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MARINE CORPS ORDER 6220.3

From: Commandant of the Marine Corps
To: Distribution List

Subj: MARINE CORPS PANDEMIC AND INFECTIOUS DISEASE (P/ID) PLANNING AND RESPONSE GUIDANCE

Encl: (1) References
(2) Pandemic and Infectious Disease (P/ID) Planning Policy Manual

1. Situation

a General

(1) Threat Environment. Operationally significant biological incidents are caused by pathogens of various types; pathogens may be viral, bacterial, or parasitic. Each type of pathogen poses specific response and recovery challenges. The challenge is distinguishing a large-scale biological event from a normally occurring disease fluctuation (e.g., seasonal influenza, or norovirus outbreak on cruise ships). The threat of a pandemic has serious national security implications for the United States. Because humans may have little or no immunity to a new or modified pathogen, pandemics may occur with substantially higher infection or mortality rates.

(a) A pandemic differs from most natural or manmade disasters in nearly every aspect. 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. Exact consequences are difficult to predict in advance because the biological characteristics of pathogens are unknown. Similarly, the Federal government's role during a pandemic response will differ based on the pandemic’s morbidity and mortality rates.

(b) Secondary effects of a pandemic could cause significant health, economic, supply and logistics chain disruption, and security ramifications; potentially including large-scale social unrest due to fear of infection or concerns about safety among individuals, families, and their associates.

(2) Per references (a) through (r), the purpose of this Order is to issue policy, outline procedures, provide guidance and align organizational roles and responsibilities within the Marine Corps for Pandemic and Infectious Disease (P/ID) planning and response activities, in addition to incorporating existing Department of Defense (DoD) Public Health Emergency (PHE) guidance into a single document.

(3) This guidance prepares the Marine Corps to plan for, respond to and mitigate infectious diseases with operational significance events, whether naturally occurring or the result of deliberate attack while enabling mission recovery and sustainment. The process of gathering, integrating, interpreting, and communicating essential information related to PHE's contributes to situational awareness and enables decision making at all levels.

(4) Per reference (c), a PHE is an occurrence or imminent threat of illness or health condition characterized by:

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

(b) A significant number of serious or long-term disabilities in the affected population considering the severity and probability of the event.

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

(d) Health care needs that exceed available resources

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

(5) The Marine Corps' organizational objectives in a PHE environment focus on the following areas:

(a) Force Health Protection (FHP) (Protect the Force)

(b) Meet force generation requirements, retain readiness, and conduct assigned missions.

(c) Achieve the appropriate balance between risk-to-mission and risk-to-forces through all stages of a PHE.

(d) Plan, prepare, implement, and sustain Continuity of Operations (COOP) to continue mission essential functions.

(e) Identify opportunities to build flexibility and adaptability into organizational processes.

(f) Return to a stable, predictable steady state of operations, retain readiness and power projection.

(6) Commanders will continue to update directed plans and corresponding capability gaps for improved data analysis and reporting generated by ongoing P/ID response and planning activities.

(7) This policy applies to all Marine Corps activities and has been written to ensure the development of optimal Marine Corps capabilities and readiness for operations and tasks in support of missions involving pandemic response activities.

(8) The Marine Corps executes measures to prepare for, prevent against, and respond to the spread of infectious diseases on its bases and among Marines and Sailors, assigned government and civilian workforce personnel, DoD contractor personnel, and military family members to mitigate the effects of any PHE to preserve and maintain the operational readiness of the Marine Corps.

(9) The Marine Corps will prepare for potential infectious diseases on its bases and installations and within forces through decentralized and synchronized planning, utilizing the National Incident Management System (NIMS) in support of federal and State, Local, Tribal and Territorial (SLTT) officials. If a public health crisis occurs, the Marine Corps must execute strategies of preparing, protecting, mitigating, responding, stabilizing, transitioning, and recovering to protect personnel, and maintain force readiness and freedom of movement.

b. Strategic Guidance

(1) Preparing and responding to infectious diseases and other health emergencies requires an active, layered defense. This active, layered defense is global, and integrates United States capabilities seamlessly in the forward regions of the world, the approaches to United States territories, and within the United States. It is a defense-in-depth that includes assisting partner countries to prepare for and detect an outbreak, and to respond to and manage cascading issues that could lead to more challenges. The priorities are force protection, as well as the protection of associated resources necessary to maintain mission readiness and the ability to meet strategic objectives.

(2) Reference (a) outlines the strategy for strengthening the nation's ability to prevent, detect, assess, prepare for, mitigate, respond to, and recover from health security threats.

(3) Reference (b) establishes goals to reduce the burden of, minimize the risk of, and mitigate the impact of seasonal and/or pandemic influenza.

(4) Reference (c) provides direction to ensure mission assurance and readiness for PHEs.

(5) Reference (d) directs DoD components to implement programs and processes that sustain a healthy force, prevent injury and illness, and protect the force from health hazards.

(6) References (e) and (f) contain regulations for preventing the introduction, transmission, and spread of communicable diseases and/or other hazardous substances from foreign countries into the United States and from one state or possession into another.

(7) Reference (g) provides amplifying guidance to support prevention, mitigation, preparedness, response, and recovery from pandemic influenza.

(8) Reference (h) provides policy, guidance, operational structure, and assignment of responsibilities for developing comprehensive PHE programs at Military Treatment Facilities (MTFs).

(9) Reference (i) outlines requirements for PHE planning and authority.

(10) Reference (j) establishes Service-wide Mission Assurance (MA) policy and assigns specific responsibilities for implementing a comprehensive, integrated, all-threats/all-hazards risk management process across enterprise-wide protection-related programs, functions, and operational capabilities.

(11) Reference (k) is the Department of Defense Functional Campaign Plan for Pandemics and Infectious Disease (DoD FCP-P&ID), which provides guidance on synchronizing DoD efforts during a public health crisis.

(12) Reference (l) is the Department of Defense Implementation Plan for Pandemic Influenza.

(13) Reference (m) establishes Service-level emergency management (EM) planning policy and contains additional guidance regarding PHEs.

c. Phasing Constructs. Per reference (l), international and domestic agencies utilize different phasing/alert constructs in relation to DoD's phasing during a PHE.

(1) Organizations such as the World Health Organization (WHO), Centers for Disease Control and Prevention (CDC), and United States

Department of Health and Human Services (HHS) all use different constructs, each of which is informed by different information requirements, and each of which provides different information and guidance to the public (e.g., the WHO uses phases to define the stages of a pandemic while the CDC uses intervals to describe the progression of a pandemic along a theoretical epidemiological curve in the United States).

(2) These constructs, while useful information that may inform DoD phases and operations serve a different purpose, do not mirror each other, and are not interdependent. As such, DoD phases do not mirror them.

d. Department of Defense Functional Campaign Plan for Pandemics and Infectious Disease (DoD FCP-P&ID). Reference (l) identifies four phases that delineate when DoD actions occur in response to a pandemic event (Phase 0 – Prepare; Phase 1 – Elevated Threat; Phase 2 – Respond; Phase 3 – Transition/Recover). The construct is driven by operational requirements, the virulence of a pandemic or infectious disease, and the spread of the virus geographically.

(1) The comparison of these stages, phases or intervals are represented in Appendix I through G. Per reference (l), the following phase descriptions reflect DoD's response to a pandemic:

(a) Phase 0 (Prepare) – Incorporates planning, surveillance, and engagement activities to shape perceptions and influence behavior. Activities executed during this phase are considered steady-state operations executed as part of the Geographic Combatant Commanders' (GCC) Theater Campaign Plan (TCP) and continue through all phases.

(b) Phase 1 (Elevated Threat) – Upon identification of a potential or actual outbreak of operational significance, the DoD takes decisive action to protect its forces from becoming infected. The focus is the protection of forces, DoD civilians, DoD contractors performing critical roles, military family members, as well as the associated resources necessary to maintain readiness; work with Interagency (IA) and partner nations, to ensure freedom of movement and coordinate mitigation strategies to prevent or limit the spread of the virus.

(c) Phase 2 (Respond) – The DoD assists civil authorities (domestic and/or international). Broader measures are taken to protect all personnel, regardless of geographic location, while maintaining the freedom of action to conduct assigned missions and as directed, support United States Government (USG) efforts to delay or halt a pandemic. The Marine Corps will mitigate the effects of an operationally significant disease outbreak on mission assurance and its forces. The focus of this phase is the protection of mission essential functions, and as directed, support USG efforts to contain

the new virus within affected areas to prevent a pandemic and prevent and gain time to implement additional preparedness measures and mitigation strategies.

(d) Phase 3 (Transition and Recover) – The DoD will redeploy remaining civil support response forces, reconstitute forces, and any preparations required for a resurgence of the pandemic. The focus of this phase is a transition from civil support operations, reconstitution of the force, and preparing for a subsequent pandemic event. During this phase, infection levels of the pandemic virus return to the levels seen for seasonal influenza, based on countries with adequate surveillance. During this phase, the Marine Corps will complete Requests for Assistance (RFAs) and scale down response operations. The focus of this phase is preparation for the transition to the next phase and prepare for resurgence.

e. Potential Impact of a Pandemic on the United States Marine Corps (USMC)

(1) Potential impact of a pandemic on operations will be significant. If personnel are absent due to illness, caring for the sick, or unwilling to risk exposure, restricted to executing travel or performing training, there would be a tremendous impact on executing current plans.

(a) Operations. The uncertainties of a pandemic environment threaten the tightly coupled organizational processes to organize, train, and equip combat-ready forces to meet Global Force Management (GFM), force generation, employment, operational planning, and crisis response requirements.

1. The PHE environment is filled with uncertainty, non-linearity, and friction which threatens organizational processes.

2. The Marine Corps may need to respond to multiple contingencies or crises while supporting Global Force Management Allocation Plan (GFMAP) requirements in a pandemic environment, exacerbating resource shortfalls (e.g., fighting a two-front war).

3. It can be assumed that military movements, including but not limited to exercises, will be constrained, and Host Nations (HN) may limit or prevent the freedom of movement of potentially exposed or sick personnel, or transit through their country.

4. Throughout a pandemic outbreak, forces must remain dominant across the full spectrum of military operations, preserving combat capabilities to deter and/or engage adversaries in any theater worldwide. If directed, support of civil authorities (e.g., Defense Support of Civil Authorities (DSCA)) during a PHE will be conducted in

accordance with applicable statutes and policies, as described in reference (r).

(b) Environment. Pandemic events must be viewed as an environment to operate within, vice an event, or a traditional enemy. This environment, which may last more than a year, will have significant operational consequences. The operational environment will alter the global strategic environment and associated commitment and employment of national and international resources.

(c) Personnel. Large portions of the population may become infected throughout the pandemic. Competing demands for low-density units (medical, mortuary) will decrease the range of options available for support. Limited civilian and medical care options for military personnel and their family members, both inside and outside the United States, will increase the stress.

(d) Transportation. There will likely be a significant reduction of transportation capacity affecting acquisition and/or distribution capabilities. Civil aviation support for strategic deployment will be reduced. Interstate transport of material and equipment to aerial ports or seaports of debarkation (Aerial Ports of Debarkation/Sea Port of Debarkation (APOD/SPOD)) and international land crossings (border closures) may decrease. Access to goods, both inside and outside the United States, may be reduced. Movement restrictions imposed by national, state, or local governments to slow the spread of a pandemic virus will likely impact operations.

(e) United States Marine Corps (USMC) Support. The priority for the Marine Corps in the event of a pandemic crisis is to protect and preserve the operational effectiveness of forces worldwide. By providing guidance on appropriate mitigation measures, available treatment, and making Personal Protective Equipment (PPE) available to personnel, the Marine Corps will lessen the impact of a PHE (epidemic/pandemic) on operational forces. The second priority is to sustain mission assurance for Marine Corps missions and to maintain the ability to meet strategic objectives. Additionally, the Marine Corps will respond quickly and effectively to the requests of civil authorities in the event of a pandemic event to save lives, prevent human suffering, and provide security within capabilities, when directed by the President of the United States (POTUS) or the Secretary of Defense (SECDEF).

f. Threat. The most dangerous threat is the emergence of a pandemic that spreads quickly with a high mortality rate. These effects will negatively impact readiness (e.g., training, manning, equipping, and deploying the force), and degrade capabilities across the whole spectrum of operations (i.e., warfighting, force generation, medical support, etc.) potentially allowing opportunities for adversarial aggression.

(1) Pathogens with pandemic potential will have rapid rates of transmission that will result in debilitating illness in military forces at levels significant enough to degrade combat readiness and effectiveness across multiple GCCs, in addition to significantly impacting domestic civil authorities.

(2) Pandemics are analogous to a traditional hazard except they are global in scope.

(3) The primary characteristics of the threat during a pandemic are:

(a) The virus' ability to reproduce within a host and exploit susceptible hosts.

(b) The ability to mutate quickly and spread, before identifying signs and symptoms.

(c) The ability to be easily transmitted from person to person. High transmissibility and rapid onset of severe symptoms could result in large numbers of people becoming sick or incapacitated simultaneously, in the absence of effective mitigation strategies.

(4) The impact of a pandemic threat may cause political, social, economic instability, and degradation of supply chain, logistics, and military readiness. While adversarial forces will be infected, their readiness and operational capability may not be impacted in the same manner or at the same time as United States and allied forces. The degree to which countries can mitigate morbidity and mortality during a pandemic and reintegrate recovering individuals into society will have a considerable impact on military force capabilities. Countries with more advanced and robust healthcare systems will be better able to respond to and mitigate many of the effects of a public health crisis.

(5) Key security concerns that would arise from the political, social, and economic instabilities include opportunistic aggression, opportunities for violent extremists to acquire Weapons of Mass Destruction (WMD), reduced partner capacity during and after a pandemic, instability resulting from humanitarian disaster or displacement, decreased production and distribution of essential commodities, and access to care and the ability to move and relocate forces globally.

(6) Response to a PHE that requires P/ID planning at USMC installations, commands, and activities may exceed the capabilities of organic installations, region, and supporting MTF resources. Extensive Federal, state, local, or other Service, HN, or private support will be required to respond to and recover from a public health crisis effectively. Close and continual liaison with military and public health planners before a crisis is critical to ensure the

Marine Corps is prepared for, and responsive to, commander and Service-level requests for support.

(7) Epidemics, though more localized than a pandemic, may carry or produce some of the same threats, such as:

(a) The virus' ability to reproduce within a host and exploit susceptible hosts.

(b) The ability to mutate quickly and spread before identifying signs and symptoms are recognized.

(c) The ability to be easily transmitted from person to person. High transmissibility and rapid onset of severe symptoms could result in many people becoming sick or incapacitated simultaneously, across international borders, thereby creating a pandemic.

g. Friendly. The potential scope of a pandemic incident is enormous, and the response to a deadly disease will involve many organizations. Accordingly, it is critical to establish communications linkages, liaison requirements, authorities, and agreements necessary to facilitate a rapid, coordinated IA and international response to a public health crisis. Further, these roles and coordination must be in effect before a crisis develops. Federal Departments, Agencies, and Intergovernmental organizations include:

(1) United States Department of Health and Human Services (HHS). The Secretary of HHS will be the primary agency coordinating the overall public health and medical response efforts across all Federal departments and agencies and serve as the principal spokesperson for the USG on PHE issues.

(2) Centers for Disease Control and Prevention (CDC). The CDC leads, promotes, and facilitates science, programs, and policies to reduce the burden of infectious disease within the United States and globally. It collaborates to create the expertise, information, and tools that people and communities need to protect their health. The CDC's pandemic preparedness efforts include ongoing surveillance of human and animal viruses, risk assessments of pathogens with pandemic potential, and the development and improvement of preparedness tools that can aid public health practitioners in the event of a public health crisis.

(a) Travel health notices issued by the CDC inform personnel and clinicians about current health issues that may impact a traveler's health, disease outbreaks abroad, special events or gatherings, and natural disasters in specific international destinations.

(b) The CDC does not generally issue advisories or restrictions for travel within the United States.

(c) During emerging global public health crises, the CDC issues Travel Health Notice advisories for areas with confirmed cases of pandemic viruses, shown in Table 1.1:

Watch Level 1	Practice usual precautions
Alert Level 2	Practice enhanced precautions
Warning Level 3	Avoid all non-essential travel

Table 1.1 - CDC Travel Health Notice Levels

a. Watch Level 1 (Green). Recommends travelers practice usual precautions for a destination, including being up to date on all recommended vaccinations.

b. Alert Level 2 (Yellow). Recommends practicing enhanced cautions for a travel destination, describes additional precautionary measures, and defines specific at-risk populations.

c. Warning Level 3 (Red). Recommends avoiding all non-essential travel to a destination; issued when an outbreak is of high risk to travelers and no precautions are available against the identified increased risk.

