.

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APPENDIX 11 TO ANNEX C TO USNORTHCOM CONPLAN 3591
COMBAT CAMERA (COMCAM) OPERATIONS

References:

a. DOD Directive 5040.2, Visual Information Policy, 30 August 2005

b. DOD Directive 5040.4 Joint Combat Camera Program, 6 June 2006

c. CJCS Instruction 3205.01A, Joint Combat Camera, 25 Aug 2006

d. AFI 33-117 Multimedia Management, 1 April 2004

e. OPNAV 3104.1 Naval Visual Information and Combat Camera Program Policy and Responsibilities, 9 February 2001

f. OPNAV 3104.1 Naval Combat Camera Program, 15 April 2002

g. DA PAM 25-91, Visual Information Procedures, 13 September 1991

h. MTTP COMCAM, May 2007

1. Situation

a. Enemy. See base plan and Annex B, Intelligence

b. Friendly. Sources of combat camera (COMCAM) documentation outside this command are provided by Air Force, Army, Navy, and Marine Corps resources.

c. Assumptions

(1) Resources Availability. COMCAM resources residing within the homeland can be utilized for pandemic influenza (PI) mitigation and response activities in support of civil authorities. A fragmentary order (FRAGO) to

appropriate USNORTHCOM operations order (OPORD) will be used to task component COMCAM units for support.

(a) Component COMCAM units are standing by to deploy active duty personnel upon receipt of deployment orders.

(b)(2)

(b)(2)

in the tasking and direction of COMCAM video and still imagery documentation operations to meet objectives levied by USNORTHCOM, Joint Chiefs of Staff (JCS), Office of the Secretary of Defense (OSD), and the White House.

(5) COMCAM forces assigned or attached to and within the USNORTHCOM AOR or designated joint operations area (JOA) (b)(2)

(b)(2)

delegated to the appropriate joint subordinate command or designated authorities. This requirement is key to maintaining USNORTHCOM and joint subordinate visibility on all DOD forces within the AOR or JOA as applicable to ensure proper force management, logistics, transportation and protection.

(6) The fundamental difference between COMCAM and visual information (VI) lies in the level of support provided and the specialized training required to operate in austere environments. VI forces supply base level support to include still photography, limited videography, and graphic support while COMCAM provides combat trained photojournalists, videographers, and still and video editing and transmission services.

2. Mission. Ensure visual information documentation is provided during all phases of USNORTHCOM operations to mitigate and respond to PI. COMCAM imagery provides situational awareness information for use by military commanders, and a valuable visual record of still and video imagery for

historical evidence of military operations. COMCAM documentation of USNORTHCOM PI mitigation and response operations supports operational briefings, status reports, intelligence activities, IO, public affairs (PA), and the historical record. COMCAM imagery may be used to counter disinformation programs in support of sensitive operations. Imagery will be used to evaluate concepts and the results of operations or campaigns.

3. Execution

a. Concept of Operations. During all phases of USNORTHCOM PI mitigation and response operations, the general objective of COMCAM is to document all activities of DOD forces and, as requested or required, other government agencies. Success of COMCAM documentation is dependent on three primary factors.

(1) COMCAM must receive coordinated mission assignments via the chain of command. It is critical that COMCAM teams are included in force movements and mission planning.

(2) Access must be given to document significant events as they occur, regardless of classification or sensitivity.

(3) Rapid transmission of COMCAM products (b)(2) (b)(2) is essential for effective support of information operations, public affairs, and other mission objectives.

b. COMCAM documentation mission assignments. Assignments for COMCAM forces can be generated at any point in the chain of command and will be coordinated via the IO chain of command. In addition to mission assignments from within the AOR, assignments may be directed down the chain of command from the highest levels.

c. Execution Process. COMCAM requirements require timely and appropriate delivery of products in response to the request.

(b)(2)

The COMCAM team will provide a daily situation report (SITREP) to N-NC/J39.

(1) Organization. Deployed COMCAM forces will be organized into teams responsible to USNORTHCOM and the Joint Task Force (JTF) or other designated joint element as assigned, (b)(2) The responsibilities of COMCAM documentation forces are in support of the plan. All COMCAM forces will support joint COMCAM taskings in the JOA.

(2) Employment. COMCAM forces will be employed throughout the USNORTHCOM AOR or JOA.

(3) Imagery Dissemination

(b)(2)

1 JTF or On-Scene Commander.

2 Joint Combat Camera Management Team.

3 Defense Imagery Management Operations Center (DIMOC).

(b)(2)

(b) Imagery (including captions and run sheets) will be distributed electronically, with the following exception: original videotapes or copies of original videotapes will be shipped as quickly as possible (b)(2) (b)(2)

(c) When electronic dissemination is impossible or when videotapes must be moved (as above), ship COMCAM imagery (including complete captions and run sheets):

1 Via traceable means.

2 Packaged and marked per DOD and service directives. Ensure classification authority and downgrading instructions are provided.

d. Tasks and Responsibilities

(1) USNORTHCOM COMCAM Support. USNORTHCOM J3 is the executive agent for COMCAM operations. Once directed, typically by JTF COMCAM coordinator/planner, COMCAM teams will be established and located as directed.

(2) The Joint Combat Camera Management Team (as required) shall

(a) Assist the USNORTHCOM, JTF and, as designated, other joint elements in developing documentation requirements and implementing the use of COMCAM resources.

(b) Coordinate logistical support requirements for the mobilization of COMCAM and their movement into the USNORTHCOM AOR.

(c) In support of mission assignments, coordinate COMCAM team logistical issues with commanders in the field.

(d) Coordinate with component commands to ensure detailed documentation of the entire scope of operations. This includes coordinating network and telecommunications connectivity to meet the requirements for transmission of imagery.

(e) Manage day-to-day COMCAM operations and administrative/logistical support.

(f) Ensure rapid movement of imagery to priority customers (see "3. a. (3) Imagery Dissemination").

(g) Coordinate review of imagery for possible public release. To meet priority mission requirements, appropriate imagery must be immediately cleared for public release. Clearance for public release is normally conducted by PA Officers, and is accomplished at the lowest possible level (for most operations, the JTF level). Imagery designated "not cleared for public release" by clearing authorities will be properly annotated. Imagery that cannot be reviewed for public release in a timely manner (same day) must not be delayed. Such imagery will be transmitted to designated customers and annotated as "not cleared for public release". If appropriate, such imagery can be reviewed for possible clearance at a later time.

(3) USNORTHCOM and Component Commands shall:

(a) Execute tasking procedures in support of this plan.

(b) Provide trained and equipped mobile COMCAM assets consistent with the forces they are tasked to support.

(c) Provide direction to ensure subordinate units support COMCAM mission requirements, and provide technical communications support for immediate transmission and movement of still and video imagery.

(d) Maintain movement authorization of COMCAM products, both public releasable and non-public releasable, prior to transmission to the (b)(2)

(e) Ensure that COMCAM imagery, both public releasable and non-public releasable, is immediately reviewed and approved for movement clearance to the (b)(2)

4. Administration and Logistics. Security classification or political sensitivity shall not be used as a basis to deny operational COMCAM documentation. COMCAM teams are trained to properly label, handle and safeguard classified material. COMCAM teams are not releasing agents (see paragraph 3.c.(2)(g)).

5. Command and Control

a. Command Relationships

(1) The Joint Combat Camera Management Team and support

personnel are under (b)(2)

(2) Command and control (C2) of (b)(2)

(3) In select situations, COMCAM units may be task organized to tactical level units. Tasking and requirements will continue to occur as described in this appendix; these units will accomplish this as practical with priority to tactical unit mission and operations.

Figure C-11-2: Command Relationships

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APPENDIX 15 TO ANNEX C TO USNORTHCOM CONPLAN 3591
FORCE PROTECTION

References:

a. USNORTHCOM Operations Order 05-01B, Antiterrorism, 15 July 2006.

b. EXORD for Standup of USNORTHCOM CONUS AT-FP Responsibility, DTG 071710Z MAY 04.

c. DOD Directive 2000.12, DOD Antiterrorism (AT) Program, 18 August 2003.

d. DOD Instruction 2000.16, DOD Antiterrorism Program Standards, 2 Oct 2006, Incorporating through Change 2, December 8, 2006.

e. DOD Handbook O-2000.12-H, DOD Antiterrorism Handbook, 9 Feb 2004 .

f. DOD Directive 3020.40, Defense Critical Infrastructure Program, August 19, 2005.

g. CJCS Instruction 5261.01E, Combating Terrorism Readiness Initiatives Fund, April 27, 2007.

h. Joint Pub 3-07.2, Antiterrorism, April 14, 2006.

i. USDP-SOLIC/CHAIRS Message, 071522Z SEP 01, Force Protection Condition Implementation .

j. (S) SecDef Memo, Antiterrorism/Force Protection Responsibilities for Canada, Mexico, and the Russian Federation, 11 Jun 01.

k. DOD Directive 4500.54, Official Temporary Duty Travel Abroad, May 91.

l. DOD 4500.54-G, DOD Foreign Clearance Guide (FCG).

1. Situation.

a. Hazards: *See Annex B, Intelligence.*

(1) Security and Stability. The threat to security, stability of local governments and the possibility of widespread civil disturbance in areas affected by a pandemic influenza (PI) outbreak will vary greatly based on the efficiency and effectiveness of the local, State, tribal, Federal and Host Nation governments. Factors which may contribute are but not limited to: level of preparation, prior experience, existing medical, law enforcement and security infrastructure, severity of the outbreak and threat levels from homegrown or transnational terrorist organizations trying to exploit the situation. These factors will likely have a direct impact on DOD's ability to assist in the management of the outbreak, contain civil unrest and deal with possible threat from terrorism against DOD facilities and infrastructure.

b. Friendly. DOD Elements supporting the USNORTHCOM PI mission address force protection (FP) during all phases of the operation. FP is a command responsibility at all levels.

c. Assumptions.

(1) DOD antiterrorism (AT) and force protection (FP) policies, procedures, standards, assignment of responsibilities, and tactics techniques and procedures (TTP) outlined in *Refs a through l* remain in effect.

(b)(2)

(3) A pandemic will not be a localized event.

(4) PI will have 2nd and 3rd order effects;

(b)(2)

(5) PI will require an integrated response from installations, local, State, tribal, Federal and Host Nation governments.

(b)(2)

d. Resource Availability. (b)(5) Organizations/units should use established Service/agency resource processes, procedures and channels to obtain necessary funding. Commanders can expect additional manning constraints and reduced force levels due to the effects of influenza exposure.

e. Planning Factors.

(1) Commanders and staff need to implement FP measures to protect their personnel, equipment and facilities during all phases of the PI operation. (b)(5) FP planners should develop FP plans that take into account reduced manning, longer response times by security elements and local authorities unable to comply with current memoranda of agreement (MOA).

(2) Additional consideration is given to the fact that DOD forces executing civil support operations under pandemic conditions will operate in an environment where DOD is not the lead agency and commanders must plan accordingly. As a minimum standard by which to assess FP capability, planners should review their FP plans and determine their ability to implement basic FP actions as well as those directed at each force protection condition (FPCON) under reduced manning conditions due to pandemic influenza exposure.

2. Mission. *Reference a and CONPLAN 3591-08 Base Plan.*

3. Execution.

a. Concept of Operation. USNORTHCOM will develop detailed FP guidance for the DOD elements in support of the USNORTHCOM PI mission as directed in the *CONPLAN 3591-08 Base Plan* contingent upon the threat environment and based upon the AT program standards (references a, b, c and d) to ensure FP mission synchronization.

b. Tasks. *Reference a.*

(1) FP Tasks and Responsibilities. Address the following when planning and executing FP in support of the USNORTHCOM PI mission. Additional tasks and responsibilities may be identified by the DOD Elements in support, and during execution, of their respective FP programs.

(b)(5)

(2) Disseminate pre-deployment, deployment and re-deployment in-transit security guidance to deploying forces.

(b)(2)

(4) Ensure access control measures allow civilian access, to include vetting of authorized civilian personnel in support of base support installations (BSI) operations.

(b)(2)

(6) Address FP during all phases of PI planning and operations.

(7) Coordinate FP issues with both DOD and non-DOD authorities as appropriate.

(8) Force Health Protection (FHP). *Appendix 6 to Annex Q.*

(b)(2)

c. Coordinating Instructions All DOD elements in support of USNORTHCOM have the following responsibilities:

(1) Coordinate all FP matters, threat information and FPCONs up and down all levels of military commands via organic command and control (C2) systems, as well as between military, civil, government, and interagency organizations.

(b)(2)

(5) Coordinate with USNORTHCOM for FPCON changes.

(b)(2)

(7) Communicate force health protection information to assigned elements.

(b)(2)

(11) Plan for the use of military installations for use as BSI or mobilization centers by Federal response agencies, reception sites for international aid donations and intermediate staging bases (ISB's) for non-combatant evacuation operations (NEO).

(12) Develop guidance for the use of full personal protective equipment (PPE) and practice universal precautions to protect personnel who must handle sick individuals or the remains of those who have died as a result of PI.

(13) Ensure systems and processes are in place to effectively track the status of USNORTHCOM personnel and individual personnel with regard to their exposure and infection with PI; and, travel to and from infected countries or regions.

4. Administration and Logistics

a. Logistics. Services and agencies retain responsibility for funding AT requirements for DOD installations in the USNORTHCOM AOR.

b. Administration. None.

c. Reports. *IAW CONPLAN 3591 and reference. a.*

(1) General. (b)(2)

d. Standard Reporting Criteria. DOD elements in support of Commander, USNORTHCOM or conducting independent operations directly under USNORTHCOM control, will submit reports per *Annex R of reference a* as directed by Commander USNORTHCOM and by this CONPLAN.

(1) (b)(2)

(2)

(3)

(4) Methods. Use most expeditious means. Declared FPCON are UNCLASSIFIED. Rationale for changing FPCON may be classified; use secure communications when required.

5. Command and Control.

a. Commander, USNORTHCOM (b)(2)

b. Command Relationships. [redacted] (b)(2) The unique inter-agency environment of operations defined within *CONPLAN 3591-08* may require modifications to traditional command relationships to allow proper execution of FP; [redacted] (b)(2) C2 relationships will be based on the situation and the assigned mission.

TABS:

A. Combating Terrorism (Omitted)
B. Physical Security (Omitted)
C. Base Defense (Omitted)

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APPENDIX 16 TO ANNEX C TO NORTHCOM CONPLAN 3591-09
CRITICAL INFRASTRUCTURE PROTECTION (CIP)

References:

a. Homeland Security Presidential Directive 7 (HSPD-7), Critical Infrastructure Identification, Prioritization, and Protection, 17 Dec 03.
http://www.whitehouse.gov/news/releases/2003/12/20031217-5.html

b. National Strategy for the Physical Protection of Critical Infrastructures and Key Assets, Feb 03.
http://www.whitehouse.gov/pcipb/physical.html

c. National Infrastructure Protection Plan (NIPP), 2006.
http://www.dhs.gov/xprevprot/programs/editorial_0827.shtm

d. DHS, Pandemic Influenza Preparedness, Response, and Recovery Guide for Critical Infrastructure and Key Resources (CI/KR), 19 Sep 06.http://www.pandemicflu.gov
/plan/pdf/cikrpandemicinfluenzaguide.pdf

e. Defense Industrial Base (DIB) CI/KR Sector-Specific Plan (SSP), 21 May 07.

f. Public Health & Healthcare CI/KR SSP, 21 May 07 (FOUO).

g. DOD Strategy for Defense Critical Infrastructure, March 2008.

h. DODD 3020.40, Defense Critical Infrastructure Program (DCIP), 19 Aug 05.

i. DODD 3020.26, Defense Continuity Program (DCP), 8 Sep 04. DOD Instruction 2000.16, DOD Antiterrorism Program Standards, 2 Oct 2006, Incorporating through Change 2, December 8, 2006.

j. DOD Manual 3020.45, Defense Critical Infrastructure Program Critical Asset Identification Process, 24 October 2008.

k. DOD Instruction 3020.45 Defense Critical Infrastructure Program Management, 21 April 2008.

l. DCIP Security Classification Guide (SCG), 15 May 07.

m. Defense Continuity Program (DCP) SCG, 15 Dec 05.

n. Defense Threat Reduction Agency (DTRA) SCG for Vulnerability Assessments (JSIVA Program), 6 May 05.

o. DOD, Defense Industrial Base Critical Infrastructure and Key Resources Sector-Specific Plan as input to the National Infrastructure Protection Plan (DSAP), 14 May 07.

p. (S//RELCAN) US Northern Command Instruction (NCI) 10-207, USNORTHCOM Emergency Action Procedures, 1 Oct 04 (U).

q. NCI 10-211, Operational Reporting, 1 Dec 06.

(b)(2)

s. AR 525-26, Infrastructure Risk Management (Army), 22 Jun 04.

t. SECNAVINST 3501.1, Department of the Navy (DON) Critical Infrastructure Protection (CIP), 16 Jun 02.

u. AFPD 10-24, Air Force Critical Infrastructure Protection, 1 Dec 99.

v. MCO 3501.36, Marine Corps Critical Infrastructure Protection (MCCIP) Program, 5 Oct 04.

w. National Infrastructure Advisory Council, The Prioritization of Critical Infrastructure for a Pandemic Outbreak in the United States Working Group, Final Report and Recommendations, 16 Jan 07.

x. HHS National Vaccine Program Office, Defining Priority Groups for Pandemic Vaccine & Antiviral Drugs: Risk Groups and Critical Infrastructure, briefing by Dr. Ben Schwartz, MD, at NVAC Meeting 19 Jul 05.

y. US Dept of Labor, OSHA Guidance on Preparing Workplaces for an Influenza Pandemic, OSHA 3327-02N 2007.
http://www.osha.gov/Publications/influenza_pandemic.html

z. HHS Centers for Disease Control, Interim Pre-Pandemic Planning Guidance: Community Strategy for Pandemic Influenza Mitigation in the United States, Feb 07.
http://www.pandemicflu.gov/plan/community/mitigation.html

aa. Websites:
www.dod.mil/pandemicflu DOD pandemic website
www.cpms.osd.mil/disasters DOD Human Capital Guide to Pandemic Planning
www.pandemicflu.gov HHS one-stop access to USG pandemic influenza information
http://www.whitehouse.gov/homeland/nspi_implementation.pdf Nat'l Strategy for PanFlu Implementation Plan
www.cdc.gov/flu/ CDC flu website
www.cdc.gov/niosh National Institute for Occupational Safety & Health
www.osha.gov/SLTC/respiratoryprotection/index.html OSHA Respiratory Protection website
http://www.who.int/csr/disease/influenza/en/index.html WHO Pandemic Alert & Response website
http://www.hhs.gov/nvpo/influenza_vaccines.html HHS activities on influenza
http://www.pandemicflu.gov/faq/pandemicinfluenza/1973.html Use of masks during pandemic
http://www.pandemicpractices.org Univ. of Minnesota CIDRAP

bb. (S) Combatant Command and Armed Services' lists of Task-Critical Assets (TCA) (U).

cc. (S)Department of Homeland Security, Office of Infrastructure Protection, Tier 1 and Tier 2 national critical asset lists (U).

1. Situation. This appendix addresses specific operational planning and execution needs of defense critical infrastructure protection (DCIP) and critical infrastructure protection (CIP) operations during a pandemic influenza (PI), applicable across the USNORTHCOM area of responsibility (AOR). Guidance to protect workers from PI is important across the board—government and private sectors, domestic and foreign, workplace and home.

(b)(2)

(b)(2)

a. Enemy. See base plan.

b. Friendly.

(b)(2)

(a) USNORTHCOM Service Component CIP staffs.

(b) USNORTHCOM Subordinate Command CIP staffs.

(b)(2)

(2) Homeland Security Presidential Directive 7 (HSPD-7) assigns the following sector-specific agencies (SSA) responsibility for the 17 national critical infrastructure/key resources (CI/KR) sectors (see NIPP p.3 for more detail). Similarly, the DCIP assigns lead agents for its 10 DCIP sectors.

(a) In each case, the respective SSA or DCIP lead agent has written a sector-specific plan (SSP) describing the sector's approach to risk management (e.g., deter or defeat threats, mitigate vulnerabilities, and minimize the consequences of man-made and natural incidents) and information-sharing.

(b) Many of the national SSPs are publicly-available on the Internet, and some are FOUO but available to appropriate government agencies by request. The following table correlates the national and DCIP sectors and leads.

National CI/KR Sector and Sector-Specific Agency	**Defense Critical Infrastructure Sector And DCIP Lead Agent**
Defense Industrial Base: DOD (DCMA) **Commercial Assets**: DHS (OIP)	Defense Industrial Base: DCMA
Banking & Finance: Treasury	Financial Services: DFAS
Telecommunications: DHS (Cyber & Telecomm) Information Technology: " "	Global Information Grid: DISA
Public Health and Healthcare: HHS	Health Affairs: ASD (HA)
Transportation Systems: DHS (TSA and USCG[1])	Transportation: USTRANSCOM Logistics: DLA
Dams: DHS (OIP)	Public Works: US Army Corps of Engineers
Energy: DOE **Nuclear Power Plants**: DHS (OIP)	
Chemical: DHS (OIP)	
Agriculture & Food: USDA, HHS[2]	
Water: EPA	
Emergency Services: DHS (OIP)	
Government Facilities: DHS (ICE, FPS)	
Postal & Shipping: DHS (TSA)	
National Monuments & Icons: Interior	
	Space: USSTRATCOM
	Personnel: DHRA
	ISR: DIA

[1]USCG is SSA for the maritime transportation mode.
[2]USDA is responsible for meat, poultry and egg products. HHS is responsible for other foods.

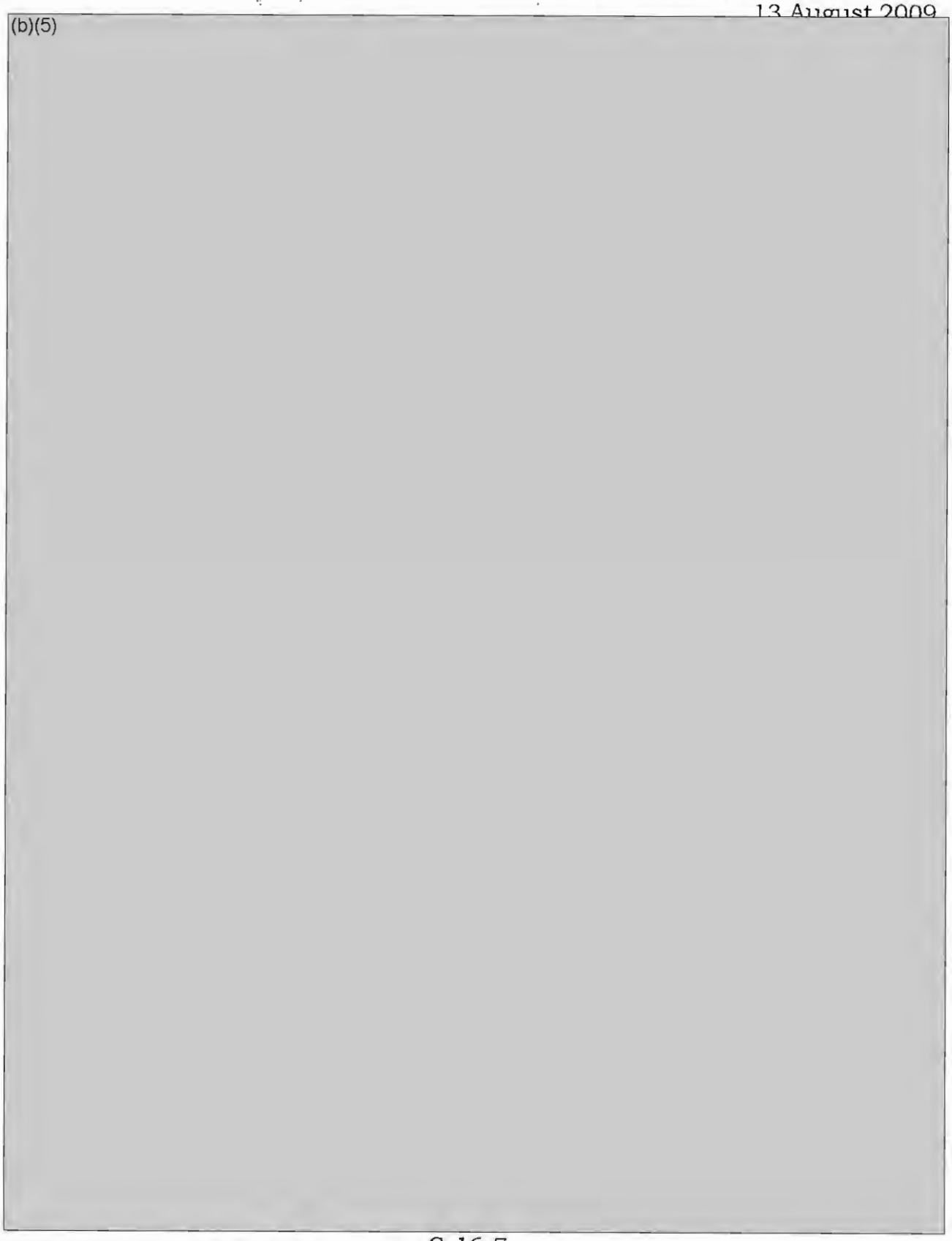
(3) There are many career fields/skill sets in our society, and in the DOD, that would be critical to the functions of society and of DOD that are not reflected in the formally-assigned sectors of critical infrastructure. These should be recognized in planning for pandemic influenza response because their failure under pandemic pressure could become catastrophic and/or lead to derivative deaths or societal disruption. Considering them in pandemic planning is important, especially in the allocation of scarce antivirals, personal protective equipment (PPE), and vaccine when produced. These include (sample list, not exhaustive):

(b)(5)

c. Assumptions.

(b)(5)

(b)(5)



(b)(5)

2. Mission. Maintain continuity of operations (COOP) for defense critical infrastructure while succeeding, when directed, in supporting COOP for national critical infrastructure.

(b)(2)

3. Execution.

a. Concept of Operations.

(1) Owners/Operators of CI. Your primary pandemic objective is to keep your CI facility/function operating, while protecting your people. As expanded in the following chart, you need to:

(a) Keep adequate staff working.

(b) Keep adequate supplies/resources/support services flowing in.

(c) Keep the virus out of your people/facility/assets; prevent its spread.

(d) Keep the virus out of your people's families.

(e) Support your people/families if infected.

Objective	**Options for Action and Planning Considerations**[1] Customize them to fit your situation
Adequate staff working	• Determine the minimum numbers and skill sets for COOP[2] • Identify staff functions that can be stopped during a pandemic • Cross-train • Identify back-up sources of staff • Establish the duty roster system that will be used to schedule staff assignments during a pandemic • Write specific delegations of authority and formal orders of succession, anticipating a 40% absentee rate

Objective	Options for Action and Planning Considerations[1] Customize them to fit your situation

	• Put key control systems and personnel in a secure area they live in for an extended period, with full-shift back-up and a complete disinfection plan in case the virus does enter the facility
	• Identify options for work from home
	  • License standard-e work software like Word and give it to key CI employees to use for work at home, emphasizing off-line work because Internet access may become problematic during a pandemic
	  • Consider options for secure dedicated supervisory control and data acquisition (SCADA) systems allowing key CI employees to monitor and control critical assets from home in emergency situations—with particular attention to the potential for commercial telecommunications systems like phone and Internet to fail during a pandemic
	• Establish liberal leave policy, including family care-giving
	• Establish a clear policy on employee compensation during pandemic-related absences (e.g., sick, patient care-giver, child care, volunteer in community pandemic response)
	  • Pay special attention to federal and state laws on this subject
	  • Remember that if schools and child care centers are closed for as long as 3 months (a common part of community pandemic planning), your CI personnel who are part of the 1/3 of American households with children will have to organize how their children will be supervised—to include staying home themselves
	• Discuss with health insurance providers what you can realistically expect from them during a pandemic
	• Know how you will communicate with CI staff and families about the pandemic, including via public media
	  • Don't wait for perfection in the message before drafting straw man texts you can improve upon later. An 85% solution is better than doing nothing because you "don't have all the facts" or "more research is needed." In a pandemic, little is

Objective	Options for Action and Planning Considerations[1] Customize them to fit your situation
	predictable but best-efforts decisions are necessary • Consider uses for infected-and-recovered personnel, who will no longer be threatened with death—such as security, receptionist or delivery duty requiring interaction with many people from outside the CI facility/function
Adequate supplies/resources/ support services flowing in	• Develop dialogue and, ideally, formal pandemic plans with suppliers (e.g., goods, services like public utility electricity, water, gas), so that you and they know what to expect and can help each other • Expect a high percentage of small-business suppliers to be bankrupted • Look hard at your and their plans for continuity in such services as food service, contract security, and waste removal • Offer to help them plan • Expect intricate just-in-time supply chains to break • Expect hoarding of all basic necessities • Organize how your CI staff will interact with suppliers while minimizing face-to-face contact and touching of common items • Do not expect magic from government. It will not happen • Plan for, and develop now, the maximum reasonable degree of self-sufficiency • Name a staff member now to be responsible for interacting personally with your local and state pandemic planners, becoming part of their planning and resource-allocation network • No matter who owns your CI facility/function, you are part of the local community • During a pandemic, you are part of the local plan, part of the local problem, and hopefully part of the local solution • During a pandemic, they can help you and they probably will expect reporting from you • Plan for pre-pandemic acceleration of required periodic maintenance, warehousing of critical supplies, accumulation of cash, etc. in order to maintain continuity of operations when up to 40% of CI staff are absent

Objective	Options for Action and Planning Considerations[1] Customize them to fit your situation

Keep the virus out of your people/facility/assets
• Prevent its spread
	• Identify to medical authorities the people you require to operate your CI facility/function
	  • If possible, procure and stage antivirals like *Tamiflu* for them
	  • Understand that a specific antiviral may or may not prove useful in a specific pandemic. But the investment cost is negligible compared to the potential value. This is not "predicting" anything, and the act doesn't require "further study." This is common-sense contingency preparation, certainly appropriate for CI protection (and arguably for family protection in preparing for pandemic, when getting near a medic who can prescribe *Tamiflu* may become impossible, whether or not it's useful in the specific pandemic—a clear case of risk management under uncertainty)
	  • Make sure your CI personnel are on a formal list to be early recipients of a new pandemic vaccine, when developed and produced
	  • Push past the theory stage and get this formalized. No list...no plan
	• Look at having key people live in the facility during the pandemic
	• Try to get your CI people out of mass transportation for commuting to work, driving individually or using small car pools at non-rush hours if possible
	  • Not only to reduce exposure, but also because loss of transit employees to infection may make mass transit unreliable
	  • A pandemic could make rush-hour traffic jams disappear
	• Organize who will provide what training, medicines, supplies and informational handouts to all CI staff for dealing with a pandemic
	  • Understand that just telling people to talk to their doctor does little to protect your CI facility/function, if you're serious about it
	  • You must make sure that your CI staff gets the knowledge and supplies they *and their families* will need to help your CI facility/function have

Objective	Options for Action and Planning Considerations[1] Customize them to fit your situation
	continuity of operations during a pandemic • This includes all the staff required to operate the CI: military, Reserve Component, Civil Service, contractors • Whether or not an individual obtains medical care from DOD TriCare is irrelevant in planning to succeed in keeping the CI you need operating • If you need the individual, then you plan and act to keep that individual and their family uninfected. Or you plan to fail • Assuming away the problem only works before the pandemic starts. Then it will be too late, because supplies that are easily and cheaply available now just won't be available then • Make CI facility entry need-to-enter only • Put a medical professional at the CI entry to screen every person for flu-like symptoms before allowing them to enter (you know you have "dedicated" staff who will come to work sick) • Require everyone entering or in the facility to wear a face-conforming N95 respirator at all times *(covering the primary means of flu transmission and infection)* • Give them one if required, along with instruction/assistance/flyer on proper fitting and use • Require everyone entering the facility to wash their hands thoroughly with soap and water or disinfecting gel/solution • Require everyone entering the facility to receive (1) an orientation briefing on pandemic influenza symptoms and defensive actions (e.g., social distancing; avoid touching common surfaces without washing/disinfecting; how to effectively wash/disinfect hands and other items; avoid touching mouth, nose and eyes; cover coughs/sneezes; no hand-shaking, etc.), and (2) a handout that says the same things, with pictures • Require anyone feeling/showing pandemic symptoms to be isolated and given appropriate care • Make seasonal flu shots mandatory for all CI workers (lowering this additional impact during a pandemic,

Objective	Options for Action and Planning Considerations[1] Customize them to fit your situation

	as seasonal flu will continue)
	• Minimize travel, conferences, meetings, group training, visitors, and other group events
	  • Look at teleconferencing, work from home, etc. to ameliorate
	• Require every work unit to audit its work procedures, aiming at reducing interpersonal contact. For example:
	  • Unshielded distance between work stations
	  • Work stations shared among shifts (how to decontaminate them)
	  • Meetings and density of people at those meetings
	  • Hallways and density of people in them
	  • Break areas and density of people in them
	  • Restrooms, density of people in them, and disinfection procedures
	  • Passing-around of items that could carry the virus
	  • Required flow of people through doors requiring touching a handle
	  • Required flow of people through security entry points—what must they touch or pass from hand-to-hand, and how to minimize that
	  • Dealing with the public—how to minimize exposure
	• Minimize deliveries requiring outsiders to enter the CI facility
	  • Organize drop-off points and receiving procedures that prevent close human contact with outsiders
	• Look at every item/delivery arriving at the facility in terms of how to minimize contact with, or destroy, any active virus particles that may be on it
	  • On smooth surfaces a flu virus may stay infective for 2 days, so one option might be to store incoming items in a dry place for 3 days before they are further handled
	  • Irradiation might be explored as an option—especially for handled items like mail
	• Install no-touch: door entry systems throughout the facility, restroom toilet flushers/faucet handles/soap & towel dispensers, trash cans
	• Instruct staff on means to do work without allowing multiple people to touch the same surfaces without

Objective	Options for Action and Planning Considerations[1] Customize them to fit your situation
	disinfecting between the touches • This may include using a tool instead of fingers for touching, and dipping the tool in disinfectant solution (such as simple chlorine bleach) • Organize meeting spaces to provide a minimum of 6-foot separation between people • Stop use of work area fans, which immediately spread virus droplets/aerosols • Write a plan for, and procure/store, pandemic supplies *and instructions* such as: N95 masks to be issued to staff; soap and disinfectant (chlorine bleach solution works) for personal use and for janitorial (and office) staff to disinfect common-use areas like restrooms, door handles, railings, water fountains, copiers, microwaves, refrigerators, coffee-makers, etc.; disinfectant dispensers at every main doorway (common on many cruise ships today, as they have a significant problem with Norwalk virus outbreaks sickening hundreds of passengers/crew at a time—you've seen reports of this in the media) and work area; disposable rubber gloves, other PPE such as gowns and goggles/face shields if appropriate for people forced to work in close proximity; lots of tissues and paper towels; emergency food and water; tools for touching door handles, security or Xerox buttons, etc (a u-shaped bicycle hanging hook works); Tamiflu or other antivirals that your medical staff may recommend and be able to procure for the organization; bedding for live-in staff; an isolated care-giving area in case needed, with full set of supplies for pandemic care-giving; etc • PPE requires training, proper wear, and conscientious use, or it can become counterproductive by generating a false sense of security • In a pandemic, do not assume that normal throw-away procedures are the right procedures • If, as expected, PPE supplies are limited, look hard at methods of disinfecting PPE, to include soaking, microwaving, storing for a few days, etc • Scientists who haven't done the homework will

Objective	Options for Action and Planning Considerations[1] Customize them to fit your situation
	argue about what works, but during a pandemic you have to make decisions, and throwing away the only PPE you have may not be the best decision • A scientist with a better idea is welcome to offer it. OSHA's published pandemic guidance (reference W, page 25) is quite clear that reuse in an emergency can be reasonable. You do the best you can • Place clear plastic cough/sneeze barriers at high-volume face-to-face CI service desks • Glove CI staff like entry security officers who must handle large numbers of IDs or other items handled by many others (virus Heaven) • Better yet, develop procedures so that such handling is not necessary • Establish a website, chat venue, or other appropriate means of pandemic communication so that CI worker concerns and good ideas are heard, shared, and acted upon in view of others
Keep the virus out of your people's families	• Prepare and distribute to all CI personnel a template "home defense plan" for pandemic influenza, including personal and home defense measures such as hygiene and disinfecting recommendations, supplies, and care-giving instructions in case a family member becomes infected (sample available from HQ USNORTHCOM/J34), to include the concept of a decontamination line to separate the sick from the well • Consider procuring/storing pandemic defense supplies for CI personnel to give to their family members, such as face-conforming N95 respirators and disinfectant solution • Telling them after the pandemic and hoarding start that they "should have bought these supplies" is meaningless
Support your people/families if infected	• Maintain current staff recall rosters, family contact data, and directions to each residence • Put in place the exact reporting mechanism that will be used to account for CI personnel and their families during a pandemic

Objective	Options for Action and Planning Considerations[1] Customize them to fit your situation

	• Understand that ¼ of American adults live alone and would have nobody nearby to care for them at home if infected during a pandemic
	  • As a CI asset owner, you have the choice to plan how care will be provided for these people, or to ignore them
	• Consider procuring/storing pandemic care-giving supplies for CI personnel with infected family members to take home
	• Organize staff to maintain daily contact with CI personnel at home, to make sure they obtain the food, water, medicine, etc they require
	• Issue for local decision: there is an assumption in many areas of pandemic planning that "family quarantine" is one method of preventing the spread of infection. This means asking all uninfected family members, not just care-givers, to stay under the same roof as a known infected person for 17 days after the last-infected family member's symptom onset (if one is to follow WHO guidance on human excretion of active H5N1)
	  • Is this always the right thing to do in your situation? Should healthy children or your CI key person be told to live where they are most likely to share a door or faucet handle or toilet, tread the same floor, or breathe the same forced-ventilation air as a known infected person?
	  • Should we plan for a situation likely to put multiple infected victims under the care of the same untrained and quite-likely unequipped caregiver?
	  • Surely, when care-giving is to be done in the home by a family member (which may be the majority of pandemic cases throughout American society), the CI asset owner should look hard at who will provide that family caregiver (1) training in both care and prevention of infection among other family members, (2) medications, (3) PPE, disinfectant and other necessary supplies, (4) food, and (5) a plan for augmented support if the caregiver becomes infected—which is highly likely. This extremely difficult—and life-threatening—situation probably

Objective	Options for Action and Planning Considerations[1] Customize them to fit your situation
	will be quite common in America during the next flu pandemic, and serious CI asset owners will plan for it—because your CI employee may well be the at-risk caregiver in that infected family. • Plan for grief and guilt counseling and psychiatric care to help your CI employees cope and remain functional

[1]Ideally as part of a complete pandemic influenza COOP plan for the CI facility/asset/function.
[2]COOP: Continuity of Operations.

(2) DOD Organizations Dependent on Non-DOD CI. DODD 3020.40, *Defense Critical Infrastructure Program (DCIP)* defines defense critical infrastructure as "DOD and non-DOD networked assets essential to project, support and sustain military forces and operations worldwide." Thus, DCIP includes CI not owned by DOD, but which may affect DOD missions.

(a) For the individual DOD installation seeing the approach of pandemic failure in local CI upon which the installation depends, it is essential to:

1 Obtain factual situational awareness (SA).

2 Communicate that SA up your chain of command.

3 Obtain DOD authority to act if necessary to support the COOP of that non-DOD CI.

(b) In cases of DCIP assets not owned by DOD, your pandemic objectives are:

1 Know their operational status during a pandemic.

(b)(2)

(b)(2)

2 Learn your options to assist in continuity of operations for that non-DOD CI, if required.

a These might include emergency provision of some resource or support, in return for priority supply of the good or service during an emergency, subject of course to proper DOD and legal procedures being followed. You may not know what might be appropriate mutual support until you open a dialogue on the possibilities.

3 Plan your options in case that non-DOD CI is degraded or ceases to function.

(b)(2)

b Planning seriously for CI in a pandemic requires that you plan your options.

(b)(2)

You and your community are going to fight this pandemic together, just as if your CI installation and your community were invaded by terrorists. A pandemic may be a tougher challenge, killing more people, and your CI personnel and their families will be threatened while out in your community.

d As DOD and civilian community pandemic planning matures, DOD guidance may address the subject of pandemic CI operations by individual installations with the local communities whose basic infrastructure they depend upon.

(b)(2)

f But a pandemic may more often present local CI crises that develop quickly but do not necessarily require immediate response.

g For these non-immediate pandemic support situations, under the Stafford Act and current Federal guidance (see NRF) the local community should first ask the state governor for state support. If the governor determines that state resources are not adequate, he may request that the President declare an emergency or major disaster and define the kind of Federal assistance needed—which might or might not be from DOD. Similar logic applies in other countries in the USNORTHCOM AOR: the host nation must first ask the Department of State for USG assistance, and any DSCA mission assignment would be made by the President or Secretary of Defense

h Installations must not get ahead of this process, unless the exact "immediate response" criteria below are satisfied

Immediate Response

"Imminently serious conditions resulting from any civil emergency may require immediate action to save lives, prevent human suffering, or mitigate property damage. When such conditions exist and time does not permit approval from higher headquarters, local military commanders and responsible officials from DOD components and agencies are authorized by DOD directive and pre-approval by the Secretary of Defense, subject to any supplemental direction that may be provided by their DOD component, to take necessary action to respond to **requests of civil authorities** consistent with the Posse Comitatus Act (18 USC 1385). All such necessary action is referred to as 'Immediate Response.'"

– *National Response Plan* (signed by SecDef), page 42

Critical Assets

"Combatant Commanders shall…act to prevent or mitigate the loss or degradation of DOD-owned critical assets within assigned regional or functional areas of responsibility. For **non-DOD-owned** critical assets within assigned regional or functional areas of responsibility, act to prevent or mitigate the loss or degradation only at the direction of the Secretary of Defense and in coordination with the Chairman of the Joint Chiefs of Staff and the ASD (HD&ASA), **with the exception** of responding to a **time-critical** event that would require specific actions by military forces to prevent significant damage to **mission-critical** infrastructure."

– DODD 3020.40, para 5.9.3

(3) Pandemic Critical Infrastructure Support of Civil Authorities. It is possible that during a pandemic, in accordance with the National Response Framework (NRF—see its CI/KR Protection Support Annex) and the National Infrastructure Protection Plan (NIPP), the President or Secretary of Defense could direct DOD support of civilian authorities with critical infrastructure having no other relationship to DOD at all.

(b)(2)

(b)(2)

(b) Dialogue toward defining as clearly as possible the CI effect desired from the support being requested in a pandemic situation with up to 40% of a normal workforce absent. For example:

(b)(5)

2 Provide specific engineering support to repair a component of a CI asset, with the desired effect of bringing it back into operation.

3 Provide specific numbers of specific skills to help operate a CI asset or system (e.g., airport, seaport, key parts of the US Postal Service—DOD already provides postal services overseas), with the desired effect of assuring its continuity of operations.

(c) Support of civil authorities in a pandemic environment, wherein DOD presumably will face infection rates similar to those of civilian society, will be difficult.

1 Pandemic CI support, where specific highly-trained skills may be required, people trained quickly, and a cohesive unit formed with these people—all while keeping them healthy—may require significant command focus and staff support.

(d) Pandemic CI support missions should be approached with careful attention to (1) the precise requirement and (2) the feasibility of DOD performing them.

(f) Pandemic impact on national critical infrastructure, which could become the object of DOD DSCA missions, may be accumulated and reported two ways from two different perspectives: (1) by the Sector-Specific Agency for the relevant National Critical Infrastructure Sector (see table above), and (2) by the relevant Emergency Support Function (ESF) Primary Agency Coordinator, in accordance with the ESF Annexes to the NRP:

Federal Emergency Support Functions

ESF	Primary Agency Coordinator
1 – Transportation	DOT
2 – Communications	DHS (Nat'l Communications System)
3 – Public Works & Engineering	DOD (U.S. Army Corps of Engineers)
4 – Firefighting	USDA
5 – Emergency Management	DHS (FEMA)
6 – Mass Care, Housing & Human Svcs	DHS (FEMA)
7 – Resource Support	GSA
8 – Public Health & Medical Services	HHS
9 – Urban Search & Rescue	DHS & FEMA
10 – Oil & HAZMAT Response	EPA
11 – Agriculture & Natural Resources	USDA
12 – Energy	DOE
13 – Public Safety & Security	DHS & DOJ
14 – Long-Term Community Recovery & Mitigation	DHS (FEMA)
15 – External Affairs	DHS

(g) While DOD (USACE) is Primary Agency for ESF 3, it is also a potential supporting agency under the NRP for every other ESF (ref: NRP p. ESF-v). Given the many overlaps among national CI sector-specific agencies and national ESF coordinators all potentially calling upon DOD for support, the potential pandemic CI support demands upon DOD could become quite large. If this happens, combatant command advice to the Joint Staff, ASD (HD & ASA) CIP staff and SecDef on prioritization of commitments for limited DOD resources (themselves under simultaneous pandemic attack) will be essential.

(h) DOD and combatant command situational awareness of pandemic CI impact that might result in assignment of DSCA missions is also important.

1 During a pandemic, the best way for DOD to gain national CI situational awareness is via information-sharing with the DHS National Infrastructure Coordinating Center (NICC), which monitors the Nation's CI and key resources (CI/KR) daily and serves as a coordinating vehicle for information-sharing across CI/KR sectors.

a The NICC is a 24/7 watch operations center, and is one of the five elements of the DHS National Operations Center (NOC).

(b)(2)

(b)(2)

d HSIN is the primary DHS network for interagency information-sharing, as directed by the Intelligence Reform and Terrorism Prevention Act of 2004.

(b)(2)

f While other Combatant Commands may not need to deal directly with the NICC, they may want to consider HSIN monitoring as may be appropriate for their needs—especially for CI during a pandemic.

g DHS coordinates CI risk assessments, working in collaboration with SSAs and other government and private sector partners. Such assessments may include threat assessments, as when a pandemic threat appears; pre-incident assessments when an event is expected (e.g., hurricane, pandemic), and post-incident damage/impact assessments—which may include geographic region impact, sector-wide impact, cross-sector impact, and national impact. Among the key agencies supporting these assessments are:

(b)(2)

j Included in the assessment process, if a Joint Field Office (JFO) has been deployed, is the DHS/OIP Infrastructure Liaison (IL) staff in the JFO, receiving event reporting from regional states, regional federal offices, regional industry associations and individual private entities.

k This is why it is important for a Combatant Commander performing a DSCA mission via a deployed Defense Coordinating Officer (DCO), Operational Command Post (OCP), or Joint Task Force (JTF) (whether in the

homeland or overseas) to assign CIP-trained personnel to coordinate directly with that deployed DHS/OIP IL staff (or host nation staff overseas) in the JFO.

1 The Combatant Commander need not wait for a disaster JFO to be formed to coordinate with the people who will become DHS IL staff in the JFO (or host nation infrastructure staff in their JFO-equivalent):

m Protective Security Advisors (PSA) are DHS/OIP representatives permanently stationed throughout the Nation to provide risk management expertise in support of full-spectrum CI/KR efforts, to include pandemic planning. They are available now, and are doing pandemic planning now.

n Pandemic (or other threat/event) requests for assistance from CI/KR entities may come to the federal government (usually at the JFO) via one of three paths:

o Via local and state government officials.

p Via ESF Primary Agency or Sector-Specific Agency representatives.

q Directly from the CI/KR entity to the NICC.

2 If a JFO is established during a pandemic, then the DCO in that JFO will receive requests for pandemic CI DSCA from appropriate primary federal agency representatives in the JFO--in the case of CI/KR requests either from the DHS/OIP IL staff or from the ESF Primary Agency staff, as validated by the FCO.

3 If a JFO is not established, then the request for DOD support should come from the Primary Federal Agency's executive secretary to the OSD executive secretary, and will be processed through OSD and Joint Staff/J34 DDAT/HD JDOMs IAW DODD 3025.1, Military Support to Civil and Joint Publication 3-26 Homeland Security, Chapter IV Civil Support.

b. Criticality. Each Combatant Command, Armed Service, Defense Agency and DOD Field Activity determines and publishes its own classified list of task critical assets (TCA) required to perform its mission-essential tasks (JMET, SMET or AMET respectively). At the national level, DHS has established its classified lists of Tier 1 and Tier 2 national critical infrastructure.

(b)(2)

(2) This USNORTHCOM AOR plan will not repeat respective classified DCA and TCA lists, nor get into specifics of the classified national CI lists, but notes them here to help respective DOD elements focus their specific regional/functional pandemic influenza planning for CIP.

c. Priorities.

(1) COP for DCI in the face of potential 40% absenteeism during peak pandemic waves.

(2) Planning for pandemic CI support to civil authorizes requests, with particular attention to (a) the precise requirement and (b) the feasibility of DOD performing the specific mission in a pandemic environment.

d. Tasks. See Basic Plan.

4. Administration and Logistics. See Basic Plan.

5. Command and Control. See Basic Plan.

Tabs:
A – USNORTHCOM CIP Points of Contact (POC).

Distribution: See Basic Plan.

TAB A TO APPENDIX 16 TO ANNEX C TO NORTHCOM CONPLAN 3591
NORTHCOM CIP POINTS OF CONTACT

1. NORTHCOM Battle Staff Future Operations Center (FOC--when operational) CIP Planner.

a. Telephone (Secure): (b)(6)

b. NIPRNET: (b)(6)

c. SIPRNET: (b)(6)

2. NORTHCOM/(b)(2)

a. Organizational Mailbox (OMB).

(1) NIPRNET: (b)(6)

(2) SIPRNET: (b)(6)

b. Web Portals.

(1) NIPRNET Operations (External):

(b)(6)

(2) (b)(2) *CIP Battle Book* on NIPRNET (Internal) (Registration required, but accessible to all NIPRNET ers):

(b)(5)

(b)(2)

(3) SIPRNET Operations (External):

(b)(6)

c. Emailed Situational Awareness. (b)(2) provides to all DOD requestors a daily (24/7 in disaster response) email forwarding selected reporting extracted from the DHS *Homeland Security Information Network* (HSIN). To be added to the list, email (b)(6) HSIN reporting extracts in this daily email include:

(b)(2)

HEADQUARTERS, US NORTHERN COMMAND
250 Vandenberg Street, Suite B016
Peterson AFB, CO 80914-3270
13 August 2009

APPENDIX 28 TO ANNEX C TO CONPLAN 3591-09
CDRUSNORTHCOM Decision Support Template (DST)

References: See Base Plan and Annex C

(b)(5)

a. USNORTHCOM Objectives. For the purpose of clarity when analyzing the CDRUSNORTHCOM decisions and the command's ability to achieve its desired end state, objectives 1 and 4 have been delineated here. The numerical designation of the USNORTHCOM objectives for this framework is:

(1) Objective 1. Defend the Homeland.

(2) Objective 2. Sustain health and safety of populace.

(3) Objective 3. Protect the nation's essential infrastructure.

(4) Objective 4. Support essential government functions.

b. Nested PI Phase Objectives. To better plan and manage the accomplishment of activities, and the achievement of desired end states, in each pandemic influenza (PI) phase – a set of phase specific objectives are developed. These phase objectives are nested and in concert with the overarching USNORTHCOM objectives, which in turn, are consistent with the DOD PI objectives. The following is a list of the seven objectives that are distributed across the six PI phases:

(1) Objective 1. (b)(5)

(2) Objective 2.

(3) Objective 3.

(4) Objective 4.

(5) Objective 5.

(6) Objective 6.

(7) Objective 7.

(b)(5)

(b)(5)

(b)(5)

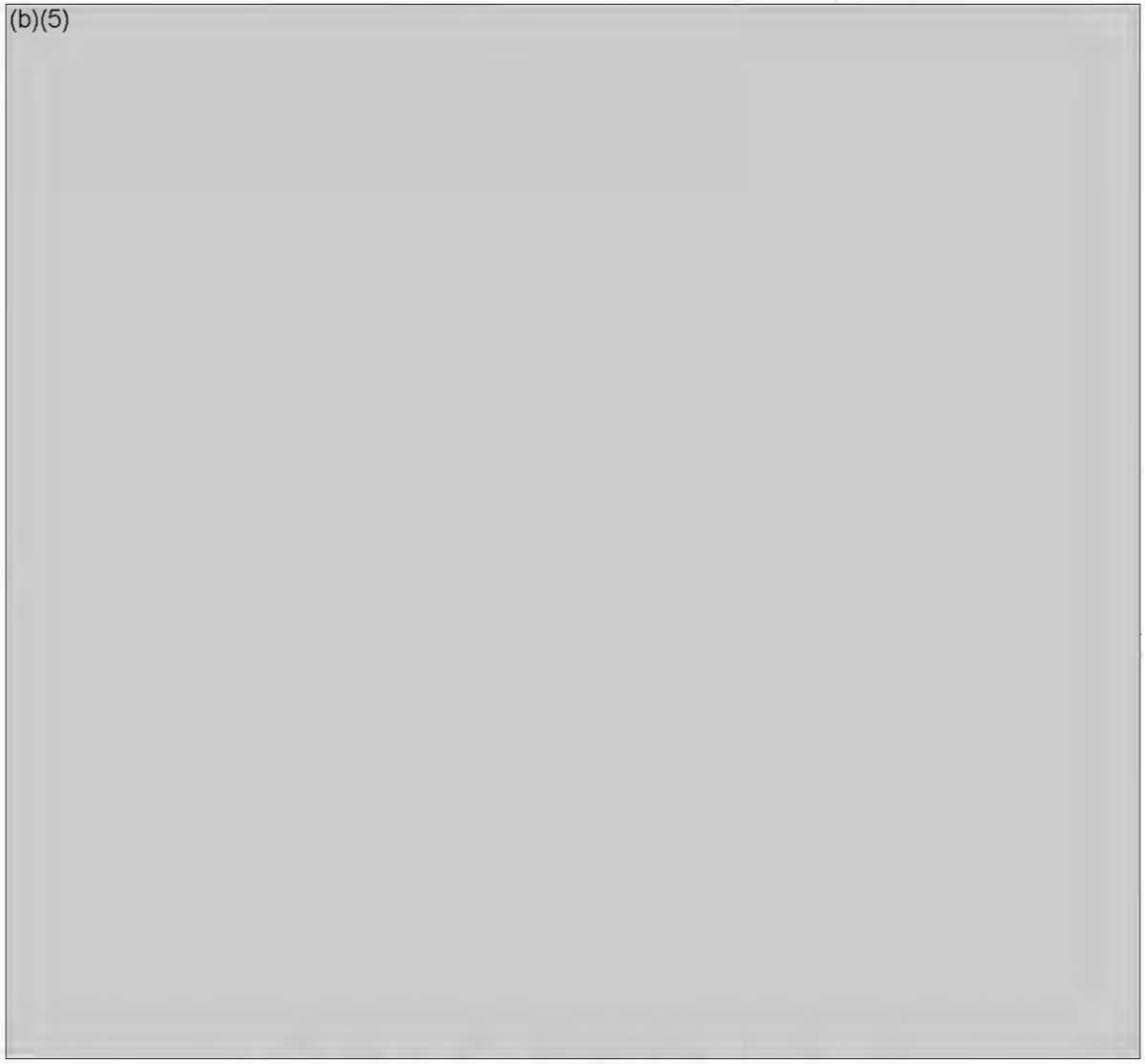
(a) Virus:

(b)(5)

(b)(5)

(b) Threat:

(b)(5)



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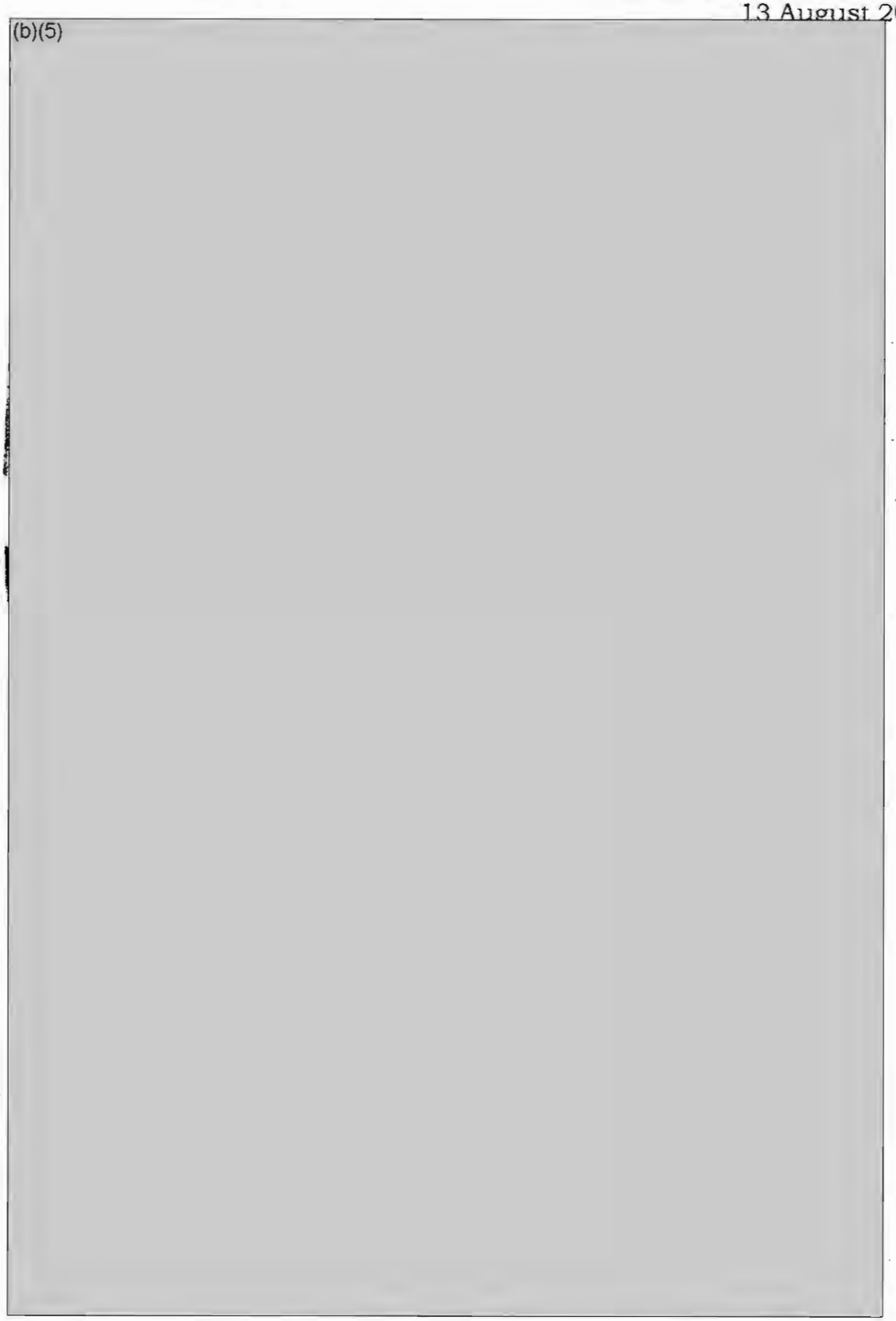

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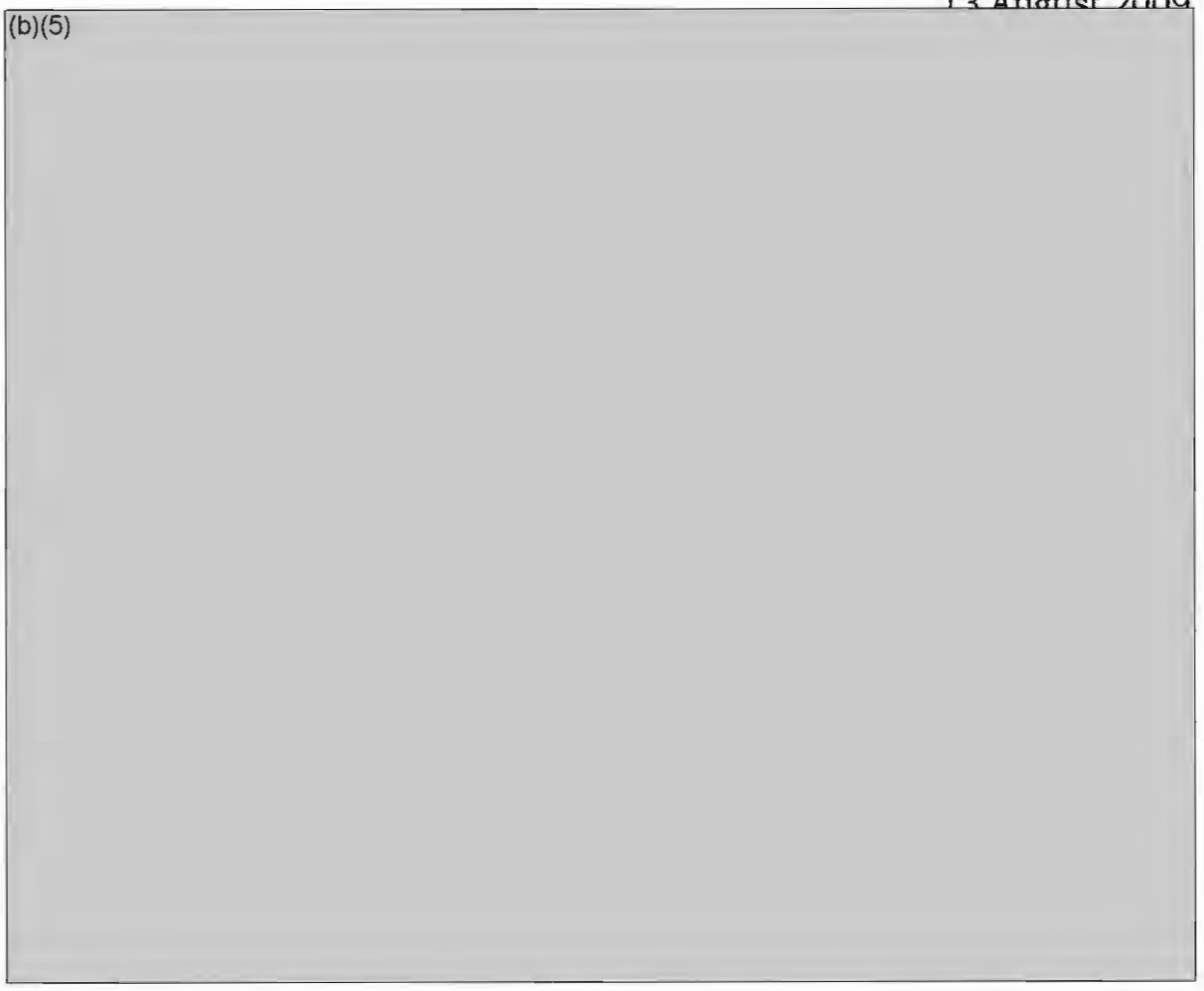

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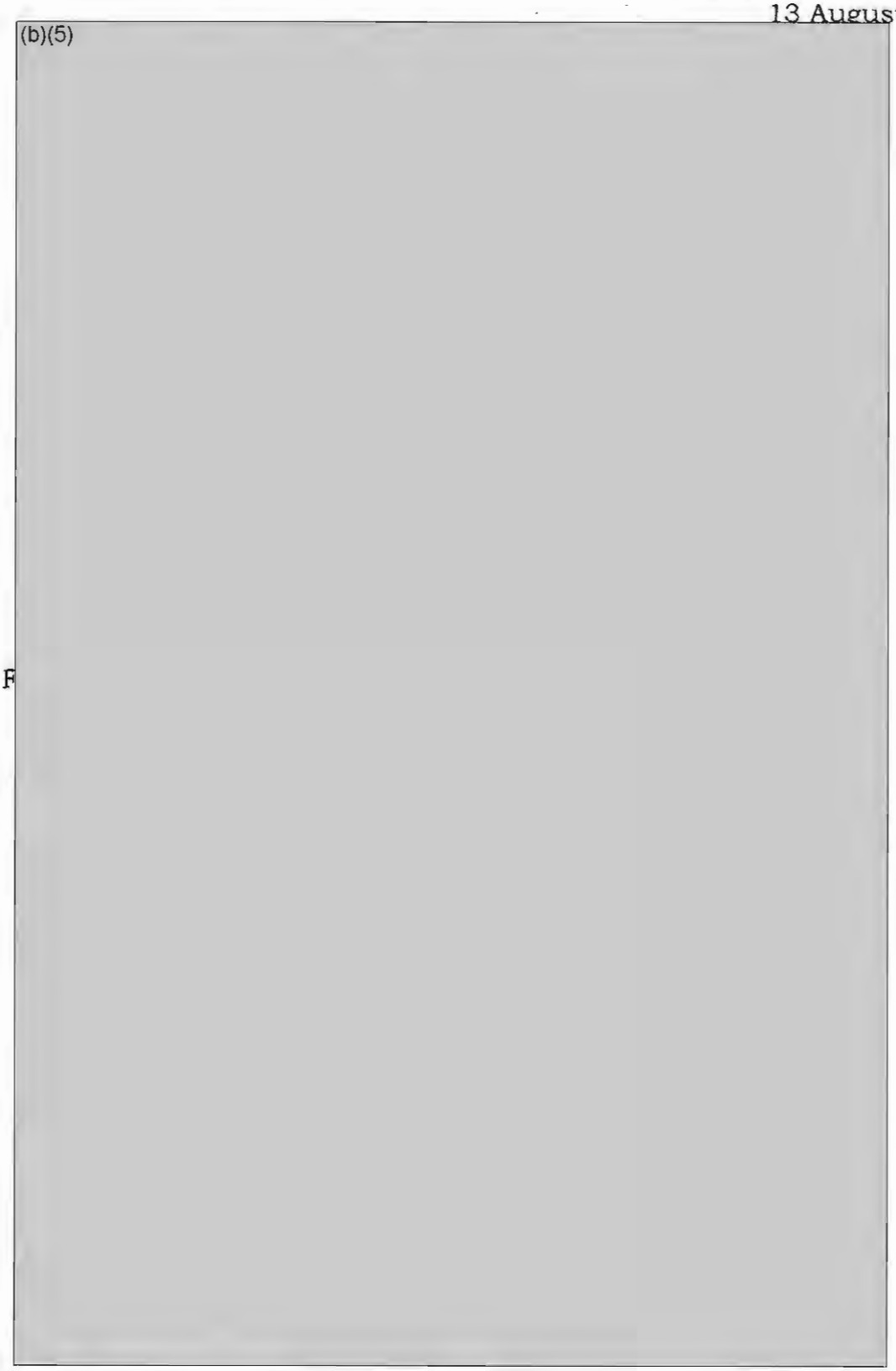

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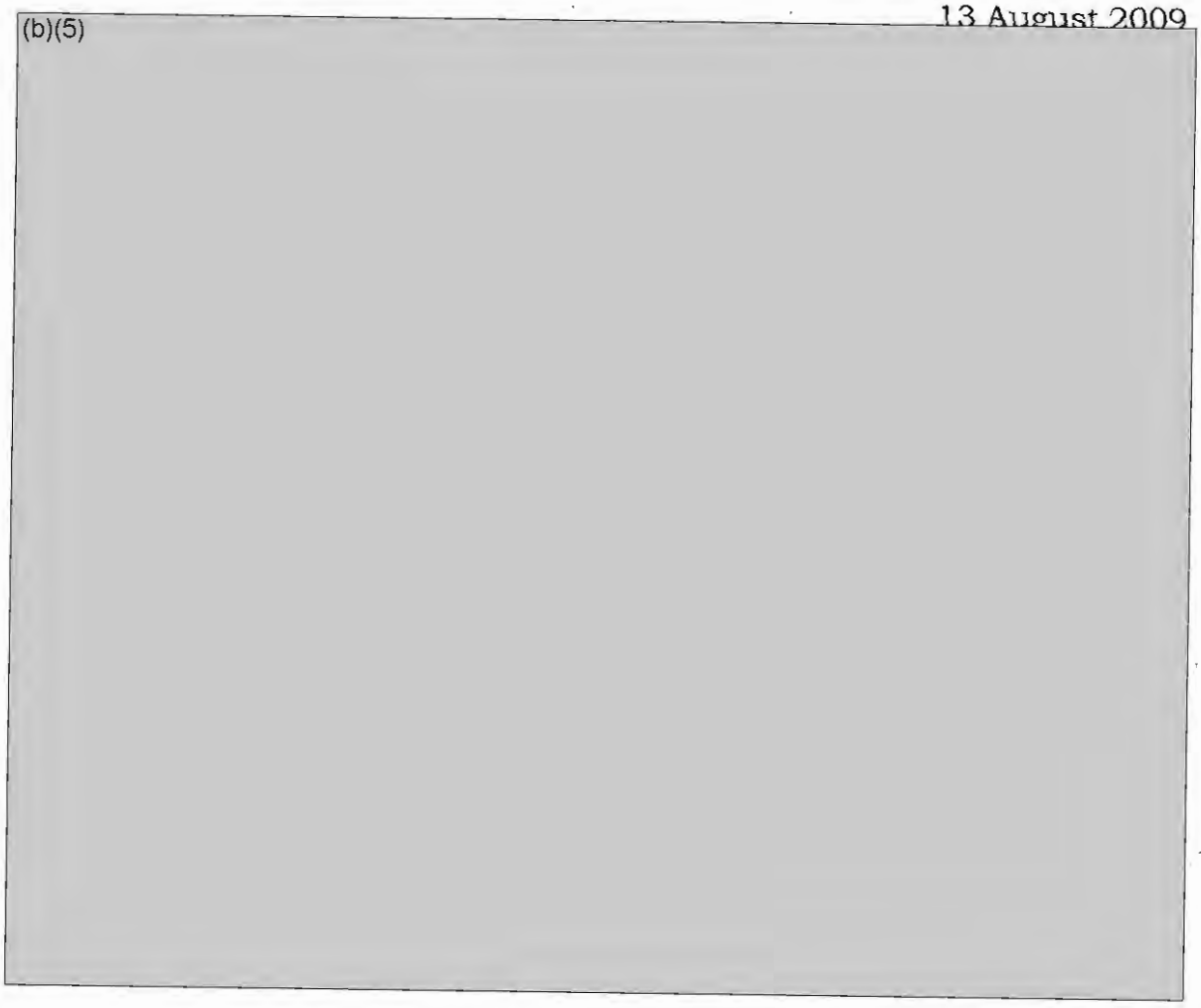

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APPENDIX 31 TO ANNEX C TO CONPLAN 3591-09
CDRUSNORTHCOM Master Task List [

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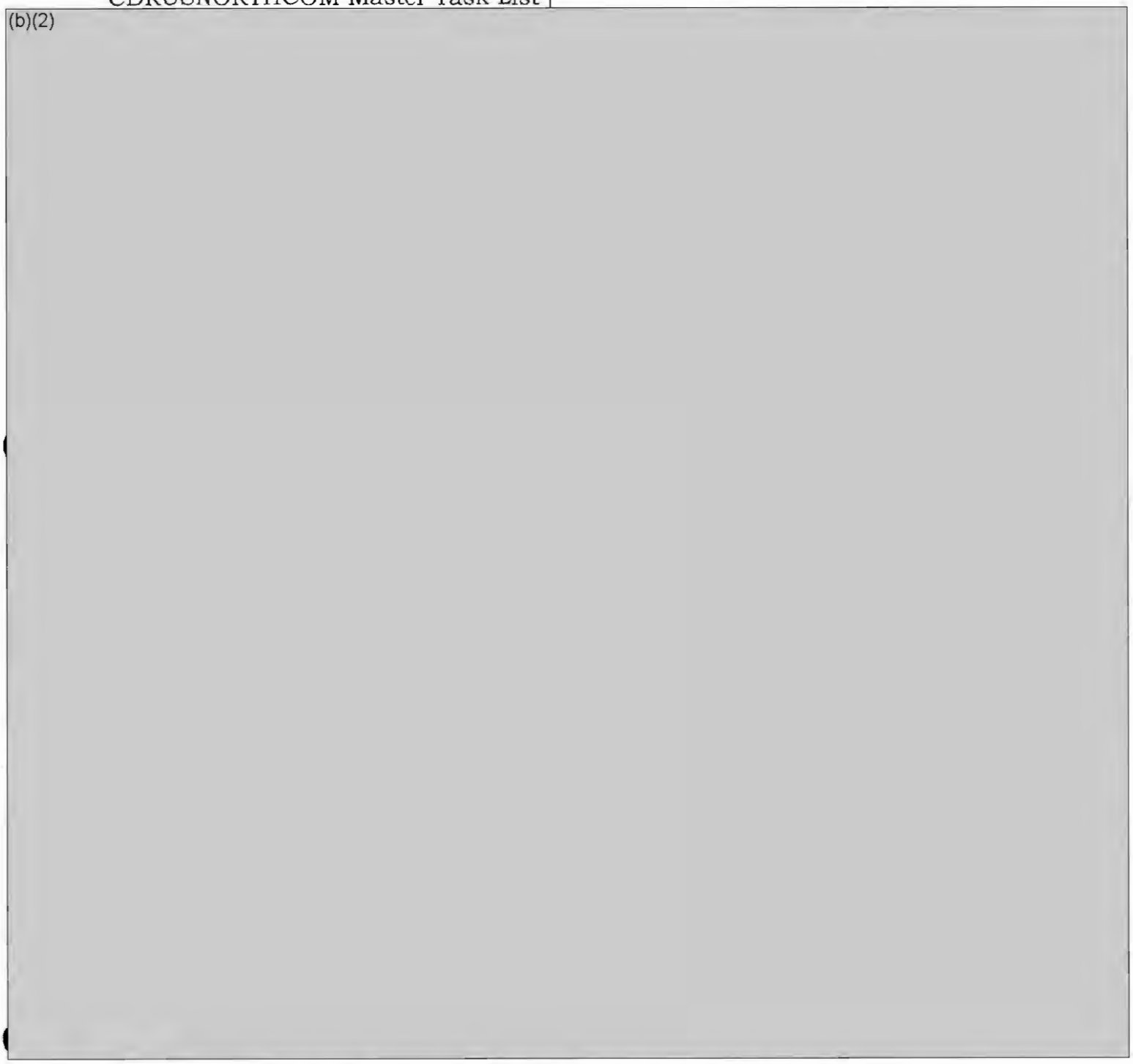

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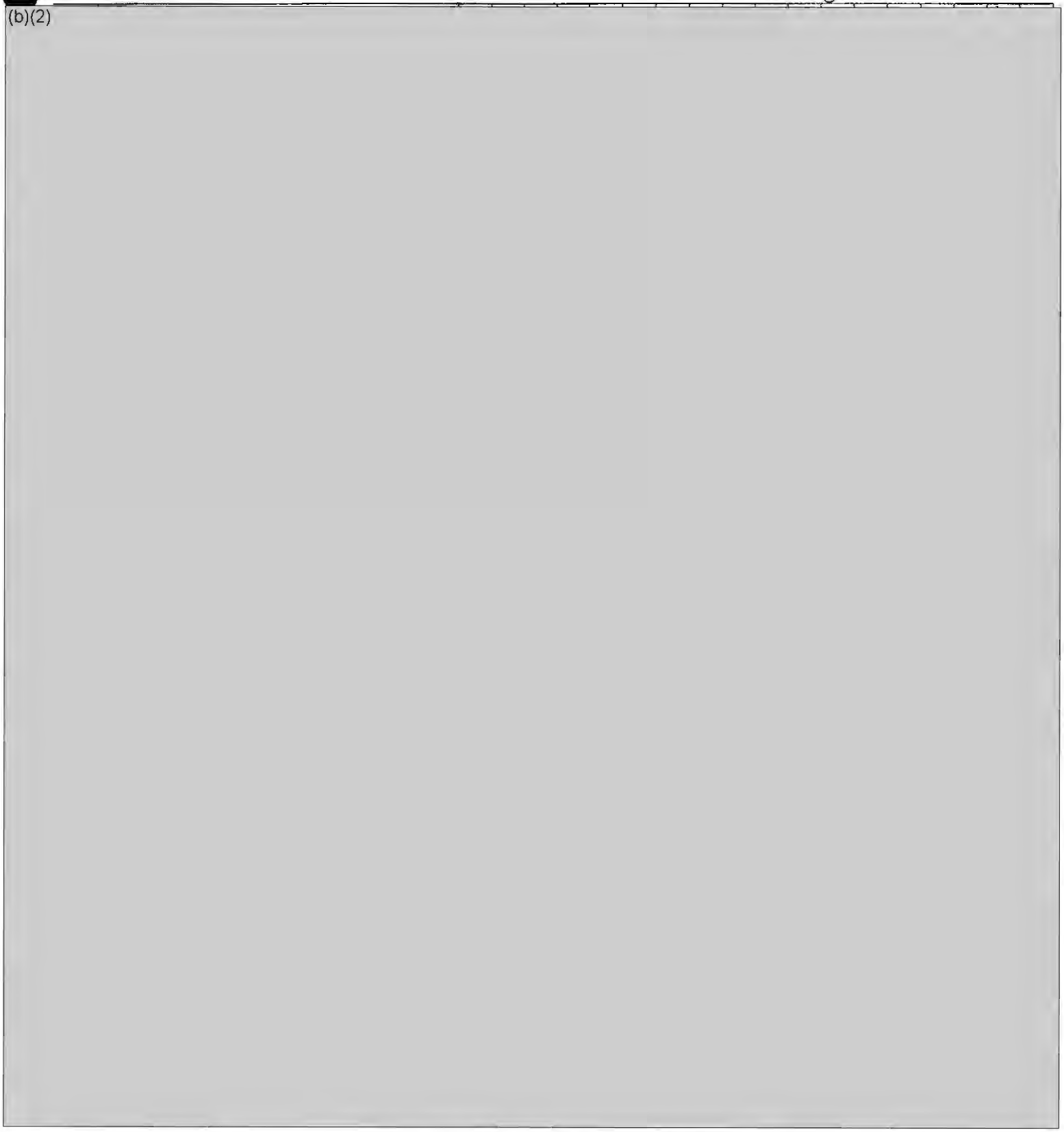

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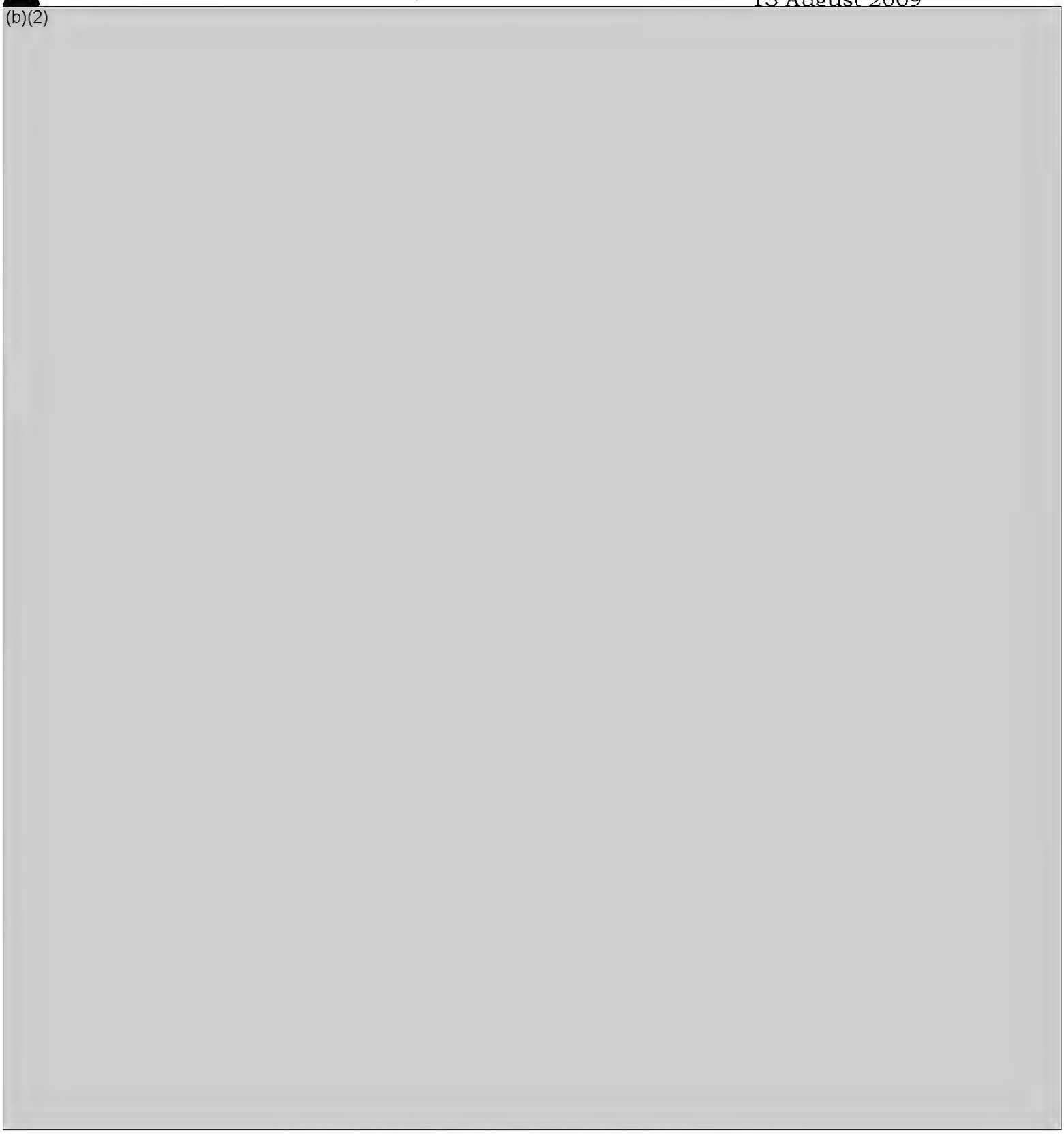

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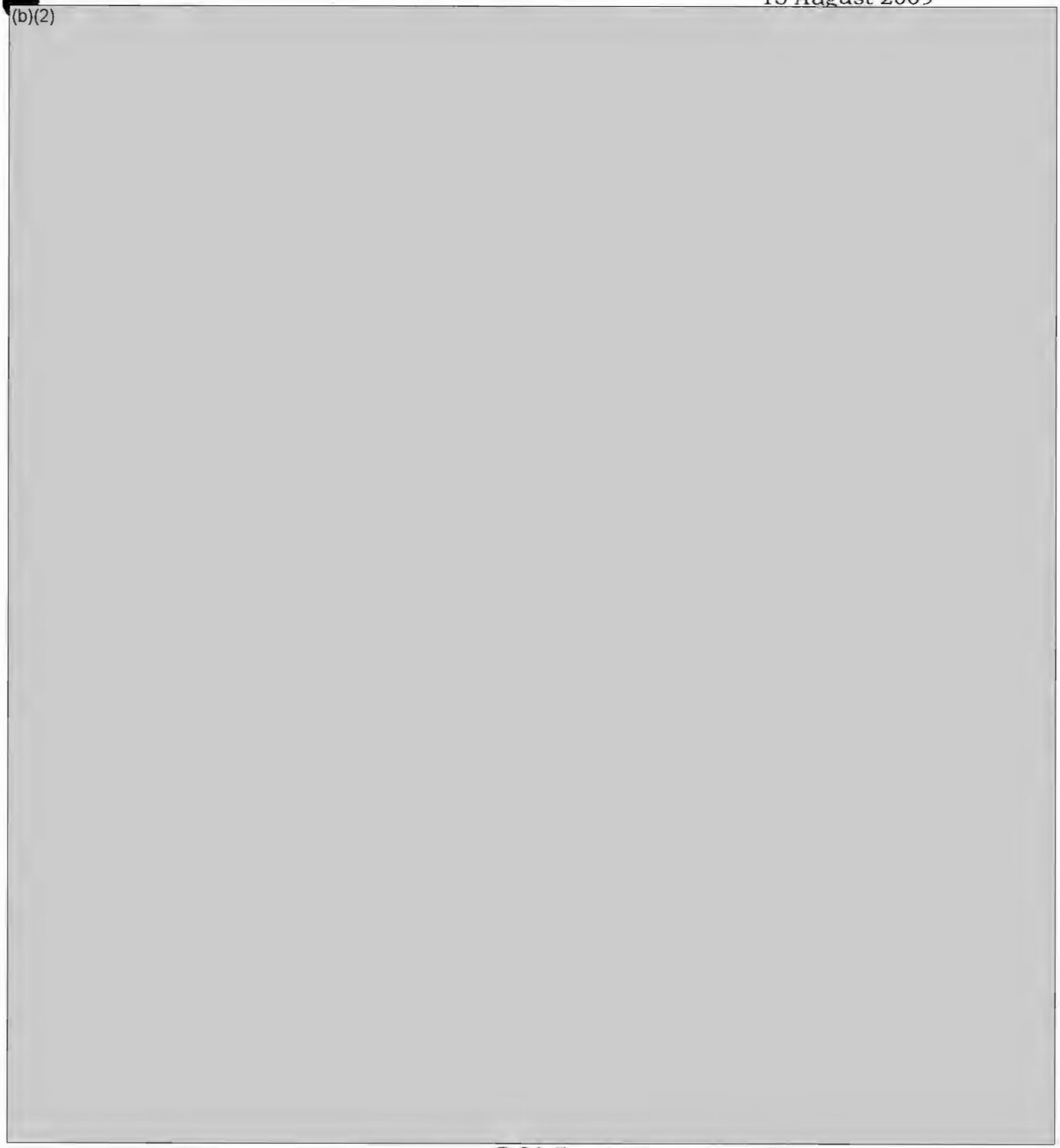

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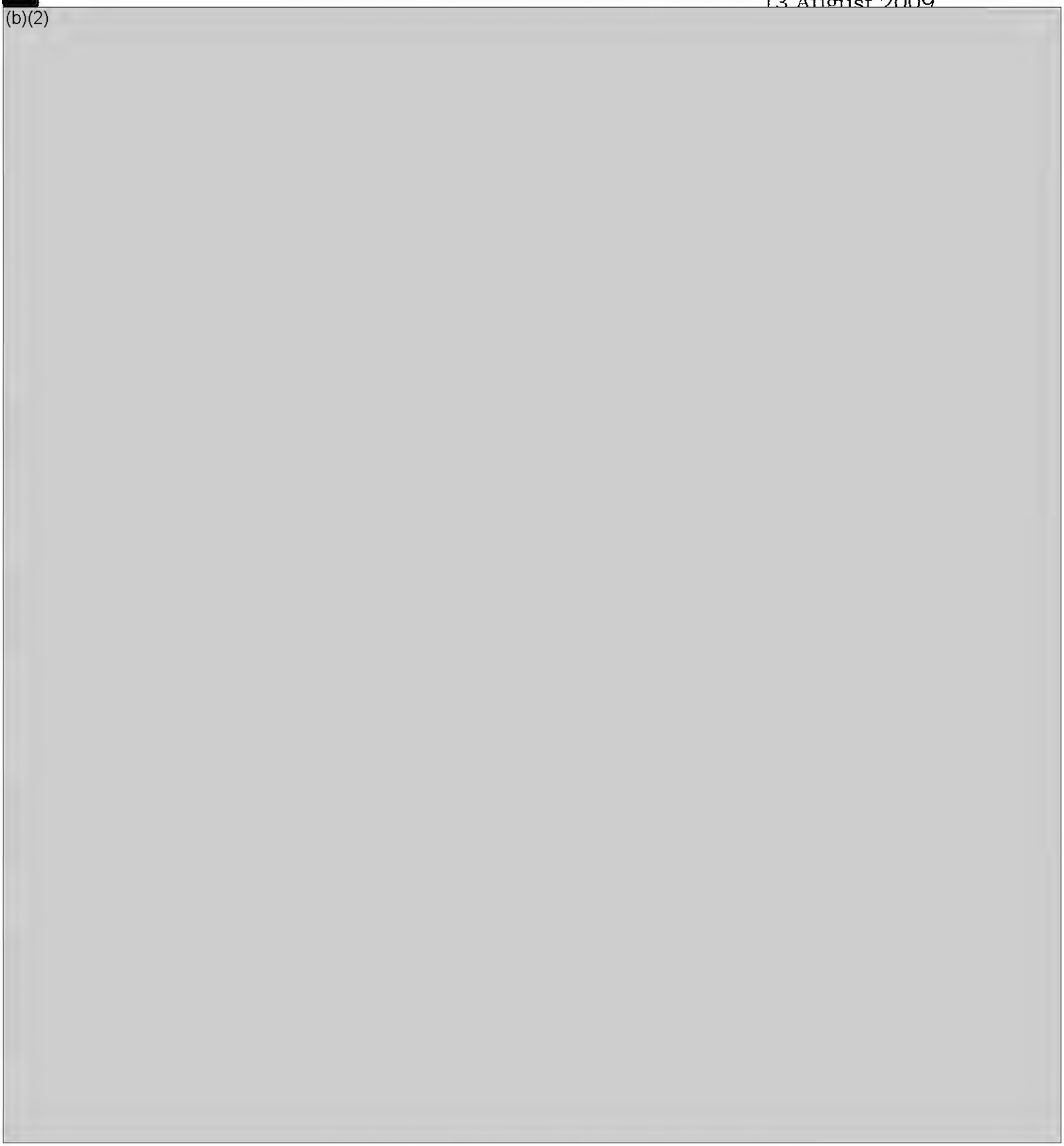

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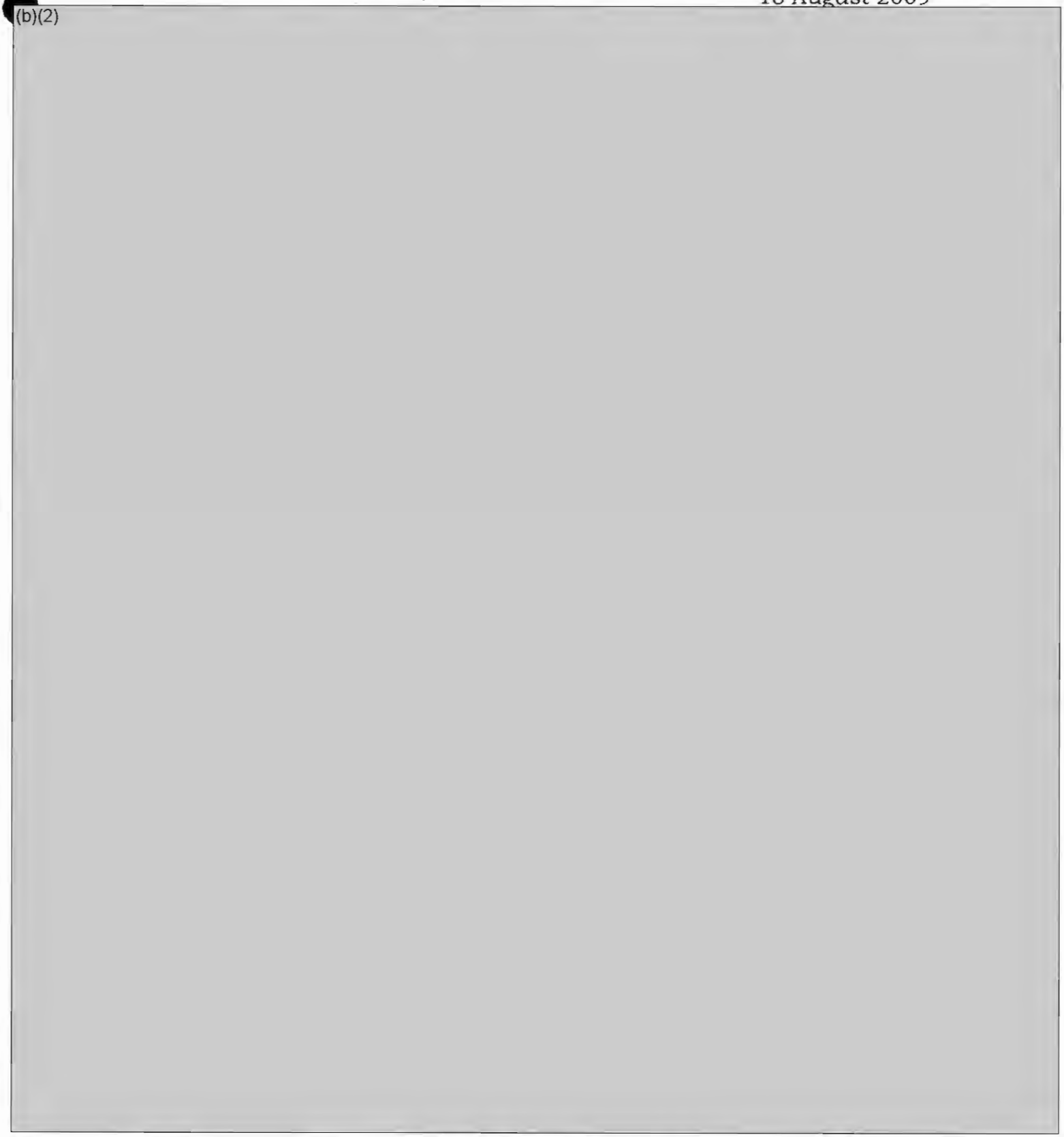

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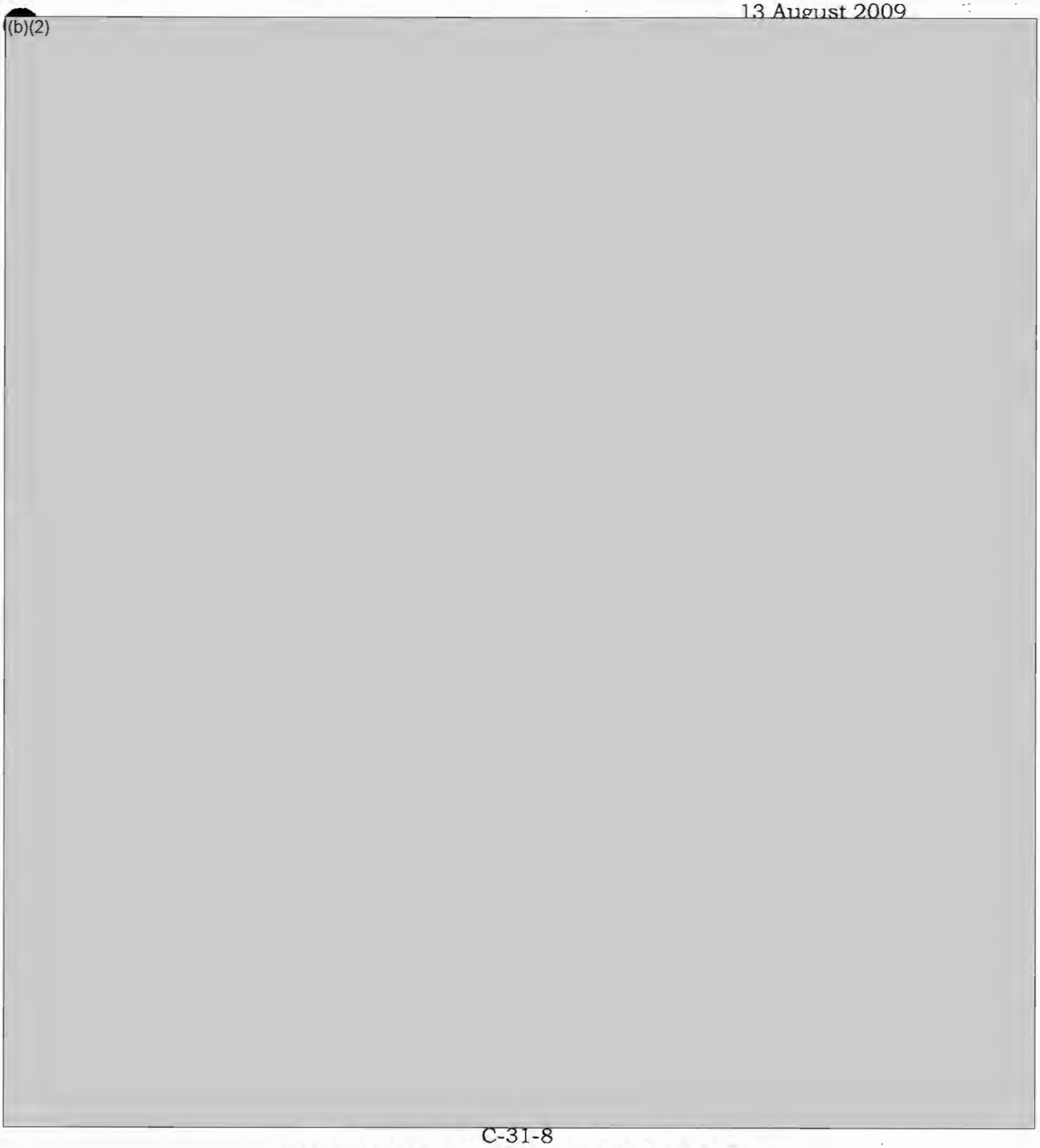

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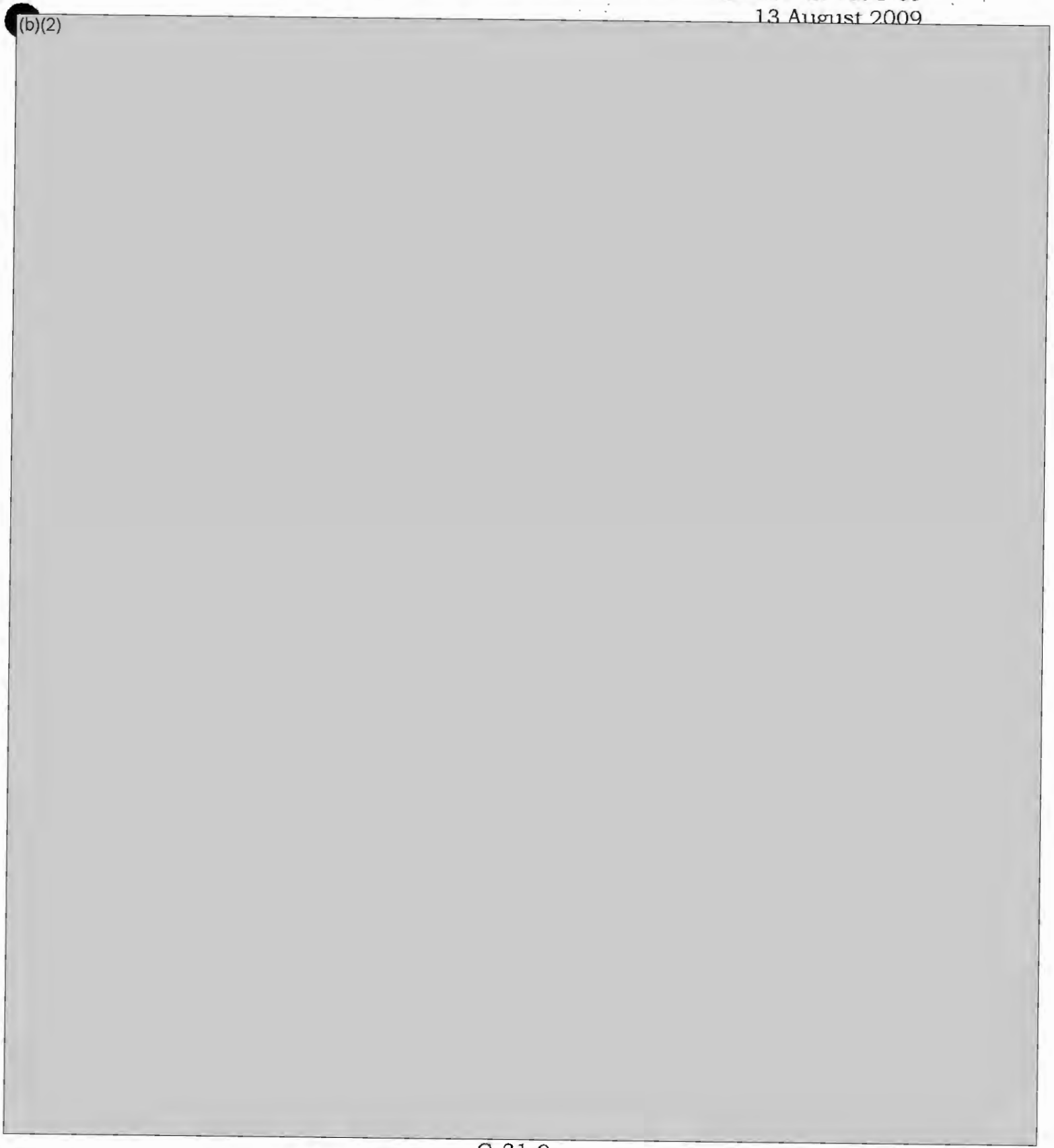

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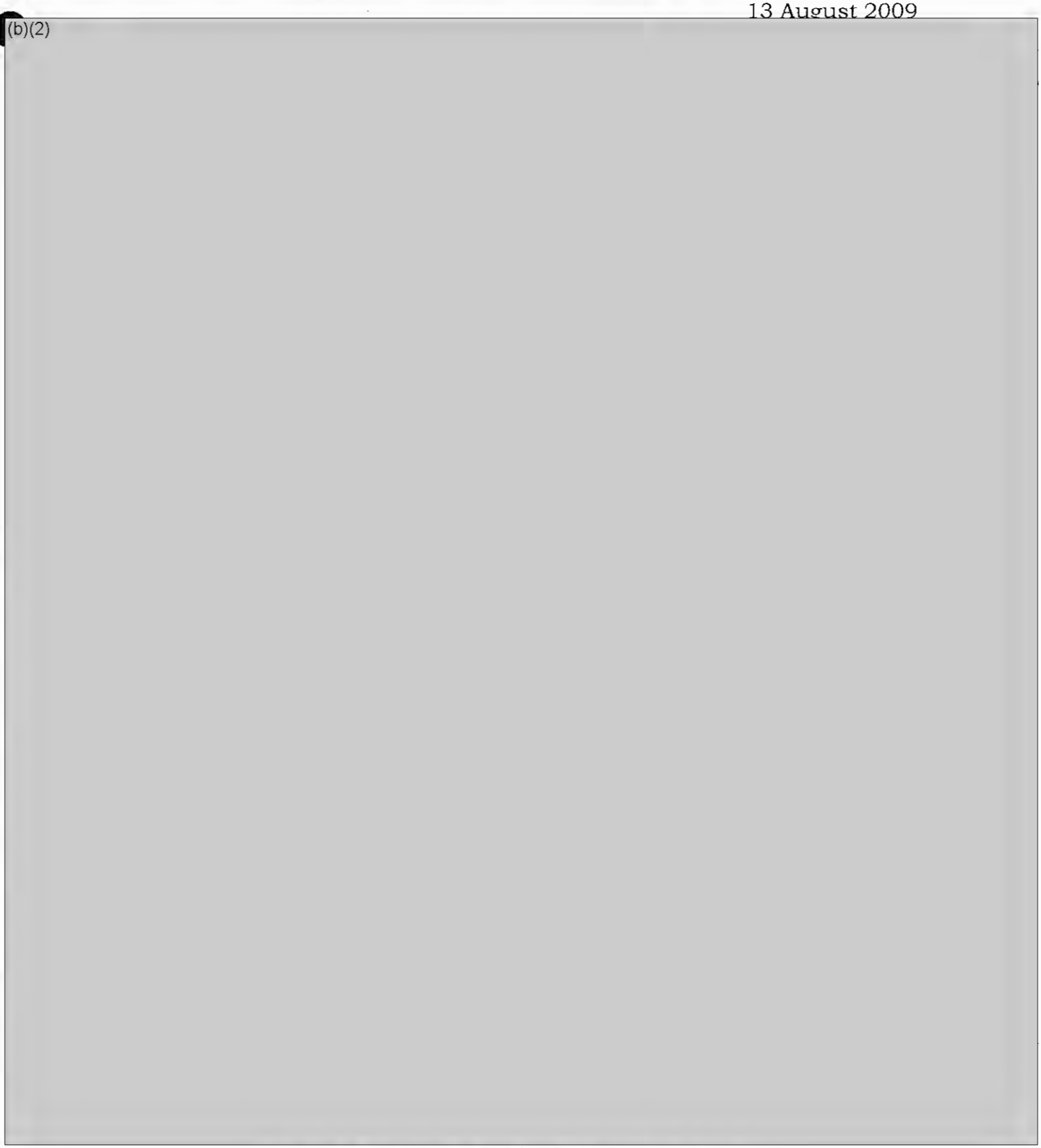

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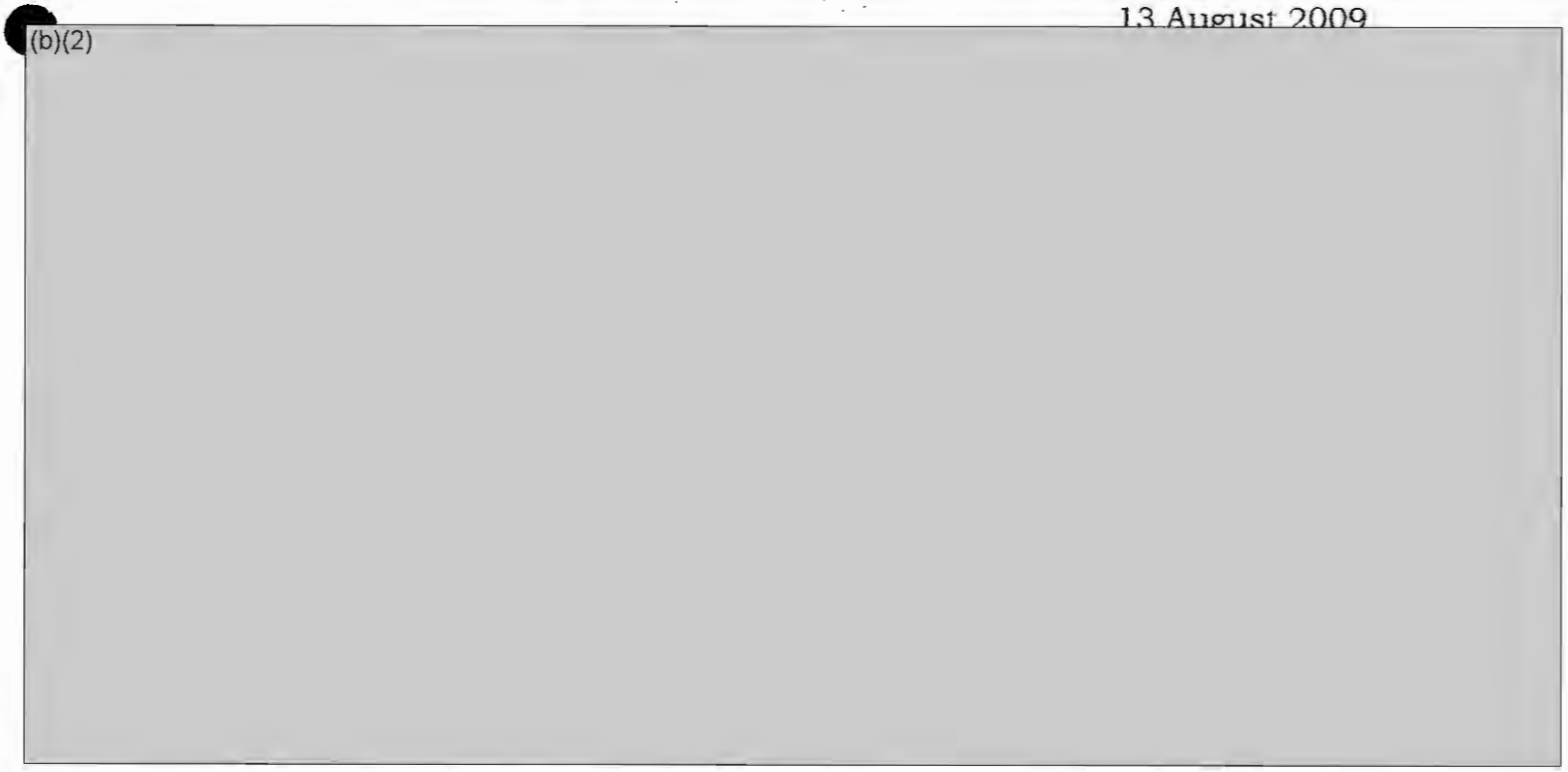

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13 August 2009

ANNEX D TO USNORTHCOM CONPLAN 3591-09
LOGISTICS

References:

a. User's Guide for Joint Operations Planning, 11 September 1994

b. USNORTHCOM CONPLAN 3501-08, Defense Support of Civil Authorities, 16 May 2008

c. CJCSI 4120.02, Assignment of Movement Priority, 15 April 2005

d. Joint Pub 4.0, Doctrine for Logistics Support to Joint Operations, 6 April 2000

e. Joint Pub 4.01, Doctrine for the Defense Transportation System, 19 March 2003

f. Deputy SecDef Memorandum, Policy on Contaminated Human Remains, 28 March 2003

g. Appendix C to JP 3.28, Civil Support

1. Situation.

a. Enemy. See Annex B, Intelligence.

b. Friendly. See base plan.