(3) United States Department of Homeland Security (DHS). The Secretary of Homeland Security is the principal Federal official for domestic incident management. Pursuant to the Homeland Security Act of 2002, the DHS 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, including biological and public health crises. The Secretary of DHS will coordinate the domestic Federal response to save lives, maintain confidence in the government, sustain critical infrastructure, and recover from a PHE within the United States and its territories.

(4) United States Department of Agriculture (USDA). The Secretary of Agriculture is responsible for the overall coordination of preparedness and response to an animal and plant disease or pest outbreak and for ensuring the safety and security of the commercial food supply.

(5) United States 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 in efforts to contain or slow the spread of biological hazards, helping to limit the adverse impacts on trade and commerce, coordinating national efforts to assist other nations that are impacted by the biological hazard event, and interdiction with all

official and non-official American Citizens (AMCITs) overseas. During a Public Health Emergency of International Concern (PHEIC), the DOS issues travel advisories for regions and/or countries with confirmed and emerging cases of communicable diseases or pandemics, represented in Table 1.2:

Level 1 – Exercise normal precautions
Level 2 – Exercise increased caution
Level 3 – Reconsider Travel
Level 4 – Do Not Travel

Table 1.2 – United States Department of State
Travel Advisory Levels

(a) Level 1 (Blue). The lowest safety and security risk advisory level. There is some risk in any international travel.

(b) Level 2 (Yellow). Recommends awareness of heightened risks to safety and security. The DOS provides additional guidance for travelers in areas of heightened concern.

(c) Level 3 (Orange). Recommends avoiding travel due to serious risks to safety and security.

(d) Level 4 (Red). The highest travel advisory due to the increased likelihood of life-threatening risks. Under such conditions, the DOS advises personnel not to travel to countries of heightened concern or recommends authorized departure from affected regions. During a crisis, the USG may have very limited ability to assist.

(e) Department of State health advisories related to travel are issued during Levels 2 through 4 when conditions of increased health risk exist, including disease outbreaks or other health-related crisis that disrupts a country's medical infrastructure. The issuance of CDC travel health notices in foreign locations may be a factor in influencing DOS actions and should be monitored for planning and response.

(6) Armed Forces Health Surveillance Division (AFHSD). The AFHSD is a joint public health organization that was established to unify surveillance efforts across the Military Health System (MHS), serving as the single source for DoD-level comprehensive military health surveillance information. The AFHSD's mission is to promote, maintain, and enhance the health of military and military-associated populations by providing relevant, timely, actionable, and comprehensive military health surveillance information products to the Armed Forces.

(7) World Health Organization (WHO). The WHO directs and coordinates health care within the United Nations (UN) system. The

WHO characterizes novel disease outbreaks and any associated declaration of a PHEIC, as required, under International Health Regulations (IHR). A PHEIC is typically accompanied by recommended actions for the international community to contain or mitigate a P/ID threat. A PHEIC will not directly trigger DoD support but may serve as an indicator that the USG may provide support that could lead to a request for Marine Corps capabilities.

h. Legal and Policy Considerations. Significant legal and policy issues could arise during operations in a pandemic environment.

(1) Emergency Health Powers (EHP). To protect military and civilian personnel, commanders are authorized to implement EHP. These special powers include containment strategies (e.g., Restriction of Movement (ROM), isolation, quarantine, social distancing), as well as medical evacuation and treatment. Commanders are authorized upon consultation with their designated Public Health Emergency Officer (PHEO) or Assistant Public Health Emergency Officer (APHEO) and legal staff to invoke these powers.

(a) Commanders outside the United States may be authorized to utilize these powers by EHP, subject to host nation laws and international agreements. In the event of a PHE, the Marine Corps will support civil authorities, at home or abroad, when directed by the President or the SECDEF.

(b) GCCs and the Marine Corps will ensure unity of effort in implementing EHP in the GCC's Area of Responsibility (AOR) and that the implementation of EHP does not violate applicable law and/or policy.

(2) Force Health Protection (FHP). Under existing FHP policy, a Combatant Commanders (CCDR) responsibility/authority for FHP is limited to assigned or attached forces under the current forces for and to its subordinate commands/headquarters. CCDR, Services, and DoD agencies will ensure unity of effort in implementing FHP in the GCC's AOR. Services retain existing FHP authorities and responsibilities. The SECDEF may, under extreme circumstances, choose to transfer FHP authority to the CCDR for all DoD personnel within their AOR. FHP measures are described below:

(a) The response to a pathogen with operational significance requires an integrated and layered approach of P/ID measures combining medical and non-medical FHP measures to prevent or reduce the spread of disease and minimize the impact on personnel and missions.

(b) FHP measures, with associated interventions, are implemented to prevent and protect personnel from becoming infected or to delay and mitigate the disease effects. They are grouped into two major categories: pharmaceutical/Medical Countermeasures (MCM) and

non-pharmaceutical/public health countermeasures.

2. Cancellation. MCO 6220.1, USMC Pandemic Influenza (PI) Response Plan, and MCO 6220.2 Disease Containment Planning Guidance.
3. Mission. The USMC will prepare for, respond to, and recover from pandemics and other PHEs to ensure the continuity of Title 10 responsibilities and provide combat-ready forces worldwide. If a pandemic event or other PHE occurs, the Marine Corps will plan, execute mitigation, interdiction, stabilization, and recovery strategies to protect personnel and maintain force readiness.

4. Execution

a. Commanders Intent and Concept of Operations

(1) Commanders Intent

(a) Purpose. Maintaining COOP by minimizing the effects of PHEs against Marine Corps forces and the impact of such emergencies on people, operations, and installation infrastructure, while simultaneously supporting, within capabilities, the USG domestic and international health emergency incident response.

(b) Method

1. Establish policy and guidance, outline roles and responsibilities, and discuss considerations, including the fundamental assumptions that must be considered to understand the unique aspects of negating or mitigating the effects of a contagious disease outbreak, including, but not limited to pandemic events.

2. Ensure P/ID planning and response activities are consistent with DoD policies, adhering to principles outlined in references (c), (d), (k), and (m).

3. Identify preparatory actions that must be taken before an outbreak to minimize the operational risk, and which apply to the concept of operations of pandemic response principles.

(c) Key Tasks

1. Conduct medical surveillance, analysis, reporting, and dissemination.

2. Conduct FHP

3. Assure capability to project and sustain combat power through the Force Generation process.

4. Support USG PHE incident response.

5. Coordinate and synchronize P/ID response plans.

(d) Essential Tasks. Coordinate and synchronize pandemic planning and response.

(e) End State(s).

1. Ensure the Marine Corps is prepared to minimize the effects of a disease of operational significance on Marine Corps missions.

2. Establish a comprehensive P/ID planning and response policy to ensure Headquarters, United States Marine Corps (HQMC), Fleet Marine Forces (FMF), Marine Corps installations, commands, and activities maintain operational effectiveness during a public health crisis.

(f) Strategic Objectives. Maintaining COOP by minimizing the effects of PHE incidents, forces maintain freedom of movement worldwide, and United States partners have the assurance of support.

(g) Desired Effects. Mitigate and contain the effects of a PHE and ensure installations and Marine Forces (MARFORs) can continue to operate in support of national interests.

(2) Concept of Operations

(a) Center(s) of Gravity

1. Contagion Center of Gravity. The center of gravity of a pathogen is its ability to become operationally significant and spread from the point of emergence/origin. An operationally significant disease can degrade the readiness and effectiveness of the force through illness and related absenteeism or disability, inhibit freedom of movement through related restrictions (ports of embarkation or embarkation, overflight activity) and generate requests to assist partners with cascading impacts on critical infrastructure and key resources, both domestically and internationally. Conversely, the use of Fourth Generation Agents (FGA) would result in a PHE. Ongoing preparedness for all hazards is intended to help protect against an incident. No illicit use or manufacture of an FGA or other nerve agent has occurred against United States. interests inside or outside the United States; however, a potential threat exists.

2. Friendly Center of Gravity. Marine Corps mission assurance, the continued functions and resilience of capabilities and assets (i.e., personnel, equipment, facilities, networks, infrastructure, supply chains), to achieve strategic objectives, primarily through processes of protecting personnel and their

sustained ability to defend the nation and conduct operations worldwide.

(b) United States Marine Corps (USMC) Synchronization Phases. This plan follows a six-phased construct: Shape, Protect, Mitigate, Respond, Stabilize, and Transition and Recover. The following process is provided as an overview of Marine Corps planning considerations. Unless specifically tasked, the Marine Corps will coordinate and request assistance from other agencies and organizations to operate in these phases.

(c) Phase Change Considerations. The phases described in this Order are not developed as an epidemiological prediction, but to guide the implementation of activities. While later phases may loosely correlate with increasing levels of a PHE, risk in the first three stages is unknown; therefore, it is possible to have situations that pose an increased pandemic risk, but do not result in a pandemic. Alternatively, although global disease surveillance methods and monitoring systems are improving, it is also possible that the initial outbreak of a pandemic will not be detected or recognized. For example, if symptoms are mild and not very specific, a pathogen with pandemic potential may attain relatively widespread circulation before being detected; thus, phases may jump from lower phases to higher phases. Conversely, if rapid mitigation efforts and containment operations are successful, Phase 4 may revert to Phase 3.

1. Shape Phase (0). Phase 0 is continuous and incorporates adaptive and flexible planning, routine surveillance, and engagement activities to assure and solidify collaborative relationships, shape perceptions, and influence behavior to be prepared for a new virus subtype. This phase occurs during an inter-pandemic period. Phase 0 includes education and training for all personnel and coordination with GCCs, HNs, IA, and international partners. Activities executed during this phase are considered steady-state operations and will continue through all phases.

a. Key Tasks

(1) Develop and exercise plans in coordination with external partners, both DoD and non-DoD, and synchronize plans with GCCs.

(2) Conduct threat surveillance and capability assessments to support Marine Corps activities, facilities, and personnel.

b. Priority of Effort. Disease Surveillance.

c. Secondary Effort. Plan development and coordination.

d. Phase Objectives and Desired Effects (Intermediate Military Objective(s) (IMO))

(1) Maintain accessions

(2) Generate combat-ready forces

(3) Maintain a sustainable cycle of medical and material readiness

(4) Maintain P/ID and COOP plans

(5) Maintain freedom of movement

e. Transition Criteria (Decision Point) - Phase 0 > Phase 1

(1) Identification of a disease of concern/potential of operational significance with regional and/or global pandemic capability.

(2) Indications and warnings of human infection(s), with a new subtype with person-to-person spread, or at most, rare instances of person-to-person spread to a close contact.

(3) Identification of new viral infection in humans or animals anywhere in the world with potential implications for human health.

(4) The CDC elevates travel health advisory levels for affected countries or regions of concern.

(5) The DOS elevates travel advisories for affected countries or regions of concern.

2. Protect Phase (1). Phase 1 begins upon receipt of information of human infection(s) with a new viral sub-type, but no person-to-person spread, or at most, rare instances of spread to close contact. During Phase 1, the Marine Corps supports all GCCs and USG efforts to prevent, contain, or limit the spread of a virus.

a. Key Tasks

(1) Continue to monitor global infections (disease surveillance) to identify potential pandemic conditions.

(2) Initiate communication activities to communicate actual and potential risks.

(3) Train the force on protective health measures and recommended actions within Health Protection Conditions (HPCONs), including, but not limited to social distancing, etc.

(4) Where appropriate, equip the force with proper PPE.

(5) Expand external coordination to include Communications Strategy (COMMSTRAT) and operations.

b. Priority of Effort. Actions to respond to and mitigate the potential pandemic include:

(1) Training/equipping

(2) Educate personnel

(3) Planning

(4) Opening strategic communication

(5) Personnel tracking and accountability.

c. Secondary Effort. Actions to maintain situational awareness include:

(1) IA/international coordination

(2) Disease Surveillance

d. Phase Objectives and Desired Effects (Intermediate Military Objective(s) (IMO))

(1) Review and validate COOP plans.

(2) Implement ROM, isolation, quarantine and screening procedures, and travel restrictions in accordance with DoD guidance or HPCON.

(3) Inventory/prioritize/pre-stage medical PPE and MCM.

e. Decisive Point(s). Publish telework and/or social/physical distancing guidance.

f. Headquarters, United States Marine Corps (HQMC) Decision Points(s)

(1) Surge Medical capacity and personnel to priority areas.

(2) Raise HPCON levels.

(3) Modify accessions policy/procedures.

(4) Stop/modify Entry Level Training (ELT), Service-Level Training Exercises (SLTE), Large Scale Exercise (LSE), and Professional Military Education (PME).

(5) Secure no-fail missions.

(6) Modify and publish Physical Fitness Test (PFT), Combat Fitness Test (CFT) and Body Composition Program (BCP) guidelines.

g. Transition Criteria (Decision Point) - Phase 1 > Phase 2

(1) Force development or force generation pipelines are disrupted.

(2) Indications and warnings identify small cluster(s) with limited person-to-person transmission, but the spread of the virus is highly localized, suggesting the virus is not well adapted to humans.

(3) The CDC elevates travel health advisory levels for affected countries or regions of concern.

(4) The DOS elevates travel advisories for affected countries or regions of concern.

(5) The virus is characterized by person-to-person transmission of an animal/human reassortant virus, able to sustain community-based outbreak has been confirmed.

3. Mitigate Phase (2). Phase 2 begins upon receiving information about small clusters with limited person-to-person transmission, indicating a significant increased risk of an epidemic or potential pandemic. Demonstration of efficient and sustained person-to-person transmission of a new virus. During Phase 2, the Marine Corps will take measures to protect the force in all affected regions while maintaining the freedom of action to conduct assigned missions. As directed, the Marine Corps will support all GCCs and USG efforts to contain the new virus and gain time to implement additional pandemic preparedness and mitigation efforts.

a. Key Tasks

(1) Pre-position key capabilities and equipment to protect MARFORs.

(2) Support USG mitigation efforts to contain the virus.

(3) Continue medical and disease surveillance; assess contacts of suspected cases of exposure to determine person-to-person transmission and risk factors for infection.

(4) In coordination with GCCs, implement HPCONs and community mitigation measures in affected and potentially affected regions.

(5) Sustain external coordination with COMMSTRAT.

b. Priority of Effort. Support USG response and mitigation efforts, regionally and/or worldwide, while maintaining freedom of movement to conduct assigned missions.

c. Secondary Effort(s). Preparation for a potential pandemic by initiating the release and distribution of pandemic virus medical stockpile material and/or MCM.

d. Phase Objectives and Desired Effects (Intermediate Military Objective(s) (IMO))

(1) Retain critical Military Occupational Specialty (MOS)/skills.

(2) Establish Permanent Change of Station (PCS) prioritization.

(3) Forecast amphibious and Military Prepositioning Forces (MPF) impacts on exercises and operations.

(4) Request supplemental funding.

(5) Suspend in-person inspection programs.

e. Decisive Point(s)

(1) Sustain/modify GFM rotations and SLTE requirements.

(2) Modify training and operations due to MPF/amphibious capacity.

f. Headquarters, United States Marine Corps (HQMC) Decision Points(s). Adjust supply and maintenance priorities for GFMAP.

g. Transition Criteria (Decision Point) Phase 2 > Phase 3

(1) Service-wide operational readiness degradation is projected.

(2) Indications or warnings of a larger cluster(s), but person-to-person spread remains localized, suggesting that the virus is becoming increasingly adaptive to human efforts and not yet fully transmissible.

(3) Increasing number of cases or clusters of novel virus infection regionally or worldwide with virus characteristics, indicating the increased potential for ongoing person-to-person transmission.

(4) The CDC elevates travel health advisory levels for affected countries or regions of concern.

(5) The DOS elevates travel advisories for affected countries or regions of concern.

(6) HHS declaration of a PHE and/or WHO declaration of a PHEIC.

4. Respond Phase (3). Phase 3 begins when indications and warnings identify large clusters of person-to-person transmission in affected geographic areas. During Phase 3, the Marine Corps will take broader measures to protect the force while maintaining the freedom of action to conduct assigned missions. As directed, the Marine Corps will support all GCCs and USG efforts to delay or halt the spread of the virus.

a. Key Tasks

(1) Continue to support GCCs and USG P/ID mitigation efforts.

(2) Perform enhanced medical and disease surveillance; assess contacts of suspected exposure cases to determine person-to-person transmission and risk factors for infection.

(3) In coordination with GCCs and MARFORs, continue and refine HPCONs and community mitigation measures in affected regions.

(4) Continue and refine external coordination with COMMSTRAT.

(5) Provide, evaluate, and revise recommendations for the use of mitigation measures; disseminate updated risk measures.

b. Priority of Effort. Necessary preparations to ensure freedom of action to conduct assigned missions during an impending epidemic or pandemic, and ensure COOP.

c. Secondary Effort. Support to USG efforts and preparation actions to ensure COOP, disperse operations, and inhibit new infections or exposure to reduce the number of cases at any given time.

d. Phase Objectives and Desired Effects (Intermediate Military Objective(s) (IMO))

(1) Surge/reduce PCS prioritization.

(2) Implement a force-wide pandemic education or information program.

(3) Redistribute medical capabilities.

(4) Resolve ground and aviation depot maintenance throughput issues.

(5) Resolve supply chain distribution issues.

(6) Resolve medical equipment distribution and allocation use issues.

(7) Publish a call for innovation in support of PHE response.

e. Decisive Point(s)

(1) Medical surveillance analysis and reporting.

(2) Stabilize next-to-deploy forces.

(3) Modify training support requests to safeguard resources.

(4) Modify Training and Readiness (T&R) for the pandemic environment.

(5) Respond to domestic/international Requests for Forces (RFF).

(6) Surge resources to support ELT recovery.

f. Headquarters, United States Marine Corps (HQMC) Decision Points(s)

(1) Activate Marine Forces Reserve (MARFORRES).

(2) Modify guidance for statutory and non-statutory boards.

(3) Adjust Pre-deployment Training Program (PTP) requirements.

(4) Modify and publish PFT, CFT, and BCP guidance.

g. Transition Criteria (Decision Point) Phase 3 > Phase 4

(1) Next-to-Deploy forces stabilized.

(2) Indications and warnings of increased and sustained transmission in the general population.

(3) Confirmation of human cases of a pandemic virus anywhere in the world with demonstrated efficient and sustained person-to-person transmission.

(4) Consistently increasing rate of viral infection identified globally and in the United States, indicating established would elevate an epidemic to pandemic status.

(5) The CDC initiates travel health Alert Level 2 or Warning Level 3.

(6) The DOS elevates travel advisory to Level 3 or 4.

5. Stabilize Phase (4). Phase 4 begins upon receipt of information the virus is spreading globally from person-to-person, signaling a failure of containment and interdiction actions. During Phase 4, the Marine Corps will protect Marine Corps forces to maintain freedom of action to conduct assigned missions and within capabilities, as directed, support USG in mitigating the pandemic effects to ensure governments and communities are capable of maintaining social order, maintaining critical infrastructure, and to minimize human suffering.

a. Key Tasks

(1) Maintain mission assurance; provide guidance on maintaining critical infrastructure and key resources.

(2) Continue to support GCCs and USG P/ID response and mitigation efforts.

(3) Increase medical surveillance and analysis.

(4) Enhance protection and treatment of personnel.

(5) Maintain COOP in the PHE environment.

(6) Continue and refine coordination to include COMMSTRAT.

b. Priority of Effort. Protect personnel while maintaining mission assurance and protecting USG vital national interests.

c. Secondary Effort. Support other USG P/ID efforts and actions to maintain COOP.

d. Phase Objectives and Desired Effects (Intermediate Military Objective(s) (IMO))

(1) Enable freedom of movement, both inside and outside the United States.

(2) Resume MARFORRES drill.

(3) Implement a modified/prioritized SLTE schedule.

(4) Synchronize MOS school throughput with Master Projection Plan (MPP).

(5) Execute Fiscal reprogramming authority.

(6) Ship-based Mission Essential Task List (METL) execution.

(7) Aviation qualifications maintained.

(8) Recover surged medical personnel.

(9) Resume routine medical care (Periodic Health Assessment (PHA)/Pre-deployment Health Assessment (PDHA)).

(10) Publish guidance on Phase 5 priorities.

(11) Publish Return-to-Work (RTW) guidelines.

(12) Resume/surge-in-person inspection programs.

(13) Prepare Congressional briefings, as required.

e. Decisive Point(s)

(1) Stabilize MPF.

(2) Reinstate Marine Corps Recruiting Command (MCRC) Command Recruiting Program (CDR).

(3) Resource remaining fiscal year deploying forces.

(4) Surge resources to support readiness and recovery.

(5) Resume family programs.

f. Headquarters, United States Marine Corps (HQMC) Decision Points(s)

(1) Modify manpower and retention policies.

(2) Surge Weapons and Tactics Instructor (Course) (WTI) and Advanced Schools.

(3) Reprioritize Fiscal programming.

(4) Resume community engagements and traditional activities (Marine Corps Ball, Parades, Marine Corps Marathon, etc.).

g. Transition Criteria (Decision Point) Phase 4 > Phase 5

(1) Force generation and/or force development processes and pipelines have adapted and/or stabilized.

(2) Declining case incident rates.

(3) Indications of an infectious disease event (transmission of virus) are slowing.

(4) Conditions that allow the re-establishment of USG national health functions without Marine Corps support.

6. Transition and Recover Phase (5). Phase 5 begins upon receipt of information that case incidence is decreasing, indicating the slowing of infectious disease transmission. During Phase 5, the Marine Corps conducts force reconstitution operations as directed by competent authority and after receiving recommendations from appropriate medical surveillance entities, and will support GCC and USG efforts to reestablish normal support conditions with key partners.

a. Key Tasks

(1) Review plans and evaluate whether response activities are proportionate to the situation.

(2) Prepare for a resurgence.

(3) Continue disease surveillance.

(4) Posture the FMF and capabilities to execute Title 10 responsibilities.

(5) Evaluate the effectiveness and adverse impact of mitigation measures.

(6) Capture and implement lessons learned.

(7) Disseminate updated risk messages, including information on measures to prepare for and respond to the possible resurgence of the infectious disease event.

(8) Continue and refine external coordination to include COMMSTRAT.

b. Priority of Effort. Redeploy Marine response forces, as directed.

c. Secondary Effort. Posture for resurgence (surge readiness); reconstitute the workforce and capabilities and consolidate resources.

d. Phase Objectives and Desired Effects (Intermediate Military Objective(s) (IMO))

(1) Reconstitute medical capacity/equipment.

(2) Reconstitute operational equipment.

(3) Publish PHE and/or P/ID after-action report(s) and best practices.

(4) Resume public graduations and ceremonies.

(5) Resume PFT/CFT/BCP.

(6) Update P/ID and/or COOP plans.

(7) Deliver Congressional briefings, as required.

e. Decisive Point(s)

(1) Reconstitute medical capability and staffing.

(2) Stabilize accessions to the end-strength model.

(3) Sustain GFMAP execution.

(4) Secure no-fail missions without GFMAP degradation.

f. Headquarters, United States Marine Corps (HQMC) Decision Points(s)

(1) Lower HPCON levels, as appropriate.

(2) Resume community engagements and traditional activities (Marine Corps Ball, Parades, Marine Corps Marathon, etc.).

g. Transition Criteria (Decision Point) Phase 5

(1) The operational impacts of the public health crisis are neutralized.

(2) Marine Corps forces are reconstituted and reset, and observable changes in the current environment suggest conditions are developing to return to Phase 0 (Prepare).

(3) An increase in reported cases or other indications of subsequent resurgence.

(4) A significant decrease in reported cases or no resurgence is anticipated.

(5) Low pandemic activity but continued outbreaks possible in some locations.

b. Tasks

(1) Deputy Commandant, Plans, Policies, and Operations (DC, PP&O) shall:

(a) Serve as the lead office on PHE management and P/ID and response matters for the Marine Corps and serve as the Point of Contact (POC) for all PHE issues and policies.

(b) Provide policy and planning guidance to enable the development of MARFOR and Marine Corps Installations Command (MCICOM) P/ID response plans.

(c) Provide policy and planning guidance to develop and maintain a PHE P/ID Plan annex to the HQMC COOP Plan.

(d) Coordinate with Health Services (HS) and HQMC to validate and review policy and planning guidance.

(e) In coordination with the Deputy Commandant, Manpower and Reserve Affairs (DC, M&RA), establish guidelines and procedures for the recall of Reserve Component (RC) personnel with critical skills per policy guidance from the Office of the Secretary of Defense, Reserve Affairs (OSD(RA)).

(f) Assist MARFORs, MCRC, Marine Corps Systems Command (MCSC), Marine Corps Logistics Command (MARCORLOGCOM), and MCICOM in synchronizing their P/ID plans with corresponding GCC biological hazard contingency plans.

(g) Submit lessons learned products created because of PHE events to the Commanding General, Training and Education Command (CG, TECOM) for archive, conduct of further analysis, and to facilitate sharing and use across the Service. Submit electronic submissions by accessing the appropriate Marine Corps Center for Lessons Learned (MCCLL) organizational mailbox at MCCLL_ops@usmc.mil (NIPRNET) or MCCL_ops@usmc.smil.mil (SIPRNET), per reference (aa).

(h) In coordination with MCICOM, develop and publish policy authorizing installations to serve as Receipt, Staging, and Storage (RSS) sites for Strategic National Stockpile (SNS) assets and as closed Points of Dispensing (POD) capable of dispensing SLTT SNS assets.

(2) Director, Health Services (HS) shall:

(a) Advise the Commandant of the Marine Corps (CMC) and his operational and medical staff concerning FHP priorities necessary to ensure COOP throughout a PHE.

(b) As outlined in reference (m), advise on policy developed by DC PP&O relating to public health support to Marine Corps EM, and other specific PHE related tasks under its purview.

(c) Provide recommendations on guidance and planning products created by DC PP&O and training products created by TECOM to ensure coordinated messaging and scientific soundness.

(d) Collect and coordinate requests for support across the Marine Corps to higher supporting elements such as the United States Navy Bureau of Medicine (BUMED), Defense Health Agency (DHA), CDC, and other health agencies.

(e) Provide long-term staffing advice to ensure public health-trained personnel are located to support future demand.

(f) Participate in established strategic Working Groups (WGs) for deterministic and situational analysis. Liaise with the Defense Intelligence Agency (DIA) via the National Center for Medical Intelligence (NCMI).

(3) Deputy Commandant, Manpower and Reserve Affairs (DC, M&RA) shall:

(a) Provide guidance to address the following in the event of a PHE:

1. Wounded, ill, and injured care

2. Childcare

3. Financial assistance

4. Locator assistance

5. Recall from Temporary Additional Duty (TAD)/leave

6. Retiree recall

7. Stop-loss / Stop-movement

8. Casualty assistance

9. Emergency family assistance

(b) Ensure screening of the Ready Reserve specifically addresses availability for activation during a PHE or crisis. Provide impacts on Selected Reserve availability (due to the critical nature of their civilian occupations) to DC PP&O no later than 180 days after the Assistant Secretary of Defense (ASD(MRA)) releases its policy for utilization of the National Guard and Reserves during a PHE.

(c) In coordination with the OSD and Office of Personnel Management (OPM), advise and inform Marine Corps leadership on

civilian (appropriated funds and non-appropriated funds) personnel work flexibilities, limitations, and responsibilities during preparation for response to and recovery from a PHE.

(d) In coordination with Deputy Commandant, Installations and Logistics (DC, I&L), advise Marine Corps leadership on emergency hiring and contracting to fill critical personnel shortages during and after a PHE involving a biological hazard or pandemic disease event.

(4) Deputy Commandant, Installations and Logistics (DC, I&L) shall:

(a) In coordination with DC, PP&O and subject to review by HS, operate as integral partners to define, assist in the development of and implement appropriate P/ID plan and response capabilities.

(b) Analyze and provide support for infrastructure protection of critical maintenance, supply, and logistics processes, facilities, and assets against biological hazards.

(c) In coordination with the Defense Logistics Agency (DLA), identify critical supplies, goods, or services that require priority delivery from industry/suppliers to ensure COOP and sustainment of personnel.

(d) Ensure Mortuary Affairs plans address fatality management assistance in the collection of ante mortem information and Deoxyribonucleic Acid (DNA) samples to ensure proper identification of remains, and advise personnel and families as needed regarding the process.

(e) Ensure guidance exists to address temporary housing during a biological hazard incident and other PHEs.

(f) In coordination with DC, M&RA, advise Marine Corps leadership on emergency hiring and contracting to fill critical personnel shortages during and after a PHE involving a biological hazard or pandemic disease event.

(g) Be prepared to support the HSS in conducting closed POD.

(h) Establish quarantine and isolation facilities with appropriate staffing and supply models, as needed.

(i) Coordinate through HS to communicate current and future manning needs of PHE officers to support installations.

(j) Ensure commanders of installations located in both inside and Outside the Contiguous United States (OCONUS) which have an APOD or SPOD consider the impact of Noncombatant Evacuation Operation

(NEO) and the potential of Repatriation (REPAT) operations during a PHE. Installation P/ID response plans should incorporate the support of NEO and/or REPAT operations. Planning considerations should include evacuation route management, short-term and long-term sheltering, medical care, transportation, security, and the impact on local, state, or HN resources and cognizant agencies.

(k) Ensure subordinate commanders understand Immediate Response Authority (IRA), Emergency Authority, and reporting responsibilities per references (s) and (y).

(5) Deputy Commandant, Information (DC, I) shall:

(a) Develop and disseminate policies regarding information, intelligence, and Command and Control (C2).

(b) In coordination with DC, PP&O and Marine Corps Cyber Command (MARFORCYBER), provide policy and procedures to support increased remote/telework requirements during a PHE.

1. Develop and disseminate policies regarding intelligence support during P/ID and other PHE scenarios.

2. Track global P/ID spread.

3. Provide threat indications, warnings, and assessments relating to PHE's.

a. Monitor secondary and tertiary effects of biological hazard events on state and non-state actors.

b. Develop and maintain IA and international relationships to share P/ID event information.

(6) Deputy Commandant, Combat Development and Integration (DC, CD&I) shall:

(a) Identify the roles and responsibilities regarding how studies, analysis, assessments, and lessons learned for PHEs (e.g., biological hazard incidents and/or pandemic diseases) will be requested, the reporting format required and the required recipients; as well as how the information will be utilized to improve plans and response capabilities.

(b) Conduct a gap analysis of PHE response capabilities and identify critical response priorities.

(7) Chaplain of the Marine Corps (REL) shall:

(a) Provide religious activity support and guidance in a biological hazard incident.

(b) Identify areas in P/ID plans that require or recommend Chaplain Service support, such as MA and Medical Services. Describe procedures to ensure pastoral support during emergencies.

(c) Identify the boundaries of service in the event of a biological hazard incident to avoid the inadvertent spread of the disease.

(d) Within existing capabilities, surge pastoral care and spiritual support for both living and deceased Marine Corps personnel.

(8) Deputy Commandant, Programs and Resources (DC, P&R) shall:

(a) Identify resource shortfalls to OSD, as applicable.

(b) Capture costs during all phases of a PHE for the ultimate reimbursement from the primary agency.

(9) Staff Judge Advocate (SJA) to the Commandant of the Marine Corps (CMC) shall:

(a) Advise the CMC and HQMC staff on the implementation of EHP to ensure implementation does not violate applicable laws or policy.

(b) Advise the CMC and HQMC staff on laws and regulations that will impact support to affected active and RC personnel, military family members, and others, as appropriate.

(c) Provide guidance on ROM during a pandemic or other PHE crisis.

(10) Director, Communications Directorate shall:

(a) Develop a comprehensive internal and external Public Affairs (PA) strategy that supports Marine Corps and DoD objectives, as directed.

(b) Ensure clear, effective, and coordinated risk communication before and during a PHE (i.e., Emergency Public Information (EPI)).

(c) Communicate/disseminate public health advisories, strategic communication themes, and other messages consistent with the ASD for PA and ASD for Homeland Defense (HD)and Global Security (GS) guidance, National and DoD policy and guidance.

(11) Commanding General, Training and Education Command (CG, TECOM) shall:

(a) In coordination with HS and HQMC, develop or update appropriate T&R tasks.