(1) U.S. Transportation Command (USTRANSCOM) provides deployment and redeployment common-user air, land, and sea transportation for forces engaged in pandemic influenza (PI) operations; and provides aero-medical evacuation and air refueling support as required. Additionally, USTRANSCOM is designated as Department of Defense's (DOD's) Distribution Process Owner, charged to integrate strategic and theater joint operations area

(JOA) distribution. When requested by a federal agency and approved by the Secretary of Defense (SecDef), USTRANSCOM may provide transportation support to non-DOD organizations, such as movement of critical capabilities or commodities, or evacuation of personnel.

(2) Defense Logistics Agency (DLA) provides logistics support for the missions of the military departments and the unified combatant commands engaged in civil support operations. The agency also provides logistics support to other DOD components and certain federal agencies, foreign governments, international organizations, and others as authorized. DLA provides worldwide reuse, recycling, and disposal solutions, to include hazardous, non-radioactive material disposal through its defense reutilization and marketing services.

(3) Defense Contract Management Agency (DCMA) provides contract administrative service support and assists USNORTHCOM in developing contingency contracting packages as required.

c. Assumptions. See base plan.

(1) Transportation will be restricted to contain the spread of the virus.

(2) Infected people, confirmed or suspected, will not be transported to any facility beyond the affected area unless their medical condition demands movement.

(3) Civil capabilities of the US Government (USG) will be overwhelmed and unable to provide or ensure the provision of essential commodities and services without support from DOD.

(4) Installation and Service support functions will quickly become short staffed and become overwhelmed.

(b)(2)

(7) There will likely be a significant reduction in civilian transportation capacity (b)(2)

(8) Without reducing the ability for local communities to respond, those DOD reserve components that are identified as available will be quickly mobilized to provide surge capabilities, especially in the areas of medical support, transportation, and logistics (DOD Title 10 Reserve Component forces).

(9) In accordance with existing agreements, and in limited circumstances, under immediate response authority, DOD will provide support to local communities.

(10) DOD can expect requests from interagency partners to support civilian mortuary affairs operations.

(11) A pandemic environment will minimize the patient evacuation effectiveness of the National Disaster Medical System (NDMS) due to limited movement, and lack of unaffected communities with excess hospital beds (see Annex Q, Medical).

(b)(2)

d. Resource Availability.

(b)(2)

(3) Support to contingency operations takes precedence unless otherwise directed by SecDef.

e. Planning Factors.

(1) Logistics planning will anticipate the possibility of sustained relief operations for a period longer than normal civil support operations due to the reduced availability of supplies.

(2) Supply consumption levels for DOD forces will be based on Service approved planning factors.

(3) Planning factors for support must consider available commercial resources as well as DOD sources, anticipating reduced availability of basic supplies from all sources.

(4) Logistics planners must take into account the degradation of port operational capabilities, to include restrictions imposed by other US and state government agencies.

(5) Logistics planners need to anticipate (b)(2) (b)(2) and plan for alternate modes of transportation wherever possible. Additionally, the availability of organic and commercial land transportation assets (i.e. trucks, buses, rail, etc.) may be significantly reduced during a pandemic period.

2. Mission. See base plan.

3. Execution.

a. Concept of Logistics Support. The concept for PI logistics support is to utilize designated base support installations (BSIs) as the logistics hub, supporting the Regional Joint Task Force (RJTF). The RJTF is responsible to plan all aspects of the logistics concept of support for DOD forces responding in a pandemic environment within their designated region. BSIs are designated with N-NC/J3 in the lead via coordination between N-NC/J4, the service components, the RJTF, and the Defense Coordinating Officer (DCO).

(1) The BSIs provide the majority of common logistics items. This support (e.g. water, fuel, food, and general supplies) is provided through either DOD or commercially contracted resources.

(2) Each Service remains responsible for providing service-unique logistics support (e.g. uniforms, special equipment, maintenance support, and service-specific items) to their forces deployed for pandemic operations.

(3) The RJTF is responsible to integrate logistics support provided from Service channels and commercial sources.

(4) In all cases, delivery of DLA-provided items will be pushed as far down the supply chain as feasible to the nearest retail distribution point, typically located on a BSI or a forward operating base (FOB).

(5) Contracting is the primary means to increase the capability at BSIs within the JOA. The RJTF may either modify existing BSI service contracts or leverage local or regional contract capability to meet logistics support requirements. In cases where a BSI has minimal capability and/or contracting support in a timely or effective manner is not feasible, the RJTF will request additional DOD logistics assets to meet requirements by sending a request for forces (RFF) message to USNORTHCOM via the JFLCC.

(6) The installation staff at designated BSIs will utilize available personnel, facilities, and equipment resources in executing missions consistent with the designation of primary agent for providing life support services and retail distribution of logistics requirements to the DOD response force. The following guidelines apply:

(a) Logistics support provided by the BSI includes lodging, food service support, general supplies (e.g. fuel, water, food, general supplies, common repair parts), common-item maintenance (e.g. wheeled vehicles and generators), retail fuel distribution, receipt store and issue of supplies, local transportation support, life support (utilities, laundry and bath, waste removal), resource management, and contracting support.

(b) The RJTF is responsible for joint reception, staging, onward movement, and integration (JRSOI) operations once DOD response forces arrive within the JOA. The BSI will support the RJTF in all aspects of reception, staging, and onward movement of the DOD response force. When deploying to a BSI with limited capability, the RJTF will ensure that adequate DOD forces are available, including a JRSOI support team.

(7) If a BSI has only austere capacity, requests for logistics forces of sufficient size and capacity to support the DOD response force and missions assigned should be promptly submitted.

b. Tasks.

(1) NORAD and USNORTHCOM Directorate of Logistics and Engineering (N-NC/J4).

(a) Ensure actions are consistent with Annex D of CONPLAN 3551, CONPLAN to Synchronize DOD PI Planning.

(b) Provide the overall concepts, policies, and guidance for logistics and engineering support of PI response forces supporting DOD PI operations.

(c) Maintain situational awareness of the logistics support for deployed forces via the RJTFs.

(d) Monitor the logistics and engineering capability of tasked units and deploying forces to support each phase of PI Response operations.

(e) Advise CDRUSNORTHCOM on logistics capabilities to ensure that operational decisions are consistent with logistics support capabilities.

(f) Determine the need for and deploy the USNORTHCOM Deployment and Distribution Operations Center (NDDOC) to synchronize movement of assets into and out of the JOAs.

(g) In coordination with USTRANSCOM J3, determine the need for and location(s) of JTF Port Opening capability.

(h) In coordination with the Service Components, RJTFs, and USTRANSCOM, identify potential ports of embarkation (POEs), ports of debarkation (PODs), intermediate staging bases (ISBs), and BSIs. Take into account the possibility of movement of infected persons, and reduced port operational capability.

(i) Establish Theater Stockage Objectives.

(2) USNORTHCOM Functional Component Commands (JFLCC, JFACC, JFMCC).

(a) Maintain accurate cost records and capture all incremental costs for reimbursement.

(3) USNORTHCOM PI Regional Joint Task Forces (RJTFs).

(a) Develop plans to ensure logistics support and sustainment for all PI forces operating in the JOA.

(b) Develop sustainability assessments for all forces in the JOA and forward to N-NC/J4.

(c) Coordinate BSI support requirements with designated installations.

(d) Maintain accurate cost records and capture all incremental costs for reimbursement.

(4) USNORTHCOM Service Component Commands.

(a) Ensure all supporting PI plans' logistics annexes and appendices are synchronized with this CONPLAN. At a minimum, these plans will provide the necessary guidance to enable the development of installation-level logistics plans.

(b) Within the confines of existing law and policy, develop and execute supply sustainment plans through the installations. The focus will be on stocking sufficient quantities of essential supplies for sustainment during the PI response. In coordination with USTRANSCOM and DLA, these plans should address the purchase, storage, management, and distribution of stockpiled materials, such as medical and general supplies.

(c) Ensure installation PI response plans include logistics planning sufficient to support quarantine missions. These plans must address housing, sustainment, medical logistics, and other logistics support required.

(d) Share installation plans among and across services as necessary to ensure a coordinated and complementary logistics support effort in regions where there are concentrations of military installations.

(e) Provide supportability assessments of BSI nominations and provide BSI support as directed.

(5) Commander, USTRANSCOM.

(a) Provide ground, sealift, and airlift support assets to transport DOD and other agency personnel, teams, and equipment as directed by SecDef.

(b) Gain and maintain situational awareness of the transportation infrastructure throughout operations, and provide a common operating picture of the status of the infrastructure to USNORTHCOM, supporting commands, services, and agencies.

(c) When requested by CDRUSNORTHCOM, provide augmentation to the NDDOC and establish JTF Port Opening capability.

4. Administration and Logistics.

a. Logistics.

(1) Supply and Distribution. The service components are responsible for administrative and logistical support for forces employed in PI operations. The support concept is built around forces deploying with a mission tailored initial level of supply. Local acquisition of supplies and services is encouraged, but may be severely limited in later phases of operations, or in particularly hard-hit areas.

(a) Distribution and Allocation. Supply support for deployed forces will be in accordance with the Concept of Logistics Support outlined in paragraph 3.a. above.

(b) Level of Supply. Forces deploying for DOD PI response will deploy with a minimum (b)(2) These items will be turned over to the gaining RJTF upon arrival.

(c) Salvage. Not used.

(d) Captured Enemy Materiel. Not used.

(e) Local Acquisition of Supplies and Services. Contracting will be necessary to support in-garrison forces to preserve their combat effectiveness and, potentially, to support civil authorities. Contracting support for in-garrison force preservation will be provided through normal peacetime host contracting activities. No Annex W was prepared for this CONPLAN to describe normal peacetime contracting activities or responsibilities. Contracting support to civil authorities will be accomplished in accordance with (b)(2)

1 The execution of this plan will generate some local contracting actions for both routine and emergency items.

a Routine purchases will include additional supplies and services necessary to support precautionary measures for the preservation and protection of USNORTHCOM-assigned units throughout the deployment period.

b Emergency purchases will generally include specialized supplies and services identified by the medical community. Customer orders will be processed through the normal supply procedures. For those centrally managed assets that are unavailable, local purchases must be approved by the appropriate primary inventory control activity.

2 The severity of the pandemic may limit the availability of local contracting sources. Contracting officers should anticipate this potentiality and take steps to identify scarce resources, develop local sources, and consolidate requirements into economical purchases.

3 Contracted services for in-garrison support will employ existing installation support contracts for equipment/facility maintenance, engineering, food service, transport, etc..

4 USNORTHCOM may access the U.S. and Canada Acquisition and Cross-Servicing Agreement (ACSA) during operations. This ACSA is the only one maintained within the USNORTHCOM AOR.

(f) Petroleum, Oils, and Lubrication (POL). The supporting BSI will be responsible for POL support for deploying forces. Otherwise, services retain responsibility for POL support to deployed PI response forces.

(g) Inter-Service Logistics Support. Inter-Service Support Agreements (ISSAs) will remain in effect.

(h) Mortuary Affairs. See Appendix 3, Mortuary Affairs of this Annex.

(2) Maintenance and Modification. Service components will be responsible to perform maintenance, equipment evacuation, and modification per service doctrine and component procedures.

(3) Medical Services. See Annex Q, Medical.

(4) Mobility and Transportation.

(a) General.

1 Component commands will use the Joint Operations Planning and Execution System (JOPES) for all force movements.

2 Force deployment will be time-phased to meet operational mission requirements per validated priorities in JOPES. CDRUSNORTHCOM, as the supported Combatant Commander, will validate movement requirements via time-phased force deployment data (TPFDD).

3 CDRUSTRANSCOM will provide required airlift and sealift IAW CJCSI 4120.02, Assignment of Movement Priority and DOD guidance.

4 Strategic lift and surface transportation will be severely curtailed as a result of movement restrictions into, and out of, PI affected areas.

5 Strategic lift forces may be subject to exceptional disease control measures to allow lift to and from affected areas without facilitating disease spreads. Allowance for these measures should be applied to planning factors.

(b) Mobility Support Force and Movement Feasibility Analysis.

1 In conjunction with RJTFs and USTRANSCOM, USNORTHCOM will determine transportation mode, movement priority, and designate POEs/PODs.

2 Seaport, ground transportation, aerial port terminals, and road conditions will continuously be assessed with regard to operational capabilities.

(5) Civil Engineering Support Plan. DOD military engineer involvement in pandemic influenza operations is not envisioned to be extensive; therefore Appendix 6 is not used in this plan. However, DOD military engineer support can be required to support civil authorities or other DOD forces engaged in PI operations when local, state, and other federal support are unable to meet the

emergency requirements brought on by the crisis. Engineer units requested and approved provide support to other federal agencies IAW the National Response Framework (NRF) and National Incident Management System (NIMS) through the executing RJTF.

(a) The severity, scope and geographic intensity of the PI can generate a variety of engineer requirements in support of military operations and civil authorities. Engineer requirements include, but are not limited to: emergency erection of field hospitals, infrastructure reconfiguration into temporary infirmaries, expanding hospitals, emergency assistance or augmentation to critical utility operations such as power, water, and sewer plant operations. (Note: Military personnel may act as assistants to other plant and utility operators. In general, military personnel will not operate the plants and utilities without the primary civilian operators in attendance.)

(b) A total force perspective for achieving engineer objectives is necessary. Non-Federalized National Guard (NG) engineer forces can conduct similar operations within the JOAs along with Title 10 Active Duty engineer forces. In accordance with the NRF, the United States Army Corps of Engineers (USACE) is designated as the Primary Agency for Emergency Support Function (ESF) #3, Public Works and Engineering.

(c) DOD forces rely on DOD facilities for real estate needs to the maximum extent possible. In the event none are available, facility requirements can be met through existing local facilities, preferably government-owned, organic, portable, relocatable substitute facilities, or field construction. Short-term leasing is also an option depending on locations and duration. No occupation of private land or facilities is authorized without specific legal authority. Real property support is obtained from the General Service Administration (GSA), USACE, NAVFAC, or other government agencies. DOD deployable force bed down assets can be considered when no other adequate facilities are available. These assets are primarily in the Army Force Provider, Navy Advanced Based Functional Components (ABFC), and Air Force HARVEST Base Expeditionary Airfield Resources (BEAR) equipment sets.

(6) Sustainability Assessment. Each RJTF will develop a sustainability assessment to ensure its ability to maintain logistics support to all forces throughout the JOA for the duration of the operation. Logistic momentum must be maintained to ensure that resources arrive where and when they are needed. In addition, waste of supplies and services must be minimized to prevent a shortage, which may jeopardize continued operations.

b. Administration. Reporting requirements will be tailored to the situation and will vary depending on both the nature and scope of the DOD response. See Annex R, Reports for more information.

5. Command and Control. See base plan and Annex J, Command Relationships.

Appendixes:
1 – Petroleum, Oils, and Lubricants (Not Used)
2 – Joint Subsistence, Food Service Support & Water Management (Not Used)
3 – Mortuary Affairs
4 – Sustainability Analysis (Not Used)
5 – Mobility and Transportation (Not Used)
6 – Engineering Support Plan (Not Used)
7 – Non-nuclear Ammunition (Not Used)
8 – Logistics Automation (Not Used)

//Signed//
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Director of Logistics and Engineering

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13 August 2009

ANNEX E TO CONPLAN 3591 Pandemic Influenza
PERSONNEL

References:

a. DODI 1300.18, 1/8/2008, Military Personnel Casualty Matters, Policies, And Procedures

b. DODI 1327.6, 4/22/2005, Leave And Liberty Procedures

c. DODI 1400.32, 4/24/1995, DOD Civilian Work Force Contingency And Emergency Planning Guidelines And Procedures

d. DODM 1348.33-M, 9/26/1985, Manual Of Military Decorations And Awards

e. DODR 7000.14-R, Department Of Defense Financial Management Regulations (FMRS)

f. JP 3-33, 2/16/2007, Joint Task Force Headquarters

g. JP 1, 5/14/2007, Joint Doctrine For The Armed Forces Of The United States

h. JP 1-0, 1/16/2006, Personnel Support To Joint Operations

i. 10 U.S.C., 5/29/2007, Armed Forces

j. JFTR Vol I, 10/1/2008, Joint Federal Travel Regulation

k. CJCSM 3122.01A, 9/29/2006, Joint Operation Planning And Execution System (JOPES) Vol I (Planning Policies And Procedures)

1. Situation. It is anticipated that personnel will be deployed within the USNORTHCOM area of responsibility (AOR) to execute the mission. This annex for personnel support establishes the administrative and personnel responsibilities, policies and planning guidance necessary to support the basic order. Individual Service military and civilian personnel policies and procedures will apply unless otherwise directed by CDRUSNORTHCOM.

a. Assumptions.

(b)(2)

(4) Planning will attempt to minimize costs, but mission execution with the correct personnel, in the correct place at the correct time will take priority over execution costs.

b. Planning Factors.

(1) Parent command/parent Service will retain administrative responsibility of deployed members (if ADCON of some or all personnel is transferred see responsibilities section for courses of action).

(2) Personnel accountability for existing (home based) personnel in the AOR (existing bases/affected area) will remain parent service command responsibility. Parent service is responsible for accountability reporting via the JPERSTAT.

(3) Family separation allowance if member on temporary duty away from permanent station for 30 or more days, and dependents do not reside at or near the temporary duty station.

(4) If due to longer than planned/anticipated rotations, or limitations to personnel replacements due to limited availability of skill or environmental factors limiting rotations, and personnel are needed past 180 days, it is a requirement of the members owning service to request needed waivers/extensions the services under the following conditions: member has

been deployed for 191 or more consecutive days or for RC member is under second call to AD for more than 30 days for same contingency.

(5) High deployment allowance is tracked, managed and implemented by the services under the following conditions: member has been deployed for 191 or more consecutive days or for RC member is under second call to AD for more than 30 days for same contingency.

(6) Timely and accurate reporting is critical in keeping the chain of command informed, as well as for more immediate identification/resolution of personnel issues. The tools and personnel must be in place at the earliest possible time to facilitate the reporting, tracking, and accountability processes.

(b)(2)

2. Mission. USNORTHCOM provides qualified personnel to meet validated mission requirements and the appropriate support to those personnel to ensure they have the resources needed to carry out their assigned duties. This annex provides:

a. USNORTHCOM CDR policy and guidance on personnel support to include awards and decorations, pay and allowances, personnel and unit rotation cycles, and deployment status.

b. Roles and responsibilities in execution of this annex to support the basic plan.

c. Policy and guidance on command and control and personnel reporting in execution of the basic plan.

d. Policy and guidance on key support services to include MWR, postal operations, chaplain activities, and legal assistance/support.

3. Execution.

a. Concept of Personnel Support. Due to large variances of potential incidents, level of support and number of agencies involved, personnel support is anticipated to be tailored to each contingency. It is anticipated that commanders at all levels will have to deal with situations in the USNORTHCOM AOR under unusually constrained resources and legal boundaries. It is expected that personnel deployed in support of a contingency response will be

provided the same level of support commensurate with their home base IAW service policy and procedures. It is recognized that there are some variances allowed per DOD mandate in certain benefits. It is USNORTHCOM's responsibility to provide equity in distribution across a joint service activity. The following issues must be considered in planning personnel support:

(1) In the USNORTHCOM AOR and mission responsibilities assigned under this plan, DOD forces and staff will have to execute response actions that are unique due to the interagency relationships, broad range of responding agencies and constraints and boundaries addressed by public law.

(2) There is a potential that forces tasked to respond/support a contingency are directly affected by the contingency (pay, housing, MWR, other basic and support services). Commanders will have to mitigate effects to forces to enhance efficiency and ensure support is provided to the members and any affected family members.

(3) A solid communication chain of command at all levels is critical to inform and protect members, their families, and interests in the affected AOR.

b. Responsibilities. Individual Service military and civilian personnel policies and procedures will apply unless otherwise directed by CDR USNORTHCOM.

(1) Personnel Requirements. Includes all US service members DOD civilians directed under this plan. The following responsibilities are assigned IAW applicable policy and guidance:

(a) USNORTHCOM assigned responsibilities:

(1) Develop and publish policies in support of this plan.

(2) Conduct IA backfills to RFF processing IAW CJCSI and JS policies. However it is anticipated that due to the pandemic environment, backfills will be unavailable.

(3) Provide policy for applicable awards and decorations.

(4) Establish reporting requirements and responsibilities within the AOR/joint operations area (JOA).

(5) Coordinate with the SecDef and Joint Staff on personnel

issues.

(6) Distributes JMD for sourcing.

(b) Services assigned responsibilities (ICW members' home base and servicing MPF:

(1) Execute pay and allowances with any variations determined or directed.

(2) Monitor, task, and process military and civilian evaluations.

(3) Monitor, track, and report casualties.

(4) Provide required personnel when tasked.

(5) Request IAs IAW service policies and procedures.

(6) ID shortfalls to N-NC.

(7) Submit requests to use RC to backfill critical service if AD deployment leaves critical gap.

(8) Implement processes to use contractors to back fill gaps left by AD deployment.

(9) Track the number of days a member is deployed. Implement high deployment rate benefit as necessary, unless applicability is waived by service secretary.

(10) Coordinate with home base to ensure completion of base required training, and training required for personnel to maintain mobilization status.

(11) Coordinate with home base to provide personnel uniform and/or equipment required to support this plan.

(c) Command Element assigned responsibilities:

(1) Document personnel requirements (JMD) in the event a Joint Task Force (JTF) is established, the JTF Commander will coordinate the

creation of a Joint Manning Document (JMD) with the N-NC/J1 and their service component. Regardless of how it is created, the JMD belongs to JTF Commander and will reflect his requirements to meet anticipated missions.

(2) JRC establishment and management IAW JP 3-33.

(3) Personnel accountability and reporting (to include casualty).

(4) JTF Personnel officers will report (specific skills) to the N-NC J1 (staff or battlestaff) if the strength of any force is forecast or actually reaches a level where mission accomplishment is jeopardized.

(5) Authorization of any special pay and allowances applicable in support of this plan.

(6) Track and report mission execution trends and personnel variances required to support the plan

(7) Request in-cycle replacements due to injury, illness, emergency leave, AWOL IAW N-NC policy

(8) Publish applicable personnel policies for JOA under control.

(2) Joint personnel reception and processing. The pandemic environment may preclude physical establishment of a joint reception center (JRC). However it is critical that accountability be established at a fidelity level consistent with capabilities available. Contingency response personnel can include local assets, deployed assets or a combination of both. Despite the source of assets used in contingency response, there are critical aspects of personnel reception and processing that must be initiated at the first stage of contingency response. Initial planning must accommodate personnel reception and accountability aspects. If physical JRC's can be established, it is the responsibility of the regional joint task force (RJTF) to establish a JRC. The JRC will be responsible for all aspects of reception, accountability, processing, redeployment, and demobilization for all personnel supporting the RJTF's response to the contingency operation. Component response plans must address timely establishment of necessary resources to support personnel reception and processing.

(3) Personnel accountability and strength reporting. Personnel accountability and strength reporting is required for all personnel deployed to or employed in the AOR in support of USNORTHCOM contingency operations.

Various reports are established to account for the required tracking and information. Each component response plan should identify the establishment a responsible party to accomplish these reporting requirements on direction. It should be anticipated that reporting requirements may be directed at initial execution of contingency operations. In the event a service member is hospitalized, it is incumbent upon the RJTF to ensure that proper coding of the member's duty status and tracking of their location is achieved through coordination with the medical treatment facility (MTF), Armed Services medical regulating office (ASMRO), and the RJTF Surgeon. In the event that a civilian medical facility is utilized, the receiving civilian medical facility will contact the nearest military installation or Tri-Care and notify them they have a DOD patient. Once this occurs, the nearest military MTF and the appropriate service will be informed, the member will be brought into the DOD system (if possible), and their information will be forwarded through command channels to ensure proper processing and accounting.

(4) Rotation/replacement policies.

(a) Rotations. Although usual rotation policy will be established by JCS, a significant potential exists that deployments into the regional construct for Pandemic Influenza will last up to 18 months, or the length of each pandemic waive, whichever is longer. Rotation and replacement operations are the responsibility of the affected Service. Component Personnel Officers will coordinate replacement and rotation through JS/J1. In addition, the Component J1 representative will record TEMPO days, as required, IAW the National Defense Authorization Act FY-01 and Service instructions.

(b) Replacements. Requests for replacement of Service will be submitted per existing Service directives and procedures. Planning factors for computing personnel attrition will be developed per existing Service procedures. Replacement personnel will be provided by the USNORTHCOM Service components through parent Service channels.

(5) NEO. Non-combatant evacuation. If circumstances occur that require noncombatant evacuation and repatriation operations, the command element will have to establish a process for tracking and accounting for evacuees. USNORTHCOM, in coordination with DOD and DOS agencies will develop and issue additional policies real-time for NEO operations.

(6) US-citizen civilian personnel. Unless waived or amended by an authorized, competent authority, all Federal Guidelines and Regulations regarding the use of civilian personnel and contractor personnel will remain in

effect. See paragraph 3.b(21).

(7) Non-US citizen labor. Not applicable.

(8) Support to detainees, which include enemy POWs, civilian internees, retained persons and enemy combatants. See Appendix 1.

(9) Formerly captured, missing, or detained US personnel. Not Applicable.

(10) MWR. Morale, Welfare and Recreation. Due to the pandemic environment, implementation of physical MWR activities may not be feasible.

(11) Casualty reporting. Casualty reporting will in accordance with service policies. The command element will initiate the reporting process to the service components and USNORTHCOM. Parallel reporting is anticipated. Next of kin notification is a service responsibility. In the event a service member is hospitalized, the JFCC/JTF (in coordination with medical personnel) will determine:

(a) Medical Evaluation. Will a medical evaluation be required and how will duty status change?

(b) Return date. What is the anticipated date that the member can return to duty?

(c) Replacements. Will a replacement be required?

(12) Decorations and awards. Only those personnel assigned to attached to a joint staff or a joint activity, as defined by DOD 1348.33-M, are eligible for joint awards (Defense decorations and unit awards). Personnel officially assigned in a temporary additional duty/temporary duty joint capacity are also eligible for joint awards. Personnel who are assigned to units that are attached to a joint activity (as a unit) are not eligible for joint awards. The Components/JTF (RTF)s will execute all joint awards via existing directives and policies.

(13) Pay and allowances. The combatant commander or the RJTF commander will determine the form of subsistence and address other unique pay and allowance issues. TAD/TDY/TCS Pay - The Component Commander is responsible for determining the appropriate type of temporary duty status of military and civilian personnel assigned/attached. Insofar as possible, a

consistent policy that ensures equitable treatment of personnel deployed in a joint environment will be executed. The RJTF commander must establish set rules for status of personnel, regardless of Service, at the operating location. Questions regarding this policy will be forwarded to Joint Staff J1 for resolution.

(14) Travel (passport, visa, theater clearance)

(a) Travel. Travel procedures will be in accordance with the Joint Federal Travel Regulation (JFTR) Volume I (military members) and Volume II (DOD Civilian Personnel). Temporary additional duty/temporary duty (TAD/TDY) Pay will be in accordance with service component, DOD and USNORTHCOM policies and regulations.

(b) Country access. Access to Canada and Mexico requires DOD civilian members to possess a valid passport or travel on official orders. In a Pandemic Environment travel between the United States and other nations may be suspended or severely restricted. Contractors and non-DOD civilians are required to possess a valid passport for entry into Canada and Mexico. Although passport requirements are normally not waiverable for US Civilians, circumstances can allow some approval for passport waivers. The RJTF will coordinate with USNORTHCOM/J1 to facilitate waiver approval. To facilitate mission success in lieu of waiver approval, planning should pre-identify those individuals who may be required to support plans cross-border. Review of applicable contracts and associated costs should be vetted to encourage procurement of passports.

(c) Split year trip w/o DOD Appropriation Act/resolution. IAW DOD Financial Management Regulation Volume 9, Chapter 5 050301, in the event of a split year funded trip, the traveler must return to his or her official duty station if no DOD Appropriation Act has been signed or continuing resolution has been enacted. Expenses incurred in returning to the traveler's duty station will be posted in the new fiscal year as necessary costs to close down operations.

(15) Medical returnees to duty. (See Annex Q) Once released and approved for return, all DOD personnel returning to duty after hospitalization will report to a reception station designated by the RJTF Commander, prior to returning to their parent unit. Service members unable to return to duty will be processed per service procedures.

(16) Leave policy. It is CDR USNORTHCOM's policy that normally

ordinary leave requests/approval during personnel support to a USNORTHCOM CONPLAN execution should be limited. In addition, the effects of, or mitigation effects against a pandemic may impact the ability of the commander to authorize leave. Any leave approved should be evaluated to ensure execution does not impact current or future mission readiness or cause detriment to the individual. Several reasons exist for this; first this will maximize the readiness and response of required capabilities and personnel. Second, the safety of personnel is considered. The situation may warrant minimizing travel, or minimizing contact within a pandemic environment. If leave is approved, the member may be subject to recall to duty prior to the end of the approved leave period.

(a) Terminal/separation . Stop-loss may be enacted if mobilization of targeted Reserve Components is implemented. This effectively stops all departures/resignation of personnel on active duty in transition to a non-active duty status.

(b) Emergency/special leave. Emergency and special leave circumstances will be considered on a case by case basis with consideration on any environmental, transportation, or personal impacts that would either increase risk to the unit, mission or individual. Pandemic effects or mitigation efforts may impact the ability of commanders to authorize emergency or special leave. It is anticipated that the JTF CC will not request replacement personnel for personnel with approved emergency or special leave.

(c))U) Permissive TDYs. Permissive TDYs that are not in direct support of the CONPLAN execution should be curtailed/disapproved.

(17) Combat zone/contingency operation benefits.

(a) Combat zone. Declaration of combat zone eligibility is required. See para 3b19d of this annex.

(b) Contingency operations. Numerous benefits are available for personnel recalled under Title 10 USC. The contingency operation must be named in a Presidential Executive Order to provide benefits to members. Programs include various medical, benefit, and educational programs such as Early Identification Program, Transitional Assistance Management Program, TRICARE Reserve Select Tier-1 and Reserve Education Assistance Program. The JFC will notify services of contingency operation declaration. It is the service and member's responsibility to ensure accurate documentation and implementation of authorized benefits.

(18) Deployability criteria for personnel unique to this operation. It is required that all personnel (military and civilian) deployed in support of contingency operations meet all deployability criteria and training as required by personnel skill codes, established medical criteria, contractual agreements, DOD policies, and service policies. Successful screening for adherence to deployability criteria must be accomplished prior to deployment. Any equipment to include personal protective equipment must be issued from the member's home station.

(19) Benefits and entitlements.

(a) Special leave. Under Title 10 section 710F (1) and (2): The secretary concerned, under uniform regulations to be prescribed by the Secretary of Defense may authorize a member, who would lose any accumulated leave in excess of 60 days at the end of the fiscal year, to retain an accumulated total of 120 days leave. In consideration of the effective date(s) or length of contingency, the JFC will advocate uniform application across members supporting USNORTHCOM contingency operations.

(b) Pass program. This program is intended for allowing personnel relief from stressors. Use of this program is dependent on RJTF CDR policies. However availability must be fair and equitable to all members deployed. Most support to contingencies will be sufficiently short enough to prevent RJTF CDR from implementing this program. However in cases of lengthy deployments where personnel rotations are beyond 60 days, shift rotations prevent adequate decompression time, or environmental conditions may exist that restrict movement thus preventing the member from taking normal leave.

(c) Rest and Recuperation leave. This is not anticipated for use in the USNORTHCOM AOR. This chargeable leave is only for eligible members deployed for a 12-month or greater period to a hostile fire/imminent danger zone. The intent is to provide members time away from a stressful environment.

(d) Hostile fire/imminent danger pay (hardship duty pay). Approval of this benefit requires DOD declaration. If contingency area of operations meets specified criteria to be declared an imminent danger pay zone, CDR USNORTHCOM will advocate to the supported CDR or DOD to request declaration.

(e) Federal income tax combat zone exclusion. Not anticipated to be applicable. However, in cases where the President of the United States declares combat zone designation for a USNORTHCOM contingency operation, this exclusion will be addressed.

(f) Free postage. Per U.S.C 39 Sec 3401, this activity is only available to members of the armed forces on duty in designated combat areas permitting them to send personal correspondence, free of postage, to addresses in the United States. It is not anticipated that this privilege would be requested for any NORAD/USNORTHCOM contingency response.

(g) Sole surviving son or daughter. In the military, a "sole surviving son or daughter" is one who is any son or daughter in a family whose parent or one or more sons or daughters served in the Armed Forces of the United States and was killed in action, died as a result of wounds, accident, or disease while serving in the US Armed Forces, is in a captured or missing-in-action status, is permanently 100 percent physically disabled or 100 percent mentally disabled due to service connection. In preexisting DOD directives, this policy previously only applied to a hostile fire/imminent danger zone and excluded times of war or national emergency, so it should not be of concern for the Services unless there is such declaration for CONUS response. It is incumbent on the Services to apply Service polices.

(h) Absentee voting/voter information. It is anticipated that the services in coordination with the Federal Voting Assistance Program (FVAP) will make every effort to ensure that a deploying member has the opportunity to participate in applicable election voting. While technology developments have allowed access to web-based products to enhance this process, some contingency environments may prevent access to some or all deployed members. It is the command elements responsibility to provide access to the FVAP and available web based, or mail programs if feasible.

(i) Red Cross notification/coordination for additional services. The RJTF commander will ensure events or incidents requiring Red Cross involvement are coordinated with the Red Cross in a timely manner.

(20) Military evaluations. Services will retain responsibility for completion and processing of military evaluations. Change of raters is not anticipated due to normally short duration (less than 90 days) of contingency operations. To minimize impacts to promotion actions, personnel assigned/attached to USNORTHCOM contingency operations for greater than 90 days will be handled on a case by case basis. It is the service responsibility

to track evaluation completion dates and notify the contingency command element of required actions.

(21) Civilian personnel policies and procedures. Policies for allowances and benefits such as danger pay allowances, overtime, compensatory time, shift differential, and Sunday/holiday premium pay and leave will be in accordance with the owning service. Biweekly Earning Limitation, Annual Limitation on Premium Pay for Emergency Work, and Annual Aggregate Limitation will be executed IAW 5 USC 5546. For allowances such as danger pay that require appropriate declaration, the JFC will advocate on behalf of all the services.

(22) Finance and disbursing.

(a) USNORTHCOM will not provide funding. Funding will come from service/agency funds during contingency operations or as reimbursable funding in the case of reimbursable support to a primary agency (PA). In the absence of a reimbursable order from a primary agency, units supporting CDRUSNORTHCOM will fund operations as contingency operations IAW DODI 7000.14-R, Vol 12, chapter 23 from current fiscal year appropriations provided in direct budget authority, independent of the receipt of specific funds for the operation. Incremental costs will be captured using unique special program codes and reported to service/agency comptrollers for potential future reimbursement. Units should also consult any service or agency specific guidance concerning contingency operations and associated cost accumulation/reporting.

(b) The Economy Act (31 U.S.C. 1535) is the funding authority for DOD support to the primary agency in planning, preparing, and conducting federal support to DSCA operations in the absence of a presidential disaster declaration or determination required by the Stafford act. For all support rendered by DOD to a primary agency under terms of the economy act, units will accurately capture total costs, including pay and allowances, for reimbursement by the primary agency. Note: the SecDef may waive reimbursement from a primary agency. In this case, units will follow contingency operations funding procedures.

(c) The Stafford Act (42 U.S.C. 5170b) is the funding authority for disaster declaration support by DOD to a primary agency (PA) when the president has issued a declaration that a major disaster or emergency exists or has determined in the immediate aftermath of an incident that emergency work is essential for the preservation of life and property. Disaster declaration support by DOD to a pa is reimbursable IAW 44 CFR sect 206.8. DOD services and agencies will ensure operational support procedures and funding

guidelines are adhered to IAW ref DODD 3025.1 and DODD 3025.15. Units will capture and invoice incremental costs IAW 44 CFR sect 206.8. DOD service and agency comptrollers will report incremental costs to DFAS-DE IAW DOD Financial Management Regulation (FMR) 7100.14r, Vol 12, chapter 23. The use of DOD FMR Vol 12 for CONUS pandemic FM operations is an authorized exception. To ensure CDRUSNORTHCOM retains complete oversight of all fiscal transactions during a pandemic event, services and agencies are directed to notify USNORTHCOM/J8 anytime they have accepted and are executing reimbursable orders which have not been tasked by CDRUSNORTHCOM for disaster assistance. A FEMA supply order provided directly to DLA during a disaster is such an example. Reimbursable support provided to civil authorities will be funded IAW applicable laws, DOD directives, and existing interagency agreements, unless otherwise directed.

(d) For billing and reimbursement, all components will: post reimbursable budget authority (RBA) in accounting systems using coding structure that identify the specific event; ensure all accounting transaction are recorded for proper identification and reporting; bill the primary agency properly and expeditiously so DOD is reimbursed in a timely manner for support provided; maintain all supporting documentation; ensure supporting documentation amounts equal amounts submitted in intra-governmental payment and collection (IPAC) transactions; provide valid contact information for financial and billing personnel on SF1080, including names and commercial phone numbers for problem resolution.

(23) Legal. See Appendix 4.

(24) Military Postal Services. See Appendix 5.

(25) Chaplain Activities. See Appendix 6.

4. Administration and Logistics. USNORTHCOM J1s will provide administrative management of assigned personnel, supported by the providing Service component, for all personnel services. Rotation and replacement policies are as stated in paragraph 3.b.(4). USNORTHCOM will conform with policy in CJCSI 1301.01C for augmentation as discussed in paragraph 3.b.(1).

5. Command and Control. USNORTHCOM will delegate appropriate authorities over assigned and attached personnel to the RJTFs. Administrative control (ADCON) normally remains with the sourcing Service or combatant command.

Appendixes
1 - Detainees, Civilian Internees, and other Detained Persons
2 - Processing of Formerly Captured, Missing, or Detained US Personnel - Not Used
3 - Finance and Disbursement (Financial Management) – Not Used
4 - Legal
5 - Military Postal Services
6 - Chaplain Activities
7 - Linguist Requirements – Not Used
8 - Contingency Contracting - Not Used
9 – Joint Emergency Family Assistance (JEFAC) for DOD personnel
10 - Pandemic Influenza Ethics

//Signed//
MARILYN H. HOWE
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Director of Manpower and Personnel

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APPENDIX 1 TO ANNEX E TO USNORTHCOM CAMPAIGN PLAN 3591-08 REGIONAL WAR ON TERROR DETAINEES, CIVILAN INTERNEES, AND OTHER DETAINED PERSONNEL

References:

a. DODD 2310.01E, DOD Detainee Program, 5 September, 2006

b. DODD 3115.09, DOD Intelligence Interrogations, Detainee Debriefings, and Tactical Questioning, 3 November, 2005

c. Geneva Convention, adopted on 12 August, 1949

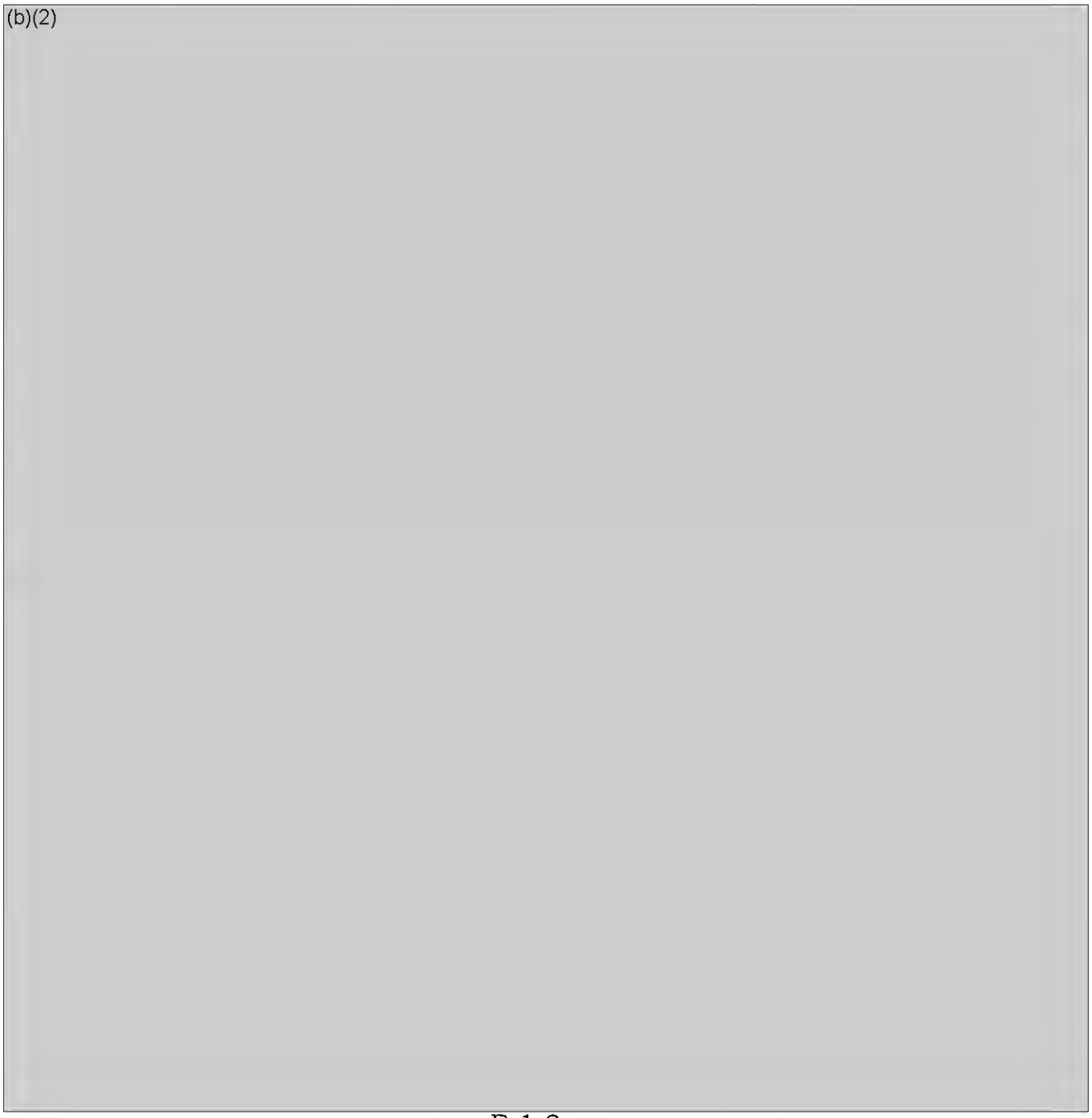
d. AR 190-8, Detainee Operations, Draft (will replace ref e when approved)

e. AR 190-8, OPNAVINST 3461.6, AFJI 31-304, MCO 3461.1, Enemy Prisoners of War, Retained Personnel, Civilian Internees and Other Detainees, 1 October, 1997

1. Situation. In execution of the base plan,

(b)(2)

(b)(2)



(b)(2)

3. Execution

a. Concept of Personnel Support.

(b)(2)

b. Responsibilities. Individual Service military and civilian personnel policies and procedures will apply unless otherwise directed by CDRUSNORTHCOM.

(1) Personnel requirements. There are two key aspects in defining personnel requirements, procurement and sustainment.

(a) Procurement of trained personnel in support of detainee operations requires the mission command element identification of required skills and quantities to USNORTHCOM. USNORTHCOM will then implement sourcing of required personnel through JFCOM.

(b) Sustainment of those individuals assigned/attached to USNORTHCOM includes USNORTHCOM responsibility for authorizations

(b)(2)

(2) Joint personnel reception and processing.

(b)(2)

(3) Personnel accountability and strength reporting.

(b)(2)

(4) Rotation/replacement policies.

(b)(2)

(b)(2)

(a) USNORTHCOM.

(b)(2)

(b) Services.

(b)(2)

(c) Command element.

(b)(2)

Geneva Convention Section V, article 70). In lieu of any environmental constraints,

(b)(2)

4. Administration and Logistics. Coordinated communication across all entities is required to ensure that all aspects of detainee operations are conducted in compliance with directed guidance.

5. Command and Control. See Annex J.

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APPENDIX 4 TO ANNEX E TO USNORTHCOM CONPLAN 3591
LEGAL ISSUES

References: a. DODD 3025.dd (draft), Defense Support of Civil Authorities, TBP

b. DODI 3025.dd (draft), Processing Requests for Defense Support of Civil Authorities, TBP

c. DODM 3025.dd (draft), Defense Support of Civil Authorities, TBP

d. AR 27-20 Claims, I June 2003

e. DA Pam 27-162, Claims Procedures, 8 August 2003

f. JAGINST 5890.1, Administrative Processing and Consideration of Claims on Behalf of and Against the United States, 17 January 1991

g. Manual for the Judge Advocate General (JAGMAN) 2004

h. AFI 51-502, Personnel and Government Recovery Claims, 1 March 1997

i. DODD 5515.8, Single-Service Assignment of Responsibility for Processing Claims, 1 November 2002

j. AR 27-3, The Army Legal Assistance Program, 21 February 1996

k. CNLSCI 5800.1E CH-1, Naval Legal Service Command Manual, 19 February 2002 with Change 1, 4 April 2003;

l. JAGI 5801.2, Navy-Marine Corps Legal Assistance Program, 11 April 1997

m. AFI 51-504, Legal Assistance, Noatary and Preventive Law Programs, 27 October 2003

n. DODD 5510.3, Authority to Convene General Courts-Martial, 30 June 1980

o. Joint Pub 0-2, Unified Action Armed Forces (UNAAF), 10 July 2001

p. AR 27-1, Judge Advocate Legal Services, 30 September 1996

q. AR 27-10, Military Justice, 16 November 2005

r. JAGI 5810.2A, Military Justice Regulations, 17 September 1993

s. AFI 51-201, Administration of Military Justice, 26 November 2003

t. AFI 51-202, Nonjudicial Punishment, 7 November 2003

u. Manual for Courts Martial United States (2008 Edition)

v. DOD 5500.7-R, Joint Ethics Regulation (JER), 25 March 1996

w. CJCSI 3121.01B, Standing Rules of Engagement/ Standing Rules for the Use of Force (S), 13 June 2005

x. DODD 3000.3, Policy for Non-Lethal Weapons, 9 July 1996

y. DODD 5210.56, Use of Deadly Force and the Carrying of Weapons by DOD Personnel Engaged in Law Enforcement and Security Duties, 1 November 2001

z. The Insurrection Act, 10 USC 331-335

aa. Posse Comitatus Act, 18 USC 1385

bb. DOD 5240.1-R, Procedures Governing the Activities of DOD Intelligence Components That Affect United States Persons, Procedure 12, Provision of Assistance to Law Enforcement Authorities, December 1982

cc. Federal Acquisition Regulation (FAR); Defense Federal Acquisition Regulation Supplement (DFARS)

dd. EO 12333, United States Intelligence Activities, 4 December 1981 (as amended)

ee. DODD 5240.1, DOD Intelligence Activities, 8 August 2007

ff. DOD 5240.1-R, Procedures Governing the Activities of DOD Intelligence Components that Affect United States Persons, December 1982

gg. DODD 5200.27, Acquisition of Information Concerning Persons and organizations not Affiliated with the DOD, 7 January 1980

hh. The Economy Act, 31 USC 1535

ii. DODI 4000.19, Interservice and Intragovernmental Support, 9 August 1995

jj. Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 USC 5121, et seq. (as amended)

kk. Quarantine Statutes, 42 USC 97, 42 USC 243, 42 USC 264

ll. The National Emergencies Act, 50 USC 1601 et seq.

mm. DODD 6010.22, National Disaster Medical System (NDMS), 21 January 2003

nn. DODD 6200.2, Use of Investigational New Drugs for Force Health Protection, 1 August 2002

oo. DODD 6200.4, Force Health Protection, 9 October 1994

pp. DODD 6200.3, Emergency Health Powers on Military Installations, 12 May 2003

qq. DODI 5200.8, Security of DOD Installations and Resources, 10 December 2005

1. Mission. The primary efforts of USNORTHCOM support in the event of a PI will be to protect and preserve the operational effectiveness of our forces throughout the world and to sustain mission assurance for USNORTHCOM missions. Missions may include:

a. Implementation of emergency health powers and force protection (FHP) measures leveraged to protect and preserve operational effectiveness and sustain mission assurance. CDRUSNORTHCOM has responsibility for FHP for forces assigned or attached to USNORTHCOM.

b. When directed by the President or Secretary of Defense, USNORTHCOM will provide support to civil authorities (DSCA) in accordance with existing US laws and applicable regulations.

c. USNORTHCOM Judge Advocate (JA) Office and subordinate/Joint Task Force (JTF) component JAs will provide the fullest possible range of legal services to units and personnel in the joint operations area (JOA) as far forward as circumstances permit. Specifically, JA will:

(1) Provide legal advice to the Commander and staff.

(2) Serve as the single point of contact for all legal issues.

(3) Monitor all legal activities within the JOA.