(b) In coordination with HS and HQMC, develop specific training materials that stress preventive measures during a biological or another PHE event.

(c) In coordination with HS and HQMC, identify appropriate delivery methods and locations to implement new training.

(d) Per the MCCLL Program (reference (aa)), collect, archive, and make available to the Force, lessons learned products generated (e.g., After Action Reports (AAR) because of PHE events to facilitate their sharing and use. Submit electronic submissions to the appropriate MCCLL organizational mailbox at MCCLL_ops@usmc.mil (NIPRNET) or MCCLL_ops@usmc.smil.mil (SIPRNET).

(12) Commanders, Marine Forces (MARFOR) shall:

(a) Support DC, PP&O in the development, coordination, integration, and synchronization of guidance, policies, strategies, concepts, doctrines, orders, and performance metrics related to cross-domain and cross-functional, service-wide pandemic, infectious disease planning, and other protection issues.

(b) Coordinate with designated GCCs in the execution of applicable Concept Plans (CONPLANs) and establish appropriate HPCONs in affected geographic regions.

(c) Synchronize staff actions with USMC supporting establishment commands and all Marine Corps attached and assigned forces to the GCC which assigned.

(d) Execute P/ID planning, coordination, and synchronization.

(e) Support CCDR requirements and integrate P/ID planning, response, coordination, and synchronization to the extent permitted by the DOS, CCDR, joint, and service guidance, including Status of Forces Agreements (SOFA).

(13) Commander, Marine Corps Installations Command (COMMCICOM) shall:

(a) Ensure commanders utilize existing WGs to address P/ID planning and coordination. Appoint appropriate core membership, to include tenant commands and activities, as applicable.

(b) Conduct situational assessment and gap analysis at the program level and ensure subordinate commanders conduct assessments

and gap analysis to identify mitigation strategies, shortfalls, and vulnerabilities at the local level.

(c) Ensure commanders coordinate with supporting MTFs, PHEOs and/or APHEOs to develop, coordinate, implement, and update P/ID plans which conform in scope and format to Appendix E, DoD directives and this Order to prevent, protect against, respond to, and recover from a PHE affecting Marine Corps installation operations. This includes coordination in implementing quarantine measures, evaluating, prioritizing, and estimating medical surge capabilities and requirements.

(d) Installation P/ID plans may be shared and coordinated with Higher Headquarters (HHQ); co-located, host, and/or tenant commands; other geographically proximate (100-mile radius) service installations; and Federal, State, and local first responder emergency planning and health authorities, to ensure synchronized logistics support efforts, particularly in areas with large military installations. P/ID plans may be exercised with external partners.

(e) In coordination with DC, PP&O and regional commanders, ensure P/ID planning and response is addressed within HQMC and installation level COOP Plans. P/ID planning in COOP plans will include:

1. Risk communications

2. Alternative work schedules

3. Telework, including RTW

4. Social (physical) distancing

5. ROM, isolation, and quarantine

6. Geographic dispersion

7. Alternate operating locations

8. PPE

9. Delegations of authority

10. Orders of succession

11. Cross training of personnel

12. Travel restrictions

13. Personnel accountability

14. Vaccinations, antivirals, MCM

(f) Establish and maintain appropriate Mutual Aid Agreements (MAAs), Memorandums of Agreement (MOAs), and Memorandums of Understanding (MOUs) with HN civil authorities, SLTT, and private sector organizations, and other federal facilities to address local support that either party might provide for response to emergencies. Ensure that Marine Corps commitments under these agreements are consistent with regulatory and statutory requirements, including specific funding authorities. Coordinate all new or re-validated agreements with appropriate organizations and command SJAs.

(g) Support DSCA activities, per references (q) and (r), as required.

(h) Within the confines of existing policy and law, develop and execute supply sustainment plans through installations, to begin stocking enough essential supplies for sustainment during P/ID response. Plans should include the purchase, storage, management, and distribution of stockpiled materials.

(i) Ensure PHEOs are identified and assigned at each Region and/or installation to coordinate PHE activities with MTFs and local health authorities. Amplified guidance regarding PHEO/APHEO roles and responsibilities are outlined in reference (c).

(14) Commander, Marine Forces Reserve (COMMARFORRES) shall:

(a) Coordinate with supporting MTFs and/or PHEOs to develop, coordinate, implement, and update P/ID plans which conform in scope and format to Appendix E, DoD directives and this Order to prevent, protect against, respond to, and recover from a PHE affecting subordinate commands and Reserve Training Center operations. This includes coordination in implementing quarantine measures, evaluating, prioritizing, and estimating medical surge capabilities and requirements.

(b) Ensure P/ID plans are coordinated and synchronized with Marine Forces North (MARFORNORTH), other relevant GCCs, HHQ, other geographically proximate (100-mile radius) service installations, and regional, State, and local emergency first response planning and health authorities.

(c) In coordination with DC, PP&O, ensure P/ID planning and response is addressed within existing COOP plans to include:

1. Risk communications

2. Alternative work schedules

3. Telework, including RTW

4. Social (physical) distancing

5. ROM, isolation, and quarantine

6. Geographic dispersion

7. Alternate operating locations

8. PPE

9. Delegations of authority

10. Orders of succession

11. Cross training of personnel

12. Travel restrictions

13. Personnel accountability

14. Vaccinations, antivirals, MCM

(d) Prepare for HQMC submission to United States Northern Command (USNORTHCOM), an assessment based upon OSD(RA) policy of which Marine Corps Reserve forces should not be available for activation given a PHE event, under appropriate authorities, due to the critical nature of their civilian occupations (first responders, health and medical professionals, transportation industry, critical infrastructure sustainment, etc.). At a minimum, this study should be broken out by State, category of recall, and skills-set, and specifically address the impact on anticipated DoD biological hazard incident response operations.

(e) Be prepared to provide Marine Corps Reserve forces to conduct the following types of operations within a pandemic environment in support of Marine Corps or DoD operations:

1. Transportation

2. C2

3. Communication

4. Engineering

5. Logistics

6. Force Protection

7. Maintenance

8. Aviation

9. Security

10. Mortuary Affairs

11. HS

(f) On order, implement policy and procedures for Pandemic Pre-Deployment Screening.

(15) Commanding General, Marine Corps Recruiting Command (CG, MCRC) shall:

(a) Ensure commanders coordinate with supporting MTFs, PHEOs and/or APHEOs to develop, coordinate, implement, and update P/ID plans which conform in scope and format to Appendix E, DoD directives and this Order to prevent, protect against, respond to, and recover from a PHE affecting Marine Corps installation operations. This includes coordination in implementing quarantine measures, evaluating, prioritizing, and estimating medical surge capabilities and requirements.

(b) Ensure P/ID plans are coordinated and synchronized with MARFORNORTH, other relevant GCCs, and with HHQ. Commands should be prepared to respond per guidance provided by HHQ, and from regional, State, and local emergency first response planning and health authorities.

(c) In coordination with DC, PP&O, ensure P/ID planning and response is addressed within existing COOP plans to include:

1. Risk communications

2. Alternative work schedules

3. Telework, including RTW

4. Social (physical) distancing

5. ROM, isolation, and quarantine

6. Geographic dispersion

7. Alternate operating locations

8. PPE

9. Delegations of authority

10. Orders of succession

11. Cross training of personnel

12. Travel restrictions

13. Personnel accountability

14. Vaccinations, antivirals, MCM

c. Coordinating Instructions

(1) This guidance is effective for planning upon receipt and execution on order.

(2) HQMC agencies' COOP response roles and responsibilities are outlined in Annex E to HQMC COOP Plan.

(3) During PHEs, DSCA will be provided on a reimbursable basis unless the POTUS ordered the operation or reimbursement is waived by the SECDEF. Support provided under IRA should be cost-reimbursable, if possible. Marine Corps organizations will capture costs during all phases of the public health crisis for possible reimbursement from the Primary Agencies.

(4) Commanders of USNORTHCOM and Indo-Pacific Command (INDOPACOM) shall be the coordinating authorities for any public health crisis and DSCA operations in their respective Joint Operations Areas (JOAs).

(5) Commanders responding under IRA will notify their appropriate service component command and Marine Corps Operations Center within 1 hour. For responses within the NORTHCOM JOA, the Marine Corps Operations Center will, within 1 hour of receipt, notify the North American Aerospace Defense Command (USNORTHCOM Operations Center) and the National Military Command Center (NMCC).

(6) The Director, Communications Directorate is the HQMC agent and delegating authority for the Marine Corps response to all media inquiries concerning Marine Corps PHE operations. Any Marine Corps response must consider possible media contributions to GCCs mitigation efforts in support of the primary agencies.

(7) Direct Liaison Authority (DIRLAUTH). DIRLAUTH is authorized with Marine Corps organizations for planning, synchronizing, and execution of this Order. Within the USNORTHCOM JOA, Commanders, MARFORs are authorized DIRLAUTH with SLTT and private sector planning partners. Outside of the USNORTHCOM JOA, the Marine Corps defers DIRLAUTH with HNs to CCDRs. In all cases, keep HQMC informed.

(8) Tenant units and activities aboard Marine Corps installations, including those of other Services, will be incorporated into installation P/ID plans.

(9) Marine Corps units/activities that are tenants or part of a joint base will ensure they are incorporated into the host installations P/ID plan; this can be accomplished through coordination through the host installation emergency manager, PHEO, or through participation in the host installations Emergency Management Working Group (EMWG).

(10) P/ID Response Plans can be stand-alone or part of other plans, (i.e., Mission Assurance Plan, Emergency Management Plan, or Installation Protection Plan.) P/ID planning should address sections prescribed in Appendix E, as appropriate.

5. Administration and Logistics

a. Summary of Revisions. This Order contains a substantial number of changes. Major modifications to this Order are as follows:

(1) Incorporates Service-level PHE planning and coordination, identifies potential decision points and decisive points, and clarifies roles and responsibilities.

(2) Chapter 2. Establishes policy on PHE Declarations, EHP, and reporting requirements.

(3) Chapter 3. Establishes policy to implement HPCONs during a public health crisis.

b. Commanders shall ensure adequate staff and budget are provided to implement comprehensive P/ID planning to meet the requirements of this Order.

c. Commanders shall publish local implementing guidance and appropriate supplemental policies. Such guidance must be consistent with this Order, commanders may implement more detailed rules to tailor their needs. CCDR CONPLANs and guidance shall be integrated into appropriate orders, training, educational programs, Standard Operating Procedures (SOP), and inspection and deployment checklists.

d. Installations are the supported commands for PHE preparation and planning. Tenant units and organizations are the supporting commands.

e. Installations P/ID plans are not authorized for destruction. Commanders/Commanding Officers shall maintain all plans until a records disposition is established.

f. Records Management. Records created as a result of this Order shall be managed according to National Archives and Records Administration (NARA)-approved dispositions in reference (ab), SECNAV M-5210.1, to ensure proper maintenance, use, accessibility, and preservation, regardless of format or medium. Records disposition schedules are located on the Department of the Navy/Assistant for Administration (DON/AA), Directives and Records Management Division (DRMD) portal page at: https://portal.secnav.navy.mil/orgs/DUSNM/DONAA/DRM/Records-and-Information-Management/Approved%20Record%20Schedules/Forms/AllItems.aspx. Refer to reference (ac), MCO 5210.11F, for Marine Corps records management policy and procedures.

g. Privacy Act. Any misuse or unauthorized disclosure of Personally Identifiable Information (PII) may result in both civil and criminal penalties. The Department of the Navy (DON) recognizes that the privacy of an individual is a personal and fundamental right that shall be respected and protected. The DON's need to collect, use, maintain, or disseminate PII about individuals for purposes of discharging its statutory responsibilities shall be balanced against the individuals' right to be protected against unwarranted invasion of privacy. All collection, use, maintenance, or dissemination of PII shall be in accordance with reference (p), the Privacy Act of 1974 (5 U.S.C. § 552a), as amended, and implemented per reference (s), SECNAVINST 5211.5F.

h. Forms. No forms are used in this Order.

i. Recommendations for changes to this Order are invited and are to be submitted to DC, PP&O via the appropriate chain of command.

j. Nothing in this Order shall detract from or be construed to conflict with the inherent responsibility of military commanders to protect personnel, property, and equipment under their commands.

6. Command and Signal

a. Command. This Order applies to the Marine Corps Total Force.

b. Signal. This Order is effective the date signed.

J. W. BIERMAN
Deputy Commandant for
Plans, Policies, and Operations

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Pandemic and Infectious Disease (P/ID) Planning Policy Manual

Chapter 1

Introduction

1. Background. Three pandemics occurred during the 20th century, each resulting in illness in approximately 30 percent of the world population, and death in 0.2 to 2 percent of those infected. Based on past information and current models of disease transmission, it is projected that a modern pandemic could lead to the deaths of up to 200,000 to 2 million Americans.

a. A virus with pandemic potential possesses the following characteristics:

(1) Easily spread among humans

(2) Spreads globally in a short period

(3) Most of the human population is susceptible to infection

b. Pandemics caused by a new pathogen may affect all countries, and exact consequences are difficult to predict.

c. Secondary effects of a pandemic could cause significant health, economic, and security ramifications, potentially including large-scale social unrest due to fear of infection or concerns about safety.

2. Assumptions

a. PHE (e.g., pandemics) are unpredictable, therefore, assumptions must be made to facilitate planning efforts:

(1) The Marine Corps may have some warning of a pandemic outbreak before significant operational impacts occur and be able to commence mitigating measures. Efficient and sustained person-to-person transmission signals are potential indicators of an imminent outbreak.

(2) All AORs will not be affected simultaneously, nor will the degree of effects be the same in each AOR.

(3) Total containment of the spread of certain diseases is not feasible.

(4) Medical facilities and resources (military and civilian) will be overwhelmed during peak periods of P/ID events. MTF personnel, units, and other medical assets will be limited due to competing operational commitments.

(5) MTFs will potentially be overwhelmed by patients, necessitating deferral of care to already overwhelmed community healthcare facilities.

(6) Treatment of military personnel and their family members may take place at outsourced facilities, with changes in priorities and altered standards of medical care during an outbreak.

(7) Partner nations will impose restrictions that inhibit freedom of movement of material and personnel to stop the spread of infectious disease into and/or out of their nations. Some military movements, basing, overflight, as well as support to coalition operations will be restricted.

(8) Some persons will become infected but not develop clinically significant symptoms. Asymptomatic or minimally symptomatic individuals may transmit infection and develop immunity to subsequent infection.

(9) While the number of patients seeking medical care cannot be predicted with certainty, in previous deadly disease incidents, about half of those who became ill sought care. With the availability of effective antivirals for treatment, this proportion may be higher in a deadly or pandemic disease outbreak.

(10) Risk groups and rates of serious illness, hospitalization, and deaths cannot be predicted.

(11) Rates of absenteeism will depend on the severity of the pandemic. Specific PHM (i.e., business and/or school closings, state government stay-inside ROM orders, social distancing, and quarantining household contacts of infected individuals) are likely to increase absenteeism rates.

(12) Disease transmission may last months in affected areas.

(13) Efficient person-to-person transmission may initiate both domestically and internationally.

(14) If a P/ID incident starts outside the United States, it will enter the United States at multiple locations and spread quickly to other parts of the country.

(15) Some coalition partners, allies, and HN governments will request military assistance and training from the USG for biological hazard or pandemic disease preparedness, surveillance, detection, and response.

(16) Biological or pandemic disease incidents will impact HN support to United States forces.

(17) A layered mix of voluntary and mandatory individual, unit, and installation-based PHM , such as limiting public gatherings, school closings, social distancing, protective sequestration, personal hygiene measures, wearing protective clothing or masks, and other protective measures can limit transmission and reduce illness and death if implemented throughout an event. Quarantine, isolation, and other movement restrictions are essential for successful containment operations.

(18) The DOS will request DoD support for selective NEO of designated non-infected individuals from areas abroad experiencing outbreaks. This will only be conducted after commercial methods of extraction have been exhausted by DOS and only when directed by the SECDEF.

(19) Under applicable authorities, DoD will assist civil authorities in support of an outbreak.

(20) The Marine Corps will be called upon to assist in the transportation of AMCITs living abroad if deemed necessary by public health officials or the DOS.

(21) RC forces may need to be quickly mobilized to provide surge capabilities, especially in transportation, C2, communications, engineering, logistics, force protection, maintenance, aviation, and security.

(22) A surge in private demand for consumer goods (stockpiling) will cause DoD shortfalls.

(23) Outside the United States operational commitments will continue at current levels and troop rotations will be impacted.

(24) There will be a significant reduction in civilian transportation capacity that could affect DoD acquisition and/or distribution.

(25) DoD assets will be tasked to support DSCA/USG response, further restraining MHSs.

(26) A pandemic of operational significance could last 18-24 months or longer.

Chapter 2

Public Health Emergency (PHE) Declarations and Emergency Health Powers (EMP)

1. Declaration of a Public Health Emergency (PHE)

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

b. Commanders must be prepared to make timely decisions to protect lives, property, and infrastructure and enable installations and/or activities to sustain mission-critical operations and essential services.

(1) Commanders should expect a level of uncertainty during the decision-making process, especially during the early stages of a PHE.

(2) PHEOs, SJAs, or Command Judge Advocates (CJAs) should be prepared to provide relevant guidance relating to authorized actions, powers, and limits of authority.

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

c. Situations that may be PHEs include the occurrence or the imminent threat of an illness or health condition with a high probability of any of the following:

(1) A significant number of deaths.

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

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

(4) Health care needs that exceed available resources.

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

d. Commanders ensure to appoint in writing or establish MOAs to ensure qualified and trained PHEOs can determine the existence of

cases suggesting a PHE affecting the installations population, ensure that sources of the health hazard (e.g., infection or contamination) are investigated, define the distribution of the illness or health condition and recommend implementation of proper mitigation and/or control measures. PHEO actions may include:

(1) Direct staff or utilize supporting MTFs to collect and analyze data on the health hazard causing the PHE, particularly when the source or hazard is unknown or novel, in coordination with applicable supporting units.

(2) Evaluate the health threat and report outbreaks and pathogen identification to public authorities, as required.

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

(4) Provide advice on appropriate health protection measures for personnel; the examination, closing, evacuation, or decontamination of a facility; or the decontamination or destruction of any material contributing to the PHE.

(5) Share information gathered during the investigation of a potential PHE with federal and SLTT public health and public safety officials to the extent necessary to protect public health and safety and for reporting potential PHEICs. Shared information may include personally identifiable health information per references (s) and (t).

(6) Notify, directly or through applicable reporting channels, the appropriate defense criminal investigative organization concerning information indicating a possible terrorist incident or other crime. Notifications to other law enforcement authorities (e.g., Federal Bureau of Investigation, SLTT police).

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

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

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

(3) In situations where there are potential conflicts with SLTT declarations, the commander and PHEO will consult their SJA/CJA for guidance, particularly in cases where the installation has concurrent Federal and State jurisdiction. SLTT public health laws vary between jurisdictions, and the SJA/CJA may be required to provide a legal opinion on the installation legal obligations to comply with the SLTT requirement. When possible, efforts should be made to resolve issues with SLTT authorities before legal action is required.

f. When the commander and PHEO determine that a PHE declaration is necessary to respond to a suspected or confirmed incident, the commander will complete a written declaration within the scope of their authority with the support and guidance of the SJA/CJA and in consultation with COMMSTRAT. The declaration must outline the situation and relevant actions that will be taken (Appendix F).

g. The declaration will be communicated within 12 hours to all installation personnel, including those individuals in tenant organizations and commands, and individuals residing on the installation, with the support of COMMSTRAT. Appropriate risk communications (e.g., HPCON) will be developed and distributed to installation personnel (e.g., MHS personnel, military family members, etc.), and guests on the installation to provide information on the situation, actions that will be taken, and where information can be obtained. If installation services are curtailed, guidance should be provided on other service availability, especially in the case of restrictions on medical care. The PHEO, MTF commander or director, COMMSTRAT, and other relevant personnel will coordinate the development and distribution of these communications. Amplifying information on HPCON measures is provided in Chapter 3 of this Order and reference (c).

h. PHE declarations terminate automatically in 30 days, unless renewed and re-reported, or may be terminated sooner by the military commander who made the declaration, any senior commander in the chain of command, the Secretary of the Military Department concerned, or the SECDEF.

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

j. In areas outside the United States, declarations of a PHE may be limited to United States personnel and subject to the requirements of applicable treaties, agreements, and other arrangements with foreign governments and allied forces, particularly in the case of non-United States installations and field activities.

2. Emergency Health Powers (EHP) and Restriction of Movement (ROM)

a. Applicability

(1) When commanders declare a PHE within the scope of their authority due to a suspected or confirmed incident, commanders are authorized to take relevant emergency actions to respond to the situation to achieve the greatest public health benefit while maintaining operational effectiveness.

(2) To the extent necessary for protecting or securing Marine Corps and/or DoD property or places and associated Service members, EHPs may include persons other than Service members who are present on an installation or other areas under DoD control, including:

(a) Reserve training centers not collocated with active-duty installations.

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

b. Emergency Health Powers (EHPs). EHPs authorized to commanders include:

(1) Directing military personnel to submit to medical examinations or testing as necessary for diagnosis or treatment.

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

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

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

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

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

(7) Controlling evacuation routes on, and ingress and egress to and from, the affected installation, command, or activity.

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

(9) Restricting movement to prevent the introduction, transmission, and spread of communicable diseases or any other hazardous substances that pose a threat to public health and safety.

c. Restriction of Movement (ROM)

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

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

(b) In the case of persons under the commander's authority other than uniformed personnel, restrictions of movement may include isolation or limiting ingress and egress to, from, or on an installation, military command, or other activity. Coordination with civilian public health officials, including the CDC, SLTT, and HN public health agencies, may be required. Sample notices of quarantine and isolation are provided in Appendix G and H.

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

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

(b) Per reference (f), the Director of the CDC may take PHM or a combination of measures the Director deems reasonably necessary to prevent the spread of disease, particularly when involving movement across state lines or international travel, including, but not limited to the initiation of infectious disease travel restrictions to specific locations or implement restrictions of contact with persons under investigation of exposure to a communicable disease.

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

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

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

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

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

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

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

(5) The needs of persons quarantined or isolated will be addressed systematically and competently.

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

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

(6) Per references (p), (s), (t) and (u), PII, including protected health information, will be used and disclosed only as necessary to safeguard public health and safety.

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

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

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

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

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

(b) Remain in assigned quarters.

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

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

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

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

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

(c) Persons other than military members may be required to submit to vaccination, treatment, or diagnostic testing as necessary as a condition of access to an installation or facility. During a declared DoD PHE, the provisions in reference (w) regarding voluntary vaccination for non-Service members do not supersede the requirements in paragraph 2.c.

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

(14) Individuals and groups subject to quarantine will be advised that violators may be charged with a crime pursuant to law(including Section 797 of Title 50, USC; Part 1382 of Title 18, USC; or Parts 70 or 71 of Title 42, Code of Federal Regulations (CFR)) and subject to punishment of a fine or imprisonment, or both.

(a) In the case of military members, the UCMJ also applies.

(b) Individuals or groups not subject to military law and who refuse to obey or otherwise violate an order issued per this Order may be detained by the commander until appropriate civil authorities can respond. The commander will coordinate with civil authorities to ensure the response is appropriate for the PHE.

(15) Any fatalities associated with quarantined or isolated individuals will be addressed to prevent the unintentional spread of contamination. The PHEO will recommend measures for reasonable and necessary testing and safe disposition of human remains after appropriate consultation with the chain of command, local SLTT public health officials, and the coroner’s office. The CDC, the Central Joint Mortuary Affairs Office, and the Office of the Armed Forces Medical Examiner will guide the testing and safe disposition of human remains per reference (x).

3. Notification Procedures

a. A declaration of a DoD PHE as defined by this Order, will be immediately reported by the commander through the chain of command to the SECDEF.

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

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

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

(3) Reporting will follow the process described in Figures 1 and 2. Figure 1 is an expansion of the right side of Figure 2 for Combatant Command (CCMD) and overseas notifications. Figure 3 provides additional guidance on interpreting these diagrams. Service-level reporting guidance is provided in this Order.

(4) Every DoD component identified in Figures 2 and 3 will ensure each of the components specified reporting relationships is established and operational.

(5) The NMCC Global Situational Awareness Facility (GSAF) is the designated DoD point of notification to the HHS SOC for potential PHEICs. The HHS SOC serves as the USG's National Focal Point (NFP) for notifications under international health requirements.

(6) Circumstances suggesting a PHE from non-DoD sources will be reported using the process described in reference (y).

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

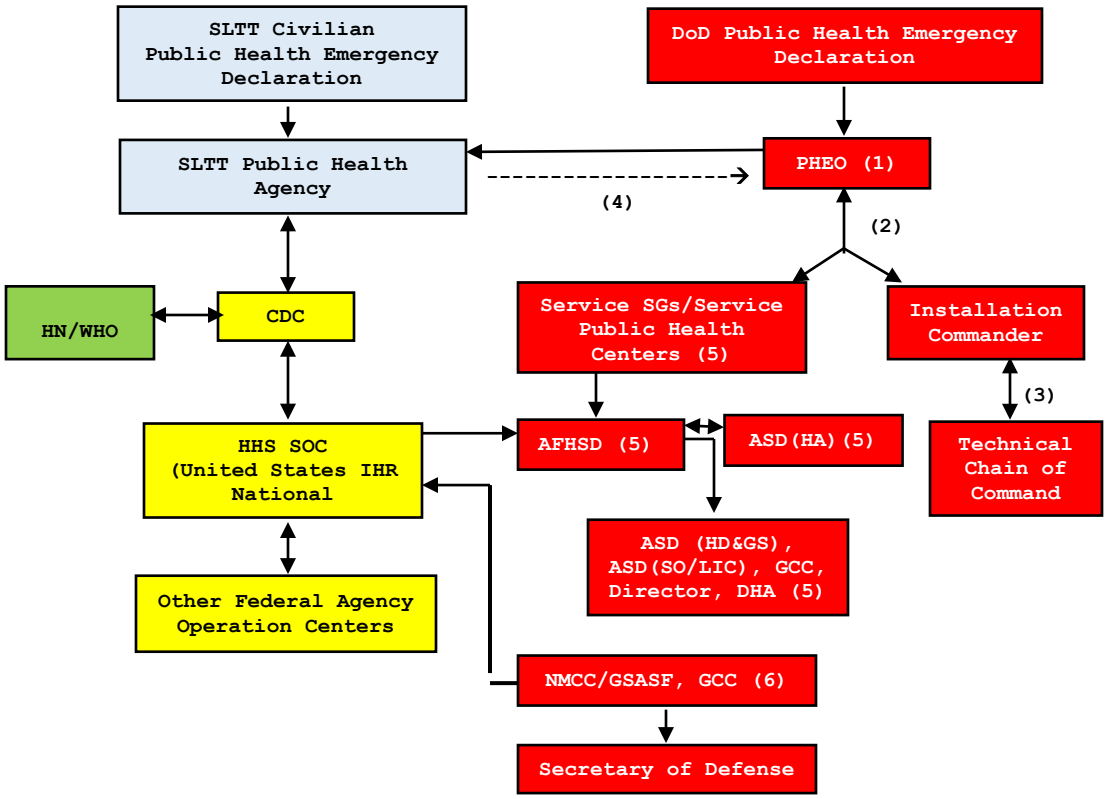


Figure 2-1 – Notification Routing Procedures

Key

Department of Defense
Other United States Government
SLTT Government
Host Nation or International Partner(s)

Formal Reporting Requirement
Other Communication Channel

Note: Numbers in parenthesis correspond with Figure 4.

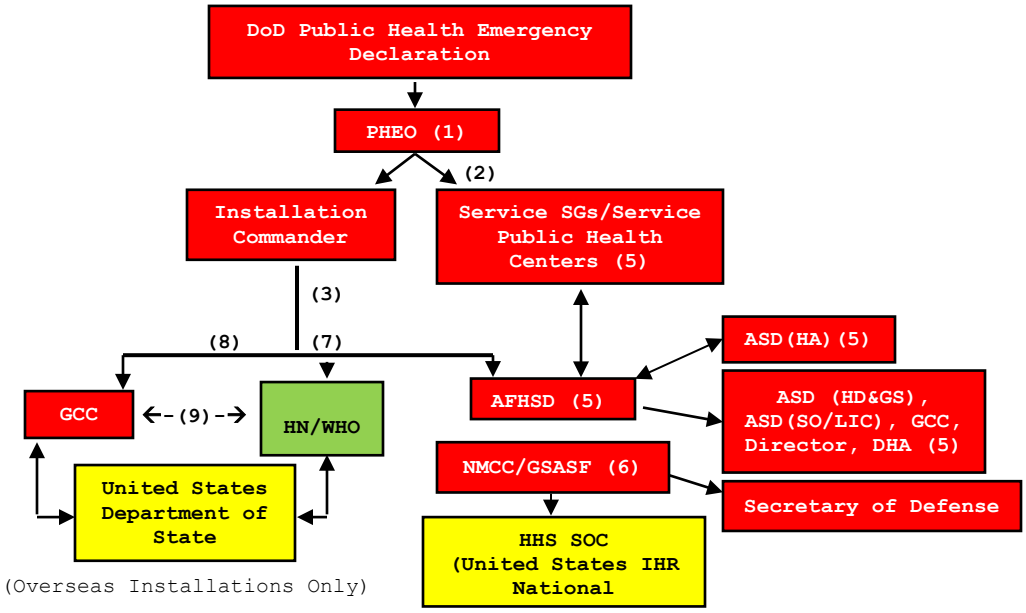


Figure 2-2 - Notification Routing Procedures
(Command and Overseas Notification)

Key

Department of Defense
Other United States Government
Host Nation or International Partner(s)
Formal Reporting Requirement
Other Communication Channel
NOTE: Numbers in parenthesis correspond with Figure 4.

1. PHEOs will initiate notification procedures for a PHE declaration with approval by the commander. For incidents that may be potential PHEICs, PHEOs will complete a report per this Order to be submitted through this same process. In some CCMDs, the Surgeons office may perform duties similar to that of the PHEO.
2. The PHEO will provide the PHE declaration and relevant information, including potential PHEIC reporting, to the commander for further reporting and the appropriate Service SG and Service Public Health Center as appropriate.
3. Depending upon theater, operational, or regional policies, the commander will notify the appropriate authorities within their technical chain of command. This may include the Service Major Command, the Service Chiefs, the CCMD, and the Service component, a joint task force, a sub-unified commander, or other entities as established.
4. The PHEO will notify appropriate SLTT public health officials of the DoD PHE declaration and accompanying response activities. In a civilian-declared PHE, SLTT officials may directly notify the PHEO or other installation POC depending on applicable agreements and communication plans.
5. The Military Department Surgeon Generals and Service Public Health Centers will transmit notifications to the AFHSD for further dissemination. While AFHSD primary notification is to the ASD for Health Affairs (HA) and to the NMCC/GSAF, other recipients of the notification will include the ASD for HD and GS; ASD for Special Operations (SO) and Low Intensity Conflict (LIC); the Military Department SGs; GCC; the Director, DHA; and other DoD offices as required.
6. The NMCC/GSAF will notify the SECDEF, CCMD, Military Services, and affected major commands of the PHE declaration as appropriate. The NMCC/GSAF will notify the HHS SOC/United States IHR NFP upon ASD(HA) approval.
7. Command reporting follows CCMD tactics, techniques, and procedures and Standard Operating Procedures (SOPs) established for line notification to the NMCC. Once joint task forces are operational, reporting will be in accordance with CCMD notification policy guidance.
8. PHEIC reporting policy under international regulations (e.g., WHO IHR) observing determinations made by the relevant CCMD, COM, and HN.
9. Based upon discussions between the HN, GCC, and COM, potential PHEICs or events related to a declared PHEIC that involve United States Government affiliated personnel and military family members will be reported to the WHO via the United States IHR NFP and potentially by the HN IHR NFP.

Figure 2-3
Explanatory Text for Figures 2-1 and 2-2

4. Reporting of Potential Public Health Emergency (PHE) of International Concern (PHEIC)

a. PHEs will be assessed as potential PHEICs and reported accordingly through the notification procedures outlined in this Order 7 Jul.

b. As part of the decision process for declaring a PHE, the PHEO will also evaluate the threat as a potential PHEIC. The determination of a potential PHEIC under international health requirements depends upon several factors:

(1) Due to the potential public health impact, these diseases must be reported immediately per international health requirements: smallpox, poliomyelitis due to wild-type virus, novel subtypes of human influenza, and severe acute respiratory syndrome. These diseases are the only ones that international health organizations specifically identify for immediate notification.