2. Specific Legal Issues

a. Claims. Commanders will ensure that all claims are promptly reported and thoroughly investigated in accordance with (IAW) applicable law and policy.

b. Legal Assistance. Service component commanders will arrange legal assistance for personnel assigned or attached to their respective forces.

c. Military Justice. Service component commanders will administer military justice within Service component channels IAW Service directives.

d. Standing Rules for the Use of Force (SRUF). While providing DSCA and conducting land Homeland Defense missions, Title 10 forces will comply with the SRUF.

e. Standing Rules of Engagement (SROE). If the President directs USNORTHCOM to conduct air and/or maritime Homeland Defense missions as part of a response to PI, DOD forces will comply with the SROE.

f. Legal Review of SRUF and (SROE). All requests for SRUF or SROE augmentation or mission-specific RUF or ROE will be coordinated with the supporting JA and through operational channels and forwarded through the USNORTHCOM JA and J3 to CDRUSNORTHCOM who may forward such requests through CJCS for approval by Secretary of Defense (SecDef).

g. Arming Policy. Forces conducting PI missions will arm only as directed by the Secretary of Defense.

h. Component and supporting commanders' and staff responsibilities. Subordinate component commanders will:

(1) Ensure all plans, orders, policies, and procedures comply with applicable law and policy, including the SRUF and arming policy.

(2) Immediately report legal issues of joint origin or that affect the external relations of Component and Joint Commands to USNORTHCOM JA.

(3) Provide a weekly status of general legal operations to CDRUSNORTHCOM, ATTN: SJA. This report will include, at a minimum, the following information:

(a) Domestic law. Incidents affecting local civil authorities, suspected violations of the RUF and/or SROE, and incidents involving US Forces and civil authorities or US Citizens.

(b) Military Justice. Incidents that may result in disciplinary action under the Uniform Code of Military Justice (UCMJ), any final disposition of such actions, and notice of any Service personnel in pretrial confinement. Immediately report all serious incidents.

(c) Claims. Any incidents that may give rise to claims for or against the US government.

i. Acquisitions during Military Operations

(1) Goods and services to satisfy US-specific requirements will be obtained IAW applicable US laws, directives, and regulations. Component and Joint Commanders do not have the authority to waive any of the statutory or regulatory requirements contained in the Federal Acquisition Regulation (FAR). DOD forces shall not procure or maintain any supplies, material, or equipment exclusively for providing DSCA, unless otherwise directed by the Secretary of Defense.

(2) Only contracting officers may enter into and sign contracts on behalf of the US Government. Only those persons who possess valid contracting warrants may act as contracting officers and then only to the extent authorized. Only those persons who have been appointed as ordering officers by competent authority may make obligations pursuant to contracts.

(3) Avoid unauthorized commitments. Although an unauthorized commitment is not binding on the US Government, in appropriate cases it may be ratified by an authorized person IAW the FAR. Unauthorized commitments are the responsibility of the person who made the commitment. In appropriate cases, such persons also may be subject to disciplinary action.

j. Intelligence oversight. Ensure intelligence oversight authorities and restrictions in references dd through gg are followed when intelligence information, personnel, or equipment are involved in DSCA operations.

k. Information Management/Sharing. Ensure references dd through gg are followed when information other than intelligence is collected, analyzed, produced or disseminated during DSCA operations.

l. International Assistance. If the U.S. accepts foreign military aid, JA will review the foreign nation ROE/RUF and arming policies for compliance with U.S. polices prior to the commencement of foreign operations. This review will be conducted in coordination with (ICW) the Department of State (DOS). Legal issues such as Status of Forces, individual liability, claims, information sharing, and use of material and equipment should be addressed in writing prior to deployment and coordinated with the DOS.

m. Quarantine/restricted movement. The States have the primary responsibility for protection of the public health. Therefore quarantine measures outside of DOD installations will be dependent on applicable state law.

(1) Restriction of movement on DOD installations. Commanders of CONUS installations are authorized to implement emergency health powers to protect DOD and non-DOD personnel on their installation. These powers include restriction of movement to include limiting ingress and egress to, from, or on the installation, isolation, and quarantine IAW references oo through qq.

(2) DOD support to civil quarantines. DOD support to civil quarantines must comply with all applicable federal statutes and regulations, to include the Posse Comitatus Act, reference aa.

n. Immediate Response and Emergency Authorities. Local military commanders possess limited authority to respond to a civil emergency.

(1) Immediate response authority. Consistent with DOD policy and directives, upon a request from local or state authorities, local commanders may exercise immediate response authority under DODD 3025.1. The sole purpose of "immediate response" is to save lives, prevent human suffering, or mitigate great property damage under imminently serious conditions. Commanders who initiate missions pursuant to immediate response authority must notify the National Military Command Center through the chain of command as soon as practical. The immediate response authority is not an exception to the Posse Comitatus Act.

(b)(2)

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APPENDIX 6 TO ANNEX E TO USNORTHCOM CONPLAN 3591-09
CHAPLAIN ACTIVITIES

References:

a. See references a through mmm of base plan

b. Joint Pub 1-05, 9 June 2004, "Religious Support in Joint Operations."

c. Joint Pub 3-33, 16 February 2007, "Joint Task Force Headquarters."

d. Joint Pub 3-27, 12 July 2007, "Homeland Defense."

e. Joint Pub 3-28, 14 September 2007, 18 December 2006, "Civil Support."

f. Joint Pub 4.06, 28 Aug 1996, "Joint Tactics, Techniques, and Procedures for Mortuary Affairs in Joint Operations."

g. DODD 1300.17, 3 February 1988, "Accommodation of Religious Practices within the Military Services", with Change 1, 17 October 1988

h. DODD 1304.19, 11 June 2004, "Appointment of Chaplains for the Military Departments."

i. Army Regulation 165-1, 25 March 2004, "Chaplains Activities in the United States Army."

j. Army Field Manual 1-05, 18 April 2003, "Religious Support."

k. Air Force Policy Directive 52-1, 2 October 2006, "Chaplain Service."

l. Air Force Instruction 52-101, 10 May 2005, "Planning and Organizing."

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1. Situation

a. Purpose. This appendix is the USNORTHCOM Religious Support Plan (RSP) for chaplain activities for planning and execution of Pandemic Influenza (PI) CONPLAN 3591. This appendix applies to all Department of Defense (DOD) forces and installations OPCON to USNORTHCOM for operations in response to PI.

b. Enemy Forces. See Annex B.

c. Friendly Forces. See base plan. Nongovernmental organizations (NGO), faith-based organizations (FBO) and community-based organizations (CBO) active in disasters which provide humanitarian assistance, disaster relief and religious support (RS) to victims, families and first responders.

d. Assumptions

(1) Pandemic influenza will cause unprecedented illness, death and disruption to normal patterns of life, resulting in emotional, psychological, spiritual and physical pressures on USNORTHCOM forces.

(2) Military families will experience the same level of absenteeism, illness and death as the surrounding populace, requiring intentional pastoral care support.

(3) Mission essential personnel will be required to stand duty for the duration of successive waves of PI while their families cope with PI at home alone, giving rise to the potential of morale and emotional issues among the force.

(4) There may be mass fatality events involving temporary interment, disinterment, and/or mass burial requiring spiritual and psychological intervention and extraordinary levels of religious support to the force.

e. Limitations

(1) Mission requirements during a pandemic influenza will exceed available resources; therefore, prioritization of missions and level of pastoral response available for each mission must be determined.

(2) RST augmentation and mobilization may be constrained. Many Reserve Component chaplains and chaplain assistants/religious program specialists are civilian clergy or first responders. Community requirements for civilian clergy and possible quarantines for all citizens may conflict with mobilization requirements.

(3) The National Guard (NG) RSTs under supervision of their Commanders, the Joint Force Headquarters State (JFHQ-State) Command Chaplain and ICW National Guard Bureau (NGB) Office of the Chaplain (NGB-OC) would normally be the primary responders to the incident but conditions and civilian obligations may limit their response.

2. Mission. The USNORTHCOM Chaplain Directorate (USNORTHCOM/HC) provides and coordinates religious support to the Command and authorized DOD personnel in order to insure the free exercise of religion for forces in the area of responsibility (AOR) conducting PI operations.

3. Execution.

a. Concept of Operations. Considerations common to all phases.

(1) USNORTHCOM/HC establishes theater religious support (RS) policy, provides RS to the Command, and coordinates RS activities of

subordinate commands and regional joint task force(s) (RJTFs) for all phases of PI operations.

(2) RSTs provide RS to authorized DOD personnel during all phases of PI operations. Service components and RJTFs provide religious support to service personnel through assigned RSTs.

(3) CDRUSNORTHCOM will employ strategic communication and public information plans in coordination with civil authorities in order to mitigate fear and miscommunication. Chaplains will contribute to this mission by advising the command on the impact of religion during PI operations.

b. Support Planning

(1) Religious Support to Military Forces. General planning considerations for ministry to DOD forces will be in accordance with Joint Pub 1-05, Joint Pub 3-28, and Joint Pub 3-33.

(a) Shortages of vaccines, anti-virals, food, water, and other life sustaining resources will exist. Therefore, coordinated ethical responses must be available to address the prioritization of distribution. See Appendix xx to Annex E, CONPLAN 3591 for ethical guidance.

(b) Social distancing may be necessary to prevent the virus spread. The impact of social distancing upon religious support must be considered. Alternative methods for worship gatherings, sacraments or rites, personal visitations, conducting burials and other pastoral responses involving personal contact will need to be devised.

(2) Medical Services. Identify coordination and planning requirements for chaplain activities in support of Annex Q.

(3) Mortuary Affairs. At the national level, the Department of Health and Human Services has responsibility to coordinate civilian fatality management with local, state, and tribal authorities. DOD mortuary affairs personnel may be tasked to assist government agencies. During such operations, military chaplains are present to provide pastoral care to DOD personnel. They may assist in mitigating stress as part of a multidisciplinary stress management process such as critical incident stress management or equivalent. Chaplains may render "honors" with respect to the remains of deceased individuals under the guidance provided by the command Chaplain or as appropriate for DOD personnel. Deaths resulting from PI may cause extraordinary

circumstances regarding disposition of remains. Chaplains must be prepared to address religious and pastoral implications of temporary interment, disinterment, and mass burial. See Annex D, Appendix 3.

(4) Joint Emergency Family Assistance Center (JEFAC.) JEFAC facilities may not be established or may be decremented due to the inadvertent spread of the disease. Limited JEFAC services may be provided by alternative means such as internet, television, radio, and telephone. See Annex E, Appendix 9.

(5) Noncombatant Evacuation Operations (NEOs). See base plan. Chaplains may provide RS to the forces involved in NEO and may provide limited support to non-DOD civilians. See coordinating instructions in Para 3e. below.

(6) Religious Support to non-DOD personnel. See coordinating instructions in Para 3e. below.

c. Employment common to all phases

(1) Joint area religious support as defined in JP 3-28 and the USNORTHCOM CS CONEMP will be employed when necessary. The Joint Staff standing defense support of civil authorities (DSCA) execution order contains military units that do not contain embedded religious support capability. USNORTHCOM/HC and the designated RJTF RST shall coordinate joint area religious support for all DOD personnel with consideration given to faith group balance.

(2) In compliance with DOD policy, chaplains are noncombatants, and will not carry or use weapons under any circumstances. Chaplain assistants and religious program specialists are classified as combatants and therefore are authorized to carry and use weapons consistent with the defined rules for the use of force.

(3) Phase 0 (Shape), Phase 1 (Prevent). During Phase 1, the priority of effort will focus on maintaining continuous PI situational awareness. Key tasks:

(a) Participate in planning efforts and exercises

(b) Coordinate with FBOs, NGOs, and CBOs to develop relationships and synchronize plans for collaborative PI response.

(c) Provide religious support (RS) to authorized DOD personnel and their families, plan for operations and secure deployment liturgical supplies.

(d) Obtain PI/DSCA related training. All RSTs in units designated for PI/DSCA operations require appropriate DSCA familiarization training.

(4) Phase 2, (Contain) and Phase 3 (Interdict). The priority of effort in Phase 2 will focus on supporting the forces conducting USG containment efforts. The priority of effort in Phase 3 will focus on supporting the forces conducting USG efforts to delay or halt the spread of the virus. Key tasks:

(a) RSTs provide RS to forces supporting the USG efforts to contain or halt the spread of the virus. Force Health Protection (FHP) and community mitigation measures will be in effect.

(b) RSTs gain awareness of the presence of NGOs, FBOs, CBOs and other civilian clergy in the AO and prepare to conduct liaison as directed. Consistent with the provisions of paragraph 3.e. coordinating instructions, RSTs prioritize RS to victims and provide requested emergency ministrations in the area designated for victims who are not expected to live.

(c) RSTs monitor stress levels and take actions to mitigate stress on assigned personnel.

(d) RSTs should be present at the following key locations.

1 Joint Field Office (JFO). The command chaplain or a senior RS representative locates at or near the JFO to serve as on-scene director of religious support and in order to advise the DCO on religious support requirements and to coordinate religious support operations.

2 Disaster Control Group (DCG). USAF forces responding to disasters will establish an installation DCG. The DCG coordinates overall incident response at the tactical level. The DCG chaplain advises the DCG on religious support requirements maintains situational awareness of incident response and supports coordination of RS operations.

3 Casualty Collection Points (CCP). RSTs are located at the CCP in order to provide RS to medical staff and victims during triage

and staging and evacuation to hospitals or Military Treatment Facilities (MTFs). See para 3.e. Coordinating Instructions on providing pastoral care to civilian victims.

4 Medical Treatment Facilities (MTF). High volume of victims at MTFs would mandate assigning additional RS to the organic RSTs of the MTF.

5 Mortuary Affairs Collection Points (MACP). Mass casualty events may result in exceedingly high demands for chaplains to support mortuary personnel and show "honor and respect" to the dead. When directed, DOD chaplains may support such efforts along with civilian disaster clergy and spiritual and faith based care providers.

(5) Phase 4 (Stabilize). Priority of effort is the protection of key population while conducting missions to protect vital national interests. Key tasks are the same as Phase 2 and Phase 3 above, to include advising the command on RS indicators that the civilian community is capable to resume normal functioning without military support.

(6) Phase 5 (Recover). Priority of effort is on providing support for the reconstitution of the force in preparation for the next wave or return to interpandemic period. Key tasks:

(a) RSTs provide RS to authorized DOD personnel and focus on reunion and reintegration issues with families and mitigating the impact of traumatic events.

(b) RSTs advise Commanders on indicators documenting the ability of civilian communities to resume normal functioning without military support.

(c) RSTs coordinate RS support activities with the National Guard and civilian organizations and other agencies operating in the area.

d. Tasks

(1) USNORTHCOM Chaplain

(a) Ensure actions are consistent with Annex E, Appendix 6 of CONPLAN 3551, CONPLAN to Synchronize DOD PI Planning.

(b) Advise CDRUSNORTHCOM on issues pertaining to the free exercise of religion and the impact of religion on military operations.

(c) Coordinate religious support activities for Title 10 forces conducting PI/DSCA in the USNORTHCOM AOR.

(d) Coordinate with RJTF Command Chaplains, Service components, and the joint staff (JS) Chaplain on request for forces for additional RST assets.

(e) Establish RS reporting formats and suspense dates for units deployed for civil support missions.

(f) Clarify RST staff coordination channels and delineate how different components interface to ensure appropriate RS. See USNORTHCOM CONOPS, CS CONEMP and battle staff standing operating procedure (BSOP) for further guidance.

(g) Establish Chaplain policy and procedures for donated goods for DOD personnel received from faith groups, charities, or individuals in conjunction with legal counsel and command policy.

(h) Establish method and means of communication with DOD RST forces.

(i) Establish method and means of communication with FBO/NGOO's.

(2) ARNORTH, AFNORTH, MARFORNORTH, USFF Command Chaplains

(a) Coordinate and validate RST unit type code/time-phased force and deployment data requirements with Service component crisis action teams, RJTF RST, and N-NC/HC.

(b) Ensure that authorized RST positions are filled in order to provide RS to service personnel.

(c) Be prepared to validate RFFs for additional RST personnel.

(d) AFNORTH shall insure that deploying USAF Expeditionary Medical System EMEDs contain embedded RS capability of the appropriate UTCs, in order to provide RS to EMEDS personnel and expected patient load.

(e) Plan for reconstitution of forces following cessation of operations.

(f) Train and equip RSTs for PI consistent with the directives of this appendix. Certify appropriate levels of training for RSTs, based upon Service Component requirements for RST deployment.

(g) Develop training for PI ethical guidance based on Appendix 10 to Annex E, and insure personnel are trained prior to the PI event.

(3) Other Supporting Commands' Staff Chaplains. Supporting commands' staff chaplains include but are not limited to Active and Reserve Service Components, Air and Army NG, and the Coast Guard. USNORTHCOM/HC coordinates OPLAN guidance and execution with all appropriate departments and commands for deployment and sustainment of forces.

(4) Regional Joint Task Force (RJTF) Chaplains

(a) Coordinate joint area RS for units OPCON or TACON to the RJTF in the joint operations area (JOA). Provide technical oversight for DOD chaplain activities in such units.

(b) Inform and advise N-NC/HC on distinctive service component organizational and operational procedures and policies, "Free Exercise" issues in the JOA, and on the religious implications of operations in the JOA.

(c) Prepare to receive a chaplain from the National Guard Bureau Office of the Chaplain (NGB-OC) in order to facilitate coordination among the RJTF Command Chaplain, NGB-OC, and NG RSTs in the JOA. The RJTF chaplain will use the NGB LNO to maintain situational awareness of ongoing operations and RS requirements.

(d) Plan for required RS augmentation to the RJTF HQs to insure 24/7 capability for the RJTF RST.

(e) Forward required RS reports to N-NC/HC IAW appropriate reporting instructions.

(f) Establish communications with FBO/NGO's in the RJTF area of operations.

(6) Chaplain Service Personnel

(a) Provide direct and indirect RS for joint component military personnel, families, and authorized civilian DOD personnel.

(b) Acquire additional training for PI/DSCA. Training should include the National Response Framework (NRF), National Incident Management System (NIMS), National Disaster Medical System (NDMS) Disaster Mortuary Affairs Team (DMORT) familiarization, Critical Incident Stress Debriefing and Management CISD/CISM (or equivalent), Applied Suicide Intervention Skill Training (ASIST), Joint Forces Chaplaincy Theater Training, PI Ethical Guidance, public affairs/mass media and Mass Casualty (MASCAL).

(c) Personnel will meet service component standards for worldwide deployment, including receipt of appropriate immunizations.

e. Coordinating Instructions

(1) Commanders will coordinate religious support for their personnel IAW JP 1-05 and JP 3-28, as applicable. The primary role of the RST is to provide religious support to authorized DOD personnel and their families.

(2) RSTs will follow command direction, joint doctrine, chaplain policy and legal counsel when providing RS during PI operations. RSTs will not normally provide religious support to non-DOD personnel. However, during rare and emergency conditions, and when directed or upon individual and personal request during civil support operations, RSTs may provide such support under the following conditions:

[a] Authorized Support: Generally, no such support could be authorized. However, in rare circumstance, when a government-imposed burden interferes with free expression, a RST could conceivably be tasked, through normal channels, to temporarily provide religious support to non-DOD affiliated personnel, until unaffiliated clergy could be arranged. Such tasking must be explicit and unambiguous. Due to Constitutional concerns, such a mission would only be considered where the needs stemming from such government imposed burden are acute, and unaffiliated clergy are wholly unavailable.

[b] Incidental Support: Support provided ad-hoc, unplanned and upon individual and personal request, during the execution of an

authorized mission. Such support incurs no incremental monetary cost and does not significantly detract from the primary role of the RST. Such incidental support must simultaneously meet the following conditions.

1 The support must be requested in an emergency situation, whereby the need is immediate, unusual and unplanned;

2 The need must be acute. Acute needs are those which are of short duration, prone to rapid deterioration, and in need of immediate and urgent care. The provision of last rights is the clearest, but not the only, example of such needs; and

3 The requested support must be incapable of being reasonably rendered by members of the clergy unaffiliated with the Armed Forces. Time, distance, and the state of communications may require such a determination to be made on the spot, by the Chaplain, based on the information available at the time.

4. Administration and Logistics

a. Logistics.

(1) Chaplain logistics, resupply, and material management are a service component responsibility.

(2) Service components will ensure chaplain supplies and material are available to support rapid deployment and subsequent sustainment until routine resupply can be accomplished. Deploying personnel will have sufficient equipment and ecclesiastical supplies to sustain effective religious support for an initial period of thirty days.

(3) Ground transportation is the responsibility of deploying units. Deploying units will provide dedicated ground transportation assets to the RSTs for their exclusive use.

b. Personnel. Reserve component/NG augmentation is essential to mission accomplishment. Augmentation procedures should be refined for expedient activation of Reserve/NG components. RSTs will follow appropriate mobilization procedures.

c. Reports

(1) Reports will be submitted as applicable IAW guidance TBD.

RJTF Command Chaplains will submit reports to the RJTF Commander and to USNORTHCOM/HC as required in the USNORTHCOM BSOP and IAW Annex R.

(2) RSTs will prepare after action reports for submission to the RJTF Command Chaplain and Service Component supervisors not later than (NLT) thirty days after completion of deployments.

5. Command and Control. See Base Plan and Annex C.

a. Communication.

(1) Coordinate security requirements for communication with appropriate authorities.

(2) Routine communication among USNORTHCOM, service components, Sub-unified Commands, NGB-OC, and the RJTF Command Chaplain directorates will be by telephone when possible. Routine communication in the JOA may be accomplished by battery operated hand held radios, satellite phones, cell phones and blackberries.

(3) Official annexes, tabs, orders, SITREPS and requests will be transmitted via authorized means of communication.

(4) Service component, Sub-unified Command and RJTF chaplains will coordinate communications internal to their commands.

Tabs
A -- Inter-Service chaplain Support – Not Used
B -- Host-Nation Religious Support – Not Used

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APPENDIX 9 TO ANNEX E TO USNORTHCOM CONPLAN 3591
JOINT EMERGENCY FAMILY ASSISTANCE CENTERS (JEFAC) FOR DOD PERSONNEL

References :

a. Homeland Security Act of 2002, Title V. Sec. 5, Emergency Preparedness and Response.

b. Department of Homeland Security, *National Incident Management System*, 01 March 2004.

c. National Response Framework, 22 March 2008.

d. Department of Defense Directive 1300.17, *Accommodation of Religious Practices within the Military Services*, 3 February 1988.

e. Department of Defense Instruction 1300.18, *Military Personnel Casualty Matters, Policies, and Procedures*, 18 December 2000.

f. Department of Defense Directive 1342.17, *Family Policy*, 30 December 1988.

g. Department of Defense Instruction 1342.22, *Family Centers*, 30 December 1992.

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o. National Transportation Safety Board, *Federal Family Assistance Plan for Aviation Disasters,* 1 August 2000.

p. USNORTHCOM Strategic Action Plan, 16 December 2003.

1. Situation.

a. General.

(1) If, despite efforts to contain it, an influenza epidemic were to become a pandemic event, communities across the globe would be overwhelmed by a health care emergency that would spread at an unprecedented rate. Fueled by the global economy and rapid transportation a pandemic disease could manifest itself near simultaneously around the world, giving little or no warning.

(2) In the event that there is an outbreak of a pandemic influenza, community services normally available to support DOD and National Guard personnel and their families will be disrupted or rendered insufficient to handle support during recovery from the catastrophic event.

(3) Most installations today host multiple Services and civilian personnel creating a joint environment. A joint response to a catastrophic event ensures all available DOD resources support a response to the needs of personnel and their families and that all the Services have an opportunity to "take care of their own."

(4) In the event of a pandemic event affecting a significant number of DOD-affiliated personnel (see paragraph 1.e.(3) below), CDRUSNORTHCOM may direct the establishment of a joint emergency family assistance center (JEFAC) to coordinate the provision of family assistance services to affected DOD-affiliated personnel by their respective Services.

(5) Actions taken to mitigate the effects of Pandemic influenza may adversely affect the ability of JEFACs to conduct its support operations. These mitigation actions (such as social distancing) may require JEFACs to:

(a) Plan and conduct operations in a "virtual" environment.

(b) Operate from satellite facilities.

(c) Develop other methods for conducting business in a pandemic environment.

(6) JEFAC leaders and staff must encourage development of new and innovative means of conducting business, and be open to considering radical means of supporting DOD personnel and their families.

b. Areas of concern.

(1) Area of responsibility (AOR). See base plan.

(2) Joint operational area (JOA). See base plan.

c. Enemy forces. See Annex B.

d. Friendly forces.

(1) Installation Response. Depending on the severity of events and the capabilities of the installation(s), installation responses will vary. The installation CDR should consider the needs of all personnel for which he/she is responsible and the resources available. Pandemic Influenza should be viewed as an environment rather than an event. Immediate support from area and regional installations may or may not be available. A JEFAC can leverage the existing support architecture provided by DOD and National Guard installations, personnel functions, logistics functions, legal functions, medical functions, and family care to ensure that every member of the DOD and National Guard to include their families are provided the support they need and are entitled to.

(2) Adjacent Installations. Support activities will be coordinated with the CDR of the installation and CDRUSNORTHCOM to insure best utilization of resources. Event circumstances may be beyond the intent of memoranda of support.

(3) Local, state and Federal agencies. Local and state agencies may be overwhelmed. A JEFAC specifically addressing the needs of DOD personnel

and their families may not only facilitate assistance to DOD personnel but also make more resources available to the local community. This can be done separately or as part of the community effort. A multitude of government organizations (GOs) and non-government organizations (NGOs) will respond to the scene and their services and benefits must be considered. The primary JEFAC link with state military forces will be its counterpart, the State National Guard Family Support Group.

(4) Joint task force (JTF/RTF) or regional joint task force (RTF). In the event a joint (or regional) task force is created/ assigned to manage the DOD response to an event, the JEFAC will be assigned/attached to that JTF/RTF/RTF commander. Additionally, coordination should occur between the JTF/RTF as well as the JEFAC commander (CDR JEFAC) and any affected Installation Commanding Officers (ICOs) or Unit Cos within their JOA.

e. Assumptions.

(1) No-notice execution of this Appendix may be required.

(2) CDRNORTHCOM will normally have OPCON with the established JTF/RTF commander having control over CDR JEFAC.

(3) The JEFAC's primary focus of effort will be to support affected DOD-affiliated personnel and their families, which for the purposes of this plan are defined as:

(a) DOD service members (active and reserve).

(b) Civilian Employees of the DOD (both civil service and non-appropriated funds (NAF)).

(c) Eligible DOD family members of (1) and (2) above.

(d) Other personnel per the JTF/RTF/CC's direction, such as: service members assigned to National Guard units; members of the Individual Ready Reserve (IRR) and their families. Any broadening of this definition should be according to guidance issues by the Office of the Secretary of Defense (OSD).

(4) The National Guard Bureau (NGB) will work closely with the CDR JEFAC to coordinate support, as necessary, for the State Guard Family Support Group and all affected National Guard personnel and their families. CJEFAC will also work to leverage state National Guard assets to assist DOD personnel and families.

(5) The JEFAC will be the lead organization to coordinate support to affected DOD personnel and their families. JEFAC operations will be independent of and complementary to support being provided by the local and regional government organizations and non-government organizations; however support must be coordinated to reduce redundant efforts and increase the level of support to DOD and National Guard personnel and families.

(6) The Services will provide support personnel and resources to CDR JEFAC to accomplish the mission.

(7) Reserve mobilization will not be authorized. Reserve augmentation according to Service directives will be utilized as required.

(8) Full accounting of affected personnel will be conducted by Service components IAW Refs l and m. Full accounting includes the muster and status (injury, death, etc.) of members and their families, their location, and updated contact information. Data will be made available to the JEFAC by USNORTHCOM/J1 for assessment purposes.

(9) In the event of an outside the continental United States (OCONUS) catastrophic event within USNORTHCOM's AOR, OSD may authorize/order the evacuation of all non-combatants, and the joint plan for DOD non-combatant evacuation and repatriation will be implemented with this plan.

(10) Multiple JEFACs will be employed if the magnitude of the event and/or its geographical breadth so dictate.

(11) JFEC operations may be constrained by "social distancing" and other control measures implemented to mitigate against the effects of Pandemic Influenza.

f. Legal Considerations. This plan to provide services and support to the affected DOD and National Guard personnel and their families is based upon existing statutory and regulatory authorities; however, adjustments to these authorities may be indicated to maximize relief and recovery efforts. Accordingly, any commander who identifies changes to laws, regulations, or policies that might better serve affected DOD and National Guard personnel and families should promptly forward proposals for such changes to CDR JEFAC and USNORTHCOM.

g. Immediate Challenges.

(1) DOD's primary mission will not cease in this environment. Planners will need to remember that other plans and activities may not only be executed within the framework of this plan, but may also be a higher priority than activities associated with CONPLAN 3551 and the associated regional plans.

(2) Due to absentee rates that may be greater than 40%, there may be serious constraints on resources and access to vital infrastructures. There may be limitations placed on services provided to communities (to include water, sewage, communications, sanitation, and emergency services).

(3) Communication infrastructure may impede ability to contact DOD and National Guard members and their families, ascertain their needs, and provide support. The Service components may not be able to contact those in greatest need.

(4) Access to the affected population may be hampered by the extent of the damage in the affected area.

(5) Conducting damage assessment and determining required capabilities may be difficult due to limited support infrastructure (transportation, roads, housing etc.).

(6) Competing priorities with other relief services and organizations over distribution of available resources may delay delivery of essential living requirements such as adequate housing (temporary and permanent), clean water, power, food, and health care.

(7) Affected DOD and National Guard personnel and family members may experience a loss of access to financial accounts and receipt of pay and benefits.

(8) Affected DOD and National Guard personnel and family members may experience severe symptoms of stress before assistance can be provided.

(9) Communications outages will limit the ability of the victims to receive information regarding assistance.

2. Mission. Following a determination by the Secretary of Defense that this plan has moved into Phase III, and upon direction from the CDRUSNORTHCOM or higher authority, the JEFAC will coordinate full-spectrum community service operations in order to facilitate a rapid return to a stable environment for the affected DOD and National Guard personnel and family members.

3. Execution. The JEFAC will be employed to publicize and coordinate all available assistance for all affected DOD and National Guard personnel and their respective family members with the intent to stabilize their lives as soon as possible in the wake of a pandemic event.

a. Concept of Operations.

(1) General.

(a) The JEFAC will provide coordination and advocacy for family assistance services for affected DOD-affiliated personnel and their families. The JEFAC may accomplish its mission concurrently with immediate actions taken by local commanders and/or a JTF/RTF and in coordination with the Services. JEFAC will leverage existing Service components and associated commands' capabilities, coordinate with the National Guard, federal agencies, NGOs, and focus all available resources where needed. The primary focus of the JEFAC is returning all DOD and National Guard personnel and family members to stability and independence, ultimately helping to restore mission readiness of all affected DOD and National Guard units.

(b) The JEFAC will leverage existing internal and external strengths, request required resources, provide crisis action planning, coordinate activities, provide real-time information, monitor execution by supporting commanders and develop transitional plans. Supporting commanders will manage delivery of support.

(c) CDR, JEFAC in coordination with USNORTHCOM J1 develops a joint manning document (JMD) to formalize the structure of the JEFAC.

(2) Employment.

(a) By direction of CDRUSNORTHCOM the JEFAC will be implemented to coordinate the response to DOD and National Guard victims of a catastrophic incident. The JEFAC may be established with or without a JTF/RTF, but will most often be assigned/attached to a responding JTF/RTF commander. CDR JEFAC, with assistance from HQ USNORTHCOM, will conduct staff estimates and, where necessary, coordinate a request for forces (RFF).

(b) The JEFAC may participate in the CDRUSNORTHCOM Command Assessment Element (CAE) to provide situational awareness in the AOR for the JEFAC requirements.

(c) The JEFAC will engage DOD databases administered by the Defense Manpower Data Center (DMDC) to estimate all DOD and National Guard personnel, respective family and civilians possibly affected by the event. In addition, the JEFAC will facilitate the tracking of affected personnel when these personnel are assisted outside their parent Service, for example when an Air Force family receives assistance from the Navy.

(d) The JEFAC will coordinate, to the extent possible, support in the manner of each Service and/or agency represented, but also ensure fair and balanced assistance.

(e) The CDR JEFAC will address any policy or legislative issues that create obstacles.

(3) Deployment. CDR JEFAC and staff will deploy to the designated command headquarters facility when directed. CDR JEFAC should be a pre-designated O-7 or above. CDR JEFAC will deploy advance personnel to the AOR as required.

(a) The JEFAC will consider a deployment location or locations based upon the needs of the victims and access to the location(s). Considerations should include locations of any federal assistance centers, US General Services Administration (GSA) pre-identified facilities, any base support installation (BSI) suggested by USNORTHCOM, and the requirements of any deployed JTF/RTF.

(b) JEFAC support may be deployed in elements, modules, or as a full complement of required services. If ARNORTH is directed to deploy its CAE, then the family support officer (FSO) will provide situational awareness in the AOR until an advance coordinating element can be deployed. The FSO will coordinate with the installation family services and Commander.

(c) The Services may identify personnel to be "deployed in place" in the AOR and to assigned to the JEFAC. Required family assistance capabilities in excess to those that are available in the affected area will be requested via requests for forces (RFFs) submitted by the JEFAC through the JTF/RTF Commander to HQ USNORTHCOM. There is no associated time-phased force and deployment data (TPFDD) for the JEFAC. The CDR, JEFAC, USNORTHCOM J1, HC and associated component elements will develop a JMD to identify JEFAC personnel requirements.

(d) The JEFAC will redeploy after transfer of responsibility for remaining JEFAC issues to an appropriate existing DOD Service or agency. An after-action report will outline suggested improvements to the appendix.

b. Tasks. Unless otherwise indicated, the location for each task will be at the site of the JEFAC(s), and the time will be upon designation of the JEFAC. Note that provision of the specific assistance below will be through Service and National Guard family assistance organizations.

(1) Service Component Installations.

(a) Financial Assistance. Provide affected DOD and National Guard personnel and family members with financial counseling to address event-driven issues and refer members to resources that provide financial assistance, in order to overcome short-term impacts and facilitate financial stability.

(b) Local Transportation. If circumstances and resources allow, provide installation/local transportation for all affected DOD and National Guard personnel and family members in order to meet their immediate healthcare, or subsistence needs.

(c) Clinical Counseling. Make available individual and family counseling to meet the needs of each affected DOD and National Guard personnel and family members, in order to alleviate complex mental health issues caused by traumatic events.

(d) Chaplain Assistance. Coordinate with NORTHCOM Command Chaplain Office to deliver Chaplain Assistance to affected DOD and National Guard personnel and family members, in order to provide comfort, spiritual support, and hope.

(e) Special Needs. Provide special needs assistance including language assistance for DOD and National Guard personnel and family members, in order to support needs assessment and case management.

(f) Transportation Planning. In the event an evacuation is ordered, coordinate transportation planning to onward destination for affected DOD and National Guard personnel and family members.

(2) Personnel Functions.

(a) Needs Assessment. Collect and disseminate DOD and National Guard personnel and family members' needs assessments of all impacted members, in order to ensure that supporting Services can fully address these needs.

(b) Quality of Life. Assess and adjust personnel distribution and Service component support requirements to complement both immediate DOD and National Guard personnel and family members' quality of life (QOL) needs and long-term restoration planning, in order to enhance morale and unit readiness.

(c) Locator Assistance. Provide locator assistance for affected DOD and National Guard personnel and family members, in order to unite all affected families.

(d) Casualty Assistance. Provide assistance to family members of casualties, to ensure that benefits are explained and claims are adjudicated properly.

(3) Medical Function. Assist family members with access to healthcare resources. Identify potential medical treatment facility (MTF) support capabilities in order to support service member's families.

(4) Morturary Affairs. Support fatality management assistance in the collection of antemortem information and DNA samples in order to ensure proper identification of remains, and advise personnel and families as needed regarding the process.

(a) This may fall outside the JEFAC in a pandemic environment.

(b) In this environment, additional personnel resources may be required.

(5) Legal Services. Advise the CDR, JEFAC regarding policy and legislative issues and/or changes that will enhance support to affected DOD and National Guard personnel and family members, in order to more rapidly return them to stability and independence.

(6) Financial Management Functions. Track incremental costs of service component operations while supporting the JEFAC, in order to request appropriations for reimbursement.

(7) Logistics Function. Provide mobility and transportation of supplies and materials that support the JEFAC, as required.

c. Coordinating Instructions.

(1) JEFAC Tasks. CDR, JEFAC will coordinate, through National Guard Bureau, with the National Guard Family Support Group in states affected by or supporting operations conducted concurrently with this plan.

(2) Tasks common to all.

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

(b) Participate in development of a transition plan which will facilitate transfer of responsibility for unresolved affected DOD and National Guard personnel and family member issues to the appropriate service component.

(c) Service components will insure Installation Disaster plans refer to the JEFAC for joint and catastrophic events.

(d) All Service components will track incremental costs associated with support of JEFAC for possible reimbursement.

(e) On order, report all lessons learned to CDR JEFAC.

d. Administration and Logistics. Based on the needs assessment recommendation of affected personnel by the CDR JEFAC and CDRUSNORTHCOM direction, service components will provide all required support for recovery operations.

4. Command and Control. IAW Base Plan and Annex J.

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ANNEX F TO USNORTHCOM CONPLAN 3591-09
PUBLIC AFFAIRS

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z. Annex F to USNORTHCOM CONPLAN 3551-07

1. Situation. See base plan.

a. General.

(1) The threat of future pandemic influenza (PI) has serious national security implications for the United States. Because humans have little or no immunity to a novel virus a pandemic can occur with substantially higher morbidity and mortality rates than seasonal influenza. Three human pandemics occurred in the 20th century, each resulting in illness in approximately 30% of the world population and death in 0.2% to 2% of those infected.

(b)(2)

(2) There are many strains of influenza that could lead to a pandemic. A current avian influenza virus, H5N1, is considered the most likely and most dangerous strain that could lead to a pandemic. Since 2003, a growing number of human H5N1 cases have been reported in Asia, Europe and Africa. More than half of the people infected with the virus have died. Most of those infected have contracted the disease directly from birds. There has been no sustained spread of human-to-human infection from this strain of influenza, though, according to the World Health Organization (WHO) it is only a matter of time before a pandemic occurs from a mutation of this or another strain. Unfortunately, no currently developed H5N1 vaccine can be depended upon to immunize against a mutated strain that might be responsible for a pandemic. A reliable, effective vaccine could take 6 months or longer to develop after a novel virus strain emerges. Once a vaccine is developed, current production capability is limited to 1% per week of total US vaccine required. Furthermore, foreign manufacturers are not expected to support US demand. The spread of this disease is exacerbated by the fact that infected individuals are contagious before showing symptoms of illness.

(3) A pandemic differs from most natural or manmade disasters in nearly every respect. The impact of a severe pandemic is more comparable to a global war than an isolated disaster such as a hurricane, earthquake or an act of terrorism. It will affect all communities. Exact consequences are difficult to predict in advance because the biological characteristics of the virus are not known. Similarly, the role of the federal government in a pandemic response will differ based on the pandemic's morbidity and mortality rates.

(4) (b)(2)

b. Enemy. (See annex B, base plan)

c. Friendly. (See base plan)

d. Assumptions. (See base plan)

(1) A pandemic influenza outbreak will create a high demand for information from our key population, external sources, and the international community.

(2) Upon confirmation of the first cases of sustained human-to-human transmissions, media organizations will run a 24-hour news cycle.

(3) Public Affairs offices will be overwhelmed with media queries regarding DOD support to civil authorities and host nations. These media queries will include information on our operations being conducted by our USG partners, prompting USNORTHCOM to refer these queries to appropriate non-DOD agencies.

(4) Establishment of physical Joint Information Centers (JICs) in the affected area will be extremely limited due to force health protections measures that are implemented to prevent the spread of the disease.

(5) USNORTHCOM will be in support of a primary agency during PI operations.

(6) In the event that a federal interagency Joint Information Center (JIC) is established, USNORTHCOM will provide representatives to that JIC (physical or virtual).

(7) Combat camera resources (as deployed by J-39) will be available to document the USNORTHCOM response (i.e., arrival of first troops, employment of DOD, significant operations, etc.) and provide product in a timely manner to USNORTHCOM PA for review and release to the media.

(8) When directed, USNORTHCOM will conduct Public Affairs operations to contribute to the overall communication goals of DOD and the USG, in order to minimize the spread and effect of PI and to maintain the confidence in the readiness of the US Armed Forces to conduct global operations.

e. Policy.

(1) DOD policy and principles of information remain the foundation for dealing with our audiences. For policy information or clarification, please contact OASD-PA (Policy).

(2) The USNORTHCOM Public Affairs posture for pandemic influenza (PI), when operations relate only to DOD personnel, is active (coordinated with interagency partners as soon as practical). The USNORTHCOM Public Affairs posture for PI, when operations are in support of our interagency partners, is active, only when coordinated,

synchronized and approved by the primary agency. Units supporting PI operations may discuss their specific mission assignments following receipt of deployment orders. Units should refrain from discussing the overall operation (of support efforts) and refer queries to the primary agency or DHHS, as appropriate. USNORTHCOM will issue public affairs guidance (PAG).

(3) All questions regarding PI will be referred to OASD- PA with info copy to US Northern Command (USNORTHCOM) PA.

2. Mission. See base plan

a. When directed by the President or Secretary of Defense, USNORTHCOM will conduct Public Affairs operations within designated operations areas to contribute to the overall communication goals of DOD and the USG in order to minimize the spread and effect of a pandemic influenza (PI) and to maintain the conditions of confidence and readiness in the US Armed Forces to conduct global operations.

b. USNORTHCOM's primary message mission will be to reaffirm confidence in the US Armed Forces ability to maintain the conditions in readiness of the US Armed Forces to conduct global operations. Themes and messages associated with this annex will primarily focus upon conveying to the respective audiences that the USNORTHCOM has the ability to conduct its missions and has adequate resources to respond to current and emerging homeland defense (HD) and civil support (CS) missions.

c. It is likely that first responders may call upon USNORTHCOM since DOD is often best-suited and well-equipped for short-notice deployments. Therefore, it will be crucial to convey constant and consistent messages and information in conjunction with or in coordination with the Department of Health and Human Services (HHS), the Centers for Disease Control (CDC), the Department of State (DOS), and other applicable US Government agencies. Any USNORTHCOM messages concerning supporting non-DOD first responders must be coordinated and synchronized with the appropriate interagency responders for consistency and accuracy of information being conveyed.

3. Execution.

a. Concept of Operations. This plan is designed to provide an overarching communication framework, from which USNORTHCOM and its subordinates can develop detailed PA plans for their specific

audiences and local populations. It is directive in nature, and provides public affairs officers with the common objectives, themes, and constructs to ensure we "speak with once voice" and that our efforts are synchronized across all phases of the CONPLAN.

(1) USNORTHCOM Communication Objectives.

(a) Prepare the internal USNORTHCOM audience for a pandemic, how best to mitigate it if it occurs within USNORTHCOM, and to inform the general public and base communities on how we would react and support other federal agencies in the case of a PI.

(b) Inform the external audience on USNORTHCOM's primary focus, which is to support military operations before, during and after a PI in CONUS and OCONUS.

(c) Implement a comprehensive communication strategy.

(d) Manage expectations and encourage preparation and prevention, not panic.

(e) Inform and educate target audiences on the nature of PI and correlate AI to PI.

(f) Communicate the supporting role of DOD to other agencies in managing a pandemic threat domestically and abroad.

(g) Make personnel aware that each command, installation, and unit has procedures and guidance for what to do in a pandemic.

(2) USNORTHCOM Strategy.

(a) Highlight USNORTHCOM's commitment to preventing the spread of this influenza by working with the World Health Organization (WHO) and other countries.

(b) Engage key military and civilian audiences on the importance of prevention.

(c) Manage expectations. Focus dialogue on USNORTHCOM's primary goal of supporting military operations before, during and after a PI in CONUS and OCONUS.

(3) Public Affairs Themes.

(a) The following general themes are approved "pre-pandemic" use. Public affairs guidance will be developed to support other phases:

1 The primary goal of USNORTHCOM in combating the spread of pandemic influenza in the US military population is to preserve the ability of our servicemen and women to provide for national defense.

2 While there is no current pandemic influenza outbreak, there is still reason to be concerned. We aren't going to wait for a crisis to develop before we take steps to educate and safeguard the American people.

3 Individuals should stay informed about pandemic influenza and prepare as they would for any emergency.

4 Preparing now can limit the effects of a pandemic. Informed public participation and cooperation will be needed for effective public health efforts.

5 The US has been working with the World Health Organization and other countries to strengthen detection of and response to outbreaks.

6 It is unlikely that control measures will prevent pandemic influenza from entering the US, but preparing now can limit the spread and effects of pandemic influenza.

7 Domestically, the Department of Health and Human Services will be the primary agency in charge of responding to a pandemic and DOD would act in a supporting role.

8 While we would support the Primary Agency in the DSCA role, USNORTHCOM must primarily focus on the health and well-being of assigned/attached DOD personnel.

(b) The following themes are approved for addressing the below objectives:

1 OBJECTIVE: Remind audiences that USNORTHCOM is prepared to defend the homeland and assist civil authorities in responding to a pandemic.

a. It would be a mistake to underestimate US military capability to respond to another crisis during a response to a pandemic.

b. USNORTHCOM has adequate resources to respond to current and emerging HD and CS missions.

c. USNORTHCOM is trained and ready to assist in the national response to a pandemic, when requested.

d. USNORTHCOM is prepared to assist the nation's PFA in response to a pandemic.

e. USG partnerships and joint efforts are the cornerstones in limiting the effects of a pandemic.

2. OBJECTIVE: Adversaries informed of continued US military capabilities, and adversaries deterred from exploiting pandemic.

a. It would be a mistake to miscalculate available US military capability during the response to a pandemic.

b. Our cooperative relationship with partner nations enhances the global/regional response to a pandemic.

c. The US military maintains a robust capability that is not obligated overseas.

d. Our military personnel are protected by the best health care available and will be able to defend the homeland and support civil authorities during a pandemic.

e. The US has the ability, and retains the right, to respond with overwhelming force to any attack against the homeland and US interests.

3. OBJECTIVE: Assist USG in preventing widespread panic.

a. During a pandemic, the USG and partner nations will communicate information as soon as it is available.

b. Accurate information sources are available (eg. pandemicflu.gov).

c USNORTHCOM is able to assist in PI prevention, preparedness and mitigation of a pandemic.

d Individuals are the first line of defense and prevention.

e The US is executing its plan to ensure that vital governmental services are provided.

f USG response will improve over time based on experiences and lessons learned.

g USNORTHCOM is engaged in planning with local, state, federal and international partners in response to a possible pandemic.

4 OBJECTIVE: Encourage internal audiences to use good public health measures.

a Individuals are the first line of defense and prevention.

b Local, State and Federal authorities are providing appropriate guidance and direction.

c Everyone has a role in preventing and mitigating risk.

d All peoples in the US, regardless of immigration status, are responsible for taking precautionary measures.

e A rapid, coordinated containment effort will limit the spread.

5 OBJECTIVE: Request that neighboring countries partner in the fight against a Pandemic.

a Cooperation among all neighbors in North America is necessary to effectively respond to a pandemic (e.g., rapidly confirm or refute reports of H5N1 transmission).

b USNORTHCOM is engaged in planning with local, state, federal and international partners in response to a possible pandemic.

c. USG partnerships and joint efforts are the cornerstones in limiting the effects of a pandemic.

d. USNORTHCOM is able to assist partner nations in preventing, preparing for and mitigating a pandemic.

e. A rapid, coordinated containment effort will limit the spread.

b. Tasks.

(1) Release Authority: Release authority will be delegated to the lowest level possible, consistent with published guidance.

(2) Reporting Requirements: Copies of all releases and a summary of media engagements will be provided to USNORTHCOM PA on a daily basis. The JTF(s) (if established) will provide daily situation reports (SITREPS) to USNORTHCOM PA by 1000 Hours Mountain Standard Time (MST) each day. SITREPS will include a summary of PA actions completed and planned for the next 24 hours, a summary of PA personnel deployed, actions of subordinate Task Forces, and any additional messages or talking points. The JTF should also provide clippings of articles published in the preceding 24 hours. If possible, provide transcripts or summaries of broadcast media reports. NIPR E-mail will be the preferred method of communication.

(3) Equipment: Deploying PAOs should be prepared to be self-sufficient. That is, they should deploy with appropriate portable computer equipment, cell phones, satellite phones, and digital photographic equipment (if available). Internet access should be available in all commercial billeting (hotels) and through the Joint Information Center (JIC). Deploying PAOs should be prepared to obtain commercial rental vehicles.

c. Coordinating Instructions.

(1) There will be no initial release of information about any pandemic outbreak, nor response operations by USNORTHCOM PA, until after the initial release is made by White House, DOS, HHS or OSD spokesperson, (or until directed by higher authority.)

(2) If an outbreak occurs, USNORTHCOM PA will play supporting roles, consistent with existing agreements and legal authorities. In this

situation, USNORTHCOM PA communication efforts would support the primary agency.

(3) USNORTHCOM and regional JTF PA information campaigns should include: building awareness of the potential threat specific to their area, encouraging audiences to develop individual preparedness skills (ie: social distancing, personal hygiene, mask use, and other infection control precautions individuals should employ during a pandemic), and communicating our capacity to respond within our own area of responsibility as well as assisting to coordinate response efforts within an international framework.

(4) Pandemic influenza information message maps developed in coordination with other Primary agencies will be used to ensure consistency, minimize anxiety, and promote realistic expectations about the pandemic. Risk communication materials will be current and updated as conditions change and circumstances warrant.

(5) USNORTHCOM shall develop additional materials unique to the AOR; services will tailor these materials for their respective service members.

d. Media Ground Rules.

(1) Release of Cleared Information. Although "information sharing" is key, PAOs must exercise "security at the source," OPSEC will be considered throughout all phases of the operation. USNORTHCOM PA will conduct Security and Policy review when necessary.

(2) Categories of Releasable Information. Each USNORTHCOM subordinate command shall develop a PA plan that is active upon approval by CDR USNORTHCOM that addresses the following issues:

(a) Force Health Protection (FHP) and safety of DOD personnel and resources.

(b) Maintenance of essential functions and services necessary to the mission.

(c) Support to the USG response (and/or DoS overseas) to a pandemic.

(d) Communication between USNORTHCOM and USG, and other DOD elements.

(3) Categories of Information Not Releasable. TBD

4. Administration and Logistics.

a. Arrangements for the Media. Normally, no special arrangements (messing, billeting, medical, transportation, communications, etc.) will be made available through government facilities or at government expense to support the media. However, if media embed with USNORTHCOM forces, they may be afforded the same support provided to USNORTHCOM forces. If required, media will be credentialed by the Joint Information Center (JIC). Except on federal military installations or within National Defense Areas, DOD has no jurisdiction over where the media may go or what they may do. The JIC should establish a media center for the media to gather, file reports, and obtain information including regular media briefings. If the JIC does not establish a media center, USNORTHCOM may establish one.

b. Security of Operations and Personnel

(1) Operations. Media will be granted maximum access to view and photograph response actions. Unless special arrangements are made to sanitize the area, the media will not be allowed access to areas where classified information or operations are apparent. Out of respect for the deceased, the media will not be granted access to scenes that include views of open corpses.

(2) Personnel. (See force protection annex).

c. Operations Security. PA will comply with OPSEC at all times.

d. Audiovisual and Visual Information. The installation PAO is encouraged to use organic assets to document the exercise. Combat camera assets should be considered and requested if necessary. Significant imagery should be forwarded to the Joint Combat Camera Center and USNORTHCOM PA. Imagery will be annotated as "cleared for public release" or "requires review." Still and video imagery produced in support of this operation must be forwarded to the DOD Defense Imagery Management Operations Center (DIMOC) at the earliest opportunity and by the quickest available means, in order to support USNORTHCOM PA and Joint Staff imagery requirements. Questions regarding imagery transmission should be addressed to the USNORTHCOM PA at COMM 719-554-6889 (DSN 692).

e. Internal Information. As news releases and statements are issued to the media, they should also be disseminated to the internal audience. An intranet website or portal should be established, if possible, with a news and information page for the event.

f. Community Relations. Community relations activities will be conducted in coordination with local, state, and federal agencies involved in the operation.