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

(a) Is the public health impact of this event serious?

(b) Is the event unusual or unexpected?

(c) Is there a significant risk of international spread?

(d) Is there a significant risk of international trade or travel restrictions?

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

d. Pursuant to international health agreements, the USG has 72 hours to formally make notification of all events that may constitute a PHEIC within the United States, as well as when the United States receives evidence of an international public health risk outside the United States.

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

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

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

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

5. Service-Level Reporting

a. Purpose. Establishes the reporting procedures and formatting required to support the execution of pandemic CONPLANs, and describes the OPREP-3, daily, monthly, and weekly reporting requirements as they pertain to the various phases of disease response.

b. Types of Reports

(1) Operations Event/Incident Report (OPREP-3). This report shall be used to report any significant pandemic or infectious disease event that warrants immediate notification to the CMC.

(a) Operations Event/Incident Report (OPREP-3) Thresholds

1. Initial confirmed pandemic virus case within a command (e.g., installation) or military treatment facility.

2. Initially confirmed cluster (i.e., > 25 cases) suggestive of a pandemic virus.

3. Significant mission impact (actual or probable) resulting from a pandemic outbreak.

4. Pandemic virus or infectious disease or potentially causing an adverse impact on potential DSCA forces allocated or to anticipated DSCA missions.

5. Other pandemic-related incidents of significant interest as determined by the reporting organization.

(b) Operations Event/Incident Report (OPREP-3) Sample Format. The required information and recommended format for an OPREP-3 report are provided in Appendix A.

(2) Situation Reports (SITREPs). The SITREP is the primary report submitted by the Marine Corps to the NMCC and the North American Air Defense (NORAD)/NORTHCOM Command Center. This report includes basic information about PI surveillance network, the P/ID situation, current and future related activities, and logistical and personnel status and requirements, as follows:

(a) Monthly. The purpose of this report is to provide situational awareness on P/ID matters during Phase 0 (Prepare) and Phase 1 (Protect). This report will capture exercises, resource requirements, readiness status and any other information deemed significant by the reporting command. The required information and recommended format for a monthly SITREP is provided in Appendix B.

(b) Weekly. The purpose of this report is to provide detailed situational awareness of specific health crisis incidents during Phase 2 (Mitigate). This report will capture resource requirements, potential shortfalls, FHP (to include HPCON status), and readiness status and any information that is deemed significant by the reporting command. This report will contain a commander's estimate concerning current and projected mission assurance risk assessments. The required information and recommended format for a weekly SITREP is provided in Appendix C.

(c) Daily. The purpose of this report is to provide specific situational awareness of health crisis events during Phase 3 (Respond), Phase 4 (Stabilize) and Phase 5 (Transition and Recover). This report will contain a commander's estimate concerning current and projected mission assurance risk assessments, the ability to conduct assigned missions/force projection, and the implementation of HPCON measures as they affect personnel within the AOR and HN support. The required information and recommended format for a daily SITREP are provided in Appendix D.

c. Requirements. Upon notification of a pandemic or health crisis, or during the implementation of Phase 0 or Phase 1, all Marine Corps Component Commands, MARFORRES, Marine Corps Combat Development Command (MCCDC), MCICOM, and Headquarters Battalion (HQBN), will provide monthly SITREPs to the HQMC Operations Center. If Phase 2 is implemented, weekly SITREPs will be submitted as determined by the HQMC Operations Center. If Phase 3, 4, or 5 are implemented, daily SITREPs will be submitted, as determined by service-level requirements.

d. Classification. All health crisis reporting classifications will be kept at the Controlled Unclassified Information (CUI) level whenever possible, however; upgraded classification may be necessary based on the circumstances and situation. Classification determination will be made by the reporting unit. All classified reports will be marked accordingly with overall classification and appropriate portion markings.

6. Implementation Outside the United States

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

b. HN ownership and control of installations outside the United States may prevent commanders from unilaterally implementing many of the provisions of this Order. Ultimately, United States authorities and control at locations outside the United States are subject to the sovereignty of the HN, except as otherwise defined in applicable international agreements, (i.e., SOFA), defense cooperation agreements, and base rights agreements.

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

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

e. All installations located outside the United States will coordinate their responses to public health emergencies with the appropriate GCC. Coordination with the Chief of Missions and DOS should be sought, as appropriate.

7. Emergency Public Information (EPI)

a. Per reference (i), a critical aspect of coordination is ensuring the consistent provision of public information, including all personnel on installations and in facilities. EM programs are responsible for the provision of accurate, timely, and verifiable public health crisis information to protected populations before, during, and after an incident via multiple pathways, including Mass Warning and Notification (MWN) systems, social media, television, commercial radio, media services, and similar systems.

b. EPI is based on the integration of complimentary crisis communication and risk communication theories and techniques. In this context, crisis communication is the ability to communicate effectively with other government agencies, the media, and personnel by delivering accurate and timely information that is designed to inform, educate, and guide personnel and their families in any necessary actions needed to protect themselves.

c. The continuous and rapid flow of information during a health crisis, facilitated by advances in media distribution methods, requires proactive, responsive, adaptive, and agile processes and capabilities. Effective communication in the pandemic environment requires consideration of many factors including means, context, and established patterns of communication. Successful communication synchronization in the information environment requires a comprehensive, harmonized process.

d. The purpose of updates and alerts is to provide the necessary information to either warn or instruct personnel and effect the necessary actions that will lead to their safety and to deliver the messages to personnel at risk, to maximize the possibility that the affected population will take protective measures, minimize the delay in taking those actions, and will serve as a mechanism to provide information.

e. All means available should be used to communicate relevant, timely information. Continuous communication of public information across each of the five preparedness mission areas – prevention, protection, mitigation, response, and recovery – serves to enhance situational awareness and resilience and should continue until recovery actions have been completed. Amplified guidance on public health crisis and risk communications is outlined in paragraph 4.i. of Appendix E.

f. Commanders must continually communicate with United States and international audiences, the public, and stakeholders (to the extent possible) about activities, intentions, and desired end-states in health crisis environments, and should consider the following:

(1) Rapid and timely communication of information to personnel during a public health crisis are critical.

(2) The more information that message recipients receive about the threat or crisis, the protective actions associated with the hazard, or how notifications about the crisis might be delivered to them in their specific location, the more likely they are to act promptly. Messaging contains information about the specific hazard the alert is for and the potential consequences, which gives context to the guidance being given in the message.

(3) Facts related to the crisis need to be stated authoritatively, confidently, and with certainty, even in circumstances in which there is ambiguity about message content factors and especially about the protective action personnel are being asked to take.

(4) The added uncertainty of the pandemic environment exacerbates daily stress and frustration. Without a constant media

and information presence to inform, educate, and assure personnel, even the best of Service efforts will be drowned out by other sources (organized or individual), resulting in reduced confidence and increased reliance on other forms of information.

(5) Consistent with national security and privacy concerns, up-to-date information regarding the status of the command should be made available on command or installation web sites. During and following a public health crisis, important information should include ROM, protective health measures, current HPCON status, and information that increases the awareness of the protected population. Providing context about activities, intentions, and desired end-states is a method of building and maintaining trust, credibility, and support.

(6) Provide accurate and relevant information to enable timely notification to affected individuals of a PHE, its termination, and the actions taken to control or mitigate the emergency. Provision of information will be performed with the installation or military COMMSTRAT and if applicable, a joint information center.

8. Public Health Measures (PHM). PHM vary in scope and magnitude and provide commanders with a range of options to deploy depending on specific trigger events and operational requirements. Commanders should examine public health options together with MCM to ensure the most comprehensive and tailored approach possible. PHMs are critical until confirmatory testing can be completed.

a. Trigger Event Responses

(1) Intelligence Warning Trigger. Following an intelligence warning trigger, commanders should weigh the credibility and immediacy of intelligence information against the potentially operationally significant impact of directing personnel to Shelter-In-Place (SIP), enter collective protective shelters, or don Mission-Oriented Protective Posture (MOPP) gear. If available, collective protection shelters and Individual Protective Equipment (IPE) provide significant and direct protection from aerosol releases of biological agents. Potential operational degradation can result from remaining within shelters or wearing IPE for extended periods, and it may be difficult to determine when to exit shelters and don IPE. There is limited utility in donning alternate respiratory protection, such as surgical masks, during an intelligence warning because these types of masks do not provide personnel with sufficient protection from many weaponized biological agents. Other protective actions, such as ROM, increasing personal hygiene, and self-monitoring, may be more appropriate responses during an intelligence warning.

(2) Weapons Event Trigger. Weapons event triggers may provide some personnel with enough warning to negate the effects of a biological attack. Personnel can seek measures to obtain protection

against direct exposure. Standard response and force protection actions should be immediately implemented.

(3) Detector alarm and Sentinel casualty triggers. Under the best circumstances, will only alert personnel that an event has occurred. Detector alarm triggers provide adequate time to prevent disease spread through the implementation of MCM. The benefits of respiratory protection in such situations will need to be carefully considered. If a sentinel casualty is the trigger event, the use of respiratory protection may help prevent person-to-person transmission.

b. Shelter-In-Place (SIP)and Collective Protection. In-place sheltering, and collective protection can provide significant and direct protection from aerosol releases of biological agents if there is sufficient warning time before an attack. Potential operational impacts may result from in-processing and out-processing and through use of contamination control areas. Commanders should consider the ability to sustain, resource constraints, and impact on morale. If a covert attack employing a contagious agent were to occur, personnel could unknowingly spread the disease if the command/installation initiates collective protection without additional respiratory protection or MCM (e.g., prophylaxis). Depending upon the trigger, it may be more useful to initiate SIP instead of collective protection. For example: In the case of a detector alarm or sentinel casualty, the agent has already been dispersed, therefore, a reasonable response to such a threat is to minimize person-to-person contact, which can be accomplished by keeping personnel confined in specific areas (i.e., workspaces or other designated areas), thereby minimizing close contact.

c. Restriction of Movement (ROM). Commanders should view ROM measures as options that can be used separately, in combination, or adapted throughout a PHE or biological event. Commanders should use the least restrictive means of ROM available while ensuring the protection of personnel. The decision to implement ROM should be based on multi-functional collaboration. The combination and/or types of measures employed will be based on the scope and severity of the situation. In certain circumstances, ROM and PHM may be the only option for mitigating disease outbreaks or exposure.

d. Increase Social Distancing. Social distancing measures can be a low-impact option to minimize social interactions when there is a threat of attack or disease outbreak. Implementation of social distancing measures following an intelligence warning decreases the potential for personnel to spread a contagious disease if an agent is delivered covertly. Social distancing measures can be effective in limiting the spread of a disease without adversely impacting operations.

e. Avoid Close Contact. Personnel should avoid close contact with others. Diseases that spread through respiratory contact can be

minimized or negated by reducing close contact between individuals. Distances can vary depending upon the disease from 3 to 8 feet.

f. Limit Large Gatherings. Commanders may need to close some or all facilities before confirmatory identification is plausible. Considerations should be given to closing select facilities such as schools, childcare facilities, exchanges, commissaries, fitness centers, movie theaters and dining facilities – areas in which minimizing close contact would be difficult.

g. Base Closure. Commanders have the option to close installations, thereby reducing the possible transmission of diseases from the local community (or from the installation to the local community) until a more complete picture of the health threat has been developed.

h. Limit Base Access. Depending on the circumstances, commanders may limit installation access. The following options provide commanders with ROM measures that are tailored to specific segments of the base population or areas of the installation to allow operations to continue as effectively as possible:

(1) Limit ingress and/or egress via perimeter gates and/or closing an air facility.

(2) Limit access to certain areas of the installation. Minimize unnecessary traffic into and out of installation facilities.

i. Quarantine. Quarantine may be applied to individuals while a disease is in a communicable stage or pre-communicable stage if transmission to other individuals would likely cause a PHE.

(1) Confirmatory identification of infection is not necessarily a precondition for quarantine. As determined by the commander, in collaboration with the PHEO, individuals who are believed to have been exposed to an infectious disease, but are not yet showing symptoms, may be quarantined while additional tests are completed. The exact duration of quarantine will be disease specific.

(2) Consideration should be given to the psychological impact of quarantine if personnel are confined or restricted to large community facilities. Quarantine may take place in an individual's living quarters or in a community-based (billeting, fitness center/gymnasium) facility.

(3) Quarantine in living quarters may be suitable for contacts (i.e., personnel who have encountered a Person(s) Under Investigation (PUI) if the facility meets their basic needs and unexposed members can be protected from exposure. Resource and supply issues will need to be considered to ensure individuals have access to basic needs.

(4) Quarantine in living quarters may involve all members of a family (infectious and non-infectious) to facilitate healthcare. Quarantine in such settings allows personnel to continue somewhat normal activities and is less intrusive than quarantine in larger settings (i.e., community facilities). Quarantine in living quarters may afford the opportunity to continue working if telecommuting is an option.

j. Isolation. Distinct from quarantine, isolation involves separating persons who have been identified as having a specific infectious illness from those who are healthy. Personnel are isolated so they can be given specialized health care and healthy individuals can be protected.

(1) Isolation allows for the focused delivery of specialized health care to persons at home, in MTFs, or in designated community facilities.

Chapter 3

Health Protection Conditions (HPCONs)

1. General

a. Reference (c) assigns HPCON levels to codify approaches to disease outbreaks given the severity of the disease and level of disease transmission in a local community.

b. HPCON levels inform actions to be taken by individual personnel, units, installations, activities, commands, and military MTFs in response to a specific health threat, and must be flexible, tailored, and incremental.

c. HPCONs serve as a framework for risk communication that is flexible and tailored to each individual PHE and can be planned with PHEOs as part of a particular PHE plan.

2. Applicability

a. Commanders are encouraged to employ the HPCON framework during a PHE to communicate specific health protection measures to the affected population, including individuals working in, residing on, or visiting the command, activity, or installation. Standardizing responses within categories ensures a measured local response.

b. HPCON levels should be synchronized with the current Force Protection Condition (FPCON) level and can include appropriate access, FHP measures, and limitation of non-critical activities.

3. Health Protection Conditions (HPCON) Procedures and Components

a. The HPCON framework can include any authorized FHP measures that may apply to the emergency and shall be coordinated with other affected installations to ensure consistent messaging across installations and services.

b. FHP measures must be integrated into existing COOP, emergency preparedness, response plans, and agreements per references (d) and (i).

c. Determination to elevate or lower the HPCON level will be made by the activity, or installation commander in consultation with the PHEO and/or the regional Naval Medical Center or MTF director, where applicable.

d. The HPCON framework may be updated during the response to the PHE as new information or guidance becomes available. Actions may be discontinued at the termination of the PHE, unless renewed by the activity or installation commander for a specified period.

e. Health measures in the HPCON framework shall be clearly defined and specified in categories based on the impact of the health threat, specific precautions, and level of effort, beginning with simple precautions, and escalating to the level of effort in subsequent categories, based upon protective measures available to personnel.

f. HPCON measures are updated as necessary as the situation evolves using available guidance and from appropriate civilian medical and public health sources. The following paragraphs serve as examples for planning purposes:

(1) Health Protection Conditions (HPCON) 0 (Normal)

(a) Condition. Routine (Normal Operations)

(b) Health Protection Guidance

1. Maintain standard precautions such as hand washing, practice cough/sneeze etiquette, diet, and exercises; vaccinations; monitor health alerts and conduct regular preparedness activities.

2. Identify telework workforce.

3. Identify mission essential personnel and alternates who must report for duty during a PHE.

(c) Specific Actions

1. Conduct regular planning and drills.

2. Review and revise plans and procedures as necessary, to include HPCON framework, per reference (c).

3. Inspect and inventory PPE.

4. Coordinate emergency response plans with the host base, tenant organization(s), and SLTT governments.

5. Emergency Operations Center (EOC) and/or watch centers conduct normal readiness and monitoring.

(2) Health Protection Conditions (HPCON) A (Report of Unusual Health Risk or Disease)

(a) Condition. Limited (Low Risk). There are instances of personnel who have been infected, including some who may not be sure when, where or how they became infected.

(b) Health Protection Guidance – (HEALTH ALERT)

1. Communicate risk and symptoms of health threat to personnel, command/activity/installation; review plans and verify training, stocks, and posture.