5. Command and Control. No change to current PA lines of communication and IAW PI CONPLAN 3591 (Base Plan).

//Signed//
JAMES W. GRAYBEAL, YC-03
Director of Public Affairs

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13 August 2009

ANNEX K TO USNORTHCOM CONPLAN 3591
COMMAND, CONTROL, COMMUNICATIONS AND COMPUTER SYSTEMS

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APPENDIX 1 TO ANNEX K TO USNORTHCOM CONPLAN 3591
INFORMATION ASSURANCE (IA)

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TBD

TAB A TO APPENDIX 1 TO ANNEX K TO USNORTHCOM CONPLAN 3591
INFORMATION SECURITY (INFOSEC)

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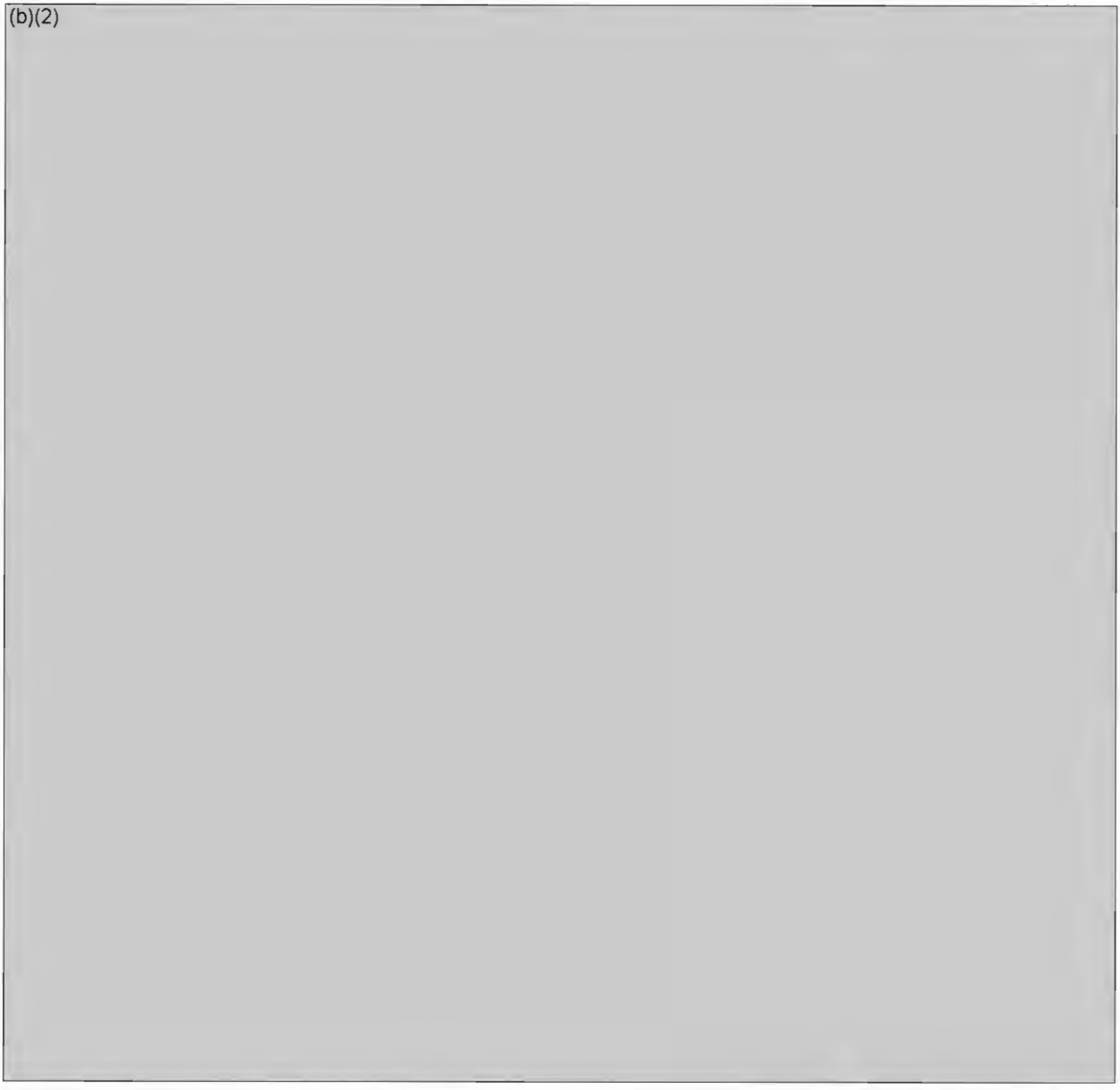

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APPENDIX 2 TO ANNEX K TO USNORTHCOM CONPLAN 3591
SATELLITE COMMUNICATIONS PLANNING

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TAB A TO APPENDIX 2 TO ANNEX K SUPPORTING USNORTHCOM CONPLAN 3591

ULTRA HIGH FREQUENCY SATCOM NETWORK LIST

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TAB B TO APPENDIX 2 TO ANNEX K SUPPORTING USNORTHCOM CONPLAN 3591

SUPER HIGH FREQUENCY SATCOM NETWORK LIST

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TAB C TO APPENDIX 2 TO ANNEX K SUPPORTING USNORTHCOM CONPLAN 3591

EXTREMELY HIGH FREQUENCY (EHF) SATCOM NETWORK LIST

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TAB D TO APPENDIX 2 TO ANNEX K SUPPORTING USNORTHCOM CONPLAN 3591
COMMERCIAL SATCOM NETWORK LIST

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13 August 2009

TAB E TO APPENDIX 2 TO ANNEX K SUPPORTING USNORTHCOM CONPLAN 3591
GLOBAL BROADCAST SERVICE (GBS) NETWORK LIST

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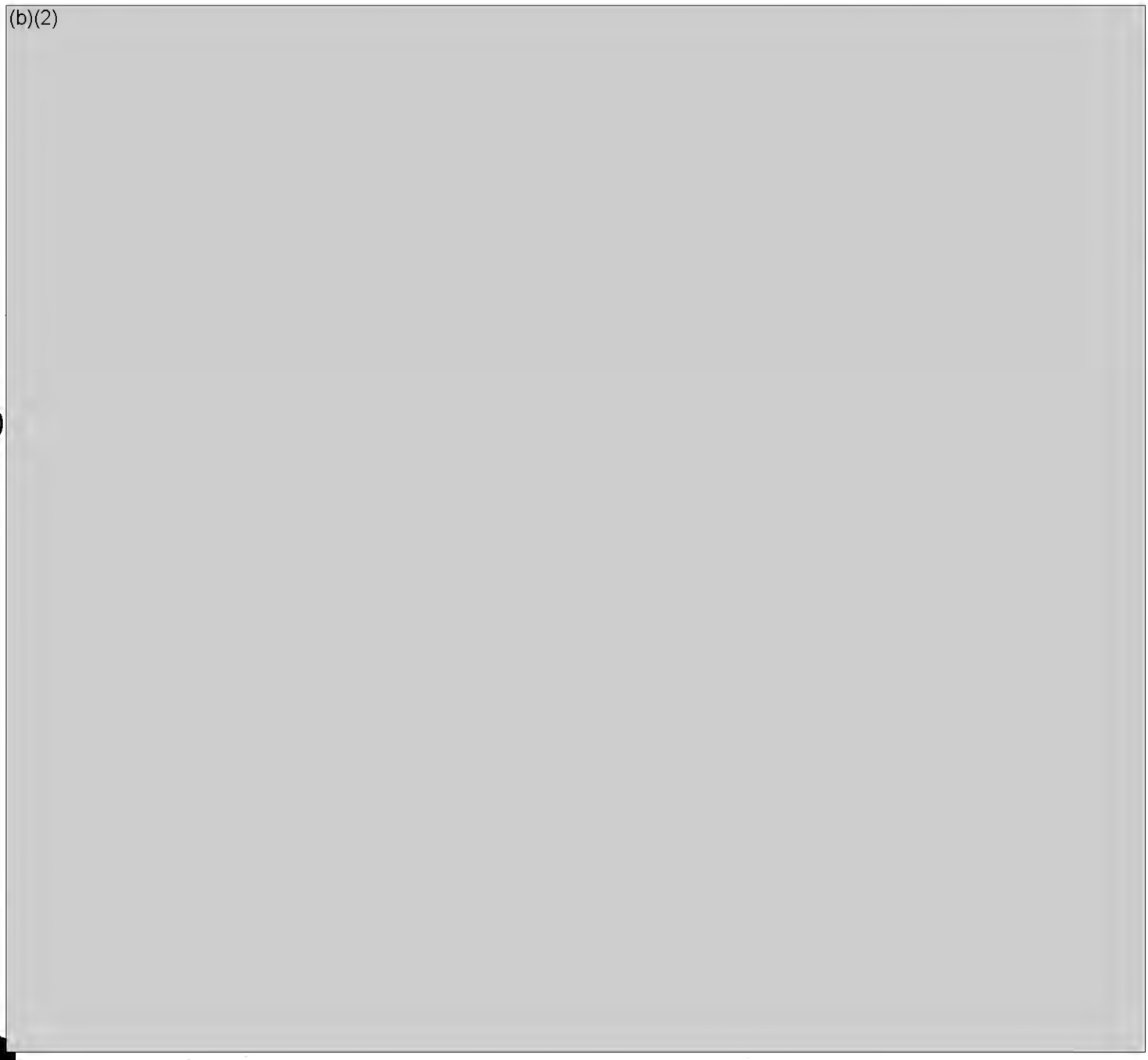

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APPENDIX 3 TO ANNEX K TO NC CONPLAN 3XXX
DEFENSE COURIER SERVICE (DCS)

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APPENDIX 4 TO ANNEX K TO USNORTHCOM CONPLAN 3591
FOREIGN DATA EXCHANGES

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13 August 2009

APPENDIX 5 TO ANNEX K SUPPORTING USNORTHCOM CONPLAN 3591
ELECTROMAGNETIC (EM) SPECTRUM MANAGEMENT

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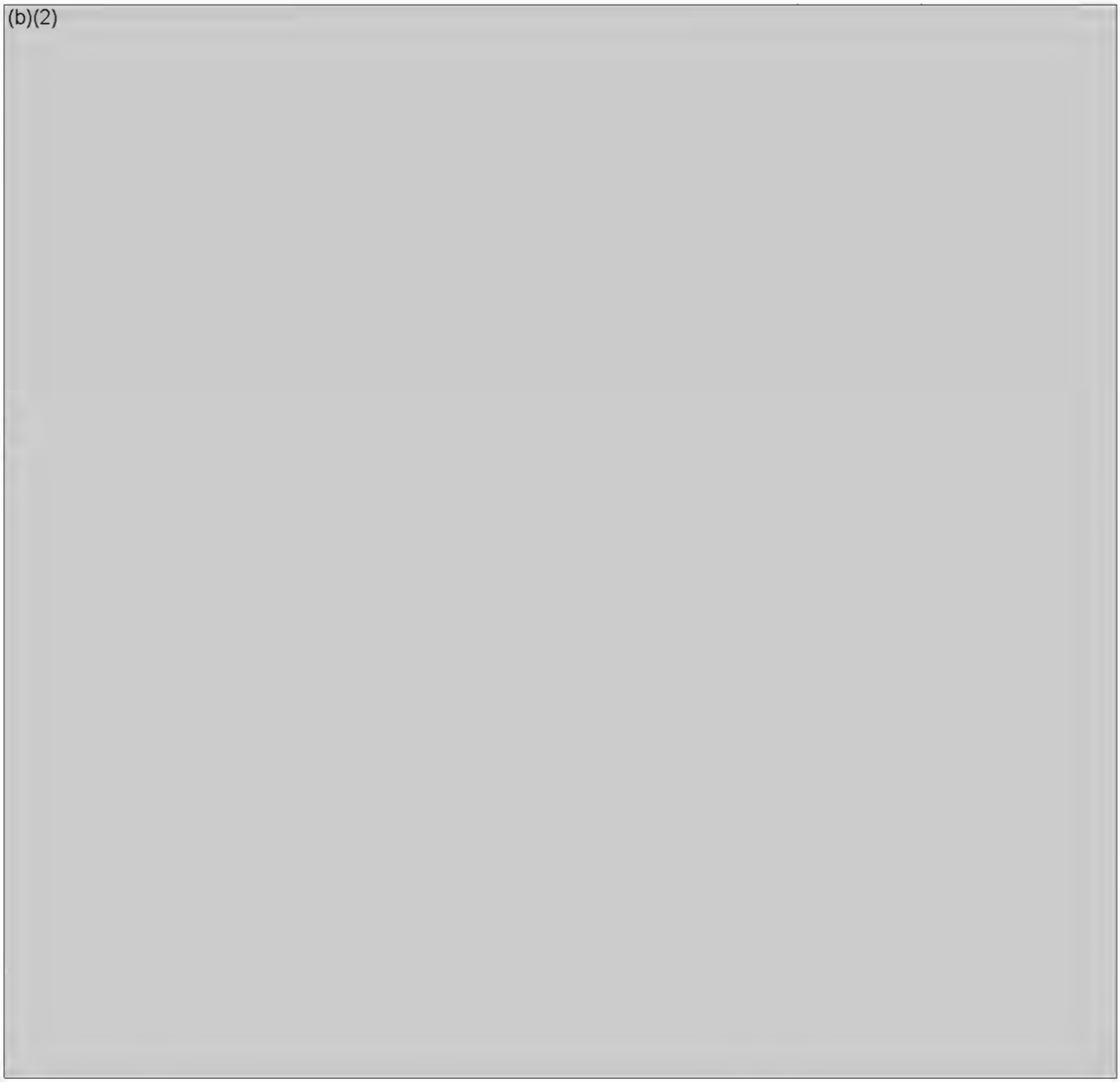

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TAB A TO APPENDIX 5 TO ANNEX K TO USNORTHCOM CONPLAN 3XXX
ELECTROMAGNETIC INTERFERENCE (EMI) REPORTING

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TAB B TO APPENDIX 5 TO ANNEX K TO USNORTHCOM CONPLAN 3591
RJTF JOINT COMMUNICATIONS-ELECTRONICS OPERATING INSTRUCTIONS (JCEOI) CONCEPT

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TAB C TO APPENDIX 5 TO ANNEX K TO USNORTHCOM CONPLAN 3591
NORAD-USNORTHCOM FREQUENCY LIST

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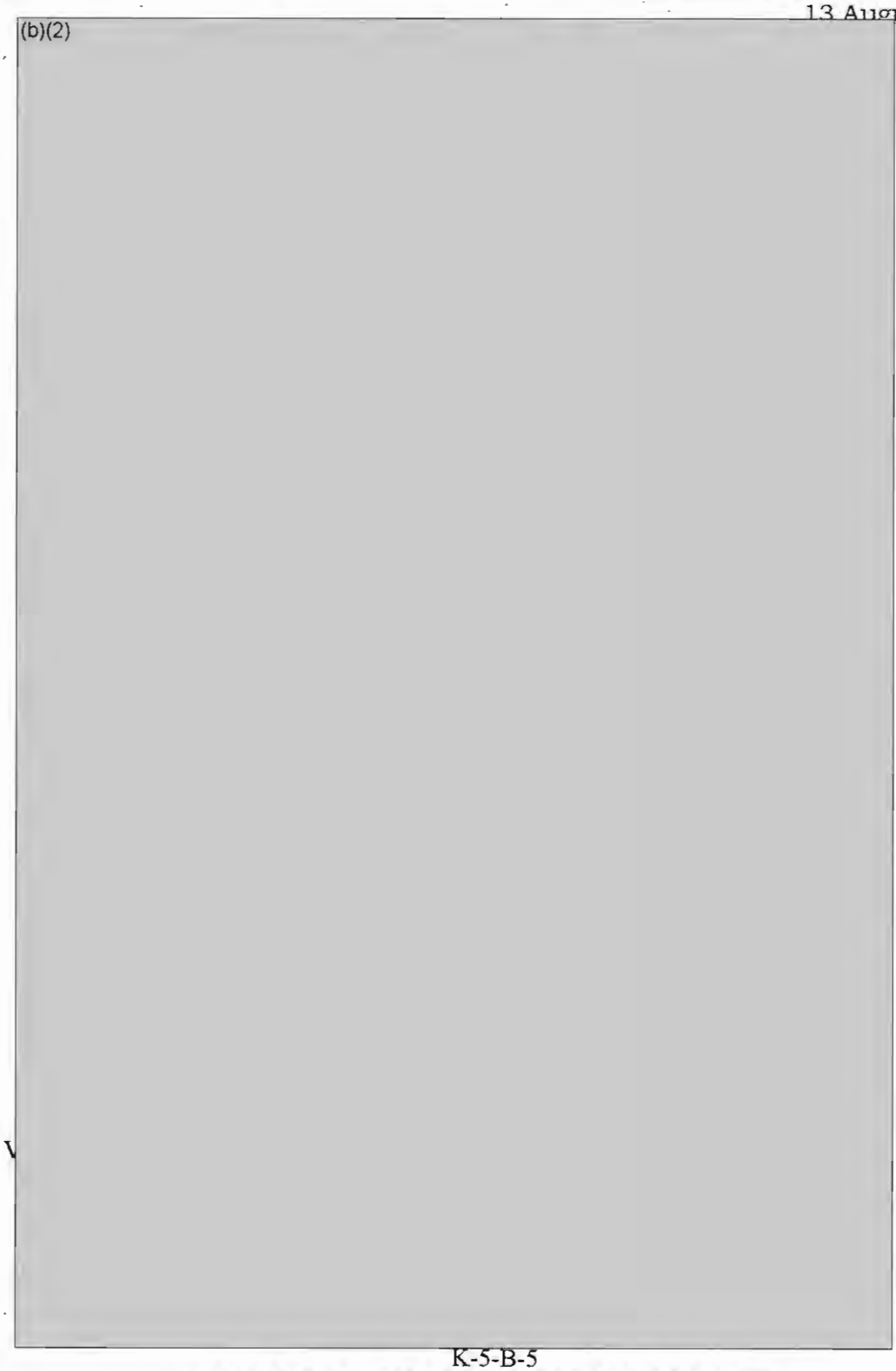

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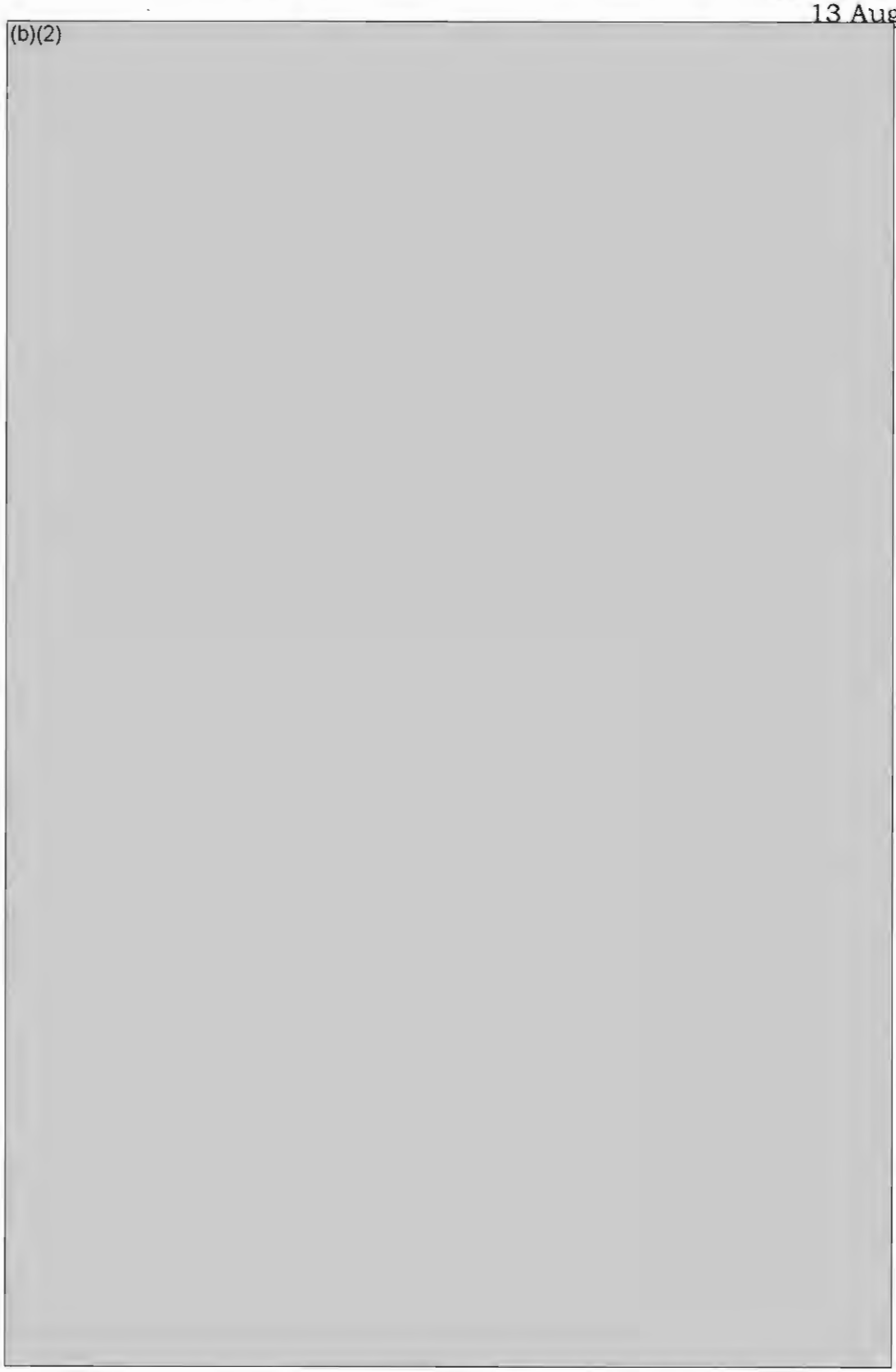

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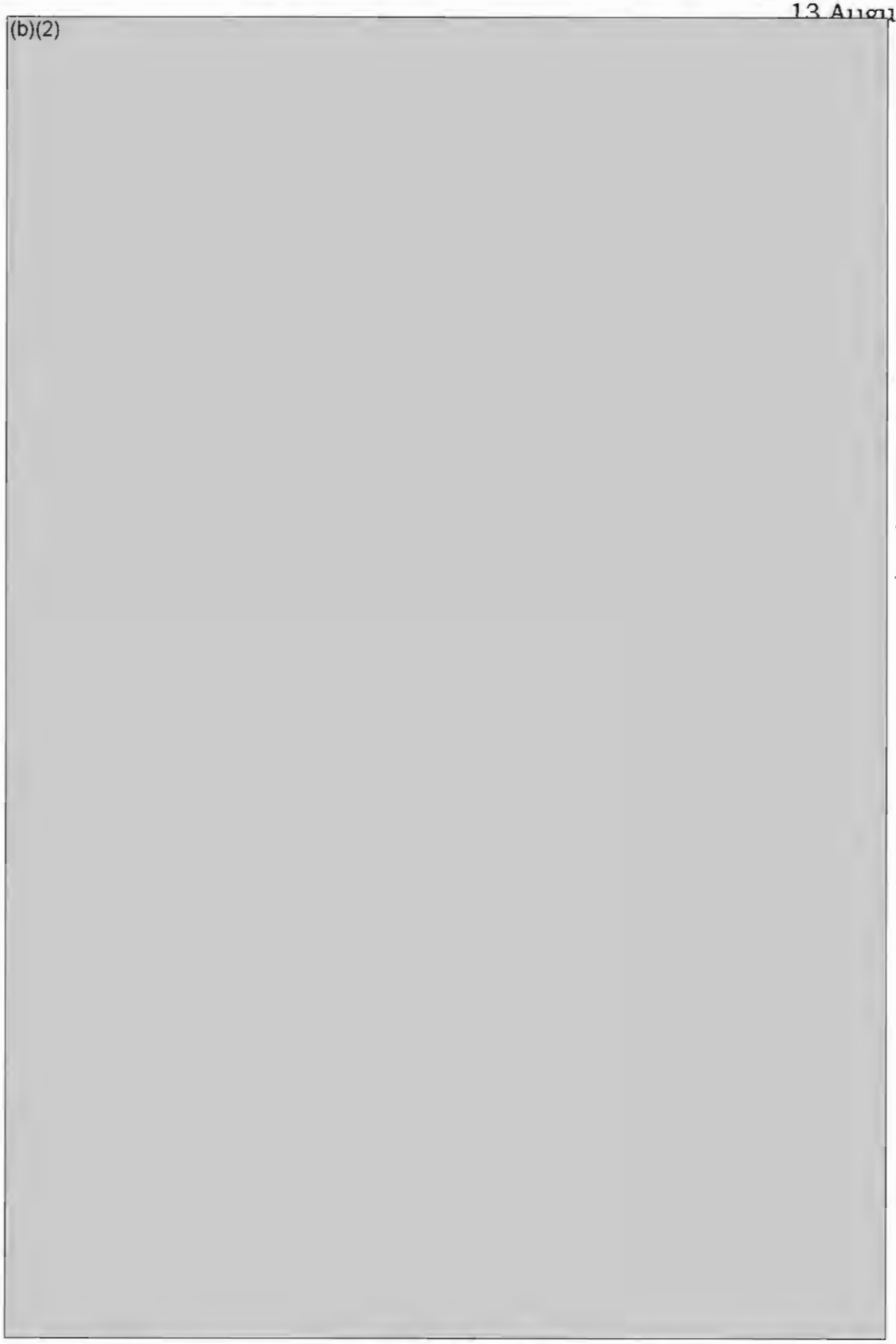

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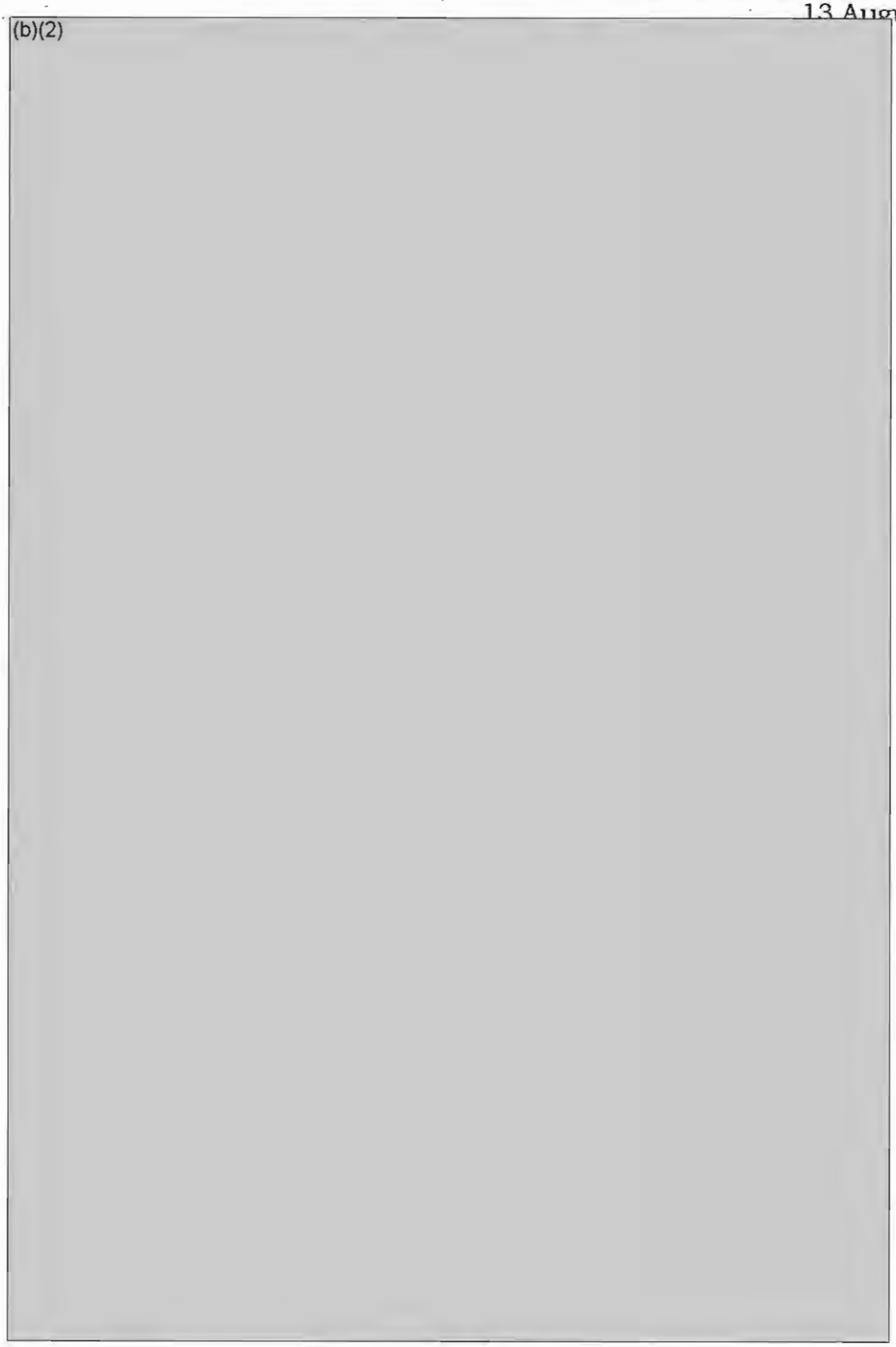

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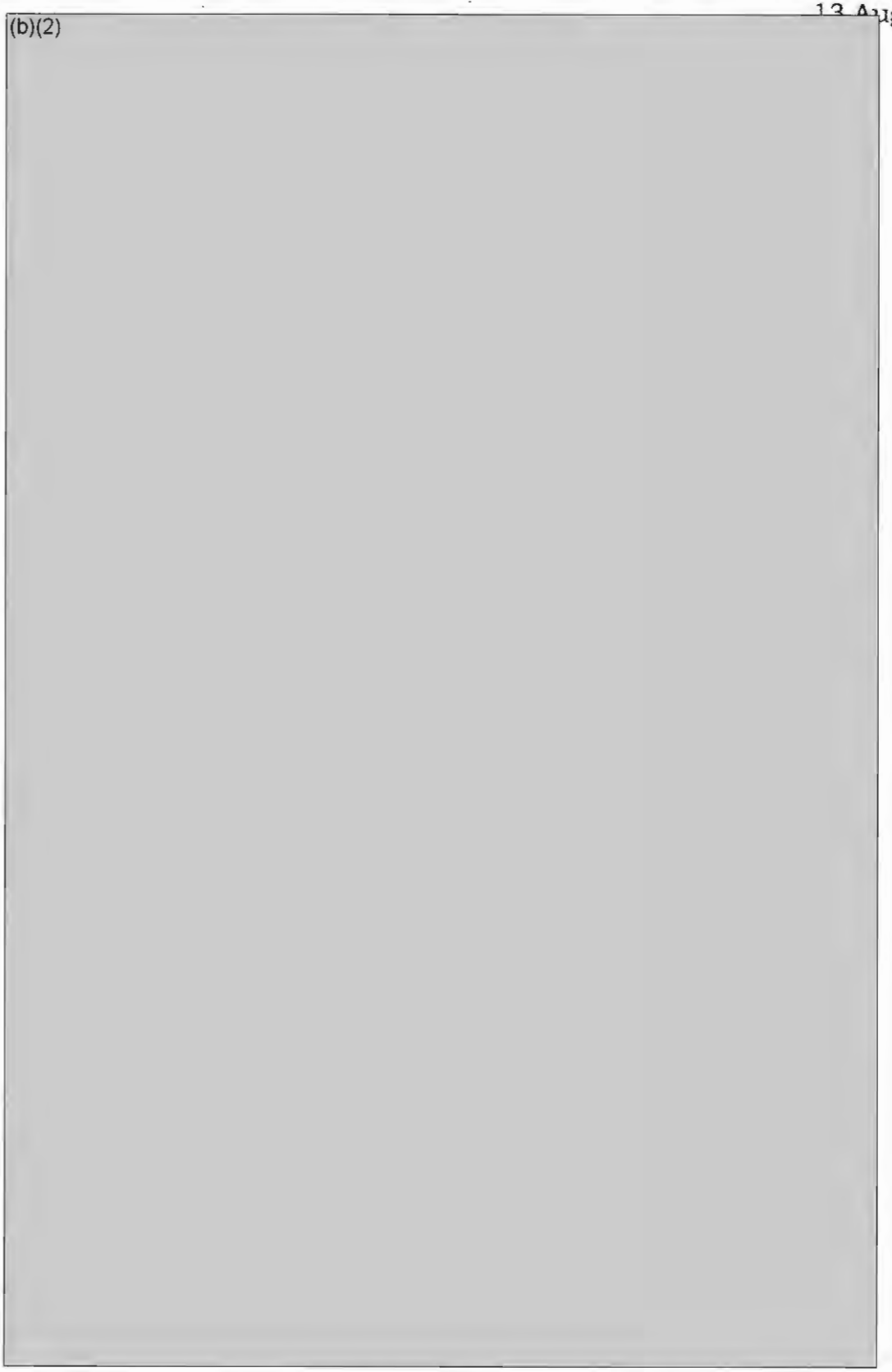

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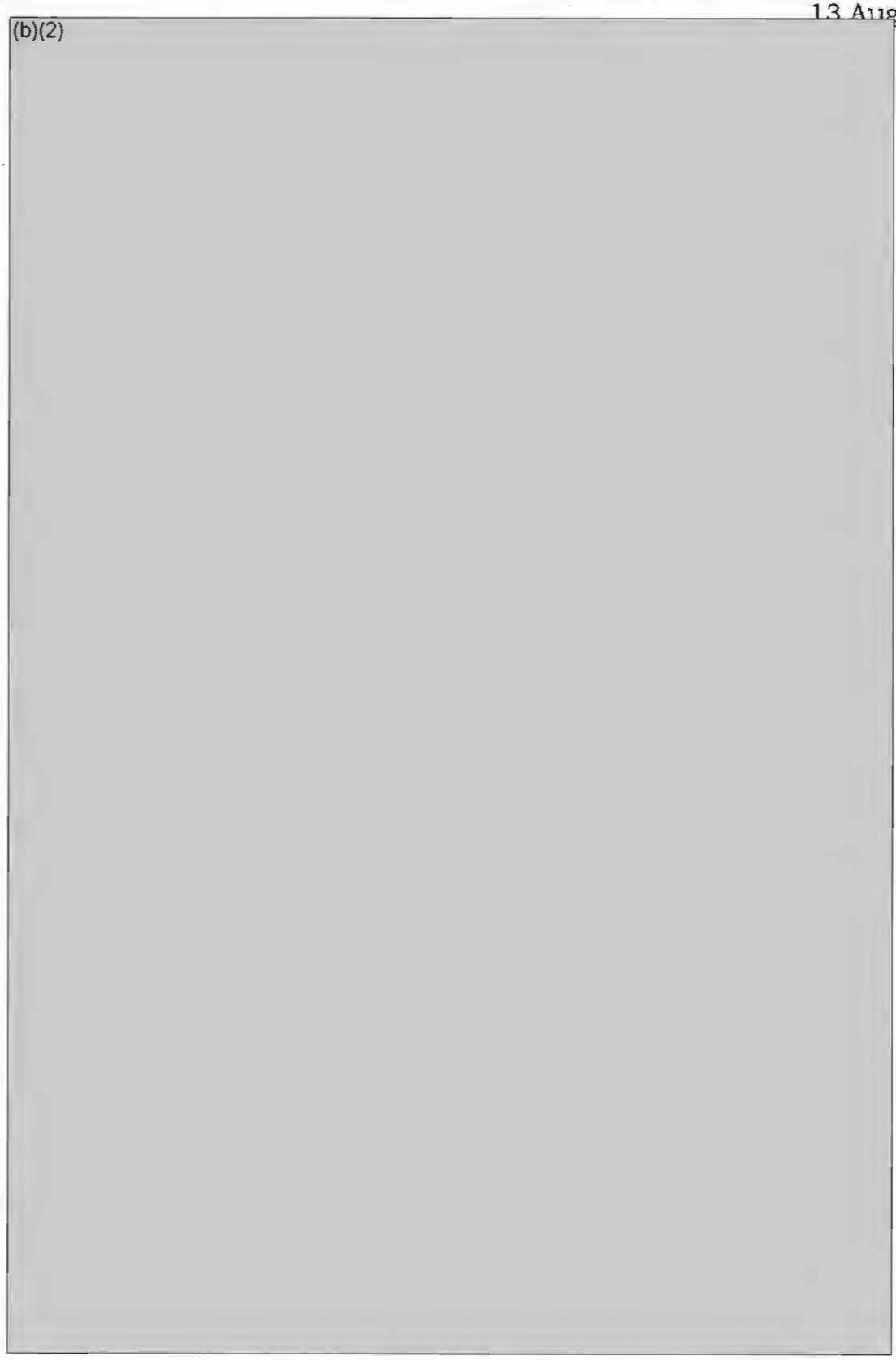

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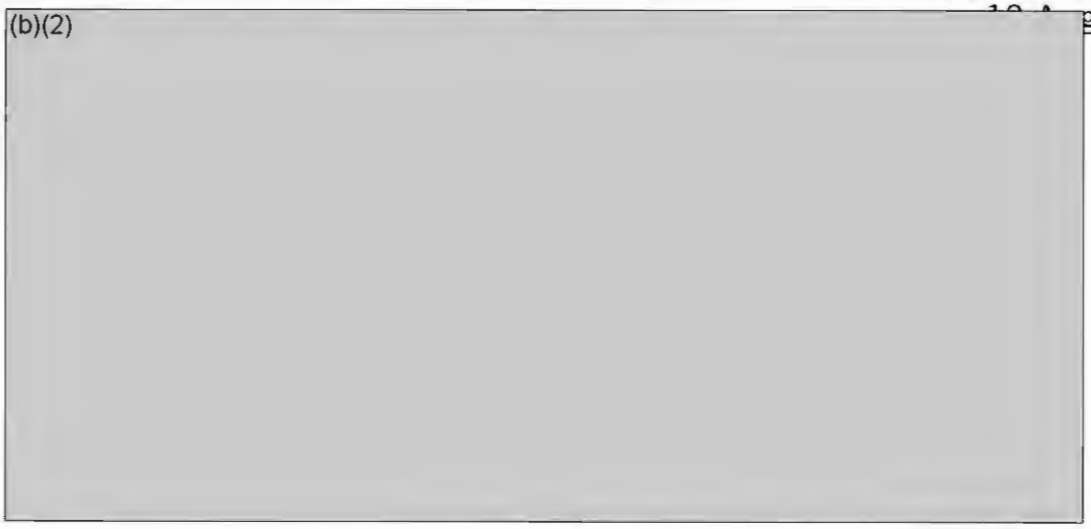

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APPENDIX 6 TO ANNEX K TO USNORTHCOM CONPLAN 3591
C4 PLANNING

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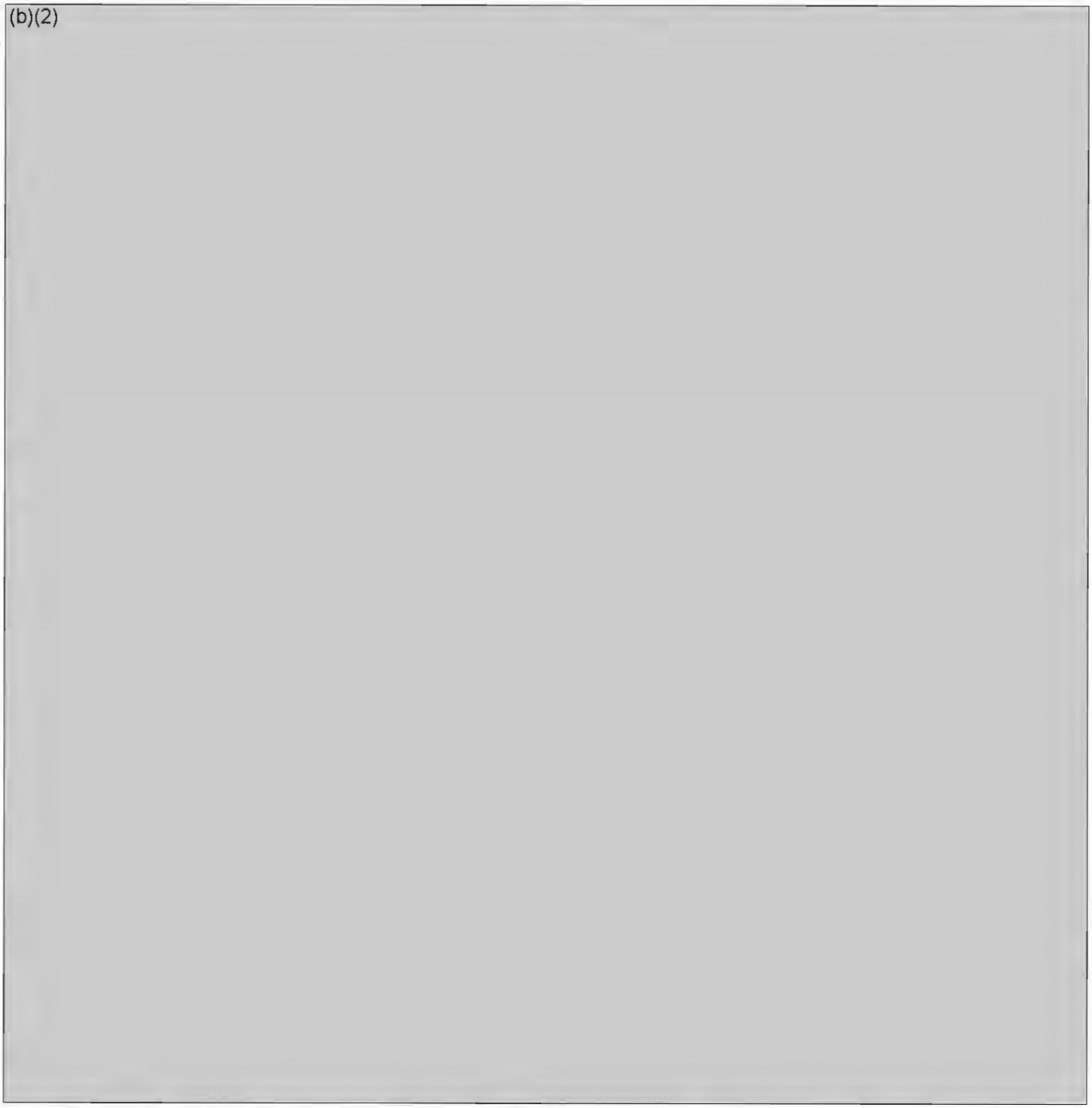

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TAB A TO APPENDIX 6 TO ANNEX K TO USNORTHCOM CONPLAN 3591
KNOWLEDGE MANAGEMENT

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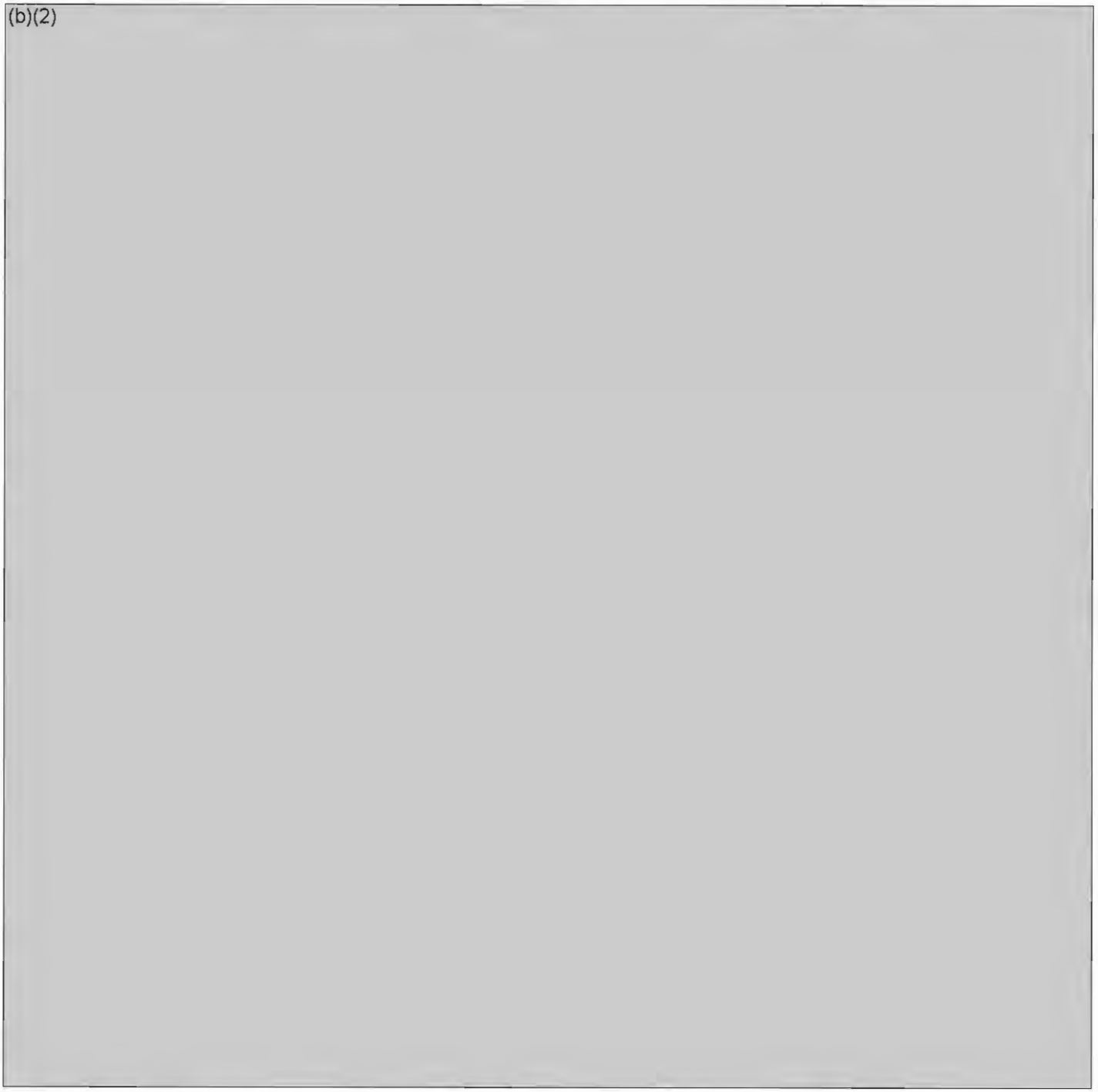

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TAB B TO APPENDIX 6 TO ANNEX K TO USNORTHCOM CONPLAN 3591
INTERAGENCY SUPPORT

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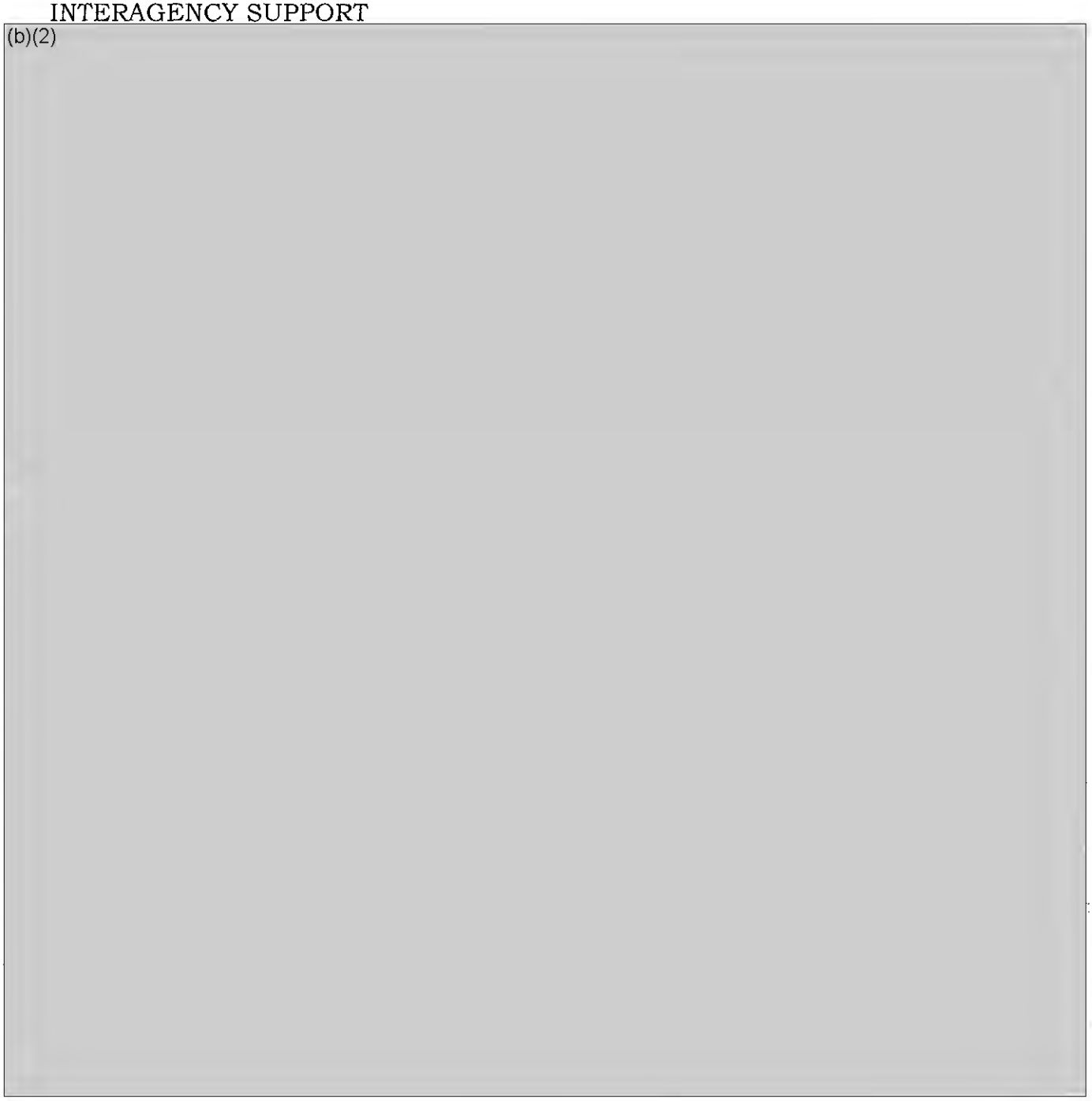

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TAB C TO APPENDIX 6 TO ANNEX K TO USNORTHCOM CONPLAN 3591
NETWORK OPERATIONS (NETOPS)

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TAB D TO APPENDIX 6 TO ANNEX K TO USNORTHCOM CONPLAN 3591
RECOVERY AND RECONSTITUTION

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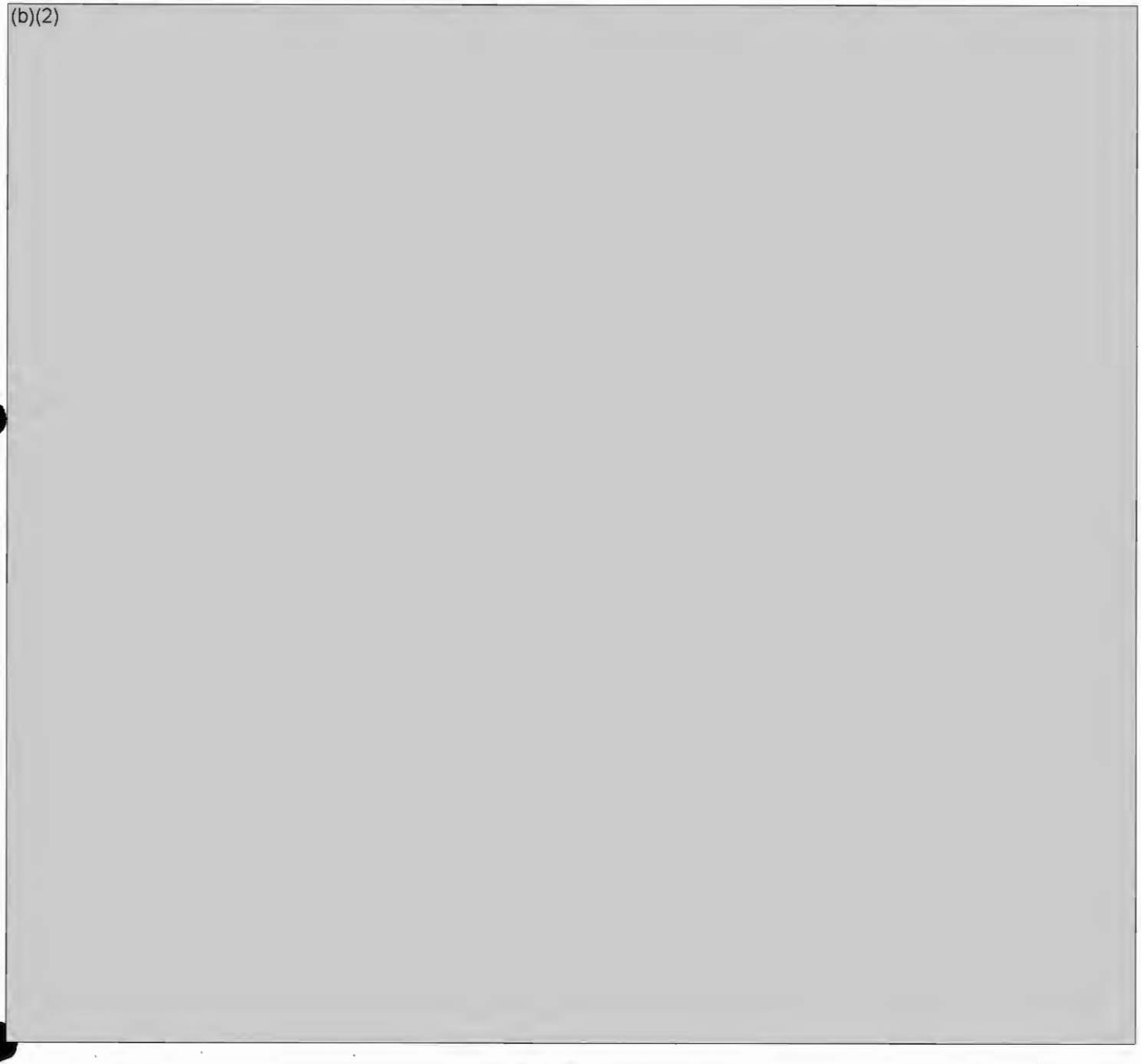
13 August 2009

TAB E TO APPENDIX 6 TO ANNEX K TO USNORTHCOM CONPLAN 3591
THEATER NETOPS CONTROL CENTER (TNCC) NETWORK COMMUNICATIONS REPORTING

(b)(2)



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TAB F TO APPENDIX 6 TO ANNEX K TO USNORTHCOM CONPLAN 3591
COMMON OPERATIONAL PICTURE (COP)

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13 August 2009

ANNEX Q TO USNORTHCOM CONPLAN 3591 FOR PANDEMIC INFLUENZA HEALTH SERVICES

References:

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b. Department of Defense Instruction 6490.2, Comprehensive Medical Surveillance, 21 Oct 2004

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d. Department of Defense Guidance for Pandemic Influenza: Clinical and Public Health Guidelines for the Military Health System, May 2007

e. ASD-(HA) Policy for the Release of Antiviral Stockpile during an influenza pandemic, 10 Aug 2007

f. ASD-(HA) Policy For Department of Defense Pre-Pandemic Influenza Vaccine Policy, 10 Aug 2007

g. Health Service Support Planning Guidance outlined in CJCSI 3110.10 (Logistics Supplement to the Joint Strategic Capabilities Plan)

h. Joint Pub 4-02, Doctrine for Health Service Support in Joint Operations. Current Edition

i. AR 40-12, Quarantine Regulations of the Armed Forces, Jan 1992

j. AFI 10-2604, Disease Containment Planning Guidance, 6 Apr 07

k. WHO Rapid Response and Containment Protocol, 13 Nov 2006

l. Pandemic Influenza: 1918 Lessons Learned, Workshop Report, Defense Threat Reduction Agency (DTRA), 6-7 Apr 2006

m. Mass Medical Care with Scarce Resources: A Community Planning Guide, Agency for Healthcare Research and Quality (accessible at www.ahrq.gov), Feb 2007

n. Department of Health and Human Services (DHHS), HHS Pandemic Influenza Plan, Nov 2004 http://www.hhs.gov/pandemicflu/plan/

o. CJCS Message, DJSM 0972-05, Influenza Pandemic Planning Guidance, 2 Sep 2005

p. DHHS Guidance on Allocating and Targeting Pandemic Influenza Vaccine, Jul 2008, http://www.pandemicflu.gov/vaccine/allocation guidance.pdf

q. Addendum to Policy dated 10 August, 2007 for Release and Use of DOD Antiviral Stockpile During an Influenza Pandemic, 4 Apr 2008

r. ASD-(HA) Policy for Department of Defense Policy for Delivery of Medical Care During Pandemics and Other Public Health Emergencies of National Significance, 1 Sep 2008

s. DepSecDef Memo: Policy Guidance for Provision of Medical Care to Department of Defense Civilians Employees Injured or Wounded While Forward Deployed in Support of Hostilities, 24 Sep 2007

1. Situation. (See Base Plan).

a. Operational Area. Given the geographical boundaries defined in the base plan and defense support to civil authorities (USNORTHCOM CONPLAN 3501), USNORTHCOM must view a pandemic as an environment to operate within, vice just a specific geographic operational area, event, or traditional enemy. USNORTHCOM must be prepared to support international partners and US civil authorities (Federal, State, local, and tribal) in responding to natural and

man-made disasters as well as acts of terrorism in a pandemic environment. The impacts of pandemic influenza (PI) across North America and the world will limit support usually provided by the Federal Government and DOD to Nations, states and communities, especially when balanced with protection of military capabilities through force health protection (FHP) USNORTHCOM must share the fundamental responsibility of defending the homeland from health and environmental threats and simultaneously be prepared to respond when an incident occurs that threatens the health and well being of the Nation.

b. Enemy Forces/Medical Threats.