2. Prepare to diagnose, isolate, and report new cases.

3. Re-emphasize avoiding contact with personnel who are ill.

4. Consider implementing telework.

(c) Specific Actions

1. Implement baseline FHP requirements according to GCC CONPLANs, DoD and service requirements, and Vulnerability Assessment (VA) results; implement standard precautions to protect health.

2. Review and update pandemic plans and procedures; inspect and inventory PPE.

3. Develop and distribute specific workforce preparedness guidance and conduct specific training.

4. As appropriate, consult local authorities and public health officials on the threat and mutual anti-terrorism, force protection and health protective measures.

5. Monitor international partner and/or visitor vetting for any identified countries of concern and provide update briefs to senior leaders for situational awareness.

6. EOC and/or watch centers at an increased level of readiness and monitoring, as appropriate.

7. Conduct epidemiological surveillance to identify evidence of disease spread.

8. Contact local DoD affiliates and HN Public Health Officials, as appropriate.

(3) Health Protection Conditions (HPCON) B (Outbreak or Heightened Exposure Risk)

(a) Condition. Moderate. Local transmission has occurred; cases occurring among close contacts OR personnel have been

infected with the virus in more than one location, region, or area, but how, when or where they became infected may not be known.

(b) Health Protection Guidance. Continue all HPCON A measures, and consider implementing the following:

1. Strict hygiene (no handshaking, wipe common-use items). If exposed, self-isolate; avoid contaminated food/water, vector control as applicable.

2. Consider declaring a PHE to inform the population of increased health threats

3. Restrict travel to affected regions and areas; advise DoD civilian employees, DoD contractors, and military family members of risk.

4. Re-scope or modify exercises in affected areas to limit the risk of exposure to personnel.

5. Institute clearly defined PPE posture for high-risk personnel.

(c) Specific Actions

1. Provide updated guidance to personnel; consider canceling all foreign visitors from countries of concern.

2. Consider canceling unofficial visits and/or tours.

3. Distribute PPE to appropriate personnel; monitor international partner or visitor vetting for any identified countries of concern.

4. Restrict entrance by personnel returning from a region or area of concern and/or having close contact with persons returning from a region or area of concern.

5. Review and conduct table-top exercises and planning for MCM distribution.

6. EOC and/or watch centers at heightened levels of readiness and monitoring, as appropriate.

7. Identify travel ban(s) to affected countries and/or states and disseminate them among the local population.

8. Interview individuals returning from affected areas for signs of illness.

9. Consider evacuation of non-mission essential personnel. Evacuation of uniformed personnel, military family members, and DoD civilians will be in accordance with the Joint Travel Regulations (JTR). The JTR (Chapter 6) provides amplifying information regarding eligibility, travel, and transportation allowances associated with evacuation.

10. Consider elevating HPCONs to HPCON C if there is a substantial threat of disease for personnel due to a local epidemic outbreak of a disease with a high morbidity rate, the imminent spread of such a disease to the local area, and/or a wide area of contamination that requires special or costly avoidance and mitigation procedures.

11. Implement vector control measures to prevent primary and secondary effects such as vector-borne disease transmission and fungal diseases through the targeted application of pesticides, fungicides, and rodent control, as appropriate.

12. Initiate infectious disease travel restrictions and/or ROM; implement restriction of contact with specific animal species.

(4) Health Protection Conditions (HPCON) C (High Morbidity Epidemic or Contamination)

(a) Condition. Substantial (Significant)

1. Confirmed cases occurring outside of close contact, but how, when, or where they became infected may not be known.

2. The spread of the disease is ongoing.

(b) Health Protection Guidance. Continue HPCON A and HPCON B measures, and implement the following:

1. Declare a PHE.

2. Consider ROM consistent with reference (c) (potentially to include quarantine, isolation, cancellation of public gatherings, avoiding congregate settings, and practicing social distancing).

3. Implement quarantine, consistent with applicable procedures, for personnel/units returning from affected areas to a lower-risk area.

4. Limit access to facilities, bases, stations, installations, and activities.

5. Re-scope, modify or cancel exercises or training.

6. Approve leave and travel on a case-by-case basis.

7. Increase the population available to telework (all non-mission critical personnel.)

8. Distribute PPE as appropriate.

(c) Specific Actions

1. Provide updated guidance to personnel; consider canceling all foreign visitors from countries of concern.

2. Consider canceling unofficial visits and/or tours.

3. Distribute PPE/IPE to appropriate personnel; monitor international partner or visitor vetting for any identified countries of concern.

4. Restrict entrance by personnel returning from a region or area of concern and/or having close contact with persons returning from a region or area of concern.

5. Validate medical surge and decontamination resources and evacuation sites.

6. Review and conduct table-top exercises and planning for MCM distribution.

7. EOC and/or watch centers at heightened levels of readiness and monitoring, as appropriate.

8. Issue legal memorandums of Quarantine and/or Isolation to affected personnel or units.

9. Implement HN MOUs/MOAs, as applicable.

10. Consider evaluating HPCONs to HPCON D if there is a local epidemic with a high mortality rate or imminent spread of such a disease to the local area.

11. Limit movement and adapt to disruptions in routine activities (e.g., school and/or work closures) according to DoD or service level guidance.

12. Consider implementing flexible work schedules; minimize face-to-face meetings; maximize the use of electronic communications (i.e., conference calls, VTC, etc.)

13. Secure and/or restrict access to common gathering areas/spaces.

14. Continue cleaning and disinfection of workspaces and common-use items per CDC and service-level guidance.

(5) Health Protection Condition (HPCON) D (High Mortality Epidemic or Contamination)

(a) Condition. Severe (High)

1. Sustained disease transmission despite public health control measures.

2. The spread is ongoing and includes most locations, regions, or areas.

(b) Health Protection Guidance. Continue HPCON A through C measures, and consider implementing the following:

1. Declare a PHE.

2. Cancel all non-essential leave and travel to affected locations.

3. Consider appropriate ROM or other restrictions of personnel critical to national security functions.

(c) Specific Actions

1. Medical monitoring, as deemed appropriate by public health officials and/or PHEOs, performed before accessing facilities, bases, stations, installation, or activities.

2. Begin recovery and reconstitution efforts.

3. EOC and/or watch centers remain at full activation.

4. Perform mass decontamination, where appropriate. Continue disinfecting common-use materials and workspaces.

5. Decrease HPCON Level as the situation warrants.

APPENDIX A

Sample Operations Event/Incident Report (OPREP-3) Report

UNCLASS (Classify as required)
MSGID/OPREP-3/REPORTING UNIT/####//
REF/A/TEL/REPORTING UNIT/DTG//
AMPN/REF A IS INITIAL MSG REPORT TO CMC//
FLAGWORD/PINNACLE FOR (HEALTH CRISIS) EVENT/-//
TIMELOC/DTG/GEOGRAPHIC LOCATION//
GENTEXT/INCIDENT IDENTIFICATION AND DETAILS OF THE PI EVENT, MEDICAL ASSESSMENT, OPERATIONAL ASSESSMENT AND COORDINATING ACTIONS SHALL BE ADDRESSED IN THIS PARAGRAPH.//
RMKS/AMPLIFYING REPORT TO FOLLOW.//
DECL/DERI: REPORTING UNIT/DTG//

APPENDIX B

Sample Monthly Situation Report (SITREP) Report

CLASSIFICATION (UNCLASS/FOUO) or other classification as required
MSGID/GENADMIN/ORIGINATING ORGANIZATION/CURRENT DATE//
SUBJ/MONTHLY (HEALTH CRISIS) SITREP//
REF/A/DOC/CMC WASHINGTON DC/07AUG13//
REF/B/DOC/DOD FCP-P/ID//
REF/C/SECDEF EXORD/DATE//
REF/D/DOC/SECDEF MOD TO REF C/DTG//
REF/E/HQMC COOP PLAN, ANNEX E/DATE//
NARR/REF A IS MCO 3504.2A, OPERATIONS EVENT/INCIDENT REPORT (OPREP-3), WHICH DIRECTS UNITS TO SUBMIT SIR REPORTS TO HQMC (ATTN: HQMC OPERATIONS CENTER) REGARDING THE DIAGNOSIS OF ANY DISEASE OR THE EXTENSIVE OUTBREAK OF ANY CONDITION AMONG PERSONNEL THAT MAY POTENTIALLY DEGRADE THE OPERATIONAL READINESS OF A UNIT, ACTIVITY, COMMAND OR INSTALLATION. REF B IS USNORTHCOM 3551-13 CONCEPT PLAN TO SYNCHRONIZE DOD PANDEMIC PLANNING. REF C IS SECDEF APPROVED EXORD THAT DIRECTS DOD EXECUTION OF USNORTHCOM CONPLAN 3551-13 AND SUPPORTING PANDEMIC AND INFECTIOUS DISEASE (P/ID) PLANS IN RESPONSE TO (PI EVENT, e.g.H1N1, COVID-19)) OUTBREAK. REF D IS SECDEF APPROVED MODIFICATION TO DOD SUPPORT TO P/ID (EVENT) EXORD THAT DIRECTS DOD EXECUTION OF USNORTHCOM CONPLAN AND SUPPORTING P/ID PLANS IN RESPONSE TO THE OUTBREAK. REF E IS ANNEX E TO THE HQMC COOP PLAN.//
POC/(NAME)/(RANK/GRADE/POSITION)/POC/-/EMAIL:(NAME@USMC.MIL)/TEL: DSN ###-####/TEL: (###) ###-####//GENTEXT/REMARKS/

1. SITUATION.
    A. Interagency (IA)/HOST NATION (HN).
        (1) DEGRADATION IN IA CAPABILITIES.
        (2) DEGRADATION IN HN CAPABILITIES IN A PANDEMIC ENVIRONMENT.
2. OPERATIONS.
    A. OPERATIONS IMPACT OF PI ON:
        (1) TRAINING
        (2) MISSION ASSURANCE
        (3) STRATEGIC COMMUNICATIONS
        (4) INFORMATION OPERATIONS
        (5) PUBLIC AFFAIRS.
3. LOGISTICS.
    A. ASSESSMENT OF LOGISTICS POSTURE IN SUPPORT OF PI PLANNING
    B. PHARMACEUTICAL COUNTERMEASURES
    C. MEDICAL COUNTERMEASURES
    D. PPE
    E. BUDGET CONSTRAINTS
    F. ADDITIONAL LOGISTICS CONSTRAINTS/IMPACTS
4. IMPACT OF PI ON MEDICAL OPERATIONS.
    A. BIOSURVEILLANCE
    B. PANDEMIC PLANNING & RESPONSE EXERCISES
    C. COORDINATION WITH IA/HN
5. PLANNING.
    A. AOR PI PLANNING OPERATIONS

B. PANDEMIC PLANNING & RESPONSE EXERCISES
C. COORDINATION WITH IA/HN
6. COMMANDERS MISSION ASSURANCE ASSESSMENT
7. ADDITIONAL INFORMATION (AS REQUIRED)
8. POC
9. RANK, NAME, ORGANIZATION, CONTACT NUMBER

Appendix C

Sample Weekly Situation Report (SITREP) Report

CLASSIFICATION (UNCLASS/FOUO) or other classification as required.
MSGID/GENADMIN/ORIGINATING ORGANIZATION/CURRENT DATE//
SUBJ/WEEKLY (HEALTH CRISIS) UPDATE//
REF/A/DOC/CMC WASHINGTON DC/07AUG13//
REF/B/USNORTHCOM CONPLAN//
REF/C/SECDEF EXORD/DTG//
REF/D/DOC/SECDEF MOD 1 TO REF C/DTG//
REF/E/HQMC COOP PLAN, ANNEX E/DATE//
NARR/REF A IS MCO 3405.2A, OPERATIONS EVENT/INCIDENT REPORT (OPREP-3), THAT DIRECTS UNITS TO SUBMIT SERIOUS INCIDENT REPORTS (SIR) TO HQMC (ATTN: MARINE CORPS OPERATIONS CENTER) REGARDING THE DIAGNOSIS OF ANY DISEASE OR THE EXTENSIVE OUTBREAK OF ANY CONDITION AMONG PERSONNEL THAT MAY POTENTIALLY DEGRADE THE OPERATIONAL READINESS OF A COMMAND, ACTIVITY OR INSTALLATION. REF B IS USNORTHCOM CONPLAN 3551-13 TO SYNCHRONIZE DOD PANDEMIC RESPONSE AND PLANNING. REF C IS SECDEF APPROVED EXORD THAT DIRECTS DOD EXECUTION OF USNORTHCOM CONPLAN 3551-13 AND SUPPORTING PANDEMIC PLANS IN RESPONSE TO A PHE. REF D IS SECDEF APPROVED MODIFICATION TO DOD SUPPORT TO (PANDEMIC CRISIS/PUBLIC HEALTH EMERGENCY) AND SUPPORTING PANDEMIC OR PHE CRISIS. REF E IS ANNEX E TO THE HQMC COOP PLAN.//
POC/(NAME)/(RANK/GRADE/POSITION)/POC/-/EMAIL: (NAME@USMC.MIL)/TEL: DSN ###-####/TEL: (###)###-####//
GENTEXT/REMARKS/
1. SITUATION. IAW ESTABLISHED INFORMATION REQUIREMENTS, PROVIDE UPDATE TO EXISTING SECDEF DECISION SUPPORT TEMPLATE (DST) OUTLINED CCIR/PIR/FFIR/EEFI.
2. IMPACT OF PANDEMIC OR PUBLIC HEALTH CRISIS ON:
    A. IMPACT ON MARINE FORCES (COMMANDERS ASSESSMENT).
    B. IMPACT ON C2 STRUCTURE/ORGANIZATION (COMMANDERS ASSESSMENT).
3. OPERATIONS. OPERATIONS OVERVIEW AND THE IMPACT OF A PANDEMIC OR PUBLIC HEALTH CRISIS ON OPERATIONAL CAPABILITY.
    A. ASSESSMENT NEXT 7 DAYS.
    B. LAND OPERATIONS.
    C. MARITIME OPERATIONS
    D. TRAINING
    E. EXERCISES
    F. AEROSPACE OPERATIONS
    G. INFORMATION OPERATIONS
    H. FORMAL SCHOOLS ATTENDANCE
    I. STRATEGIC COMMUNICATION
    J. PUBLIC AFFAIRS
4. IAW ANNEX B OF CONPLAN _____, PROVIDE A STATUS OF THE PANDEMIC SURVEILLANCE NETWORK.
5. THREAT OUTLOOK ASSESSMENT, INTSUM AND DISUM REPORTING.
6. EMERGING THREATS WITHIN THE JOA WHICH MAY AFFECT THE REGIONAL BALANCE OF POWER.

7. SUMMARY OF SUSPECT INCIDENTS WITHIN JOA ASSOCIATED WITH THREAT FORCES AND THE IMPACT OF A HEALTH CRISIS ON THEIR ABILITY TO CONDUCT OPERATIONS.
8. CHANGES TO CCIR.
9. LOGISTICS.
    A. IDENTIFICATION OF EMERGING FORCE REQUIREMENTS/UNITS/ASSETS, AS VALIDATED AND SOURCED BY FORCE PROVIDER.
    B. IMPACT OF HEALTH CRISIS ON POINT OF EMBARKATION (POE)/POINT OF DEBARKATION (POD), AND IDENTIFIED JOINT, RECEPTION, STAGING, ONWARD MOVEMENT, AND INTEGRATION (JSROI) LOCATION AND THE HEALTH CRISIS IMPACT ON THESE LOCATIONS.
    C. MOVEMENT AND FORCE TRACKING TIMELINE (IMPACT ON MOVEMENT TABLES, FORCE ROTATIONS, ETC.)
    D. ASSET/CARGO/EQUIPMENT TABLE, (ACTUAL MOVEMENT/FORCE TRACKING TIMELINES).
    E. COMMAND EXPECTATIONS FOR ADDITIONAL FORCE(S)/ASSET SOURCING.
    F. FACILITIES (CRITIAL INFRASTRUCTURE/BASE SUPPORT INSTALLATION/OPERATIONAL STAGING AREAS).
    G. LOGISTIC SHORTFALLS ATTRIBUTED TO THE HEALTH CRISIS.
    H. STATUS OF PPE.
    I. STATUS OF QUARANTINE/ISOLATION/RESTRICTION OF MOVEMENT.
10. MEDICAL.
    A. FORCE HEALTH PROTECTION (FHP) STATUS (HEALTH PROTECTION CONDITION (HPCON)).
    B. STATUS OF MEDICAL FACILITIES (INCLUDE BIOSURVEILLANCE AND TREATMENT CAPABILITY).
    C. SHORTFALLS.
    D. ASSESSMENT NEXT 7 DAYS.
11. COMMUNICATIONS.
    A. OVERVIEW OF IMPACT OF HEALTH CRISIS COMMUNICATIONS.
    B. PERSONNEL SHORTFALLS.
12. PERSONNEL.
    A. TOTAL TROOP STRENGTH
    B. OPERATIONAL READINESS/COMBAT EFFECTIVENESS.
    C. PERSONNEL STATUS
        (1) NUMBER OF PERSONNEL TAD IN AFFECTED AREA
        (2) NUMBER OF PERSONNEL ON LEAVE IN AFFECTED AREA
        (3) PERSONNEL SHORTFALLS
    D. CASUALTY DATA.
        (1) DEATHS
        (2) HOSPITALIZED
        (3) ONGOING TREATMENTS
        (4) NUMBER OF PERSONNEL QUARANTINED
        (5) NUMBER OF PERSONNEL ISOLATED
        (6) RESTRICTION OF MOVEMENT
13. COMMANDERS MISSION ASSURANCE ASSESSMENT
14. ADDITIONAL INFORMATION (AS REQUIRED)
15. POC.
16. RANK, NAME, ORGANIZATION, CONTACT INFORMATION.