(1) Threats. Recent avian influenza (AI) cases have raised concern that avian influenza could undergo genetic re-assortment or mutation, and demonstrate sustained and efficient transmission properties from human-to-human, resulting in a global pandemic. A pre-pandemic vaccine for current H5N1 strain exists and will be distributed per Assistant Secretary of Defense (Health Affairs) guidance. A Pandemic specific vaccine does not exist and could take up to 6 months or more, to develop and produce an effective vaccine after the pandemic's emergence. There will be a 30% infection rate and up to 40% absenteeism. Many health care providers will become ill. The increased need for hospitalization and critical care will result in shortages of multiple resources including personnel and equipment. Half of the ill will seek health care. Three percent of the population will require hospitalization and 0.2 – 2% will die. The production of sufficient quantities of vaccine will not occur rapidly enough to reduce the operational impact of PI during the primary outbreak. USNORTHCOM support to civil authorities during an influenza pandemic must be addressed concurrently with the mission to provide for the nation's defense.

(2) Environmental Threat: A feature of the avian virus is its ability to infect a wide range of hosts, including birds and humans. Animals are the most likely reservoir for the avian virus, resulting in the potential to spread to the human population. While a pandemic influenza will not cause physical destruction of critical infrastructure, it will ultimately threaten critical infrastructure operations by removing essential personnel from the workforce for weeks to months. This may have an impact on public health conditions.

(3) Civilian Medical Infrastructure. A pandemic will overwhelm the current civilian healthcare system. The increase in patients requiring hospitalization and critical care will result in shortages of multiple resources including personnel and equipment. This will create a situation so overwhelming that local, state, tribal, and non-military Federal responders cannot manage the situation.

(4) Military Medical Care Infrastructure. (b)(2)

(5) Bioscientific Capabilities and Biothreats. (b)(2)

c. Friendly Forces. See Base Plan.

d. Medical Assumptions.

(1) Efficient and sustained human to human transmission signals an imminent pandemic.

(2) Some persons will become infected but not develop clinically significant symptoms. Asymptomatic or minimally symptomatic individuals can transmit infection and develop immunity to subsequent infection.

(3) While the number of patients seeking medical care cannot be predicted, in previous pandemics about half of those who become ill sought care. With the availability of effective antiviral drugs for treatment, this supposition may be higher in the next pandemic.

(4) Rates of absenteeism will depend on the severity of the pandemic. In a severe pandemic, absenteeism attributable to illness, the need to care for ill family members and fear of infection (b)(2) lower rates of absenteeism during the weeks before and after the peak. Certain public health measures (b)(2) are likely to increase rates of absenteeism.

(5) (b)(2)

(6) The DOD will support DHHS in the national effort by, among other things, conducting medical and laboratory surveillance and diagnostic testing through DOD members of the laboratory response network (LRN), and by participating on the Food and Drug Administration vaccines and related biologic products advisory committee and the Centers for Disease Control (CDC) advisory committee on immunization practices as influenza vaccine recommendations are formulated.

(7) Use of antiviral drugs may reduce the impact on the US population, (b)(2)

(8) There will be an increase demand for antibiotics due to potential increase incidence of viral and bacterial pneumonia.

(9) Shortages in medical staff, medical material, and equipment will (b)(2)

(10) Individuals will require two doses of vaccine for an effective immune response.

(11) Vaccine prioritization will be in accordance with DHHS guidance. Pre-pandemic vaccine, where available, will be administered as the first dose. (b)(2) Use of a pandemic vaccine will require emergency use authorization (EUA) or investigational new drug (IND) exemption.

(12) A pandemic will quickly overwhelm existing laboratory capabilities. The most intense testing will be during the early stages of the pandemic.

(13) (b)(2)

(14) In most instances, it will be best to treat patients with influenza in place. If the patient must be moved, infection control procedures must be utilized. In extreme circumstances there may be a requirement to move index cases for evaluation or critical medical care.

(15) In-flight and shipboard influenza outbreaks will spread rapidly.

(b)(2)

(16) Containment in the early phases of the pandemic will limit, slow or stop the spread of a novel human to human transmissible influenza virus.

(17) Effective pharmaceutical and non-pharmaceutical interventions (NPI) will lower the attack rate and peak of the epidemic.

(18)

(b)(2)

(19) Once past the containment phase, the efficacy of quarantine and isolation efforts will be limited by the resources required to maintain effective isolation and quarantine and the spreading of virus by minimally ill or asymptomatic cases.

(20) The efficacy of quarantine and isolation efforts will be limited by the fact that a small percentage of those infected will never develop signs or symptoms but will still be infectious.

e. Limitations.

(b)(2)

(2) PI virus (transmissibility/morbidity/mortality) cannot be accurately defined or predicted during planning and will require real time guidance as the pandemic progresses.

(3) Timetables for vaccine EUA or IND rulings by the Food and Drug Administration (FDA) are uncertain.

(4) The Assistant Secretary of Defense Health Affairs (ASD[HA]) is the DOD anti-viral release authority. DOD stockpiles will be released IAW their

existing guidance.

2. Mission. See base plan. CDRUSNORTHCOM provides health service support (HSS) to military forces and other designated personnel in support of this CONPLAN to provide force health protection to protect assigned forces from injury, illness, and health hazards and to render responsive casualty treatment through all taxonomies of care.

3. Execution.

a. Concept of Operations. USNORTHCOM will maintain joint HSS readiness and respond to crisis operations across the USNORTHCOM AOR in order to save lives, prevent suffering, and minimize disease and illness within a pandemic environment. The USNORTHCOM Surgeon will coordinate actions through the refinement of plans, conduct training and exercises, improve the common operating picture (COP), conduct surveillance, shape policy and legislation, and refine response concepts in coordination with joint HSS agencies to improve efficiency and effectiveness in response to pandemic.

(1) Transition. While no direct Federal assistance is authorized prior to a Presidential declaration, under the Stafford Act (ref E-4-22), when an incident poses a threat to life and property that cannot be dealt with effectively by State and local governments, FEMA may request DOD to use its resources prior to a declaration to perform any emergency work "essential for the preservation of life and property". IAW DOD Directive 3025.1, *DOD Manual for Civil Emergencies*, when time does not allow the commander or installation to obtain prior approval from higher HQ, and in response to a direct request from a civil authority, the installations may respond." Within hours, immediate response reporting is required to higher authorities. Timely information flow will be key to all support planning efforts.

(2) Responsibility and Command Relationships.

(a) DHHS provides the primary Federal-level medical response elements. These elements include: Incident Response Coordinating Teams (IRCT) and National Disaster Medical System (NDMS). DOD medical capabilities may be requested to augment and/or sustain DHHS medical elements and local community medical assets in order to save lives, minimize human suffering and reduce the spread and impact of the PI virus. DOD as the primary Federal-level patient evacuation response element will perform patient evacuation in support of civil authorities. (b)(2)

(b)(2) may need to be addressed in mission planning.

(b) Medical support from DOD will be coordinated through CDRUSNORTHCOM, through the CDR, JFLCC, to CDRJTF through the defense coordinating officer (DCO). The RJTF will coordinate directly DOD medical actions with their corresponding FEMA Regional PI joint field office (JFO) ESF#8 section. The JFLCC will coordinate medical actions with the DHHS secretary operations center/NDMS operations support center (DHHS SOC/NDMS OSC).

(c) Immediate response authority is limited by US law and DOD directives. Medical commanders should fully understand the parameters outlined in US Code, Title 10 and applicable DOD directives before providing immediate response medical assistance.

(d) During all phases of support, DOD medical forces will remain under the command and control of US military commanders but will support DHHS as outlined above.

(3) Hospitalization. Hospitalization in a PI environment will require an expansion of health care capabilities to include minimal care beds and intensive care beds. Health and human services expansion may require the use of non-medical treatment type facilities such as gyms, barracks, etc. The Secretary of Defense (SecDef) may order an expansion and/or activation of all CONUS-fixed hospitals requested by DHHS as rapidly as possible to care for casualties. Although HSS is a Service Component responsibility, DOD healthcare facilities will serve as joint assets to maximize availability of hospital beds and services. Joint staffing of facilities as a prerequisite to joint use is not required; however, joint augmentation may be directed. These facilities will treat all authorized beneficiaries. (See Appendix 3, Hospitalization.)

(4) Patient Movement. Each component commander is authorized to regulate patients among their organizations. Ground transport is the preferred means of evacuation. Patients with known or suspected to be infected with highly contagious diseases such as initial cases of a new type of influenza that has the potential to cause a pandemic should be treated "in place" or with minimal transportation to medical authorities. (See Appendix I, Joint Patient Movement, for evacuation of infected patients via DOD aircraft.) Patient evacuation within the AOR will be regulated by the Global Patient Movement Requirements Center (GPMRC), Scott AFB, IL under US Transportation

Command which will serve as the Theater Patient Movement Requirement Center. (See Appendix 1, Joint Patient Movement)

(5) Other Health Services Support.

(a) When directed, HSS will be provided to affected civilians as part of civil support operations when the State and local medical infrastructures are insufficient to support its population and no other alternatives are available in order to relieve pain and suffering.

(b) DOD civilians who are deployed with US Forces in the operational area (OA) are eligible for treatment (see reference s).

(c) DOD contractors who are deployed in support of US Forces are only eligible for emergency care (life, limb, eyesight or undue suffering) unless it is specified differently in their contract.

(d) Members of the Public Health Service are eligible for care.

(e) Medical treatment facilities will potentially be overwhelmed by DOD patients and beneficiaries. Treatment may be prioritized in the following order: active duty, TRICARE Prime enrolled dependents of active duty, TRICARE Prime enrolled retirees and their dependents, all other beneficiaries. Key and essential DOD civilians and contractors may also be authorized treatment.

(6) Joint Blood Program. The USNORTHCOM's Surgeon's office will establish a Joint Blood Program Office (JBPO) as required. (See Appendix 2 Joint Blood Program.)

(7) Force Health Protection. Commanders will institute FHP activities and health surveillance programs to prevent Disease Non-Battle Injury (DNBI). These programs are integral to pre-deployment, deployment, and post-deployment operations. Commanders should include FHP personnel in the initial deployment planning stages to estimate the health and environmental threats and provide countermeasures and training. (See Appendix 6 Force Health Protection)

(8) Theater Evacuation. The CONUS evacuation policy is up to 60 days; however, the evacuation policy for pandemic operations may need to be tailored to the situation and cannot be pre-determined.

(9) Dental Services. Dental care for US military forces will be limited to treatment necessary to relieve suffering and alleviate impairment of an individual's ability to adequately perform assigned missions. Routine dental service support will be limited. Dental personnel will be used throughout the OA in a medical treatment and care role, supporting DOD and, upon, request, civilians, IAW the Services' current doctrine.

(10) Veterinary Services. (See Appendix 12 Veterinary Support.)

(11) Preventive Medicine. Preventive Medicine elements will deploy to the OA early in the deployment in order to assess the threat to the RJTFs, establish required surveillance systems to monitor disease outbreaks among the force, and work with State and local official if requested.

(12) Mortuary Affairs. DOD medical personnel will provide medical support to mortuary affairs operations in accordance with Annex D.

b. Lines of Effort. To support the strategic objectives (see base plan) the CDR USNORTHCOM has identified two main lines of effort: Conduct mission assignments and Support to US Government (USG), and eight supporting lines of effort. HSS activities will be synchronized in support of these:

(1) Slowing the PI Spread. Conduct operations to manage or slow the spread of pandemic influenza into or within CONUS.

(a) Support sequestration, quarantine, and isolation operations during a PI event.

(b) Support medical screening.

(c) Support nation-wide medical countermeasures efforts to mitigate a Pandemic.

(2) Support Public Health Care. As directed, and within capabilities, provide support to the public health care system in order to expand the nation's health care capacity, provide treatment to persons who have contracted pandemic influenza, and diminish unhealthy conditions within communities.

(a) Establish and sustain alternate care facilities.

(b) Support medical countermeasures programs.

(c) Transport and secure critical medical supplies.

(d) Supplement health and medical services.

(e) Support national disease / casualty tracking systems.

(f) Support eradication of infected avian populations.

(g) Supplement public services providing water and sanitation.

(h) Provide physical security to medical facilities.

(i) Support occupational and environmental health assessments / surveys to include risk assessments (e.g. conduct health surveillance in AI cullers, conduct hospital surveys for infection control practices).

(b)(2)

(a) Provide HSS to civilian agencies (technical assistance, medical logistics, evacuation, etc.).

(b) Provide HSS assets to support mandatory quarantine operations.

(c) Provide support to ensure HSS personnel are protected, that the delivery of essential HSS goods and services are maintained, and that medical sector remains functional despite significant and sustained worker absenteeism.

(4) Support Public Information Efforts. Support the efforts of local, state, tribal, and federal agencies to inform the American public. Develop and disseminate public health warnings and announcements using appropriate risk communication and coordination procedures to provide FHP information to DOD beneficiaries and workforce within the area of responsibility (AOR).

(5) Governmental Functions. Protect critical governmental functions at the local, state, tribal, and federal level to ensure the sustainment of essential government services to the populace.

(a) Support the medical infrastructure in order to maintain continuity of operations (COOP) / continuity of government (COG) operations.

(b) Support local/state governments and utilities to ensure uninterrupted flow of essential services (i.e. water, sanitation, food supplies, medical supplies, evacuation, etc).

(6) Force Health Protection: move paragraph to "A" position

(a) Implementation of the USNORTHCOM immunization and prophylaxis strategy.

(b) Provide force health care and implement enhanced FHP measures and education.

(c) Sequestration/Isolation/Quarantine of deploying/redeploying forces in support of NORTHCOM Operations.

(7) Foreign Humanitarian Assistance/Disaster Relief. As directed, and within capability, provide aid to allies/partner nations.

c. CONPLAN Phasing. See base plan.

(1) Shape Phase (0): This phase occurs in an inter-pandemic period and is a continuous phase incorporating adaptive planning, routine surveillance and engagement activities to assure and solidify collaborative relationships, shape perceptions, and influence behavior in order to be prepared for a new influenza viral subtype.

(a) Develop and/or acquire educational materials on AI/PI to disseminate to assigned or apportioned forces and their beneficiaries.

(b) Support ESF#8 Medical interagency planning and coordination.

(2) Prevent Phase (1): This phase begins upon receipt of information of human infection(s) with a novel viral sub-type but no human-to-human spread. Success in this phase is to identify a new influenza viral subtype, and limit the spread of the virus geographically and within populations. Actions taken during this phase include plan development, coordination, exercises, and rehearsals. Primary objectives include:

(a) Conduct internal training and exercises.

(b) Coordinate with, rehearse and conduct training and exercises with DOD and interagency partners.

(c) Identify pre-deployment medical requirements for USNORTHCOM PI operations.

(d) Develop, coordinate and communicate FHP guidance.

(e) USNORTHCOM Medical Operations Center (MOC) will monitor epidemiological surveillance from National Center for Medical Intelligence (NCMI), Centers for Disease Control and Prevention (CDC), and WHO.

(f) Develop further AOR specific-guidance based on ASD (HA) guidelines for allocating scarce medical resources during a pandemic.

(g) Work to ensure clear, effective and coordinated risk communication before, during, and following a pandemic. (See Appendix 10 to Annex E).

(h) Assist USNORTHCOM director of operations in identifying select critical and critical forces for the purpose of distributing antiviral medications and pandemic vaccines.

(i) Exercise mechanisms to access or provide active and passive surveillance within the USNORTHCOM AOR during a PI event.

(3) Contain Phase (2): This phase begins with sustained human to human transmission of a novel influenza virus in small clusters with localized spread. The RJTFs will stand up to develop situational awareness and connectivity. During this phase USNORTHCOM components will take measures to protect the USNORTHCOM population in the localized region(s) while maintaining the freedom of action to conduct assigned missions. Decisive to this phase is CDRUSNORTHCOM's and Command Surgeon's ability to access health surveillance information to achieve situational awareness and the initiation of HSS reporting. Success for Phase 2 is establishment of medical interagency and intergovernmental synchronization, ongoing public health advisories updated and expanded to meet DOD and public needs, and FHP measures are expanded to meet requirements. As directed, USNORTHCOM components will support USG efforts to contain the pandemic and gain time for implementation of additional pandemic reduction measures. Primary objectives include:

(a) USNORTHCOM Command Surgeon will focus the MOC on accessing health surveillance information to achieve situational awareness and the initiation of HSS reporting.

(b) Identify HSS requirements.

(c) Implement pre-deployment medical screening measures.

(d) Implement, expand and verify the health surveillance system capabilities.

(e) Prepare to receive, store and issue Class VIII medical supplies and equipment for assigned units and personnel.

(f) Identify and ensure the laboratories in support of the LRN are operational and assess their analytical capacity.

(g) Expand interagency/intergovernmental medical coordination.

(h) Support dissemination of public health information.

(i) Coordinate with other combatant commands and Service Chief's staffs to consider expanding FHP measures and force health care conditions as warranted.

(j) Implement isolation/quarantine measures as appropriate.

(k) Implement social distancing measures as appropriate.

(l) In concert with USNORTHCOM Judge Advocate, identify and coordinate medical credentialing requirements as required and as necessary.

(4) Interdiction Phase (3): This phase begins with case(s) in North America or when indications and warnings identify large clusters of human-to-human transmission. Medical forces deploy to slow the spread of PI to prevent an un-remediated outbreak throughout the AOR. Decisive to this phase is USNORTHCOM's ability to identify the outbreak before it becomes unmanageable. Success is defined by slowing the spread of the pandemic and deployed HSS forces are positioned and operational to support phase 4. Primary objectives include:

(a) Deploy HSS assets.

(b) Support JRSOI process.

(c) Disseminate updated FHP measures.

(e) Support medical screening and quarantine operations at ports of entry.

(f) Support medical screening, vaccination and distribution of prophylaxis.

(g) Support quarantine/cordon sanitaire. Assist in isolation of infected persons.

(h) Validate requests for the distribution of critical medical resources.

(i) Support public health risk communication and awareness efforts.

(j) Support eradication of infected avian populations.

(k) Support casualty tracking systems.

(5) Stabilize Phase (4): This phase begins upon receipt of information the pandemic is spreading globally signaling a failure of containment or when state and Local resources are overwhelmed and the request for federal assistance is made. The objective of this phase is to rapidly expand health care capacity and medical services to minimize human suffering and to continue to support USG in mitigating the effects of the pandemic on the US population. This phase ends upon decrease of case incidence, indicating the slow of the pandemic wave and a re-establishment of government functions without the support of USNORTHCOM assets. Primary objectives include:

(a) Deploy additional HSS assets.

(b) Support expansion of public vaccination efforts.

(c) Support COOP/COG.

(d) Collect and analyze data through medical surveillance and laboratory systems. Continue on-going medical situational awareness.

(e) Continue risk communication activities.

(f) Continue to collaborate federal partners to identify additional HSS requirements.

(g) Communicate with key health and medical agencies / organizations and neighboring jurisdictions.

(6) Recover Phase (5). Phase 5 begins with receipt of information that the incidence of cases is decreasing, indicating the slowing of the pandemic wave and local, state and federal agencies are capable of assuming DOD support functions with civil control and no degradation of operations. Success of this phase is the transfer of HSS assets to their home station. The phase ends when response forces complete redeployment and control is transferred to their respective commanders.

(a) Prepare for subsequent pandemic waves.

(b) Coordinate post-deployment medical screening measures.

d. Tasks.

(1) Army North (ARNORTH)

(a) Develop and maintain a supporting plan to the USNORTHCOM Pandemic Influenza CONPLAN (Annex Q).

(b) BPT coordinate FHP measures and implementing instructions with service headquarters between military installations and deployed forces in USNORTHCOM designated OA.

(c) BPT serve as JTF Surgeon to oversee / conduct HSS operations for regional JTFs.

(d) BPT deploy a medical representative to the CMD Assessment Element (CAE) to provide incident awareness and early identification of potential requirements.

(e) Assist in developing time-phased force and deployment data (TPFDD) for deployable HSS elements.

(2) Air Force North (AFNORTH).

(a) Develop and maintain a supporting plan to the USNORTHCOM Pandemic Influenza CONPLAN (Annex Q).

(b) BPT coordinate FHP measures and implementing instructions with service headquarters between military installations and deployed forces in USNORTHCOM designated OA.

(c) BPT augment the JFLCC and RJTF staffs conducting PI operations in the USNORTHCOM OA.

(d) Assist in developing TPFDD for deployable HSS elements.

(3) Marine Forces North (MARFORNORTH).

(a) Develop and maintain a supporting plan to the USNORTHCOM Pandemic Influenza CONPLAN (Annex Q).

(b) BPT coordinate FHP measures and implementing instructions with service headquarters between military installations and deployed forces in USNORTHCOM designated OA.

(c) Assist in developing TPFDD for deployable HSS elements.

(4) U.S Fleet Forces Command (USFFC).

(a) Develop and maintain a supporting plan to the USNORTHCOM Pandemic Influenza CONPLAN (Annex Q).

(b) BPT coordinate FHP measures and implementing instructions with service headquarters between military installations and deployed forces in USNORTHCOM designated JOAs.

(c) Assist in developing TPFDD for deployable HSS elements.

(5) Joint Task Force Alaska (JTF-AK).

(a) Develop and maintain a supporting plan to the USNORTHCOM Pandemic Influenza CONPLAN (Annex Q). Conduct HSS planning and coordination for likely Alaska contingencies and civil support operations within the JTF-AK JOA.

(b) BPT receive medical augmentees for the JTF-AK Surgeon staff.

(c) BPT provide a Surgeon's assessment identifying likely RFAs from other Federal Agencies.

(d) Maintain continuous medical situational awareness for possible PI operations and events in the Alaska JOA.

(e) BPT recommend Alaska-specific FHP measures and sustainment guidance.

(f) BPT provide prioritization of HSS force flow recommendation to USNORTHCOM/J3 and USNORTHCOM Command Surgeon.

(6) Joint Force Headquarters National Capital Region (JFHQ-NCR).

(a) Develop and maintain a supporting plan to the USNORTHCOM Pandemic Influenza CONPLAN (Annex Q).

(b) BPT receive medical augmentees for the JTF-NCR Surgeon staff.

(c) BPT provide a Surgeon's assessment identifying likely RFA's from other Federal Agencies.

(d) Maintain continuous medical situational awareness for possible PI operations and events in the NCR JOA.

(e) BPT provide prioritization of HSS force flow recommendation to USNORTHCOM J3 and USNORTHCOM Command Surgeon.

(7) Joint Forces Land Component Commander (JFLCC).

(a) Plan and coordinate HSS support across the regional JOAs.

(b) Establish and maintain a medical common operating picture within the JOA and medical reporting mechanism (See Annex R).

(c) Establish and coordinate a comprehensive medical logistics system for Class VIII A and B.

(d) Conduct risk communication activities.

(e) Collect and analyze data through surveillance and laboratory systems within the assigned regional JOA.

(f) Collaborate with State, local and federal agencies on-site assistance.

(g) BPT address the needs of special populations.

(h) Coordinate with ESF#s 1, 3, 6, 8 and 11 counterparts within the assigned JOA.

(i) BPT provide a prioritization of medical force flow recommendation to USNORTHCOM/J3 and Command Surgeon USNORTHCOM.

(j) Identify a trained medical spokesperson to assist with dissemination of information to the public and ensure every entity is speaking the same medical theme.

(k) Provide HSS assets to support the JRSOI process.

(l) BPT support screening and limited quarantine operations at ports of entry.

(m) BPT conduct medical screening, vaccination and distribution of prophylaxis.

(n) BPT assist in quarantine/isolation operations.

(o) O/O coordinate for the transportation, distribution, maintenance, and storage of critical medical resources.

(p) BPT deploy Surgeon staff as part of two RJTF staffs.

(q) BPT execute PI operations in designated JOAs.

(8) Joint Forces Maritime Component Commander (JFMCC).

(a) BPT deploy Surgeon staff as part of one RJTF staff.

(b) BPT provide HSS assets to support the JRSOI process.

(c) BPT support screening and limited quarantine operations at ports of entry.

(d) BPT conduct medical screening, vaccination and distribution of prophylaxis.

(e) BPT assist in quarantine/isolation operations.

(f) BPT provide transportation, distribution, maintenance, and storage of critical medical resources.

(g) Conduct risk communication activities.

(h) BPT coordinate medical joint activities of air forces ISO of PI operations.

(9) Joint Forces Air Component Commander (JFACC).

(a) BPT deploy Surgeon staff as part of one RJTF staff.

(b) BPT provide HSS assets to support the JRSOI process.

(c) BPT support screening and limited quarantine operations at ports of entry.

(d) BPT conduct medical screening, vaccination and distribution of prophylaxis.

(e) BPT assist in quarantine/isolation operations.

(f) BPT provide transportation, distribution, maintenance, and storage of critical medical resources.

(g) Conduct risk communication activities.

(h) BPT coordinate medical joint activities of air forces ISO of PI operations.

e. Coordinating Instructions.

(1) Direct liaison is authorized (DIRLAUTH) among subordinate unit Surgeons and USNORTHCOM Surgeon.

(2) Subordinate units will comply with CDRUSNORTHCOM Force Health Protection/Preventive Medicine Guidance. Specific threat and geographical guidance will be published in subsequent orders and/or messages.

(3) USNORTHCOM Medical Operations Cell.

(a) Medical threat information derived from DOD organizations and civilian health care agencies will enter USNORTHCOM through the MOC. The purpose of the MOC is to maintain presence within the USNORTHCOM adaptive HQ structure in a central location under the direction of the Command Surgeon. Led by the MOC Chief, the MOC provides reach back to comprehensive health services expertise to assess the disease and environmental threats, develop Force Health Protection (FHP) guidance and develop medical concept of operations. It provides critical interface and liaison between the Joint Operations Center (JOC), the Operations Planning Center (OPC) and other USNORTHCOM Battle Staff nodes.

(b) Medical intelligence data received by the MOC will be assessed by the Combined Intelligence Fusion Center (CIFC) for context and fusion with other intelligence community products, if required.

4. Administration and Logistics.

a. Administration. Once operational, Surgeons will coordinate all activities and reporting requirements for subordinate medical units operating in the AOR utilizing the MEDSITREP as prescribed in Annex R of this CONPLAN. Until a JTF is operational, the DCO will be the primary point of contact within the AOR and through the JRMP will coordinate activities and information flow through the USNORTHCOM Medical Operations Center (MOC).

b. Concept of Logistics.

(1) Medical logistics will be organized to support the 6 phased construct and will be tailored and flexible in order to support mission requirements. Synchronization of medical logistic support operations will be executed using a Single Integrated Medical Logistics Manager (SIMLM). Upon implementation of Theater Lead Agent-Medical Material (TLAMM) within the USNORTHCOM AOR, the TLAMM will integrate SIMLM operations across the spectrum of medical logistic operations. (See Annex D).

(a) Phase 0, Shape. Priority of logistics effort, support assessment and planning, conduct gap analysis for medical material requirements. Defense Medical Standardization Board (DMSB) provides distribution protocols for medical material in concert with the National Implementation Plan (NIP).

(b) Phase 1, Prevent. Priority of logistics effort focus supports preparedness. The infrastructure support needed will be identified to include identification of Base Support Installation (BSI). Plan and coordinate for the deployment and distribution of DOD stockpiles and critical medical materiel/equipment. Train and rehearse.

(c) Phase 2, Contain. Procure necessary materiel to meet potential surge requirements. Coordinate Joint Reception, Staging and Onward Movement, and Integration (JRSOI) and logistics support requirements.

(d) Phase 3, Interdict. Priority of logistics efforts focus supports deployment, expansion of JRSOI capabilities, and supporting preparations for execution of mission. Provide civil support as directed.

(e) Phase 4, Stabilize. Priority of logistics effort is on sustained logistics support. Begin planning for reconstitution of forces and equipment at home station.

(f) Phase 5, Recover. Priority of logistics effort is on redeployment and reconstitution at home station. Reconciliation of excess unused medical material and supplies and proper disposition of remaining stocks. Maintain proper fiscal accountability of CL VIII material.

5. Command and Control

a. Command Relationships. (See Base Plan.) As the principal medical advisor to CDRUSNORTHCOM, the USNORTHCOM Surgeon will coordinate and synchronize all medical resources allocated to CDRUSNORTHCOM and ensure their effective use to meet the mission. The relationships between medical units of the components are established within the organizational structure of the component commands.

b. Communications.

(1) Routine coordinating communication, plans, orders, reports and requests for information between USNORTHCOM Surgeon, Component, and the RJTF Surgeons will be transmitted via the most expeditious means

available within the USNORTHCOM JOA. HSS personnel and units will leverage all available technology to support medical communication requirements, to include: telephone, radio, electronic computer transmission, and message traffic.

(2) Blood management messages will be passed by NIPRNET or SIPRNET, teleconference and AUTODIN message.

(3) The USTRANSCOM Regulating and Command and Control Evacuation System (TRAC2ES) will be the primary and preferred means of communicating patient movement requests (PMR's).

(4) Public Affairs. The media will play an important role in reporting and shaping public opinion concerning PI operations. Any DOD response must take into account possible media contribution repercussions. Coordination with all units is key for a "one voice" effort. The JFO JIC will provide information to the media. The OASD-PA is the DOD focal point for all media inquiries concerning DOD PI operations. Delegation of release authority to the USNORTHCOM Public Affairs Office, and in turn to the appropriate C2 HQ, is allowed ISO this plan. (See Annex F).

APPENDIXES:
1 - Joint Patient Movement System
2 - Joint Blood Program
3 – Hospitalization
4 - Returns to Duty
5 - Medical Logistics
6 - Force Health Protection
7 – Host Nation Health Support - (Not Used)
8 –Medical Planning Responsibilities and Task Identification (Not Used)
9 -Veterinary Medicine

//Signed//
James W. Terbush
CAPT, MC, USN, FS
Command Surgeon

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APPENDIX 1 TO ANNEX Q to USNORTHCOM CONPLAN 3591 for Pandemic Influenza
JOINT PATIENT MOVEMENT SYSTEM

References:

a. CJCS Instruction 4120.02, "Assignment of Movement Priority", 15 April 2005

b. DOD Instruction 6000.11 Patient Movement September 1998

c. DOD Directive 6010.22 National Disaster Medical System

d. USTRANSCOM Inerim BWCW Policy, March 2003

e. DOD Directive 6000.12 Health Services Operations and Readiness

f. DOD Directive 4500.9 Transportation and Traffic Management

g. DOD Directive 5158.4 United States Transportation Command

h. DOD 4515.13-R Air Transportation Eligibility

i. Command Arrangements Agreement (CAA) between CDR, USTRANSCOM and CDR, USNORTHCOM, 22 March 2005 (DRAFT)

1. Situation.

a. Friendly. No change.

b. Assumptions and Defintions. Assumptions related to patient movement under Annex Q of this CONPLAN apply to this appendix.

(1) Joint patient movement (DOD beneficiary patients/homeland defense operations) will be in accordance with existing patient movement tactics, techniques, and procedures until such time as requirements exceed capability. Capabilities will be adjusted to meet operational needs by phase (see base plan for phasing).

(2) Inter-regional patient movement will be limited and performed on a case by case basis.

(3) Coordination and planning with Department of Health and Human Services (DHHS) will occur to ensure proper request for activation of National Disaster Medical System (NDMS).

(4) In a declared public health emergency, local transportation assets may not be sufficient to meet the demand.

2. Mission. To provide a concept of operation for patient movement (PM) in support of pandemic influenza operations in the USNORTHCOM area of responsibility (AOR). The primary mission of the DOD PM system is to safely transport patients within the USNORTHCOM AOR to the appropriate level of care as required.

3. Concept of Operations.

a. State or tribal requests for Federal medical transportation assistance are executed by ESF #8 in coordination with ESF #1, Transportation.

b. At the request of HHS, DOD coordinates and provides support for the evacuation of seriously ill or injured patients to locations where hospital care or outpatient services are available. DOD is responsible for regulating and tracking patients transported on DOD assets to appropriate treatment facilities (e.g., NDMS non-Federal hospitals) in coordination with NDMS medical interagency coordination group (MIACG),.

c. HHS is the primary federal agency responsible for the patient transportation mission.

d. In accordance with (IAW) ref d, USTRANSCOM will plan and execute PM and aero-medical evacuation support for USNORTHCOM operations through a supported/supporting relationship.

(2) Quarantine and isolation (Q/I) will likely be initiated during a PI event; if this occurs, infectious patients will not be moved unless specific authorization is given by CDRUSNORTHCOM in coordination with CDRUSTRANSCOM and the primary federal agency.

e. Tasks.

(1) USNORTHCOM SURGEON.

(a) Maintain situational awareness of bed capacity across the AOR. Obtain surge capacity data with NDMS partners on a recurring basis, while also pursuing ways to incorporate state efforts that are not included in this data.

(b) Coordinate PM planning with USTRANSCOM, NDMS, DHHS, CJTF(s) and service coordinators.

(2). Commander, United States Transportation Command (CDRUSTRANSCOM).

(a) IAW ref d, USTRANSCOM will plan and execute PM and aeromedical evacuation support for USNORTHCOM civil support operations through a supported/supporting relationship.

(b) 618 /tactical air command center (TACC) will act as USNORTHCOM's air mobility division (AMD).

(c) 618/TACC execute USNORTHCOM aeromedical evacuation requirements.

(d) USTRANSCOM's global PM requirements center (GPMRC) will act as NORTHCOM's PMRC.

(e) CDR USTRANSCOM, through the Air Mobility Command Commander, will retain and exercise control of aeromedical evacuation forces executing the mission.

(3) GPMRC shall:

(a) Perform bed apportionment, transport-bed plan development, bed reservation, destination MTF designation, and ITV.

(b) Assume responsibility as PMRC in the USNORTHCOM AOR.

(c) Serve as the PMRC for the NDMS, in accordance with the NDMS partnership agreement and guidelines provided by the joint director of military support (JDOMS).

4. Coordinating Instructions. USNORTHCOM will facilitate and identify requirements for joint PM and transportation issues through the Medical Interagency Coordination Group. Representation in this Group should include, but not be limited to, individual representatives from the Veterans Administration, the Department of Homeland Security, DHHS, the Assistant Secretary of Defense for Health Affairs USNORTHCOM, USTRANSCOM, USAMEDDCOM, USAF SG, BUMED and Department of Transportation.

5. Command and Control

(a) DHS, in coordination with ESF #2, is tasked in the National Response Framework (NRF) to provide communications support required for ESF #8 execution.

(b) DOD is responsible for tracking patients transported on DOD assets to aerial port of debarkation /NDMS patient reception areas and to subsequent medical treatment facilities.

(c) The PMRC will be the focal point for patient tracking through the use of TRANSCOM regulating and command and control evacuation system (TRAC2ES).

(d) Requests for DOD to manage patient tracking on non-DOD assets is beyond any current NDMS or NRF agreement and must be staffed as a request for assistance through the Office of the Secretary of Defense (OSD) and JDOMS.

ACKNOWLEDGE RECEIPT

Tabs
A – List of Aeromedical Staging Facilities – Not Used
B – List of Aeromedical Evacuation Aircraft – Not Used
C – Evacuation Requirements – Not Used
D – CONUS based Reception and Distribution – Not Used
E – Tactical/Intra-theater Strategic Movement of Infections Patients in a Biological Warfare Environment – Not Used

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APPENDIX 2 TO ANNEX Q to USNORTHCOM CONPLAN 3591 for Pandemic Influenza
JOINT BLOOD PROGRAM

References:

a. DOD Instruction 6480.4, "Armed Services Blood Program Operational Procedures" 5 August 1996

b. Code of Federal Regulations (CFR), "Food and Drugs," Title 21 parts 200 to 299, and parts 600 to 799.

c. Joint Pub 4-01, 17 June 1997, "Joint Doctrine for Defense Transportations System."

d. Joint Pub 4-02, 31 October 2006, "Health Service Support."

e. Army FM 4-02.70, Navy NAVMED P-5120 & Air Force AFMAN (I) 41-111, "Standards for Blood Banks and Transfusion Services," American Association of Blood Banks, current edition.

f. Army TM 8-227-3, Navy NAVMED P-5101 & Air Force AFMAN 41-119, "Technical Manual," American Association of Blood Banks, current edition.

g. Army TM 8-227-12, Navy NAVMED P-6530 & Air Force AFH 44-152, "Joint Blood program Handbook," 1 January 1998.

h. OPNAVINST 6530.4A, "Department of the Navy Blood Program," 14 October 1994.

i. AF INST 44-109, "Air Force Blood Program," 1 March 2000.

j. AR 40-3, Chapter 5, "Army Blood Program,"12 November 2002.

k. National Response Plan, November 2004.

1. Situation. See Base Plan.

2. Mission. To provide guidance for operation and management of the Joint Blood Program within the area of responsibility (AOR) during a pandemic event, and how it interfaces with the US Northern Command (USNORTHCOM) joint blood program office (JBPO).

3. Execution.

a. Concept of Operations.

(1) The Department of Health and Human Services (DHHS) monitors blood availability and maintains contact with the American Red Cross, American Association of Blood Banks (AABB) Inter-organizational Task Force on Domestic Disasters and Acts of Terrorism, and as necessary, its individual members to include the Armed Services Blood Program Office (ASBPO), to determine:

(a) The need for blood, blood products and the supplies used in their manufacture, testing, and storage.

(b) The ability of existing supply chain resources to meet these needs; and,

(c) Any emergency measure needed to augment or replenish existing supplies.

(2) If the blood product requirements exceed the capacity of the civilian blood agencies, or if blood distribution or storage assistance is required, DHHS will send a request for assistance (RFA), through DOD channels to USNORTHCOM.

(3) The USNORTHCOM JBPO, in coordination with the ASBPO, will manage and coordinate all aspects of DOD blood product support and DOD blood distribution assets in the AOR, regardless of Service component.

(4) The ASBP has different blood distribution and storage assets in CONUS. There are two designated Armed Services Whole Blood Processing Laboratories (ASWBPL), which are major blood product distribution hubs. The two ASWBPL locations are as follows: "ASWBPL-

East" located at McGuire AFB, NJ and "AWSBPL-West" located at Travis AFB, CA.

(5) Deployable blood distribution assets include blood supply units (BSU) and blood transshipment systems (BTS). Additionally, DOD medical treatment facilities can be used for limited expanded blood product storage.

(6) If DHHS requests distribution assets, the USNORTHCOM JBPO will coordinate with JFCOM to designate a BSU and/or BTS to accommodate AOR blood distribution and storage requirements within the AOR.

b. Coordinating Instructions.

(1) The ASBPO is a Level I member on the AABB Inter-organizational Task Force on Domestic Disasters and Acts of Terrorism.

(2) Coordinate with transportation assets to ensure the most expeditious method is used for moving blood within USNORTHCOM's AOR. Priority on military air (MILAIR) will be given for the movement of blood products. As an alternative, Angel Flights can be used to move critical medical supplies, to include blood, even with restricted air space.

4. Administration and Logistics. See Base Plan and Annex Q.

5. Command and Control.

(1) The following formats and frequencies for the DOD blood report (BLDREP) and blood shipment reports (BLDSHPRPT) will be utilized unless the USNORTHCOM JBPO determines otherwise:

(a) Blood Report (BLDREP).

1 Purpose: The BLDREP is a standardized report used in the worldwide ASBP to report blood inventories, request blood, and project requirements.

2 Originator: MTF, BSU, BTC, BPD, AJBPO, JBPO.

3 Method of transmission: Message traffic is the primary mode of transmission; however, use of the voice template is an acceptable alternative. (See figs B-I, B-2, and B-3.) Communications

capabilities of the originator and addressee, as well as the urgency of the message subject and text material, determines method of transmission.

4 Frequency of transmission/update: Frequency required is as follows, unless otherwise directed.

a MTF to BSU: Daily as of 2359Z; report required no later than 0200Z.

b BTC to AJBPO/JBPO: Daily as of 2359Z; report required no later than 0400Z.

c BPD to AJBPO/JBPO: Daily as of 2359Z; report required no later than 0400Z.

d BSU to AJBPO/JBPO: Daily as of 2359Z; report required no later than 0400Z.

e AJBPO to JBPO: Daily as of 0400Z; report required no later than 0800Z.

f JBPO to ASBPO: Daily as of 0800Z; report required no later than 1200Z.

5 Formats for Blood Report:

a Text:

PRIORITY: Determined by JBPO/AJBPO
FM: Input sending location (your) Plain Language Address (PLAD)
TO: Input receiving location (BSU, AJBPO) Routing Indicator (RI), if available, and PLAD
INFO: Input information addressee RI and/or PLAD
CLASSIFICATION: Determined by JBPO/AJBPO
OPER: Input operation name
MSGID: Input report type and reporting unit name and ID code
ASOFDTC: Date-time (Zulu) of Message
REPUNIT: Name, designator code, and activity brevity code of unit
BLDINVT: Total of each product on hand by amount and product code
BLDREQ: Total number of each product requested (amount/code)
BLDEXP: Total number of each product expiring in the next 7 days
BLDEST: Estimate total number of each product required for resupply in the next 7 days by amount and product code
CLOSTEXT: Additional comment, remarks, or information

DECL: Message downgrading instructions; mandatory if message is classified.

b Example of completed text format:

PRIORITY ***UNCLASSIFIED***
FM CINCUSACOM NORFOLK VA//JOZM//
TO RUEAUSAIASBPO WASHINGTON DC
INFO RUEOLIA/ASWBPL MCGUIRE AFB NJ
RULYOGBIRHEVAZZICJTF ONE EIGHT ZERONJUSURG MAINIFT BRAGG//
UNCLAS
OPERIUPHOLD DEMOCRACY//
MSGID/BLDREP/CJTF- I80 JBPOIBLDIOCTIAN
ASOFDTGII 5000 I OCT94//
REPUNITj32NDMED BN (LOG) BLDPLT/G/CAMP DEMOCRACY HAITI//
BLDINVTl32NDMED BN (LOG) BLDPLT/G/I 15JS/3 I JT/3JU//
BLDREQ/30JQ//
BLDEXP/32NDMED BN (LOG) BLDPLT/G/49JS/24JT//
BLDESTl32NDMED BN (LOG) BLDPLT/G/45JS//
CLOSTEXTiREQUEST 30JQ FOR DELIVERY ON 200CT AND 2NOV. CHANGE STANDING
ORDER TO 4554 FOR DELIVERY ON 14TH OF EACH MONTH/I
***UNCLASSIFIED**

c Voice format:

(Addressee) This is (Originator) Blood Report. Addressee answers:
Originator responds: This is (Originator)
Flash Immediate Priority Routine Top Secret Secret Confidential Unclassified
BLOOD REPORT-"Give the line number and then the required information in ( )."
1. As of (Date-time-zone of this report)
2. Unit - (Reporting unit name/designator)
3. Activity (Reporting unit's activity brevity code)
4. Location (Location of reporting unit afloat for delivery) Naval vessels only (hospital ship)
5. Rendezvous (Naval ships only (hospital ships) estimate day, time, month, year-of rendezvous)
6. Arrival (Arrival at the projected rendezvous location)
7. Status of (Name/code of the unit or activity reporting blood status if other than message originator)
9. Activity (Reporting units' activity code letter if other than originator)

9. On Hand (Number/code each product on hand)
10. Needed (Number/code product requested)
11. Expiration (Estimate of total number of products by group/type to expire in next 7 days)
12. Resupply (Estimate of total number of products by group/type required in next 7 days)
13. Narrative
14. Time (Day-time-zone when required)
15. Authentication (Message authentication in accordance with JTF procedures)

(b) Blood Shipment Report (BLDSHIPREP).

1 Purpose: The BLDSHIPREP is a standardized report used in the worldwide ASBP to report blood shipments. The BLDSHIPREP should be used by any medical facility to notify the receiving facility that blood has been shipped.

2 Originator: ASWBPL, BPD, BSU, BTC.

3 Method of transmission: Message traffic is the primary means of transmission; however, use of the voice template is an acceptable alternative. (See figs B-4, B-5, and B-6.) Communications capabilities of the originator and addressee, as well as the urgency of the message subject or text material should determine the method used.

4 Frequency of transmission/update: Frequency is as required or directed to provide information on blood shipments.

5 Formats for Blood Shipment Report:

a Text:

PRIORITY: Determined by JBPO/AJBPO
FM: Input sending location (your) PLAD
TO: Input receiving location (BSU, AJBPO) RI if available, and PLAD
INFO: input information addressee RI and/or PLAD
CLASSIFICATION: Determined by JBPOIAJBPO
OPER: Input operation name
SUBJ: BLDSHIPREP
MSGID: Input report type and reporting unit name and ID code
ASOFDTC: Date-time (Zulu) of message
REPUNIT: Name, designator code, and activity brevity code of unit
ISHIPD: Blood product/number by blood type/and total number shipped

BLDSHP: Air bill or Transit Control Number (TCN)#/aircraft or flight #/estimated time of arrival (date and time)
POC: Point of contact (name, rank, phone number and location)
CLOSTEXT: Additional comment, remarks, or information
DECL: Message downgrading instructions mandatory if message is classified

b. Example of completed text format:

PRIORITY ***UNCLASSIFIED***
01 02 011813Z NOV 94 RR RR UUUU
FM ASWBPL MCGUIRE AFB NJ//
TO RUERHNA/CDR 44TH MED BDEfi28Tl-l CSH//
lNF0 ASBPO WASHINGTON DC//
CINCUSACOM NORFOLK VAIIJ02MN
UNCLAS
OPERIUPHOLD DEMOCRACY//
SUBJ/BLOOD SHIPMENT TO CAMP DEMOCRACY, HAITI/PASS TO 28TH CSH//
MSGID/BLDSHIPREP/ASWBPU/
ASOFDTGi3 I2 I OOZOCT94N
REPUNIT/P3//
ISHIPD
/BP/OPOS/ONEG/APOS/ANEG/BPOS/BNEG/ABPOS/ABNEG/TOTCT BP//
lJ/ 221 51 IO/ 31 31 21 01 Of 4511
BLDSHP/-l-ON FM4484 4304 990 I XXX/AMC AQZ04PI 00306lO2 1830ZNOV94/lN
POCIGROSHEL/MAJIASWBPL/PRJPHN DSN440-3373/2442//
CLOSTEXT / ICED 3 I 17OOZOCT94 / SHIPPED TO CHARLESTON AFB VIA FEDX ON 3 I OCTI 994 / FROM CHARLESTON AFB TO PORT-AU-PRINCE, CARRIED BY AMC
MlSSION# AQZ04PlOO ON 306 DAY//
***UNCLASSIFIED+++

c. Voice format:

(Addressee) This is (Originator) Blood Report. Addressee answers:
Originator responds: This is (Originator)
Flash Immediate Priority Routine Top Secret Secret Confidential Unclassified
BLOOD SHIPMENT REPORT-"Give the line number and then the required information in ( ).'I
1. As of (Date-time-zone of this report)

2. unit (Reporting unit's name or designator)
3. Activity (Reporting unit's activity brevity code)
4. Location (Location of reporting unit lat/log (MT), Naval vessels only (hospital ship); Project,
LAW/LONG, UMT or place name for delivery of products)
5. Rendezvous (Hospital ships estimated day, time, month, year-of arrival (Naval ships only))
6. Arrival (Projected shipment arrival location)
7. Product (Brevity codes of products being shipped)
6. 0 Positive (Number of units)
9. 0 Negative (Number of units)
10. A Positive (Number of units)
11, A Negative (Number of units)
12. B Positive (Number of units)
13. B Negative
14. AB Positive
15. AB Negative
16. Total
17. Control
16. Mission
19. Arrival
20. Boxes
21. Contact
22. Phone
23. Narrative
24. Time
25 Authentication
(Number of units)
(Number of units)
(Number of units)
(Total number of units of the blood product being shipped)
(Air bill number or transportation control number. Air flight number assigned)
(Mission number assigned)
(Estimated arrival-day, time, time zone, month, of shipment arrival at destination)
(Number of boxes in shipment)
(Name of shipper's POC)
(24-hour telephone number of shipper's POC)
(Message hour, minutes, time zone required)
(Message authentication in accordance with JTF procedure)

(2) Since the ASBP and will be working closely with DHHS and other civilian blood agencies, classification of reports should be kept at the lowest possible level.

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APPENDIX 3 TO ANNEX Q to USNORTHCOM CONPLAN 3591 for Pandemic Influenza
HOSPITALIZATION

References:

a. The Public Health Security and Bioterrorism Preparedness and Response Act of 2002, 42 USC., 300h-11, as amended by the Homeland Security Act of 2002, 6 USC., 313(5) (The National Disaster Medical System (NDMS) Statute).

b. National Disaster Medical System Memorandum of Agreement: For Definitive Medical Care, 30 September 2005.

c. TRI-CARE Help E-Mail Service Newsletter (THEMS) October 2004. Volume 3, Issue 1.

d. Center Disease Control Influenza Pandemic OPLAN, 11 October 2007.

e. Department of Health and Human Services, Draft Guidance on Allocating and Targeting Pandemic Influenza Vaccine, 23 October 2007.

f. www.DOD.mil/pandemicflu, Pandemic Influenza: Clinical and Public Health Guidelines for the Military Health System, May 2007.

g. Pandemic Influenza: Warning, Children At-Risk, An Issue Brief by Trust for America's Health and the American Academy of Pediatrics, October 2007.

h. Center for Disease Control, Interim Containment and Mitigation Strategy, October 2007.

i. The Public Health Security and Bioterrorism Preparedness and Response Act of 2002,42 USC., 300h-11, as amended by Homeland Security Act of 2002, 6 USC (The NDMS Statute).

j. National Disaster Medical System memorandum of agreement: for Definitive Medical Care, 30 September 2005.

k. TRI-CARE Help E-Mail Service Newsletter (THEMS) October 2004. Volume 3, Issue 1.

l. National Strategy for Pandemic Influenza, Implementation Plan One Year Summary, Homeland Security Council, July 2007 .

1. Situation. No change.

2. Mission. See base plan. Employment of Local, State, Federal, and Private hospitalization resources in response to pandemic influenza.

3. Execution.

a. Concept of Operations.

(1) In the event of a pandemic influenza, the Secretary of DHHS will declare a public health emergency. Natioan Disaster Medical System (NDMS) assets will be activated in support of Local, State and private hospitals as warranted.

(2) Local, State, Private and Federal health care facilities, health care providers and emergency medical responders will respond first to the first wave of a pandemic event. As the pandemic intensifies and additional waves develop, Local, State, and Federal health care assets may become overwhelmed; leading to a request for assistance from DOD.

(3) To safeguard the health of the US Population, including DOD personnel and beneficiaries, US health care facilities and military treatment facilities (MTFs) must incorporate into emergency plans the following Department of Health and Human Services (DHHS)/Centers for Disease Control and Prevention (CDC) pandemic influenza (PI) planning guidelines:

(a) Effective medical surveillance/screening protocols to include laboratory testing procedures and establishment of working relationships with laboratory response network (LRN) reference facilities and CDC in order to accurately identify PI cases. Note: At the onset of a PI outbreak, CDC will define the terms for probable, suspect, and confirmed cases.

(b) Planning and coordination with local community and state authorities (i.e. public health), to assure optimum use of hospital facilities.

(c) Containment and mitigation strategies to reduce spread of the virus and its impact on the medical facility and health care staff. This includes applying masks to suspected or confirmed PI cases and implementing isolation procedures as soon as cases are identified.

(d) Targeted and effective use/administration of antiviral medications.

(e) Procedures for the receipt, storage, distribution of medical supplies and equipment from federal stockpiles. It is imperative to incorporate sustainment strategies.

(f) Hospitals must anticipate and plan for an increase in surge capacity and an increase in treatment of patients with respiratory illness. Contingency plans must address the increased need for medical staff support, critical care beds, and ventilator and monitoring equipment.

(g) PI management and treatment of pediatric populations

(h) Protection of health care staff considerations to include implementation of personal protective equipment protocols.

(i) Health care worker illness surveillance

(j) Medical risk communication strategies (see Annex 10 to Appendix E).

(k) Identify criteria and methods for measuring compliance with response measures (e.g. infection control practices, case reporting, patient placement, and health care worker illness surveillance).

(l) Build on existing emergency preparedness and response plans for bioterrorism events, severe acute respiratory syndrome, and other infectious disease emergencies. Incorporate and correlate

USNORTHCOM six phase PI construct with US Government PI phasing guidance.

b. Coordinating Instructions.

(1) NDMS will be a coordinated effort by the NDMS Federal partners, working in collaboration with the states and other appropriate public or private entities to provide health services, health-related social services, and appropriate auxiliary services to respond to the needs of victims of public health emergencies, including a PI event. NDMS Federal partners will be present at locations, and for limited periods of time, when such locations are at risk.

(2) DOD Theater Hospitalization and Definitive Care capabilities are considered joint and as such care for all DOD beneficiaries regardless of Service affiliation. Joint staffing of facilities is not a prerequisite for joint use. Commanders of medical assets outside the affected area must be prepared to assist as needed during a PI event.

(3) DOD PI patients may be treated by both civilian and DOD medical personnel in emergency situations when DOD medical treatment assets are not readily available.

(4) DOD first responder and forward resuscitative care will be organic to individual units or will be provided on an area support basis as coordinated by the regional joint task force (RJTF).

(5) NDMS Federal partners and Non-Federal health care facilities agree to plan jointly for the admission, treatment, transfer and discharge of all patients during a PI event.

(6) Installations and MTFs must consider alternative medical care sites in their planning such as home care and alternative triage locations. Note: Refer to DOD Guidance for Pandemic Influenza; Clinical and Public Health Guidelines for the Military Health System

(7) Bed Reporting: In addition to the Medical SITREP, the global patient movement requirements center will report the number of beds available to the NORAD NORTHCOM Operations Center (NNOC) or military operations center on a daily basis via transportation command regulating and command and control evacuation system (TRAC2ES).

(8) Laboratories. The health care provider must ensure that appropriate supervisory personnel in the laboratory are alerted regarding

the submission of a specimen from a patient with PI exposure risk factors. Rapid antigen testing must be conducted under biosafety level 2 biocontainment conditions using a Class II biological safety cabinet. Laboratories must not attempt to isolate influenza viruses from patients with a suspected novel influenza virus infection unless the laboratory meets the biocontainment conditions for BSL-3 with enhancements or higher. Laboratories should prepare to process significant numbers of specimens quickly during the early stages of a pandemic to determine if patients with respiratory illness have been infected with the PI strain. Details on laboratory planning and diagnostics are posted on the DOD PI watchboard at: www.DOD.mil/pandemicflu. Updates to the guidelines will be made and posted as necessary, including any change in standards of clinical practice, likely pandemic strain candidate(s), and laboratory diagnostics, case definitions, recommended infection control practices and PPE, etc. Specimen collection procedures and testing can be obtained at any supporting DOD MTF, the Air Force Institute for Operational Health, Risk Surveillance Division (AFIOH/RSRH) (https://gumbo.brooks.af.mil/pestilence/Influenza/), or a World Health Organization (WHO) reference laboratory (www.who.int) in the area of responsibility . Viral isolates should be submitted to the CDC in accordance with DOD guidelines for possible use in vaccine development. DOD laboratories registered as LRN reference facilities for influenza testing must handle samples as a top priority with rapid processing under appropriate Biosafety level conditions. Sample results will be disseminated to DOD, CDC, and WHO Influenza Program Offices.

(9) Hospitals should plan to treat a high number of patients with respiratory distress. Support of greater numbers of critically ill patients will require increased medical staff, more ventilators, and more monitoring equipment. Requests for additional support will be coordinated through the Surgeon's office.

(10) Medical and public health needs will be significant. The DOD will use existing resources when initially responding to PI affecting military populations and installations.

(11) Planning and coordination with local community authorities, including public health authorities, will be critical to assure optimum use of hospital facilities.

(12) Patient Management. Detailed guidelines for patient evaluation and management are found at www.DOD.mil/pandemicflu within the document entitled: Pandemic Influenza: Clinical and Public Health Guidelines for the Military Health System, May 2007. At the onset

of a disease outbreak, CDC will define the terms for probable, suspect, and confirmed cases. Geographic combatant commanders will use these CDC definitions. Additionally, Annex 8 of reference (w) outlines a range of activities that could be taken to prevent PI spread in hospitals and communities.

(a) Patients suspected of having PI will be masked and isolated as soon as recognized. Antiviral treatment protocols are described in detail in Appendix 6.

(b) Medical evaluation for patients suspected of having PI will include routine evaluation to determine influenza type (i.e., Type A or not Type A) and applicable laboratory and radiological evaluation as required.

(c) Patients known to have PI will not need decontamination prior to entering either civilian or military treatment facilities. They will, however, need to be masked (i.e., disposable surgical mask) in order to prevent the spread of respiratory droplets that may infect others.

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APPENDIX 4 TO ANNEX Q to USNORTHCOM CONPLAN 3591 for Pandemic Influenza
RETURN TO DUTY

1. Situation. See base plan.

2. Mission. To coordinate with N-NC J-1 an effective and efficient method of returning individuals to duty once hospitalization or treatment of care is completed.

3. Execution.

a. Concept of Operations. All USNORTHCOM members who are returned to duty must report to an established holding location to ensure proper transportation and accountability is obtained to move the individual back to their respective unit/Command. Evacuation policy is to be determined.

b. Coordinating Instructions. NORTHCOM J-1 will provide a clear, concise, efficient and effective return to duty policy and procedure.

4. Administration and Logistics.

5. Command and Control. IAW with base plan. Reporting will be in accordance with Annex R.

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APPENDIX 5 TO ANNEX Q to USNORTHCOM CONPLAN 3591 for Pandemic Influenza
MEDICAL LOGISTICS (CLASS VIII) SUPPORT

References:

a. JP 4-02, Health Service Support.

b. Department of Defense Influenza Pandemic Preparation and Response Health Policy Guidance,"25 Jan 2006.

c. ASD/HA Policy, "Policy for the Release of TAMIFLU Antiviral Stockpile during an Influenza Pandemic," 10 Jan 2006.

d. AR 40-61, "Medical Logistics Policies and Procedures", 1995

e. ASD/HA Memorandum "Centrally Funded Influenza Pandemic Response Materiel Guidance," 29 Sep 2006

1. Situation.

a. Facilities.

(1) The theater lead agent for medical material (TLAMM) and single integrated medical logistics manager(s) (SIMLMs) will coordinate medical re-supply using existing contracting mechanisms (e.g. Defense Logistics Agency (DLA), prime vendor, and installation medical support activities).

(2) The Services can facilitate the delivery of health services logistics systems (HSLS) through the following agencies: DLA, Naval Medical Logistics Command (NAVMEDLOGCOM), Air Force Medical Logistics Command (AFMLO), and the US Army Medical Materiel Agency (USAMMA).

(3) Medical assets pre-positioned in the USNORTHCOM area of responsibility (AOR).

(a) US Army.

1 US Army Medical Command (MEDCOM) consequence management (CM)/chemical, biological, radiological, nuclear and high yield explosives (CBRNE) packages are located in multiple locations. USNORTHCOM Surgeon shall coordinate with US Army to determine locations and availability of CM/CBRNE Packages. US Army Office of the Surgeon General (OTSG) is the release authority.

2 Installation support packages (ISP) are located at each Army medical treatment facility (MTF).

(b) US Air Force. CM Sets are located at Air Force bases. USNORTHCOM Surgeon shall coordinate with USAF to determine locations and availabilities of CM Sets.

(c) US Navy. The Navy currently does not have any requirement for pre-positioned CM sets located in the USNORTHCOM AOR.

b. Assumptions.

(1) The Services when funded and as authorized by law will pre-position stocks throughout the AOR.

(2) Each unit will deploy with basic load of Class VIII supplies.

(3) The Defense Medical Standardization Board (DMSB) will develop a PI formulary.

(4) The Strategic National Stockpile (SNS) can deploy a push package within 12 hours to the incident. The push package can then be operational 48 hours after deployment.

(5) USAMEDCOM has Special Medical Augmentation Response Team (SMART)-Logistics Teams at each Regional Medical Command (RMC) ready to deploy in support of operational medical logistics requirements to include assessment and assistance.

(6) Movement of vaccines during a pandemic influenza (PI) event may be performed under emergency use authorizations (EUA).

2. Mission. To provide the concept of operations for medical logistics support.

3. Execution.

a. Organization and Function.

(1) The TLAMM, once implemented, will report to the CDRUSNORTHCOM.

(2) USNORTHCOM will designate a SIMLM. The SIMLM will be designated immediately to meet the medical logistics requirements of deploying forces and will execute command and control of medical logistics units until the establishment of a RJTF.

(3) The joint force air component commander (JFACC) will develop a patient movement items (PMI) plan for the USNORTHCOM AOR in coordination with the Air Mobility Command (AMC)/SGXL-PMI Manager.

(4) Initially, the TLAMM and the SIMLM(s) will provide logistics assistance to deployed medical elements, coordinate the flow of logistics information/flow of Class VIIIA materiel from sources of supply, installation medical supply activities (IMSAs) and forward distribution points. It will also coordinate the distribution/ transportation of Class VIIIA materiel to US forces deployed in support of civil support operations. The TLAMM and SIMLM(s) will maintain visibility (including in-transit visibility) of theater Class VIIIA materiel assets, provide decision support tools, redirect shipments, implement cost accounting procedures with reporting mechanisms, and cross-level Class VIIIA assets at the direction of the JTF-Medical Commander.

(5) SIMLM will coordinate continuous Class VIII (A&B) support to all DOD medical units within the AOR in concert with the TLAMM designated installation medical support activities (IMSA).

b. Tasks. See Annex Q (Health Services) for specific tasks.

c. Coordinating Instructions.

(1) The combatant commander, through the command Surgeon, is responsible for health service logistical system in the AOR. The command Surgeon will maintain close ongoing contact with all activities having command over medical materiel support to deployed forces in order to monitor the status of Class VIIIA sustainability.

(2) Liaison with air lifters and ground transportation agencies may be required to establish a higher priority for movement and distribution of Class VIIIA materiel. Ongoing coordination with theater logisticians to ensure adequate emphasis and priority for medical materiel is essential.

(3) In support of a PI response the Assistant Secretary of Defense (Health Affairs) (ASD/HA) has prepositioned antiviral medications and antibiotics. ASD(HA) has procured antivirals and/or vaccines for DOD utilization which are stored in global DLA depot locations. Utilizing ASD/HA Policy "Policy for Release of Department of Defense Antiviral Stockpile during an Influenza Pandemic," and ASD/HA Memorandum "Centrally Funded Influenza Pandemic Response Materiel Guidance," USNORTHCOM Surgeon will identify a point of contact (name, phone, email) to ASD(HA) [FHP&R/LOG] and DLA joint logistics operation center for coordination of access and release and place request to the National Military Command Center identifying:

(a) Location by Department of Defense activity address and name.

(b) Quantities requested:

1 Antivirals shall be requested per instructions:

a Tamiflu per bottle in multiples of 48.

b Relenza per treatment (EA) in multiples of 16.

2 Vaccines, when available, shall be requested per unit case (BX, CS, etc).

(c) Required delivery date (RDD) and priority.

(d) Project code of 3GL.

(4) Upon approval from ASD(HA), NMCC shall notify DLA of release. DLA shall then process release of materiel. Primary shipment method shall be commercial. If commercial shipping is not available then USTRANSCOM will coordinate shipments. USTRANSCOM coordination shall involve Surgeon/RJTF Surgeon who, in both commercial and USTRANSCOM shipments, shall maintain control of the materiel. TLAMM may receive and distribute shipments.

4. Administration and Logistics.

a. Medical Materiel Sustainability Assessment. Medical logistics sustainability relies on early re-supply of deployed medical forces. The expectation is units will initially deploy with 10 days of supply.

b. Policy. Deploying units will deploy with their basic load of Class VIII(A&B) during the deployment. Initial resupply will be through Service component channels until accounts are coordinated and established through the TLAMM/SIMLM.

5. Command and Control.

a. As the principal medical advisor to CDRUSNORTHCOM, the USNORTHCOM Surgeon exercises directive authority for the Commander over all medical resources allocated to CDRUSNORTHCOM and ensures their effective use to meet the mission. The relationships between medical units of the components are established within the organizational structure of the component commands.

b. Requisitions will be forwarded via voice, teletype, data transmission using existing legacy automation systems, and primary systems - Defense Medical Logistics Supply System (DMLSS) or Theater Army Medical Management Information System (TAMMIS). Priority of requisitions will be in concert with existing Service regulations unless otherwise directed. Requisitioning procedures and requisitions will be unclassified unless the operational situation dictates otherwise.

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APPENDIX 6 TO ANNEX Q TO USNORTHCOM CONPLAN 3591
FORCE HEALTH PROTECTION (FHP)

References:

a. OASD(HA) Memorandum 06-008, Policy for Pre- and Post-deployment Serum Collection, 14 March 2006

b. OASD(HA) Memorandum 05-011, Post-deployment Health Reassessment, 10 March 2005

c. OASD(HA) Memorandum 04-001, Policy for Department of Defense Deployment Health Quality Assurance Program, 9 January 2004

d. OASD(HA) Memorandum 03-007, Policy for Use of Force Health Protection Prescription Products, 24 April 2003

e. OASD(HA) Memorandum 03-022, Medical Surveillance Information Strategy for Force Health Protection, 6 November 2003

f. OASD(HA) Memorandum 01-017, Updated Policy for Pre- and Post-Deployment Health Assessments and Blood Samples, 25 October 2001

g. DOD Directive 2000.12, "DOD Antiterrorism/Force Protection Program," 18 August 2003

h. DOD Instruction 2000.16, "DOD Antiterrorism Standards," 02 December 2006

i. DOD Instruction 2000.18, "Department of Defense Installation Chemical, Biological, Radiological, Nuclear and High-Yield Explosive Emergency Response Guidelines", 4 December 2002

j DOD Directive 6200.04, "Force Health Protection", 9 October 2004 (Certified: 23 April 2007)

k. DOD Directive 6490.02E, "Comprehensive Health Surveillance", 21 October 2004 (Certified: 23 April 2007)

l. DOD Instruction 6490.03, "Deployment Health", 11 August 2006

m. Joint Publication 4-02, Health Service Support, 31 October 2006

n. Joint Chief's of Staff Memorandum 006-002, Updated Procedures for Deployment Health Surveillance and Readiness, 1 February 2002

o. Technical Bulletin Medical 507 and Air Force Pamphlet 48-152(I), Heat Stress Control and Heat Casualty Management, 7 March 2003

p. DD Form 2766, "Deployment Medical Record"

q. DD Form 2795, "Pre-deployment Health Assessment"

r. DD Form 2796, "Post-deployment Health Assessment"

s. DD Form 2900, "Post-deployment Health Reassessment"

t. USA Center for Health Promotion and Preventive Medicine (CHPPM) Technical Guide 244, The Medical NBC Battlebook, August 2002

u. Field Manual 21-10, Field Sanitation and Hygiene, November 1988

v. USNORTHCOM Antiterrorism Operations Order (OPORD) 05-01B, 15 July 2006

w. USNORTHCOM Instruction 10-211, Operational Reporting, 1 December 2006

x. Updated Procedures for Deployment Health Surveillance and Readiness, JCS MCM-0006-02

y. Chemical Warfare (CS) Agent Exposure Planning Guidelines, JCS MCM-0026-02

z. Occupational Safety and Health Administration. Guidance on Preparing Workplaces for an Influenza Pandemic. OSHA 3327-02N 2007

1. Situation

a. Health Threat. The NORAD and USNORTHCOM medical fusion cell (MFC) will provide current threat information in order to provide specific FHP guidance as required. Appendix 6 tabs a-c provide the basic FHP information with respect to (WRT) chemical, biological, and radiological health threats. Component commands and assigned JTFs will further describe the health threat in the area of responsibility (AOR) regarding infectious disease, environmental hazards, food, water, sanitation, and other health threats that have the potential to reduce combat effectiveness. The N-NC SG medical operations cell (MOC) consisting of FHP subject matter experts (SME) and components will continue to assess and update FHP guidance as required.

(1) Infectious Diseases.

(a) Naturally-occurring disease will pose a risk to forces in the USNORTHCOM AOR. Risk may be endemic disease that exist in regions of the AOR or may be emerging diseases (e.g., SARs) from outside the AOR. Specific FHP guidance WRT these diseases will be provided prior to Phase 2 of the operation.

(b) Man-made biological agents will be introduced via intentional or unintentional means. Specific FHP guidance WRT these agents will be provided either in Phase 1 or Phase 2 of the operation.

(2) Environmental Hazards.

(a) Weather and Geography. Harsh climates (e.g. extreme hot, cold, rain, dusts, altitude) can lead to environmental injuries (heat exhaustion/ stroke, hypothermia, trench foot, dust induced respiratory problems, or altitude sickness). FHP SMEs will factor in climates when providing FHP guidance.

(3) Food and Water. Contaminated food and water constitute an immediate risk to force health. Contaminated food and water supplies cause different types of acute enteric diseases (e.g., typhoid, cholera, salmonella, giardiasis, amoebiasis, botulism, and hepatitis). Food and water may also be used as a vehicle to deliver chemical, biological, radiological or nuclear (CBRN) warfare agents to DOD forces. Deployed personnel must provide security and consume approved food and water sources.

(4) Sanitation. Sanitation practices are key to eliminating or reducing disease and non-battle injury (DNBI). Preventative medicine (PM) teams will provide guidance to commanders WRT instituting appropriate sanitation methods for deployed forces.

(5) Other Hazards. The full spectrum of health threats (e.g., CBRN agents, toxic industrial chemicals/materials, industrial operations, hazardous flora and fauna, vector-borne, animals) will be encountered across the full range of military operations (ROMO) to be executed in the AOR. FHP and specific exposure guidance will be refined based on the type of operation (i.e., homeland defense or civil support).

b. Friendly. See Annex Q

c. Assumptions.

(1) Force Health Protection (FHP) activities promote, improve, conserve, and restore physical and mental health of USNORTHCOM forces, including DOD civilians, and Service members. Annex Q provides a summary of care eligibility WRT health service support (HSS). The core of FHP is health risk assessment (HRA).

(2) An "all hazards" approach to FHP, the same as force protection, applies to the NORTHCOM AOR. FHP activities will be implemented via this plan, execution orders, and other means, as necessary.

(3) FHP measures will be instituted via force protection (FP) conditions in accordance with (IAW) the USNORTHCOM OPORD (ref v.). FHP measures initiate FHP activities prior to and in conjunction with specific CONPLANs.

(4) FHP SMEs will be deployed in the early phases of an operation to characterize health threats and execute health risk assessments (HRAs).

(5) Health threats in the AOR may not be characterized by civil authorities; therefore, FHP assets will be required to characterize the health threats prior to DOD forces entering into hazardous environments.

(6) Data from National Guard response teams (e.g., Weapons of Mass Destruction Civil Support Teams) will be available for DOD use.

(7) DOD personnel will be deployed healthy, fit, and compliant with pre-deployment requirements.

d. Legal Considerations. See Annex Q.

2. Mission. Support CDRUSNORTHCOM strategic objectives and the lines of support through FHP capabilities. FHP activities focus on promoting and sustaining a fit force, preventing battle injury (BI) and DNBI, protecting against the full spectrum of health hazards, and delivering medical and rehabilitative care.

3. Execution.

a. Concept of Operations. FHP is a force multiplier enabling deployed personnel to execute mission tasks. FHP SMEs (e.g., expertise in preventive medicine, occupational and environmental health (OEH), CBRN, public health, and veterinary medicine) will develop and implement directives and guidance to minimize BI/DNBI. FHP activities also support medical planning WRT resource estimation and provide information to scope deployed and follow-on medical care if required.

(1) Pre-deployment Screening. Screening and individual medical readiness are integral to the overall deployment process. Commanders are responsible for ensuring deploying personnel (military and DOD civilian), regardless of anticipated length of stay, are assessed prior to departure and determined to be medically fit for deployment. Personnel will complete the DD Form 2795 and the DD Form 2766 will be reviewed prior to deployment by the unit's supporting medical staff, which will provide recommendations on the individual's deployment eligibility. Personnel will deploy with current DD Form 2766 to include blood type, medication/allergies, special duty qualifications, immunization record, DD Form 2795, and summary sheet of past medical problems.

(a) Immunizations. Personnel must have completed all immunizations listed below.

1 Hepatitis A (series complete, or dose one at least 14 days prior to departure).

2 Tetanus-Diphtheria (every 10 years unless otherwise indicated).

3 MMR (proof of vaccination or proof of positive antibody titer).

4 Influenza (current vaccine administered, seasonal dependent).

(b) In addition, the following immunizations may be required for selected personnel based on threat and/or operational activities and environment. Other immunizations may be identified via specific HRAs.

1 Hepatitis B for medical personnel, special forces, and others at occupational risk of exposure to blood and body fluids (e.g., military police, firefighters, and mortuary affairs).

2 Rabies vaccine required for personnel at occupational risk of exposure.

3 Smallpox (IAW current DOD policy).

4 Anthrax (IAW current DOD policy).

5 Tuberculosis Skin Test (Mantoux). Test is required IAW current DOD policy; however, personnel at occupational risk of exposure WRT specific deployments in the USNORTHCOM AOR will be identified and tests administered.

(c) Personnel must have a current human immunodeficiency virus (HIV) test on file IAW Service policy. Additional testing requirements will be identified via DEPORD/EXORD for military, civilian, and contractors.

(d) Serum samples will not be required for USNORTHCOM CONUS deployments unless specifically identified via DEPORD/EXORD or specific risk-based exposure scenario (e.g. CBRNE response). If a serum sample is required, a pre-deployment serum sample could be accomplished through the mechanism of HIV testing.

(e) Personnel will deploy with a 90-day supply of personal prescription medications.

(f) Personnel will deploy with required standard medical equipment (e.g., glasses, inserts, etc.).

(2) Medical Intelligence. FHP SMEs will review and analyze medical intelligence and surveillance data. Preliminary assessments may be initiated based on the information available WRT potential health threats, countermeasures, endemic infectious diseases, OEH stressors, mental health (including stress, suicide, and traumatic stress), food and water safety, field sanitation, and personal hygiene requirements.

(3) OEH Site Assessment. FHP SMEs will evaluate proposed bed down sites and troop locations, and collect OEH data/information to provide commanders health risk-related recommendations. The result of site assessment(s) is to ensure forces are bedded in non-contaminated areas, or areas where exposures do not pose a health risk.

(4) Health Surveillance. Surveillance is the systematic and routine collection and analysis of threats and hazards (from deployed workplaces, environmental contaminants, CBRN materials, and vectors) and related illness data. Health surveillance includes OEH and medical components, and addresses exposures potentially causing acute or delayed health effects.

(5) OEH Assessments. FHP SMEs will identify, evaluate, and control OEH hazards to ensure deployed forces are protected. Data/information collected is used in the HRAs and risk mitigation strategies.

(6) Individual Protective Equipment (IPE)/Personal Protective Equipment (PPE).

(a) IPE (i.e., mission oriented protective posture (MOPP) ensemble) can be used to protect against various health hazards. FHP SMEs will be required to determine if MOPP ensembles are sufficient to protect personnel against the potential health threat(s). MOPP gear is required for deployment unless orders indicate otherwise.

(b) PPE will be identified and issued to personnel for protection from health hazards as known. PPE includes such items as repellents and bed-nets for mosquitoes, earplugs for noise hazards, goggles for eye hazards, respirators from inhalation hazards, or aprons and gloves for splash hazards. Pre-

selection of PPE may be completed based on planning scenarios; however, FHP SMEs will be required to determine whether PPE is adequate after arrival into the AOR.

(7) Health Risk Assessment. HRA is the process of identifying and evaluating OEH threats in populations or locations over a specified time period. At a minimum, FHP SMEs must qualify the risk(s), fuse health surveillance data, and provide courses of action to the commander supporting the mission task while maximizing FHP. The HRA facilitates the tracking of exposures to the individual in order to perform epidemiological studies and document exposures in the deploying member's medical record.

(8) Vulnerability Assessments. Vulnerability assessments are required to ensure risks are minimized to forces in relation to food, water, and CBRN and hazardous materials. Reference t. provides a basic process for risk assessments and may be combined with Service unique vulnerability assessment processes to produce a media-specific vulnerability assessments.

(9) Post-deployment Screening Procedures

(a) Personnel will complete DD form 2796 within 5 days after redeployment and meet with a primary care manager (PCM), if necessary, to discuss post-deployment health concerns and responses, including post-traumatic stress disorder (PTSD).

(b) DD Form 2900 will be completed 90 - 180 days after re-deployment.

b. Tasks. IAW JP 4-02, commanders will develop and implement an FHP plan, which applies to all assigned and attached personnel, DOD personnel performing official duties in the AOR, and contractor personnel employed directly by DOD.

(1) USNORTHCOM Command Surgeon FHP Responsibilities

(a) Develop FHP directives and guidance in concert with (ICW) OASD(HA) and Joint Staff.

(b) Plan, coordinate and execute HSS tasks with component commands, other DOD components, State Health Authorities, inter-agency and Coalition partners at the local, regional and national levels.

(c) Integrate medical intelligence, environmental surveillance, and syndromic surveillance efforts in collaboration with DOD components and other federal agencies via early warning systems in order to identify potential health threats.

(d) Identify, prioritize, and coordinate risk mitigation for DOD health sector critical infrastructure ICW the OASD, the Joint Staff, Component Commanders, the Services, National Guard Bureau (NGB), DOD agencies and the private sector.

(e) Develop/exercise health surveillance/intelligence/information reporting requirements ICW OASD, the Joint Staff, Component Commanders, the Services, NGB, DOD agencies and other Unified Commands.

(f) Ensure FHP is considered in all planning phases of an operation.

(g) Establish medical/FHP common operating picture to include medical forces and BI/DNBI trends.

(h) Support medical resource estimation to provide the appropriate forces for the identified mission set(s).

(2) Component Command and JTF FHP Responsibilities

(a) Ensure FHP is considered in all planning phases of an operation.

(b) Establish coordinated FHP and health surveillance programs to include programs identified in the Concept of Operations (para 3.a.).

(c) Deploy FHP SMEs to the AOR and incident site as early as possible to identify/confirm the medical and OEH threat to develop/refine/implement FHP plans.

(d) Educate deploying personnel on potential and actual health threats and how to use appropriate IPE/PPE and countermeasures. Use appropriate risk communication techniques to address the following areas at a minimum:

1 Endemic diseases including acute diarrheal, vector-borne diseases, and rabies.

2 Environmental health threats including topography and climate as it relates to health and safety, contamination and pollution, and dangerous flora, fauna, insects, and animals.

3 OEH threats affecting potential for injury and illness.

4 Mental health information to include deployment-related and traumatic stressors, and suicide risk.

5 Food and water safety.

6 Field sanitation and personal hygiene.

(f) Ensure an OEH site assessment is completed prior to bed down of forces.

(g) Ensure vulnerability assessments and HRAs are completed prior to operating in hazardous environments.

(h) Ensure approved sources of food and water are available. If unavailable, conduct a HRA and discuss w/ commanders as required.

(i) Monitor the efficacy of the FHP plan and subsequent guidance. Make recommendations for modification(s) as required.

(3) JTF Surgeon

(a) Plan and coordinate FHP implementation within the JTF.

(b) Ensure adequate preventive medicine assets are requested and deployed to implement an effective OEHS program.

(c) Ensure all deploying forces have met pre- and post-deployment FHP requirements.

(d) Forward OEHS assessments and results to the US Army Center for Health Promotion and Preventive Medicine.

(4) National Guard Bureau (NGB)

(a) Plan, coordinate and execute FHP program IAW USNORTHCOM, DOD, JCS, and Service directives and guidance.

(b) Ensure all deploying forces have met pre- and post-deployment FHP requirements specified in the supported EXORD.

(c) Ensure adequate preventive medicine assets are requested and deployed to ensure comprehensive exposure assessments and health risk management as defined in FHP guidance documents.

(5) DOD Agencies

(a) Plan, coordinate and execute FHP program IAW USNORTHCOM, DOD, JCS, and Service directives and guidance.

(6) FHP SME Responsibilities (Predeployment)

(a) Review relevant intelligence products from the National Center for Medical Intelligence (NCMI), Armed Forces Health Surveillance Center (AFHSC), USNORTHCOM medical fusion cell, and local medical intelligence sources. Initiate assessments based on operational and medical intelligence.

(b) Inform commanders of the health threat and potential impact on mission(s).

(c) Perform preliminary HRAs and determine preventive and protective requirements for health hazards in the AOR. Include analysis of weather, altitude, terrain, endemic diseases, local food and water sources, zoonotic diseases, parasites, hazardous plants and animals, and potential exposure to CBRN and toxic materials.

(d) Analyze disease vector profiles if available and determine vector suppression requirements for unit pesticide application.

(e) Determine additional immunization and prophylaxis requirements and issue directives and guidance as required.

(f) Conduct pre-deployment briefings on the health threat and hazards of the operation. Provide individual training to deploying personnel WRT specific protective measures and use of required IPE/PPE.

(g) Educate medical personnel on recognition, prevention, and treatment of probable diseases, injuries, and exposures.

(h) Establish monitoring programs that measure OEH and mental health stressors affecting deployed personnel.

(7) FHP SME Responsibilities (Deployment).

(a) Execute programs as identified in the Concept of Operations (para. 3.a) and Component Commander/JTF responsibilities.

(b) Communicate health risks to commanders.

(c) Initiate DNBI surveillance in concert with health care delivery and OEH assessment completion. Review emergency and primary care logs daily to support surveillance.

(d) Conduct epidemiological investigations of suspected disease outbreaks. Factor results into HRAs.

(e) Report suspected/confirmed disease trends to local and component commanders and notify the NORAD and USNORTHCOM Surgeon's office ASAP.

(f) Conduct periodic sanitation inspections focusing on areas of public concern. Field sanitation practices are essential in maintaining force heath to include maintaining clean and dry clothing (especially socks, underwear, and boots), frequent hand washing, proper dental care, and bathing with water from an approved source.

(g) Conduct periodic inspections water systems and waste water systems as applicable.

(h) Conduct area monitoring for disease causing vectors. Seasonal variability should be considered to identify potential changes in insect populations. Results of vector monitoring will be coordinated with pest control personnel for action when necessary.

(i) Monitor climatic conditions and recommend work rest cycles, fluid consumption (not to exceed 1 ½ quarts of water per hour under severe heat/work conditions), and other preventive measures as necessary. Acclimatization to increased temperatures and humidity may take up to 14 days.

(j) Conduct workplace evaluations to identify health hazards in industrial areas if workplaces are set-up to support operations.

(k) Maintain educational programs and perform risk communication to keep deployed personnel aware of current and changing health threats.

(l) Assess if contingency combat stress teams are necessary for deployed forces.

(m) Recommend contamination control procedures based on the threats/hazards present in the AOR.

(n) Monitor the efficacy of the FHP plan and subsequent guidance based on completed HRAs. Make recommendations for modifications as required.

(o) Update medical intelligence and health hazard assessments by working with USNORTHCOM J34, NCMI, CHPPM-Global Threat Assessment Program, and other sources as identified.

(8) FHP SME Responsibilities (Redeployment).

(a) Conduct briefings to personnel exiting AOR. Include possible diseases that may manifest after deployment and procedures for terminal countermeasures (e.g., chemoprophylaxis) if administered.

(b) Ensure that post-deployment health assessments are completed and medical follow-up is scheduled if required.

(c) Ensure sampling data (e.g., air, water, food, soil, and fauna) is archived.

(d) Support site restoration/remediation efforts as required.

(e) Update medical intelligence and health hazard assessments by working with USNORTHCOM J34, NCMI, CHPPM-Global Threat Assessment Program, and other sources as identified.

(f) Assist in after action reports and lessons learned reporting as directed by USNORTHCOM and Component headquarters.

c. Coordinating Instructions.

(1) Participating units will maintain vigorous FHP programs to significantly reduce the disease and non-battle injury (DNBI) risk. Programs will be conducted in accordance with applicable service and component directives and regulations.

(2) Personnel will be immunized IAW this CONPLAN and service directives, and updated via EXORD requirements.

(3) Organic FHP capabilities will receive a high priority for deployment in accordance with component mission requirements. Because of the risk of PI, the primary force health protection priority is personal hygiene. Additional FHP priorities include food and water safety, environmental factors including climatic injuries, infectious diseases, disease vectors and their control, education, mental health assessment, and dental hygiene.

4. Administration and Logistics

a. Administration. See Annex Q.

b. Logistics. See Annex Q. There are no unique logistic requirements to satisfy FHP requirements.

5. Command and Control. See base plan. There are no unique relationships WRT FHP.

Tabs
A- Lead Force Health Protection Responsibilities for APODS/SPODS – Not Used
B--Contagious Disease Health Threat FHP Guidance
C-Force Health Protection (FHP) Deployment Occupational and Environment Health Surveillance – Not Used

//Signed//
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APPENDIX 9 TO ANNEX Q to USNORTHCOM CONPLAN 3591 for Pandemic Influenza
VETERINARY MEDICINE

References:

a. National Response Framework, January 2008

b. Department of Defense Directive 6400.4, "DOD Veterinary Services Program", August 2003

c. Army Regulation 40-905, SECNAVINST 6401.1B, AFI 48-131, 29 August 2006, Veterinary Health Services

d. Army Regulation 40-657, NAVSUP 4355.4H, MCO P10110.31H, 21 January 2005, Veterinary/Medical Food Safety, Quality Assurance, and Laboratory Service

e. FM 4-02.18, December 2004, Veterinary Service Tactics, Techniques, and Procedures.

f. MEDCOM Pamphlet 525-1, 1 October 2003, Medical Emergency Management Planning

g. United States Department of Agriculture, National Animal Health Emergency Management System Guidelines, Response Strategies: Highly Contagious Diseases, September 2005

h. United States Department of Agriculture, Summary of the National Highly Pathogenic Avian Influenza (HPAI) Response Plan, August 2007

1. Situation

a. General

(1) Purpose. To provide a concept of operation for military veterinary support, assign tasks, and provide guidance on military

veterinary issues in support of the USNORTHCOM response to pandemic influenza (PI).

(2) Background.

(a) Domestic events involving agriculture or animals occur due to various causes and may require the assistance of DOD. Influenza A may affect animals only, humans only, or humans and animals.

(b) Avian influenza (AI) – the bird flu – is a disease caused by a virus that infects domestic poultry, wild birds (like quail, cranes, geese, and ducks) and pet birds like parrots. Each year, there is a bird flu season just as there is for humans, and, as with people, some forms of flu are worse than others.

(c) Avian influenza viruses can be classified as low-pathogenic (LPAI) or highly-pathogenic avian influenza (HPAI) based on the severity of illness they cause. LPAI has existed in the United States since the early 1900's and is not uncommon here. It causes birds to become ill and can be fatal to some of them. This strain of the disease poses no serious threat to human health. However, some LPAI virus strains are capable of mutating under field conditions into HPAI viruses. HPAI is an extremely infectious and fatal form of the disease which, once established, can spread rapidly from flock to flock. H5N1 HPAI is the type currently detected in parts of Southeast Asia and Eastern Europe. This strain has been reported to be frequently transmitted in select Southeast Asian human population in direct contact with infected birds with high mortality rates, exceeding 50%.

(d) There have been three HPAI outbreaks in poultry in the United States in 1924, 1983, and 2004. No significant human illness resulted from these outbreaks. There is no evidence that HPAI currently exists in the United States.

b. Assumptions.

(1) There are several types of incidents where DOD veterinary or other assets might be tasked to respond and provide support to civilian authorities. These include animal disease outbreaks such as avian and swine influenza.

(2) The United States Department of Agriculture (USDA) is responsible for protecting American agriculture from exotic or foreign animal diseases, including avian influenza. It advises individuals,

private sectors, and state, local, and tribal governments, on appropriate biosecurity measures both before and after a disease is introduced. It also helps develop, support, and carry out surveillance for disease agents of concern. The USDA is designated the primary agency and coordinator for emergency support function #11 (ESF-11), Agriculture and Natural Resources Annex of the National Response Framework (NRF). Similarly, state departments of agriculture through their authorities and corresponding state response plans provide the primary leadership of the state response although the USDA will still provide the bulk of the funding for local response operations.

(3) The USDA works closely with international organizations like World Organization for Animal Health (OIE), the United Nations' Food and Agricultural Organization (FAO), and the World Health Organization (WHO) to assist HPAI-affected countries and other neighboring countries with disease prevention, management, and eradication activities. The USDA also maintains trade restrictions on the importation of poultry and poultry products from countries currently affected by H5N1 HPAI.

(4) The Department of Interior is responsible for managing wildlife, including migratory birds, under various laws and treaties, and for ensuring public health on more than 500 million acres of land across the country. Three organizations have roles in the Department's efforts related to HPAI: the US Geological Survey (USGS), the US Fish and Wildlife Service and the National Park Service. The USGS is the scientific arm of the Department and is supporting international HPAI research efforts by contributing information and expertise about migratory birds and bird movements. USGS scientists from the National Wildlife Health Center and the Alaska Science Center, in conjunction with the US Fish and Wildlife Service and the State of Alaska, strategically sample migrating birds for H5N1 in the Pacific Flyway. USGS is also monitoring reported migratory waterfowl and shorebird mortality events for the presence of H5N1.

(5) The resources of agricultural agencies, including technical resources will quickly be overwhelmed in a multi-state event. USDA and many states have mechanisms in place to mobilize and deploy animal health professional volunteers. Many of these professionals are employed in private veterinary practice or academia. The USDA can also request animal health and other medical professionals from the Commissioned Corps of the Public Health Service, the National Disaster Medical System, and other federal agencies. The number of these professionals is limited.

(6) DOD support to animal health authorities in animal disease outbreak responses is anticipated in several functional areas and may not all be veterinary specific. DOD may be tasked to provide support in the areas of disease surveillance, biosecurity/disease containment, field investigation, epidemiology (disease tracking, animal movement, tracing, modeling, and disease eradication planning), laboratory processing and analysis, risk assessment, and disease agent expertise. DOD may also be tasked to assist in other areas such as decontamination, movement control, and disposal of animal carcasses or plant materials. In addition to personnel skilled in all of these functional areas, DOD has personnel trained in command and control and operational execution and may be requested to integrate into the Incident Command System to support the Primary Federal Official (PFO).

(7) DOD veterinary support will also be required to support military forces responding to a disease outbreak. Support includes food inspection (dining facilities, rations, and procurement), disease surveillance, and medical support to military working animals.

(8) Support from DOD veterinary resources during a declared disaster will be requested and funded in accordance with the National Response Plan and existing mechanisms for requesting other DOD support, IAW with the Base Plan.

2. Mission. CDRUSNORTHCOM provides veterinary support in conjunction with or separate from other joint health service support (HSS) to US military forces, coalition forces, and civilian support in support of this concept plan (CONPLAN) and annex.

3. Execution.

a. Concept of Veterinary Operations.

(1) DOD veterinary support for declared national emergencies or National Special Security Events (NSSE) will be requested IAW established procedures.

(2) DOD veterinary support may be requested by the US Department of Agriculture (USDA) or other federal agencies in response to Incidents of National Significance and other emergencies without a Presidential Disaster Declaration. An example is a significant animal disease outbreak such as avian influenza. In such cases the Secretary of Agriculture may issue a Secretarial disaster declaration, quarantine designation or declare an "extraordinary emergency" and assistance from

DOD may be requested. The Secretary of Agriculture or his designated representative will request assistance from the Department of Defense through the Executive Secretary. In coordination with the Defense Veterinary Liaison Officer and the Command Veterinarian, USNORTHCOM, the Executive Secretary will validate the authenticity and feasibility of the request and forward it for SecDef approval.

(3) Phase 0, Shape. Actions taken during this phase include plan development, exercises, and rehearsals.

b. Tasks.

(1) CDRUSNORTHCOM.

(a) Integrate veterinary and agricultural information and surveillance efforts in collaboration with DOD components and other federal agencies via early warning systems in order to identify potential threats such as an outbreak in animals both abroad and within the NORTHCOM area of responsibility (AOR).

(b) Coordinate exercise participation and response processes at national, regional, and local levels with other Unified Commands, DOD Components, and other federal and state agencies.

(c) Establish and maintain contact with the Office of Emergency Management and Homeland Security, US Department of Agriculture Animal and Plant Health Inspection Service (USDA APHIS); Emergency Management, Veterinary Services, APHIS; US Department of Interior US Geological Survey (USGS) and other federal and DOD agencies (particularly DOD Veterinary Services Activity) involved in an animal disease surveillance and emergency response. The Command Veterinarian, USNORTHCOM, will normally coordinate this liaison. The Command Veterinarian will also assist the Defense Veterinary Liaison Officer and the joint Director of Military Support (JDOMS) in validating authenticity and feasibility of requests for veterinary assistance from federal and state agencies.

(2) Services.

(a) Army (DOD Executive Agent for Veterinary Services).

1 Be prepared to (BPT) to provide veterinary resources to include military specialists trained in foreign animal disease diagnosis,

laboratory diagnosis, epidemiology, microbiology, immunology, entomology, pathology, and public health.

2 Ensure training and readiness of veterinary personnel for response to an agricultural emergency including avian influenza. In conjunction with the USDA, train Veterinary Officers as Foreign Animal Disease Diagnosticians to the maximum extent possible.

3 Ensure veterinary assets are trained and capable of working within the Incident Command System outlined by the National Incident Management System.

4 Develop veterinary assets capable of providing Military Support to Civilian Authorities using an all-hazards approach.

5 When a joint task force (JTF) is expected to deploy, BPT nominate a US Army Veterinary Corps Officer to serve on the staff of the JTF Commander and to advise the JTF Commander and JTF Surgeon on veterinary support issues.

6 Report any unusual wildlife illnesses or die-offs on military installations to the respective state veterinarian or department of agriculture.

(b) Other Services.

1 BPT to provide resources to include military specialists trained in laboratory diagnosis, epidemiology, microbiology, immunology, entomology, pathology, and public health.

2 BPT to provide laboratory support to assist and augment the capabilities of the US Department of Agriculture and other federal agencies.

3 Report any unusual wildlife illnesses or die-offs on military installations to the respective state veterinarian or department of agriculture.

4 Phase I, Prevent. This phase begins on order. JTFs stand up to develop situational awareness and connectivity. Decisive to this phase is USNORTHCOM's ability to achieve situational awareness and connectivity prior to the first reported human-to-human transmission.

c. Phase Tasks

(1) Army (DOD Executive Agent for Veterinary Services).

(a) In the event of an agricultural emergency where a DCO and JTF are not deployed, nominate a US Army Veterinary Corps officer as a Defense Veterinary Coordinating Officer (DVCO) to serve as an on-site point of contact for DOD veterinary functions.

(b) When a JTF is to deploy, nominate a US Army Veterinary Corps Officer to serve on the staff of the JTF Commander and to advise the JTF Commander and JTF Surgeon on veterinary support issues. This may require nomination of several officers to serve in each task force as described in Annex Q of the base plan.

(2) Phase II, Contain. This phase begins on order. Forces deploy to help in containing/limiting/slowing the spread of (PI) to prevent an unremediated outbreak throughout the AOR. Decisive to this phase is USNORTHCOM's ability to identify the outbreak before it becomes unmanageable.

(a) In the event that a Defense Veterinary Coordination Officer (DVCO) is deployed in lieu of a DCO and/or a JTF, the DVCO will serve as DOD's single point of contact in the Joint Field Office with DCO duties as outlined in the Base Plan and Annex Q.

(b) Requests for assistance (RFAs) and requests for forces (RFFs) will be processed through the DVCO IAW Base Plan and Annex Q.

(3) Phase III-V, (Interdict, Stabilize, Recover). IAW with Base Plan and Annex Q.

c. Coordinating Instructions.

(1) The USDA will formally request DOD support through the Executive Secretary, DOD when other federal veterinary resources are inadequate or inappropriate to respond to an agricultural incident.

(2) The USDA will maintain and exercise plans for a coordinated Federal response. The USDA will integrate DOD and other federal and state response agencies into these plans.

4. Administration and Logistics. IAW Base Plan and Annex Q.

5. Command and Control.

a. Deployed individuals and units remain under military command. In the case where only veterinary assets are deployed and no DCO or JTF has been designated, the senior deployed veterinary officer or the Defense Veterinary Coordinating Officer will serve as the military officer-in-charge and will report to CDRUSNORTHCOM. Where there is a DCO and/or a JTF, the chain of command will go through the senior veterinary officer to the DCO or JTF commander, as appropriate, to CDRUSNORTHCOM.

b. USDA, the Federal Emergency Management Agency, or other agencies receiving support will reimburse DOD for all incremental expenses in accordance with established procedures and the NRF.

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13 August 2009

ANNEX R TO USNORTHCOM CONPLAN 3591
REPORTS

References:

a. CJCSM 3150.03B, *Joint Reporting Structure Event and Incident Reports*

b. CJCSM 3150.05C, *Joint Reporting Structure Situation Monitoring Manual*

c. CJCSM 3150.01A, *Joint Reporting Structure General Instructions*

d. CJCSI 6241.04, *Policies and Procedures for Using United States Message Text Formatting*

e. USNORTHCOM INSTRUCTION (NCI) 10-211, *Operational Reporting*

1. Purpose. This annex sets forth the reporting procedures that must occur to support the execution of CONPLAN 3591. It describes the monthly, weekly and daily reporting requirements as they pertain to the various phases of CONPLAN 3591.

2. Mission. See Base Plan and apply the following reporting considerations. Services, Components, Subordinate Commands and DOD agencies implement CONPLAN 3591 by execution of their supporting plans in order to plan for and respond to a pandemic influenza environment. The premise of mission execution is centralized planning with decentralized execution and reporting procedures that support senior leader situational awareness, assessments and recommendations that supports CDRUSNORTHCOM level decision support template.

3. Concept of Operations.

a. Reporting Channels.

(1)The focal point for CONPLAN 3591 reporting is the NORAD-USNORTHCOM Command Center. Combatant commands, Service and DOD Agencies making the report may copy other organizations as required for coordination. [

(b)(2)

(2) NORAD-USNORTHCOM Command Center will review and assess the reports and, as needed, incorporate the significant Avian Influenza / Pandemic Influenza (AI/PI) events to the National Military Command Center (NMCC). The NORAD-USNORTHCOM Command Center will require detailed reporting with sufficient information to support recommendations that are made in support of the CDRUSNORTHCOM Decision Support Template; this may require a revision or modification of existing reporting requirements.

(3) Should an AI/PI crisis action team be formed; Services, Components, Subordinate Commands and DOD agencies will provide in-depth situation specific reporting as found within Appendix 1 of this Annex, or as modified as the situation directs.

(b)(2)

(b)(2)

(3) Media Reports. Media reports information; see the Basic Plan, Annex F, Public Affairs.

(b)(2)

c. Classification. All AI/PI reporting classifications will be kept at For Official Use Only level whenever possible; however, upgraded classification level

may be necessary based on situations or circumstances. Classification determination will be made by the reporting unit. All classified reports will be marked accordingly with overall classification and appropriate portion markings.

d. Responsibilities.

(1) Services, Components, Subordinate Commands and DOD.

(a) Provide updates to the NORAD-USNORTHCOM Command Center. [

(b)(2)

e. Coordinating Instructions.

(1) Services, Components, Subordinate Commands and DOD agencies conducting a mission analysis for developing commander's estimates will refer to Annex C, Appendix 28 for Commander's Critical Information Requirements (CCIRs) which encompass: Priority Intelligence Requirements (PIRs), Friendly Forces Information Requirements (FFIRs) and Environmental Requirements (ERs) that will effect reporting requirements.

(2) Combatant commands, Services and DOD Agency Senior Leaders shall initiate direct contact with Deputy Director of Operations (DDO) at the NMCC on any significant AI/PI development.

(3) Service components of combatant commands will report via their unified command structure. All other Service assets will report through their respective Service.

Appendixes
1 – Reports

//Signed//
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APPENDIX 1 TO ANNEX R TO USNORTHCOM CONPLAN 3591
REPORTS

References:

CJCSM 3150.03B, *Joint Reporting Structure Event and Incident Reports*
CJCSM 3150.05C, *Joint Reporting Structure Situation Monitoring Manual*
CJCSM 3150.01A, *Joint Reporting Structure General Instructions*
CJCSI 6241.04, *Policies and Procedures for Using United States Message Text Formatting*
USNORTHCOM INSTRUCTION (NCI) 10-211, *Operational Reporting*

(b)(2)

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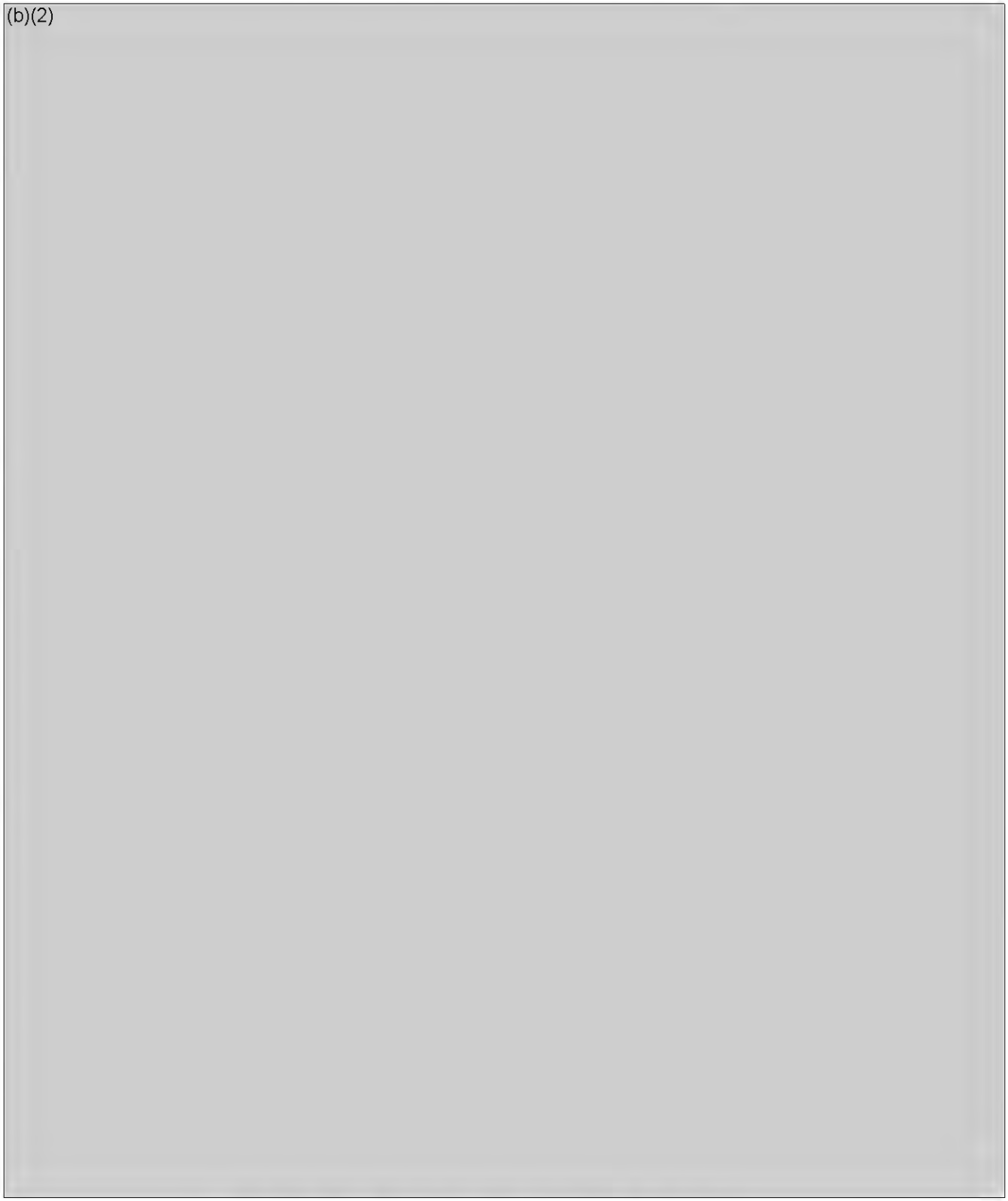

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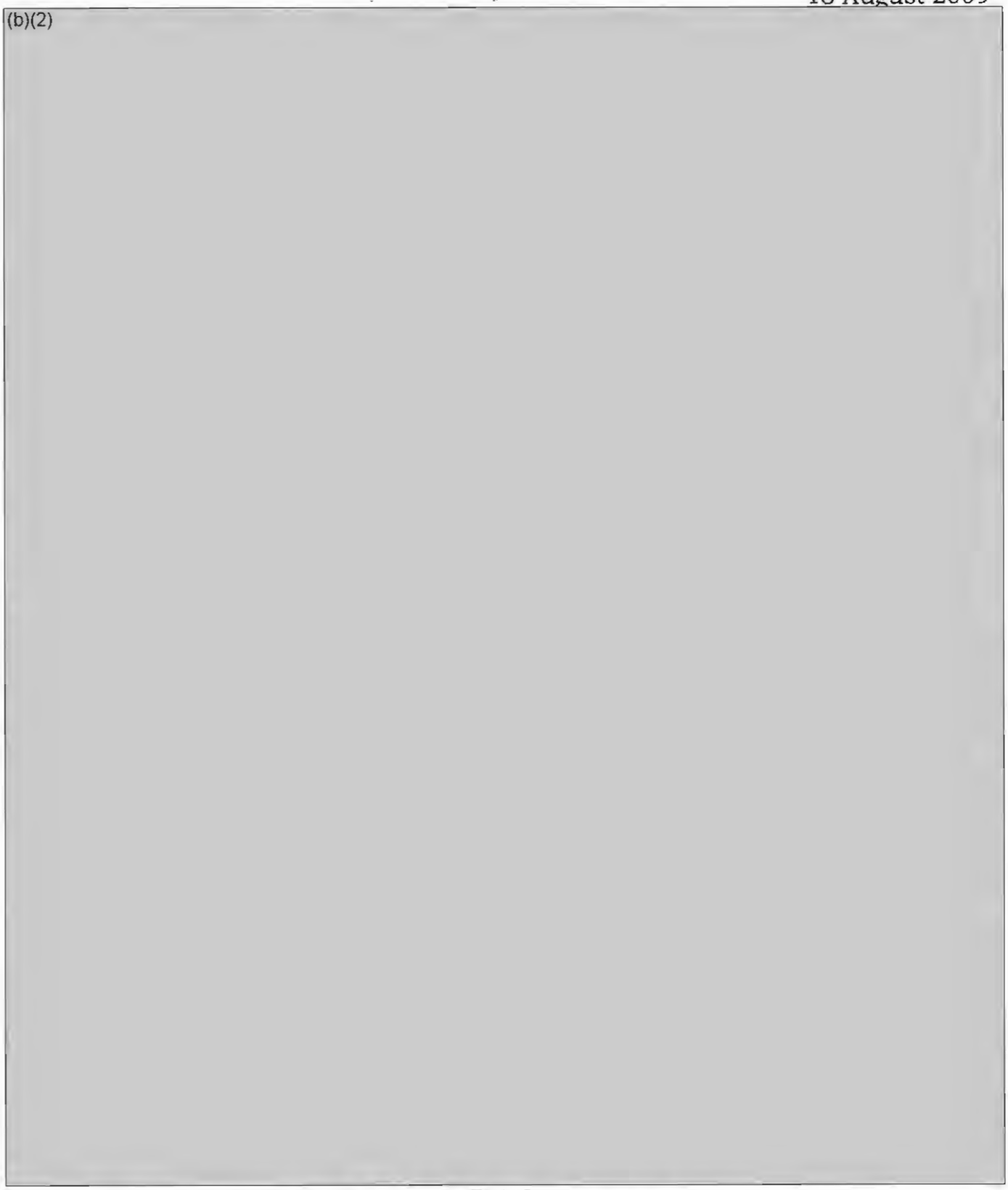

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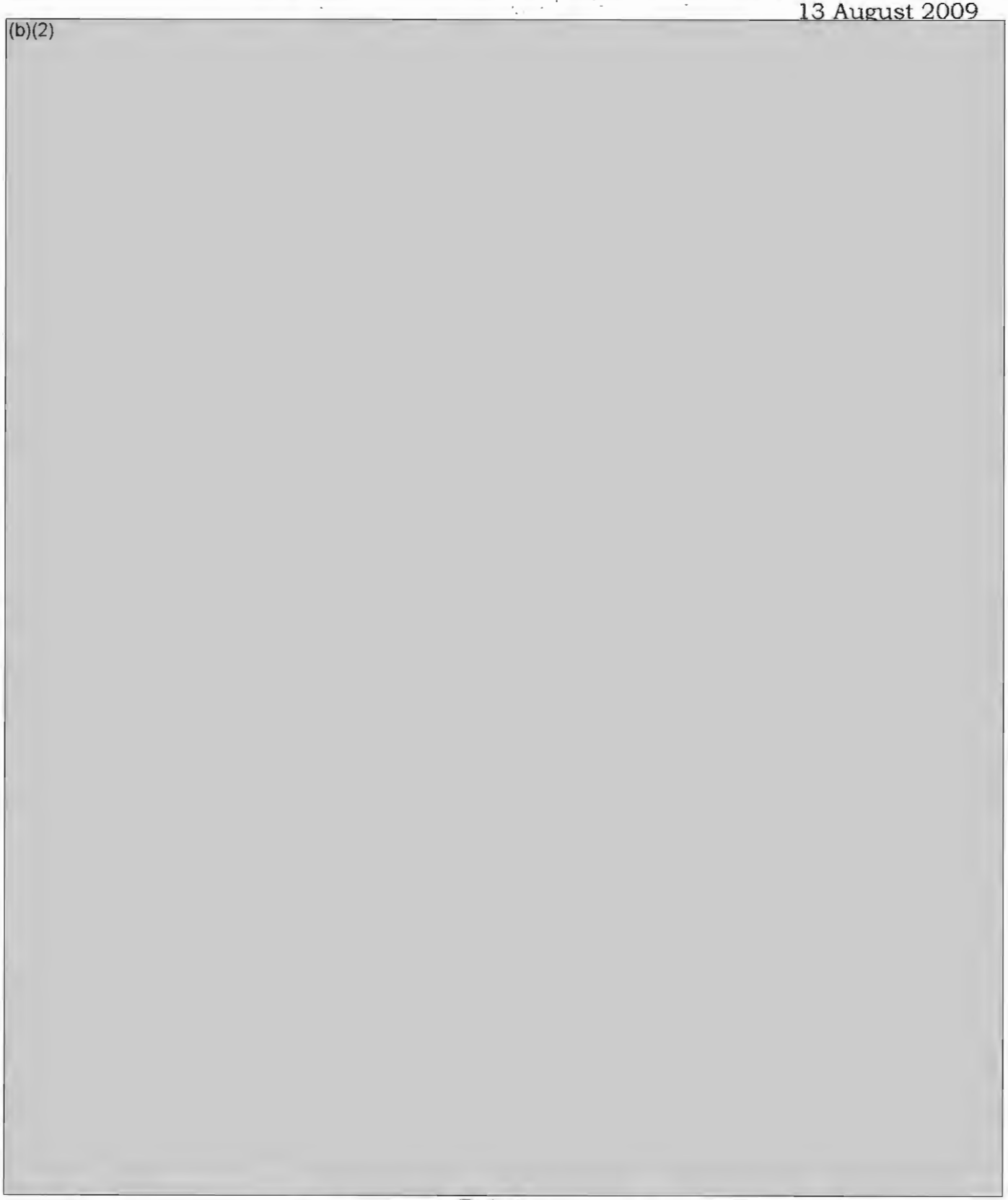

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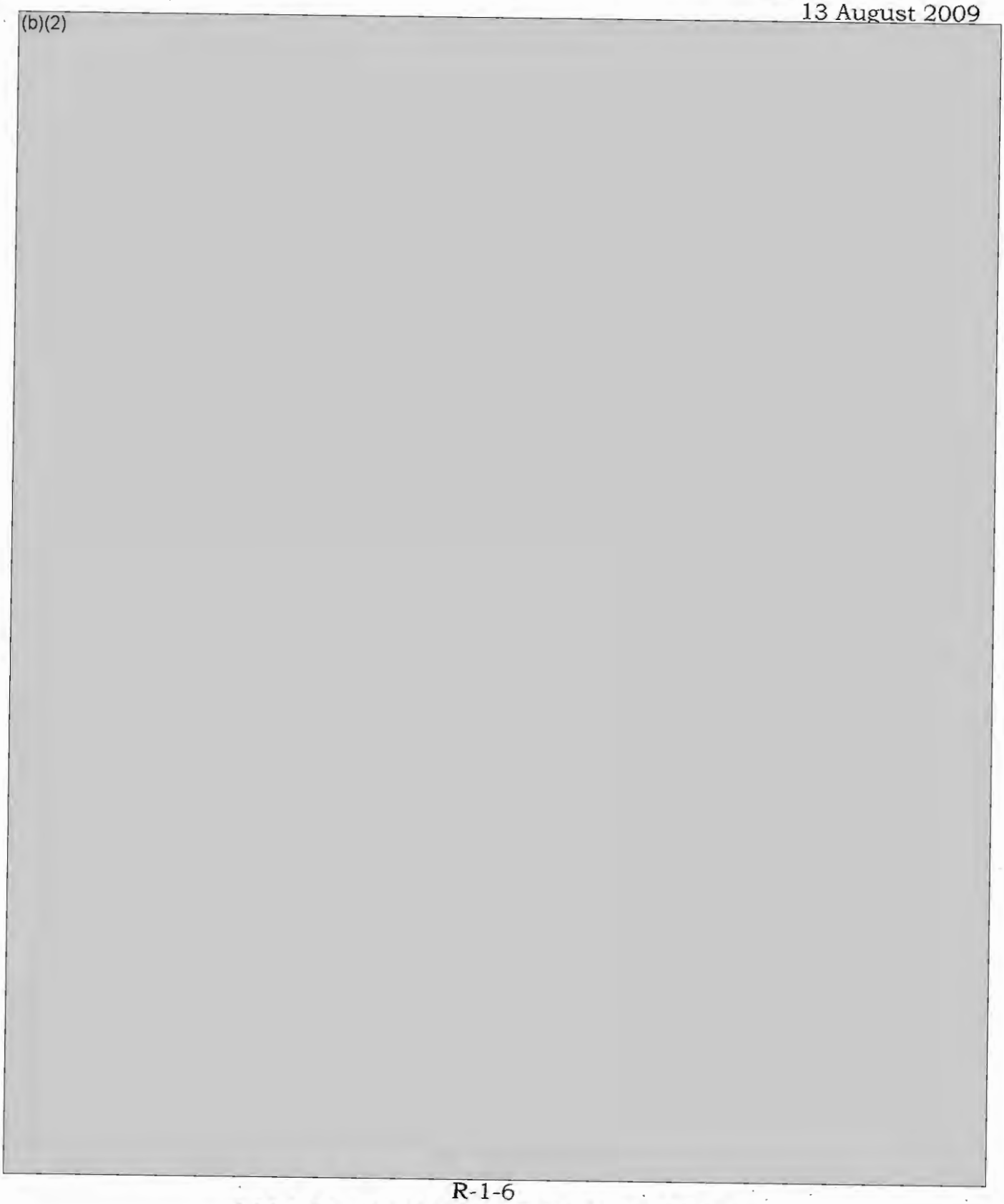

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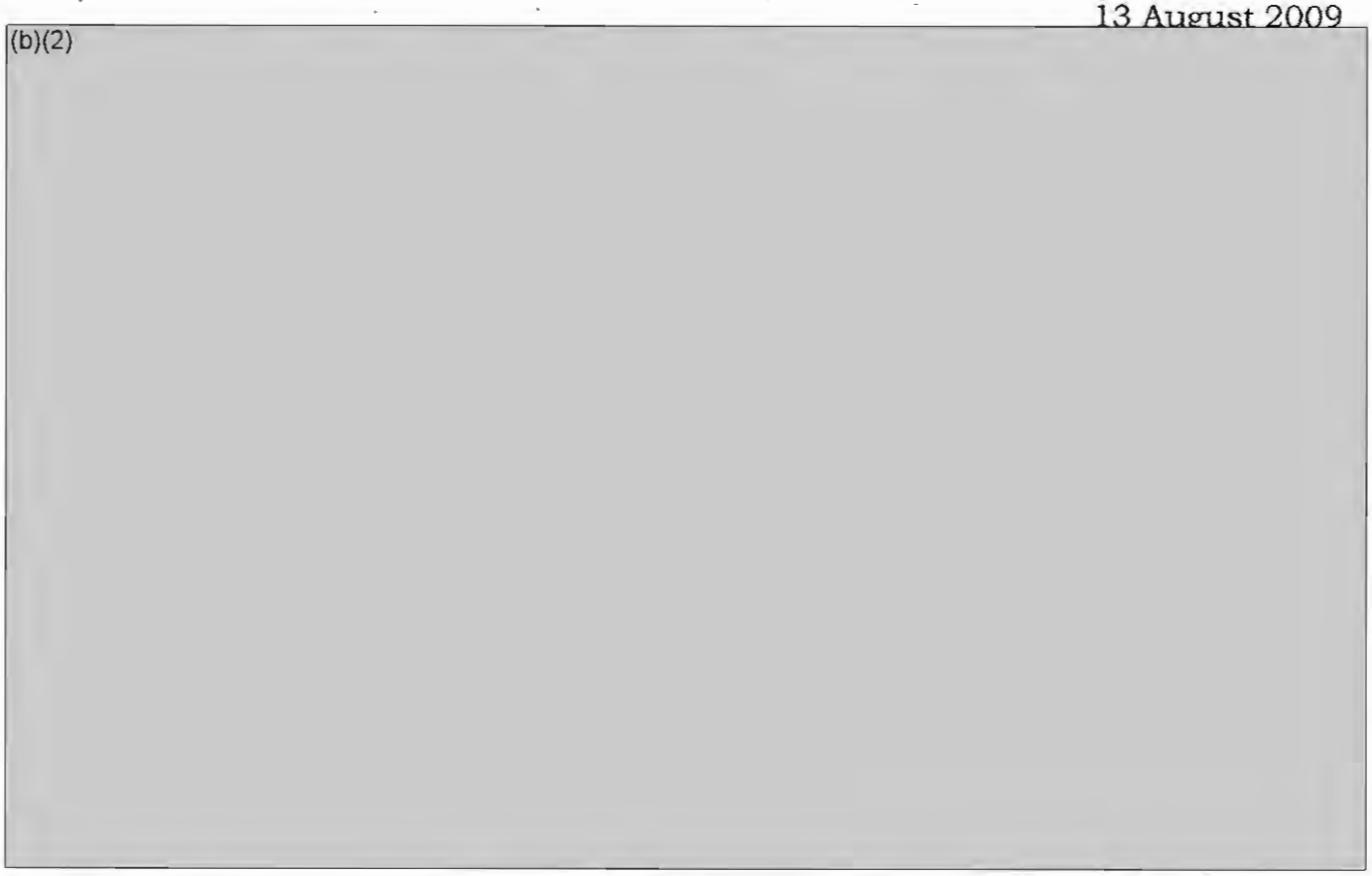

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ANNEX V TO USNORTHCOM CONPLAN 3591-09
INTERAGENCY COORDINATION

References:

a. National Strategy for Pandemic Influenza, November 2005

b. National Strategy for Pandemic Influenza Implementation Plan, May 2006

c. Homeland Security Act of 2002, 25 November 2002

d. DOD Strategy for Homeland Defense and Civil Support, June 2005

e. DOD Implementation Plan for Pandemic Influenza, August 2006

f. CDRUSNORTHCOM CONPLAN 3551-07, DOD Global Pandemic Influenza Concept Plan, 1 October 2007

g. CDRUSNORTHCOM CONPLAN 3501-08, Defense Support of Civil Authorities (DSCA), 16 May 2008

h. World Health Organization (WHO) Global Influenza Preparedness Plan, March 2005

i. Department of Homeland Security Pandemic Influenza Contingency Plan (DRAFT), December 2006

j. Department of Health and Human Services Pandemic Influenza Plan, November 2005

k. Department of State, Office of Medical Services Pandemic Influenza Plan, 22 June 2007

l. Department of Agriculture's Role in the Implementation Plan for the National Strategy for Pandemic Influenza, 3 May 2006

m. Security and Prosperity Partnership (SPP) of North America, North American Plan for Avian & Pandemic Influenza, August 2007

n. Homeland Security Presidential Directive 8 (HSPD-8), Annex 1, National Preparedness – Development of a Standardized National Planning Process and Integration System, December 2007

o. Department of Homeland Security, Integrated Planning System (IPS) Interim Draft, Ver. 2.5, 21 October 2008

p. Department of Homeland Security, National Response Framework (NRF), January 2008

q. Title 31, USC, Section 1535-36, Economy Act

r. Title 42, USC, Section 5121-206, Stafford Act

s. DODD 3025.1, Military Support to Civil Authorities, 1 January 1993

t. DODD 3025.15, Military Assistance to Civil Authorities, 18 February 1997

u. DOD Joint Publication 3-28, Civil Support, 14 September 2007

v. Department of Homeland Security, National Incident Management System (NIMS), 1 March 2004

w. Department of Homeland Security, National Response Plan - Catastrophic Incident Supplement (NRP-CIS), September 2006

x. DOD CJCS Standing DSCA EXORD, 28 May 2008

y. Title 18, USC, Section 1385, Posse Comitatus Act

z. DODD 5525.5, DOD Cooperation with Civilian Law Enforcement Officials, 15 January 1986, w/ Change 1, December 1989

aa. CDRUSNORTHCOM CONPLAN 3502, Civil Disturbance Operations (CDO), 23 January 2007

1. Situation

a. General. The threat and possibility of a global influenza pandemic, primarily from, but not exclusive to, the H5N1 virus, have serious medical, economic and security implications for the United States and its North American neighbors. It is important that North American countries work together, with common goals and objectives, as we plan and prepare our nations for the potential of pandemic influenza (PI). For the United States, it is vital that the Federal government coordinates, integrates and synchronizes its efforts throughout all of its departments, agencies and organizations as it plans activities and actions to respond to PI. References n and o facilitate integrated planning and clarify lines of responsibility between Department of Defense (DOD) and many governmental and non-governmental agencies. CONPLAN 3591 execution requires the support of all appropriate government agencies. Failure to integrate planning early will cause seams in synchronization of the Federal Government's efforts to carry out the Homeland Security spectrum of operations (HSSO); prevent, protect, respond and recover and may cause shortfalls in resources needed to support mission accomplishment, and could jeopardize the overall success of operations.

b. Purpose. The intent of this annex is to provide interagency partners with a single reference to the USNORTHCOM CONPLAN 3591-08, USNORTHCOM Response to Pandemic Influenza. It provides a framework that can be shared which highlights how USNORTHCOM expects to plan for and conduct operations in preparation for and response to a pandemic influenza.

c. Interagency Relationships:

(1) The National response to a PI event will include support from DOD, with certain capabilities and within PI specific limitations, to primary and/or coordinating agencies. USNORTHCOM will have to balance the requirement to enable force projection and protect military capabilities through Force Health Protection (FHP) and providing support to civil authorities. As such, USNORTHCOM must maintain the existing relationships it has with the primary and coordinating agencies responsible for planning for and participating in the response to PI. The relationships that USNORTHCOM has with governmental and non-

governmental agencies play a critical role in our ability to execute this CONPLAN.

(2) The Commander of USNORTHCOM is authorized to provide civil support (CS) in response to actual or potential natural or man-made disasters, or other emergencies requiring DOD-augmented support within the USNORTHCOM AOR. Civil Support and Defense support of civil authorities (DSCA) is provided when a Federal agency requests DOD assistance or when DOD is directed to provide assistance to a Federal primary agency by the President or the Secretary of Defense (SecDef), under the auspices of the National Response Framework (NRF). Civil Support is a complex, multi-echeloned mission with guiding authorities, policy directives, and operational doctrine that have evolved over the past several years to better adapt to changing requirements in the Federal departments and agencies and the private sector. Civil Support does not include those DOD missions directed by the President, under Constitutional Article II authority in his role as Commander-In-Chief, to defend the country against threats.

(3) During Civil Support, DOD is in a supporting role to a primary federal department or agency, when that department or agency requests DOD assistance and it is approved by the SecDef or designated representative, or authorized in separate established authorities. It is vital to fully understand the appropriate authorization for the provision of the requested support, as well as the reimbursement mechanism. DSCA may be provided to Federal, State, tribal and local authorities for all types of events across the preparedness spectrum in order to protect, prevent, and respond to incidents, whether natural or manmade, routine or catastrophic. It may include Federal military forces; Reserve Component forces, including the National Guard; DOD agencies and components; and DOD civilian and contractor personnel. DSCA is a subset of the larger concept of civil support (CS).

d. U.S. Goals, Objectives, Priorities:

(1) National Strategy. Preparing for a pandemic requires the leveraging of all instruments of national power, and coordinated action by all segments of government and society. The President's National Strategy for Pandemic Influenza reflects the federal government's approach to the pandemic threat.

(a) The pillars of the National Strategy for Pandemic Influenza remain relevant through the full spectrum of events that precede, declare and embody a pandemic. The pillars are:

1 Preparedness and Communication

2 Surveillance and Detection

3 Response and Containment

(b) The National Strategy guides how the Federal government prepares, detects and responds to an influenza pandemic with the intent to:

1 Stop, slow or otherwise limit the spread of a pandemic to the United States.

2 Limit the domestic spread of a pandemic, and mitigate disease, suffering and death.

3 Sustain infrastructure and mitigate impact to the economy and the functioning of society.

(2) Implementation Plan for the National Strategy for Pandemic Influenza (NIP). The NIP provides a directive framework to the National Strategy and assigns preparedness and response tasks to Federal departments and agencies and describes US Government (USG) expectations of non-Federal entities, including State and local governments, the private sector, international partners, and individuals. The NIP states that the SecDef will be responsible for protecting American interests at home and abroad. Additionally, the SecDef may assist in the support of domestic infrastructure and essential government services or, at the direction of the President and in coordination with the Attorney General, the maintenance of civil order or law enforcement, in accordance with applicable law. The SecDef will retain command of military forces providing support.

(3) Secretary of Defense and DOD Guidance. The SecDef and the Office of the Secretary of Defense (OSD) outlined that DOD would take action by establishing clear mission parameters which preserve combat capabilities and readiness; save lives and reduce human suffering. Accordingly, assets and resources provided by DOD for support will be accomplished with these priorities in mind.

(a) The first priority of DOD support in the event of a pandemic will be to provide sufficient personnel, equipment, facilities, materials and pharmaceuticals to care for DOD forces, civilian personnel, dependents and beneficiaries (including contractors overseas) to protect and preserve the operational effectiveness of our forces throughout the globe.

(b) DOD's second priority is to sustain mission assurance for DOD missions and to maintain the ability to meet our strategic objectives.

(c) Additionally DOD will respond quickly and effectively to the requests of civil authorities in the event of a PI to save lives, prevent human suffering, and provide security, within capabilities, when directed by the SecDef or the President of the United States (POTUS).

(4) DOD Strategic Objectives. The DOD objectives are to:

(a) Sustain mission assurance.

(b) Protect key population, critical infrastructure and capabilities.

(c) Support USG PI response efforts.

(d) Maintain effective communication.

(5) United States Northern Command Concept Plan 3551-07, DOD Global Concept Plan to Synchronize Response to Pandemic Influenza (CONPLAN 3551). USNORTHCOM was directed by the SecDef to coordinate the planning and synchronization of DOD plans in support of US Government efforts to mitigate and contain the effects of a pandemic influenza. Accordingly, USNORTHCOM developed CONPLAN 3551 in coordination with combatant commands, Services, Defense Agencies and Interagency partners. The purpose of the CONPLAN is to provide a synchronized, common operating structure and detailed planning guidance for the development and execution of coordinated combatant command, Service and DOD Agency plans to prepare for and respond to PI. CONPLAN 3551 identifies six phases that delineate when DOD actions will occur in response to an influenza pandemic. This CONPLAN (CONPLAN 3591) uses the same phasing construct. The following phase descriptions reflect USNORTHCOM response to PI:

(a) Phase 0 - Shape - incorporates planning, surveillance, and engagement activities to shape perceptions and influence behavior.

(b) Phase 1 - Prevent - support USG efforts to prevent or limit the spread of the virus.

(c) Phase 2 - Contain - take measures to protect the USNORTHCOM population in the localized region(s) while maintaining the freedom of action to conduct assigned missions, and as directed, support USG efforts to contain the new virus within a limited area in

order to prevent a pandemic and gain time for implementation of additional pandemic preparedness measures.

(d) Phase 3 - Interdict - take broader measures to protect the USNORTHCOM population while maintaining the freedom of action to conduct assigned missions, and as directed, support USG efforts to delay or halt a pandemic influenza wave.

(e) Phase 4 - Stabilize - protect the USNORTHCOM key population, maintain freedom of action to conduct assigned missions and within capabilities, and as directed, support USG in mitigating the pandemic effects in order to ensure governments and communities are capable of maintaining social order, maintain critical infrastructure, and minimize human suffering.

(f) Phase 5 - Recover - conducts force reconstitution operations and as directed will support USG efforts to re-establish normal support conditions with key partners.

e. Federal Government Roles and Responsibilities:

(1) The role of the Federal Government in a pandemic response will differ in many respects from its role in most other natural or manmade events. The distributed nature of a pandemic, as well as the sheer burden of disease across the Nation, means that the physical and material support States, localities, and tribal entities can expect from the Federal Government will be limited in comparison to the aid it mobilizes for geographically and temporally bounded disasters like earthquakes or hurricanes.

(2) It is important for the Federal Government to coordinate closely its efforts to gather relevant data and overall situational awareness in a timely manner from the initial phases of a pandemic until recovery is complete, and to communicate its approach to its international partners, State, local and tribal entities, critical infrastructure owners and operators, and the public. The Federal Government must maintain complete situational awareness and be ready and able to take decisive action to ensure a comprehensive and timely national response to a pandemic.

(3) The Federal Government bears primary responsibility for certain critical functions. These functions include:

(a) The support of containment efforts overseas and limitation of the arrival of a pandemic to our shores.

(b) The provision of clear guidance to State, local, and tribal entities, the private sector and the public on protective measures and responses that should be taken.

(c) The modification of the law and regulations to facilitate the national pandemic response.

(d) The modification of monetary policy to mitigate the economic impact of a pandemic on communities and the Nation.

(e) The procurement and distribution of vaccine and antiviral medications.

(f) The acceleration of research, development, testing, and evaluation of vaccines and therapies during an outbreak.

(4) The National Response Framework (NRF) will form the basis of the Federal pandemic response. It defines Federal departmental responsibilities for sector-specific responses, and provides the structure and mechanisms for effective coordination among Federal, State, local, and tribal entities, the private sector, and non-governmental organizations (NGOs). Pursuant to the NRF and Homeland Security Presidential Directive 5 (HSPD-5), the Secretary of Homeland Security is responsible for coordination of Federal operations and resources, establishment of reporting requirements, and conduct of ongoing communications with Federal, State, local and tribal governments, the private sector and NGOs.

(5) A pandemic will present unique challenges to the coordination of the US Government response. Support from the Federal Government to affected communities will differ in kind and character from that given during more traditional natural disasters. The impact of a pandemic can last for many months. A pandemic is a sustained public health and medical emergency that will have sustained and profound consequences for the operations of critical infrastructure, the mobility of people and freight, and the global economy. Health and medical considerations will affect foreign policy, international trade and travel, domestic disease containment efforts, continuity of operations (COOP) with the Federal Government, and may other aspects of the Federal response.

f. Department and Agency Partner Roles and Responsibilities:

(1) Specific roles and responsibilities for Federal Departments and Agencies are included in the Implementation Plan for the National

Strategy for Pandemic Influenza (NIP). These roles and responsibilities and resulting actions may require coordination with DOD and potentially require DOD support. There are roles and responsibilities delineated within each of the following topics:

(a) International Efforts

(b) Transportation and Borders

(c) Protecting Human Health

(d) Protecting Animal Health

(e) Law Enforcement, public Safety, and Security

(f) Institutions: Protecting personnel and ensuring continuity of operations

(2) The NIP translates the National Strategy for Pandemic Influenza into over 300 specified tasks for all Federal departments and agencies. These tasks direct the Federal departments and agencies to take specific and coordinated actions to achieve the goals of the National Strategy, using the full spectrum of their resources, including personnel. An examination and analysis of all these tasks may result in implied tasks for DOD coordination and support.

(3) The NIP specifies actions and tasks for the Federal departments and agencies. Examination and analysis of these tasks may result in implied coordination by and support from DOD assets and capabilities. The tasks and actions are organized according the U.S. Government's stages for PI.

(4) The primary role for the Federal departments and agencies that have significant responsibilities in preparation for and response to PI follow:

(a) Department of Health and Human Services (DHHS). The Secretary of Health and Human Services will be responsible for the overall coordination of the public health and medical emergency response during a pandemic, to include coordination of all Federal medical support of communities; provision of guidance on infection control and treatment strategies to State, local and tribal entities, and the public; maintenance, prioritization, and distribution of countermeasures in the Strategic National Stockpile; ongoing

epidemiologic assessment, modeling of the outbreak, and research into the influenza virus, novel countermeasures, and rapid diagnostics.

(b) Department of Homeland Security (DHS). The Secretary of Homeland Security, will be responsible for coordination of the Federal response as provided by the National Strategy for Pandemic Influenza, the Homeland Security Act of 2002, and HSPD-5, and will support the Secretary of Health and Human Services' coordination of overall public health and medical emergency response efforts. The Secretary will be responsible for coordination of the overall response to the pandemic, implementation of policies that facilitate compliance with recommended social distancing measures, the provision of a common operating picture for all departments and agencies of the federal Government, and ensuring the integrity of the Nations' infrastructure, domestic security, and entry and exit screening for influenza at the borders.

(c) Department of State (DOS). The Secretary of State will be responsible for the coordination of the international response, including ensuring that other nations join us in our efforts to contain or slow the spread of a pandemic virus, helping to limit the adverse impacts on trade and commerce, and coordinating our efforts to assist other nations that are impacted by the pandemic.

(d) Department of Agriculture (USDA). The Secretary of Agriculture will be responsible for overall coordination of veterinary response to a domestic animal outbreak of a pandemic virus or virus with pandemic potential and ongoing surveillance for influenza in domestic animals and animal products. The Secretary of Agriculture will also be responsible for ensuring that the Nation's commercial supply of meat, poultry, and egg products are wholesome, not adulterated, and properly labeled and packaged.

(e) Department of Transportation (DOT). The Secretary of Transportation will be responsible for coordination of the transportation sector and will work to ensure that appropriate coordinated actions are taken by the sector to limit spread of infection while preserving the movement of essential goods and services and limiting the impact of the pandemic on the economy.

(f) Department of the Treasury. The Secretary of the Treasury will be responsible for monitoring and evaluating the economic impacts of the pandemic and will help formulate the economic policy response and advice on the likely economic impacts of containment efforts. The Secretary of the Treasury will also be responsible for preparing policy

responses to pandemic-related international economic developments, for example, leading the Federal Government's engagement with the multilateral development banks (MDB) and international financial institutions (IFI), including encouraging MDB and IFI efforts to assist countries to address the impact of pandemic influenza.

(g) Department of Labor. The Secretary of Labor will be responsible for promoting the health, safety, and welfare of employees and tracking changes in employment, prices, and other economic measurements.

(h) Other Cabinet heads will retain responsibility for their respective sectors. All departments and agencies will be responsible for developing pandemic plans that (1) provide for the health and safety of their employees (2) ensure that the department or agency will be able to maintain its essential functions and services in the face of significant and sustained absenteeism (3) provide clear directions on the manner in which the department will execute its responsibilities in support of the Federal response to a pandemic as described in this Plan; and (4) communicate pandemic preparedness and response guidance to all stakeholders of the department or agency.

g. Assumptions. See Base Plan. Planning assumptions are also found in the NIP, the DRAFT Federal Pandemic Influenza Strategic Plan and the DOD Implementation Plan for Pandemic Influenza (DIP).

h. Legal and Policy Considerations. See Base Plan.

2. Mission. When directed by the President or SecDef, CDRUSNORTHCOM conducts operations in response to an influenza pandemic within designated AOR to mitigate the impact on our Nation's welfare.

3. Execution

a. Commander's Intent

(1) Purpose. Maintain defense of the homeland while limiting the long-term impact of an influenza pandemic in order to preserve the fundamental freedoms, security, health, and safety of our nation.

(2) Key Tasks

(a) Develop plan in coordination with interagency and intergovernmental partners.

(b) Identify internally sourced regional joint task force (s) (RJTF(s)) Headquarters.

(c) Monitor global infections to identify influenza pandemic.

(d) Request for forces of additional required RJTF(s) Headquarters.

(e) Train and Rehearse.

(f) Receive Operational Control over external RJTF(s).

(g) Deploy RJTFs.

(h) Pre-position key capabilities.

(i) Enhance force health protection (FHP) for USNORTHCOM population.

(j) Set priority of support.

(k) Resource RJTFs with required capabilities, as necessary.

(l) Support USG containment efforts.

(m) Maintain Mission Assurance.

(n) Support USG mitigation efforts.

(o) Prepare for next wave.

(p) Return control of forces to parent organization.

(q) Reconstitute USNORTHCOM forces.

(3) End State. The pandemic is over, or PI is no longer considered a threat within the area of responsibility (AOR). POTUS or SecDef direct DOD to return to normal operations and Phase 5 (recover phase) is complete.

(a) Military forces have been relieved by proper authorities and have been transferred to their respective commands for redeployment.

(b) CDRUSNORTHCOM relinquishes control over deployed forces upon notification of their redeployment.

b. Anticipated Coordination and Support from Federal Department and Agency Partners:

(1) Specific roles and responsibilities for DOD are included in the NIP. These roles and responsibilities and resulting actions may require coordination with other Federal departments and agencies and potentially require their support. There are DOD roles and responsibilities delineated within each of the following topics:

(a) International Efforts

(b) Transportation and Borders

(c) Protecting Human Health

(d) Protecting Animal Health

(e) Law Enforcement, public Safety, and Security

(f) Institutions: Protecting personnel and ensuring continuity of operations

(2) The DOD Implementation Plan for Pandemic Influenza (DIP):

(a) The DIP provides guidance to and directs the military to develop plans to prepare for, detect, respond to, and contain the effects of a pandemic on military forces, DOD civilians, DOD contractors, dependents and beneficiaries. The DIP also directs that military plans for PI will address the provision of DOD assistance to civil authorities both foreign and domestic.

(b) The DIP provides nineteen critical planning categories that should be considered in all DOD PI plans. These categories were derived from the Homeland Security Council's (HSC) five planning priorities and thirteen priority areas. Additionally the DIP aligns the critical planning categories with the National Strategy pillars and priorities. This alignment provides related tasks and actions DOD must complete to

achieve the goals set forth by the National Strategy. An examination and analysis of these planning categories, subsequent alignment, and resultant DOD tasks and actions may highlight required coordination with and support from other Federal departments and agencies.

c. Coordinating Instructions:

(1) Direct Liaison Authority (DIRLAUTH) is authorized with the Federal Department and Agency partners listed in this CONPLAN for the purposes of planning, synchronizing and execution of this plan.

(2) DIRLAUTH among subordinate units, service forces conducting Immediate Response operations and Title 32/state active duty forces, as well as other Federal forces conducting PI operations in the USNORTHCOM AOR.

(3) Service and functional components will capture costs during all phases of the PI response for ultimate reimbursement from the primary agency.

(4) CDRUSNORTHCOM shall be the coordinating authority for any USNORTHCOM members (military and civilian) conducting civil support PI operations in the USNORTHCOM AOR. Such forces, with the exception of US Transportation Command (USTRANSCOM) forces not assigned to the NORTHCOM Deployment and Distribution Operations Center (NDDOC) will normally be OPCON to CDRUSNORTHCOM upon arrival at duty location for PI.

(5) Any Service installations and forces responding under immediate response authority must notify the N2C2 at the time they notify the National Military Command Center (NMCC) IAW Deputy SecDef's 25 Apr 05 guidance on, "Reporting Immediate Response Requests from Civil Authorities."

(6) All PI operations will be provided on a reimbursable basis unless the operation was ordered by the POTUS or reimbursement is waived by the SecDef. Immediate response should be provided to civil authorities on a cost-reimbursable basis, if possible.

(7) Communicate/disseminate common public affairs, strategic communication themes and messages consistent with ASD (PA) and Office of the Assistant Secretary of Defense for Homeland Defense and Americas' Security Affairs (ASD (HD&ASA)) guidance, National and DOD policy and guidance.

(8) Conduct exercises and rehearsals with other USNORTHCOM components and subordinates, military services and the Interagency (IA) including state and local organizations.

(9) PI Policy Issue Process:

(a) The process provides a formal structure for addressing and resolving issues associated with Pandemic Influenza.

(b) Issues are derived from all DOD Components, Congressional inquiries, and Government Accountability Office Reports.

(c) Issues are received by the ASD (HD&ASA) and the Joint Staff.

(d) All issues are vetted at the monthly Pandemic Influenza Task Force (PITF) meeting where the appropriate lead and supporting DOD Component are assigned.

(e) Issues that cannot be successfully resolved by the PITF or require senior official guidance are presented at the Pandemic Influenza Steering Committee quarterly meeting.

(f) An official response to each issue will be drafted to the appropriate organization(s) to close out the issue.

(g) The Pandemic Influenza Steering Committee will determine if issues have been successfully resolved and closed out.

4. Administration and Logistics. See Base Plan and Annex D.

5. Command and Communication. See Base Plan and Annex K.

//Signed//
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13 August 2009

ANNEX Y TO USNORTHCOM CONPLAN 3591-09
STRATEGIC COMMUNICATION

References:

a. US National Strategy for Public Diplomacy and Strategic Communication, June 2007

b. US Joint Forces Command Commander's Handbook for Strategic Communication, September 2008

1. Situation. See Basic Plan.

a. General. This annex provides strategic communication (SC) guidance informed by higher directives and partner agency coordination and synchronized with Joint Staff and Office of Secretary of Defense (OSD) for implementation by DOD. This annex is USNORTHCOM's guidance for the AOR to all components and subordinates. SC is defined as "Focused Government efforts to understand and engage key audiences to create, strengthen, or preserve conditions favorable to advance national interests and objectives through the use of coordinated information, themes, plans, programs, and actions synchronized with other elements of national power."

b. Potential Audiences.

(1) DOD key personnel:

(a) All military personnel; Active, Reserve, National Guard

(b) DOD government civilians

(c) DOD contractors

(d) DOD family members

(2) US citizens:

(a) Domestic

(b) Abroad

(3) Friends, allies and peer competitors:

(a) State, local, provincial, and tribal governments

(b) Foreign military personnel

(c) Civilian populations

(4) Adversaries:

(a) Terrorists

(b) State governments of adversarial nations

(c) Civilian populations of adversarial nations

c. Enemy. See Annex B (Intelligence).

d. Friendly.

(1) Organizations to focus efforts in support of this operation:

(a) USG Departments. See Basic Plan.

(b) Department of Defense. Office of the Secretary of Defense (Public Affairs) (OSD (PA)). OSD (PA) and Joint Staff Strategic Effects Division synchronize strategic communication plans and actions across the Joint Staff with the Services, the Combatant Commands, Office of the Secretary of Defense and other United States Government agencies to provide effective collaboration and planning; support DOD policy and plan development; and assess their effectiveness.

e. Assumptions. These assumptions are only in support of Annex Y.

(1) Messages and education on health protection will become increasingly effective as a pandemic outbreak is imminent.

(2) Media organizations will begin a 24-7 news cycle upon notification of an impending pandemic. Public Affairs (PA) offices will be overwhelmed with queries regarding DOD support to civil authorities and host nations (HNs).

(3) During initial stages of a pandemic, accurate information on virus spread will be difficult to obtain.

(4) Some partners or neighbors will request military assistance and training from the USG for Pandemic Influenza (PI) preparedness and response. This will include information support in many cases.

f. Legal and Policy Considerations. Significant legal and policy issues could arise during operations in an influenza pandemic. (See annex E) Additional authorities needed to accomplish SC efforts will be requested by the executing agency (i.e., PA, IO, etc.).

2. Mission. See Base Plan.

3. Execution.

a. Concept of the Operations. This SC annex is designed to provide an overarching DOD communication framework, from which all USNORTHCOM Staff, Subordinates and Components can support the larger USG SC efforts during an influenza pandemic in the AOR. SC efforts will be most effective when they synchronize what we say, what we do and what we say we do. This annex provides SC elements in each organization with some common objectives, effects and themes. These templates are designed as guidance for personnel that generate messages through words and actions. The templates are intended to inform the messages and not intended to draft messages for the experts.

(1) Phase 0 – Shape.

(a) Phase Objective: USNORTHCOM is prepared for Pandemic Influenza. (b)(2) This phase includes education and training for the USNORTHCOM population, and interagency and international partners.

(b) Effect: USNORTHCOM PI plans synchronized and shared with mission partners.

(c) SC Themes:

1 (b)(2)

2 Preparedness is essential to mitigate effects of a pandemic (individual, community/local, state, etc.).

3 The ability of DOD personnel to do their job of protecting American citizens, including DOD family members, is a high DOD priority.

(2) Phase I – Prevent. The SC focus in this phase is accurate reporting to the key population. We need to accurately reflect and to the best of our knowledge inform DOD members of critical facts relating to the potential hazard. During this phase USNORTHCOM will support USG informational efforts to prevent or limit the spread of the virus with prioritized support to the primary agency, if designated.

(a) Phase Objective: USNORTHCOM prepared for Pandemic Influenza.

(b) Effect: USNORTHCOM PI Plans synchronized and shared with mission partners.

(c) SC Themes:

1 Education and understanding will enhance preparedness.

2 Preparedness is essential to mitigate effects of a pandemic (individual, community/local, state, etc.).

3 USG has plans to mitigate and contain a virus.

4 The ability of DOD personnel to do their job of protecting American citizens, including DOD family members, is a high DOD priority.

5 Transparency and accurate reporting by all affected audiences enables better preparation.

(3) Phase 2 – Contain. The SC focus of this phase is to inform audiences to limit travel outside local areas to minimize spread. As directed, support USG efforts to contain the new virus within a limited area in order to prevent a pandemic and gain time for implementation of additional pandemic preparedness measures.

(a) Phase Objectives:

1 USG efforts to delay or halt virus supported.

2 USNORTHCOM population protected.

3 Mission assignments accomplished.

4 USG protection of vital national interests supported.

(b) Effects:

1 Virus does not impair USNORTHCOM population.

2 With SecDef approval, USG efforts supported.

3 Maintain freedom of action.

4 Anticipate traditional and emerging threats to deter, prevent, and defeat attacks.

(c) SC Themes:

1 Every individual has a role in containing this virus.

2 Individual and local-level actions are key to virus containment.

3 DOD retains the capability to defend the homeland and protect its vital interest during an outbreak.

4 US will use all necessary capabilities to defend the homeland and protect its vital interest during an outbreak.

5 US will uphold its global security agreements.

6 HD remains DOD's top priority.

7 This outbreak requires a global effort to contain the spread.

8 The US is cooperating with other countries for this virus outbreak.

9 The ability of DOD personnel to do their job of protecting American citizens, including DOD family members, is a high DOD priority.

(4) Phase 3 – Interdict. The SC focus of this phase is broader measures to protect the USNORTHCOM population while maintaining the freedom of

action to conduct assigned missions. As directed, USNORTHCOM components will support USG efforts to delay or halt a pandemic influenza wave.

(a) Phase Objectives:

1 USG efforts to delay or halt virus supported.

2 USNORTHCOM population protected.

3 Mission assignments accomplished.

4 USG protection of vital national interests supported.

5 Anticipate traditional and emerging threats to deter, prevent, and defeat attacks.

(b) Effects:

1 Virus does not impair USNORTHCOM population.

2 With SecDef approval, USG efforts supported.

3 Maintain freedom of action.

4 Anticipate traditional and emerging threats to deter, prevent, and defeat attacks.

(c) SC Themes:

1 Travel within the affected area can increase spread of the virus and may be life threatening.

2 Troop rotations may be impacted for force health reasons.

3 Individual preparedness is the most effective prevention.

4 DOD is engaged with private industry to obtain vaccines for our personnel.

5 Obtain vaccination at the earliest opportunity.

6 DOD maintains a robust HD capability during this crisis.

7 Populace should be realistic about potential impact of this virus outbreak.

8 The ability of DOD personnel to do their job of protecting American citizens, including DOD family members, is a high DOD priority.

(5) Phase 4 – Stabilize. The SC focus of this phase is for USNORTHCOM components to protect the USNORTHCOM population; maintain freedom of action to conduct assigned missions; within capabilities and as directed, support USG in mitigating the pandemic effects in order to ensure governments and communities are capable of maintaining social order; maintain critical infrastructure; and minimize human suffering.

(a) Phase Objectives:

1 USNORTHCOM population protected.

2 Mission assignments accomplished.

3 USG protection of vital national interests supported.

(b) Effects:

1 Virus does not impair USNORTHCOM population.

2 Maintain freedom of action.

3 Anticipate traditional and emerging threats to deter, prevent, and defeat attacks.

4 With SecDef approval, USG efforts supported.

(c) SC Themes:

1 DOD will support an Enduring Constitutional Government. (NSPD 51 and HSPD 20)

2 The U.S. will emerge from this crisis as a stronger nation.

3 This crisis will strengthen international partnerships.

4 It is imperative to follow instructions of public authorities.

5 Vaccines will be distributed according to established policy.

6 Increased international vigilance during a crisis will complicate terrorist planning and actions.

7 The ability of DOD personnel to do their job of protecting American citizens, including DOD family members, is a high DOD priority.

(6) Phase 5 – Recovery. The SC focus of this phase is USNORTHCOM force reconstitution operations and as directed supporting USG efforts to re-establish normal support conditions with key partners.

(a) Phase Objectives:

1 USNORTHCOM population protected.

2 Mission assignments accomplished.

3 USG protection of vital national interests supported.

4 USG return to pre-pandemic phase supported.

5 USNORTHCOM capabilities reconstituted.

(b) Effects:

1 Virus does not impair USNORTHCOM population.

2 Maintain freedom of action.

3 Anticipate traditional and emerging threats to deter, prevent, and defeat attacks.

4 Per SecDef approval, USG efforts supported.

(c) SC Themes:

1 We must move forward following this crisis, however we should continue to prepare for subsequent waves.

2 DOD has resumed more normal troop rotations.

3 Adversaries should not underestimate our resolve to fully recover and emerge stronger.

4 Lessons learned as a result of this crisis are applicable to other crisis.

5 The ability of DOD personnel to do their job of protecting American citizens, including DOD family members, is a high DOD priority.

(7) Themes to avoid:

(a) Discussion of mortality rates resulting from the virus outbreak.

(b) DOD can protect all members and their families.

(c) Any reference to DOD as the Primary Federal Agency.

b. Tasks. Staffs, Subordinates, and Components will synchronize actions and words to support the Regional Plan objectives by performing the following:

(1) Build awareness of PI threat before a pandemic.

(2) Inform and reassure key populations.

(3) Educate audiences on virus mitigation and encourage preparedness.

(4) Communicate USNORTHCOM's primary mission, capacity to support others when requested and approved, and capability to defeat attempts to exploit a pandemic.

c. Coordinating Instructions.

(1) There will be no initial release of information about any disease outbreak, or response operations by any command, until the initial release is made by White House, DOS or DOD spokesperson, or until directed by higher authority.

(2) If an outbreak occurs, DOD may play supporting roles, consistent with existing agreements and legal authorities, in implementation of movement controls, transportation, logistics and medical support. In this situation, DOD communication efforts would also provide support to the Primary Federal Agency.

(3) Staff, subordinate and component information efforts should include building awareness of the potential threat specific to their area,

encouraging stakeholder audiences to develop individual preparedness skills, (e.g., social distancing, personal hygiene, mask use, and other infection control precautions individuals should employ during a pandemic) and communicating our capacity to respond within their own area of responsibility as well as assisting to coordinate response efforts within an interagency framework.

(4) Pandemic influenza information messages developed in coordination with other federal agencies will be used to ensure consistency, assuage anxiety, and promote realistic expectations about the pandemic. Risk communication materials will be current and updated as conditions change and circumstances warrant.

(5) Department of State has USG lead to implement SC with neighbors and partner nations; USNORTHCOM PA and IO will orient their activities and messages to support these efforts.

4. Administration and Logistics. See Basic Plan.

5. Command and Signal. See Basic Plan.

a. Required Authorities.

(1) USG lead for SC is DOS. DOD SC lead is the SCIG.

(2) DOD PAG is approved by OSD(ASD) (PA).

(3) Military IO employment has specific approval channels.

b. Relationships.

(1) Public Diplomacy. DOS is USG lead for Public Diplomacy. USNORTHCOM lead for Military Support to PD is the NORAD-USNORTHCOM (US) Political Advisor (POLAD) office (Commercial Tel: (719) 554-6191 or SIPR email: nc.polad.omb@northcom.smil.mil).

(2) Strategic Communication. OSD(PA) is lead for DOD SC. The NORAD-USNORTHCOM Deputy Chief of Staff for Communication is the Director responsible for SC. J5 is the lead for SC planning. (Commercial Tel: (719) 554-1430 or SIPR email: nnc.fpcstratcomm.omb@northcom.smil.mil).

(3) Public Affairs. See Annex F. The ASD (PA) is lead for DOD PA. The NORAD-USNORTHCOM PA Office is the USNORTHCOM lead for PA support to operations (Commercial Tel: (719) 554-6889 or SIPR email: nc.pa.omb@northcom.smil.mil).

(4) Military Information Operations. See Appendix 3 to Annex C.

//Signed//
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Director, Plans Policy and Strategy