Appendix D

Sample Daily Situation Report (SITREP) Report

CLASSIFICATION (UNCLASS/FOUO) or other classification as required.
MSGID/GENADMIN/ORIGINATING ORGANIZATION/CURRENT DATE//
SUBJ/DAILY (HEALTH CRISIS) SITREP//
REF/A/DOC/CMC WASHINGTON DC/07AUG13
REF/B/USNORTHCOM CONPLAN//
REF/C/SECDEF EXORD/DTG//
REF/D/DOC/SECDEF MOD 1 TO REF C/DTG//
REF/E/HQMC COOP PLAN, ANNEX E/DATE//
NARR/REF A IS MCO 3405.2A, OPERATIONS EVENT/INCIDENT REPORT (OPREP-3), THAT DIRECTS UNITS TO SUBMIT SERIOUS INCIDENT REPORTS (SIR) TO HQMC (ATTN: MARINE CORPS OPERATIONS CENTER) REGARDING THE DIAGNOSIS OF ANY DISEASE OR THE EXTENSIVE OUTBREAK OF ANY CONDITION AMONG PERSONNEL THAT MAY POTENTIALLY DEGRADE THE OPERATIONAL READINESS OF A COMMAND, ACTIVITY OR INSTALLATION. REF B IS USNORTHCOM CONPLAN 3551-13 TO SYNCHRONIZE DOD PANDEMIC RESPONSE AND PLANNING. REF C IS SECDEF APPROVED EXORD THAT DIRECTS DOD EXECUTION OF USNORTHCOM CONPLAN 3551-13 AND SUPPORTING PANDEMIC PLANS IN RESPONSE TO A PHE. REF D IS SECDEF APPROVED MODIFICATION TO DOD SUPPORT TO (PANDEMIC CRISIS/PUBLIC HEALTH EMERGENCY) AND SUPPORTING PANDEMIC OR PHE CRISIS. REF E IS ANNEX E TO THE HQMC COOP PLAN.//
POC/(NAME)/(RANK/GRADE/POSITION)/POC/-/EMAIL: (NAME@USMC.MIL)/TEL: DSN ###-####/TEL: (###)###-####//
GENTEXT/REMARKS/
1. SITUATION. IAW ESTABLISHED INFORMATION REQUIREMENTS, PROVIDE UPDATE TO EXISTING SECDEF DECISION SUPPORT TEMPLATE (DST) OUTLINED CCIR/PIR/FFIR/EEFI.
2. IMPACT OF PANDEMIC OR PUBLIC HEALTH CRISIS ON:
    A. IMPACT ON MARINE FORCES (COMMANDERS ASSESSMENT).
    B. IMPACT ON C2 STRUCTURE/ORGANIZATION (COMMANDERS ASSESSMENT).
3. OPERATIONS. OPERATIONS OVERVIEW AND THE IMPACT OF A PANDEMIC OR PUBLIC HEALTH CRISIS ON OPERATIONAL CAPABILITY.
    A. ASSESSMENT NEXT 7 DAYS.
    B. LAND OPERATIONS.
    C. MARITIME OPERATIONS.
    D. TRAINING
    E. EXERCISES
    F. AEROSPACE OPERATIONS
    G. INFORMATION OPERATIONS
    H. FORMAL SCHOOLS ATTENDANCE
    I. STRATEGIC COMMUNICATION
    J. PUBLIC AFFAIRS
4. IAW ANNEX B OF CONPLAN _____, PROVIDE A STATUS OF THE PANDEMIC SURVEILLANCE NETWORK.
5. THREAT OUTLOOK ASSESSMENT, INTSUM AND DISUM REPORTING.
6. EMERGING THREATS WITHIN THE JOA WHICH MAY AFFECT THE REGIONAL BALANCE OF POWER.

7. SUMMARY OF SUSPECT INCIDENTS WITHIN JOA ASSOCIATED WITH THREAT FORCES AND THE IMPACT OF A HEALTH CRISIS ON THEIR ABILITY TO CONDUCT OPERATIONS.
8. CHANGES TO CCIR.
9. LOGISTICS.
    A. IDENTIFICATION OF EMERGING FORCE REQUIREMENTS/UNITS/ASSETS, AS VALIDATED AND SOURCED BY FORCE PROVIDER.
    B. IMPACE OF HEALTH CRISIS ON POINT OF EMBARKATION (POE)/POINT OF DEBARKATION (POD), AND IDENTIFIED JOINT, RECEPTION, STAGING, ONWARD MOVEMENT, AND INTEGRATION (JSROI) LOCATION AND THE HEALTH CRISIS IMPACT ON THESE LOCATIONS.
    C. MOVEMENT AND FORCE TRACKING TIMELINE (IMPACT ON MOVEMENT TABLES, FORCE ROTATIONS, ETC.)
    D. ASSET/CARGO/EQUIPMENT TABLE, (ACTUAL MOVEMENT/FORCE TRACKING TIMELINES).
    E. COMMAND EXPECTATIONS FOR ADDITIONAL FORCE(S)/ASSET SOURCING.
    F. FACILITIES (CRITIAL INFRASTRUCTURE/BASE SUPPORT INSTALLATION/OPERATIONAL STAGING AREAS).
    G. LOGISTIC SHORTFALLS ATTRIBUTED TO THE HEALTH CRISIS.
    H. STATUS OF PPE.
    I. STATUS OF QUARANTINE/ISOLATION/RESTRICTION OF MOVEMENT.
10. MEDICAL.
    A. FORCE HEALTH PROTECTION (FHP) STATUS (HEALTH PROTECTION CONDITION (HPCON)).
    B. STATUS OF MEDICAL FACILITIES (INCLUDE BIOSURVEILLANCE AND TREATMENT CAPABILITY).
    C. SHORTFALLS.
    D. ASSESSMENT NEXT 7 DAYS.
11. COMMUNICATIONS.
    A. OVERVIEW OF IMPACT OF HEALTH CRISIS COMMUNICATIONS.
    B. PERSONNEL SHORTFALLS.
12. PERSONNEL.
    A. TOTAL TROOP STRENGTH
    B. OPERATIONAL READINESS/COMBAT EFFECTIVENESS.
    C. PERSONNEL STATUS
        (1) NUMBER OF PERSONNEL TAD IN AFFECTED AREA
        (2) NUMBER OF PERSONNEL ON LEAVE IN AFFECTED AREA
        (3) PERSONNEL SHORTFALLS
    D. CASUALTY DATA.
        (1) DEATHS
        (2) HOSPITALIZED
        (3) ONGOING TREATMENTS
        (4) NUMBER OF PERSONNEL QUARANTINED
        (5) NUMBER OF PERSONNEL ISOLATED
        (6) RESTRICTION OF MOVEMENT
13. COMMANDERS MISSION ASSURANCE ASSESSMENT
14. ADDITIONAL INFORMATION (AS REQUIRED)
15. POC.
16. RANK, NAME, ORGANIZATION, CONTACT INFORMATION.

Appendix E

Sample Format and Attachments for a Pandemic and Infectious Disease (P/ID) in Support of Global Pandemic Concept Plan (CONPLAN) Template

1. General. Installation and/or command P/ID plans should provide detailed procedures, information, and guidance to prepare for and respond to disease outbreaks, whether naturally occurring (i.e., pandemic) or due to biological attacks, to protect installation personnel and critical resources. This plan will support sustainment of mission operations during disease outbreaks, if required. The plan should be maintained in an executable state via periodic updates. When available, lessons learned from exercises and real-world events, should be incorporated into the plan.

2. Plan Components. Three specific components are generally necessary for the P/ID plan: (1) table of contents; (2) basic plan; and (3) attachments (annexes, appendices and/or tabs).

3. Basic Plan. Plans may be tailored to meet specific requirements, and should contain, at a minimum, seven sections: (1) references; (2) tasked organizations; (3) situation; (4) mission; (5) execution; (6) administration and logistics; and (7) C2. Planners may add additional sections as required. To the extent possible, the basic plan should be brief, saving detailed information for the attachments. Where applicable, the plan may reference other installation plans (e.g., installation security plan, medical contingency response plan) rather than restate the information.

a. References. List applicable DoD, Services, and installation specific guidance, as well as any other references required to execute the plan.

b. Tasked Organizations. Identify installation organizations tasked to support the plan. Identify the size and breakout of the installation population. Include assigned Services units, tenant units, geographically separated units, joint or coalition forces, military civilians, DoD contractors, military family members, HN or third country civilians, and guests.

(1) Supporting Forces. Identify military units or organizations outside of the installation that support the plan.

(2) Supporting Organizations. Identify non-military organizations identified for support via MAAs, MOAs, or MOUs.

c. Situation. Describe the most probable conditions for implementing this plan. Identify other plans that are likely to be implemented concurrently with this plan.

(1) Threat. Identify the biological hazard threat, including infectious diseases, to the installation. Consider enemy/terrorist use of biological warfare agents (pathogens/toxins) as well as naturally occurring disease outbreaks.

(2) Key Assumptions. Outline major planning assumptions used in P/ID development.

d. Mission. Outline the basic purpose of the plan. Include the mission of the installation. Address the likelihood and circumstances that may require the installation to continue operations during a biological attack or disease outbreak. If assigned, attached, or transitioning forces must sustain mission operations, address impacts to the plan.

e. Execution. Identify the authority to execute the plan and the general process for implementation. Highlight the major tasks each installation organization and/or functional community must perform to carry out the plan.

(1) Phasing Structure. Identify distinct transition points in the plan where significant changes occur (e.g., threat, lead organization, level of effort). Include information as to how transitions will take place, to include reporting requirements.

(2) Limiting Factors (LIMFAC). Identify factors that may significantly impact execution of the plan. Specify how often LIMFACs will be reviewed and updated.

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

g. Command and Control (C2). Identify command relationships both internal and external to the installation. List installation control centers used in the plan along with the individual or organization responsible for their operation. Outline the succession of command and provisions for continuity of command. Include provisions for C2 of supporting forces and organizations. Outline methods of communications to be used.

4. Annexes. Where applicable, annexes may reference other installation plans (e.g., installation security plan, medical contingency response plan) rather than restate the information.

Planners should consider incorporating the following annexes to facilitate decision making and coordination.

a. Detection, Sampling, and Identification of Biological Agents

(1) Identify detection, sampling, and identification resources available on the installation, as well as resources assumed to be available through MOA/MAAs. Suggested areas of focus include:

(a) Create procedures for the revision of detector operations mode and sampling tempo IAW the FPCON, trigger event, or outbreak.

(b) Create a threat-specific environmental sampling plan.

(c) Create threat-specific water surveillance and testing plan.

(d) Create threat-specific food surveillance and testing plan.

(e) Identify laboratories (national, reference, and sentinel) available for presumptive and confirmatory analysis. Outline their capabilities and limitations. Include documentation requirements for identified labs, and the anticipated timeline between installation submission of sample(s) and receipt of results.

b. Medical Surveillance

(1) Outline installation medical surveillance procedures.

(2) Include generic templates for use during contact tracing and epidemiological investigations that address specific symptoms and/or diseases.

(3) Specify team composition for contact tracing and epidemiological investigation teams.

(4) Identify training requirements for non-Public Health personnel assisting with rapid contact tracing and epidemiological investigation teams.

(5) Outline procedures for the conduct of epidemiological investigations.

(6) Outline the self-monitoring plan for installation personnel. Consider required supplies, educational materials, or other types of aid necessary for personnel self-monitoring to determine onset of symptoms and guidance on when and how to use.

(7) Outline medical surveillance capabilities of local laboratories and hospitals.

(8) Outline procedures and limitations on providing and/or requesting information from the local medical communities.

c. Medical Intervention and Treatment

(1) Identify the planning factors to estimate the number of installation personnel requiring medical intervention and/or treatment in the event of a biological incident or pandemic.

(2) Describe the installation vaccination and prophylaxes distribution and administration plan. Include required stockpiles for vaccines and prophylaxes. Consider follow-on monitoring of the effects to personnel after administration, including adverse reaction reporting requirements (i.e., Vaccine Adverse Event Reporting System (VAERS)).

(3) Identify PPE/IPE requirements for healthcare providers and patients in medical treatment facilities.

(4) Address the update of immunization records.

(5) Plan for behavioral casualty triage and management.

(6) Outline the biological triage plan.

d. Individual and Collective Protection

(1) Address IPE and PPE requirements and the distribution plan for the installation population. Consider unique requirements for forces transiting the installation (TPFDD).

(2) Specify collective or SIP protection measures applicable to the biological threat(s).

(3) Identify tasked organizations to support shelter operations, including roles and responsibilities, resources required, etc.

e. Security

(1) Identify the steps to enhance perimeter surveillance in response to biological intelligence warnings or actual events.

(2) Outline contacts and procedures for the conduct of investigation if an outbreak is suspected to be the result of a terrorist attack. Address chain of custody requirements.

(3) Identify procedures to collaborate with local law enforcement and/or military authorities.

(4) Consider possible FPCON adjustments based on biological threats or pandemic events.

(5) Identify the procedures that will be used to secure and control access into and out of quarantine/isolation facilities.

(6) Specify the procedures that will be used to provide security for the transfer of laboratory samples/specimens.

(7) Describe the steps to conduct an installation water and food VA. Develop an associated plan for the protection of installation food and water supplies.

(8) Outline rules for the use of force for enforcement of security requirements during the response to biological incidents.

f. Logistics and Supply

(1) Outline the steps taken to ensure the availability of supplies and laboratory test kits for performing epidemiological investigations.

(2) Identify logistic requirements necessary to support each phase of a biological response or pandemic and identify sources available to support tasks.

(3) Outline procedures for expeditious access to the SNS or War Reserve Material (WRM) supplies.

g. Contamination Mitigation Plan

(1) Identify resources required to mitigate health effects to personnel from exposure to biological agents. Address personnel (medical, patients, and responders), equipment and facilities.

(2) Identify contamination control measures for the MTF and quarantine/isolation facilities that limit the unintentional spread of contamination and reduce the requirement for decontamination efforts.

(3) Identify resources required to perform decontamination activities. Address decontamination requirements for patients, medical personnel, responders, mission equipment, and facilities.

(4) Outline contamination control procedures for the MTF and all identified quarantine/isolation facilities.

h. Restriction of Movement (ROM)

(1) General

(a) Identify anticipated installation-specific application of ROM (i.e., use of facilities for quarantine and isolation operations, lock down the installation and allow individuals to move freely within the fence, sector the installation and limit movement between sectors, etc.).

(b) Identify roles and responsibilities for implementing and maintaining ROM.

(2) Quarantine and Isolation

(a) Identify facilities for use in quarantine and isolation operations. Identify additional resources required once quarantine/isolation is initiated. Include procedures for initiating quarantine/isolation operations.

(b) Identify the steps to provide monitoring, medicine, and medical care to personnel in isolation and/or quarantine.

(c) Outline a working quarantine plan for use when mission operations must continue. Address the active monitoring of personnel in working quarantine.

(d) Identify IPE/PPE requirements for occupants of quarantine/isolation facilities.

(e) Identify appropriate infection control measures within isolation facilities (Standard Precautions, Airborne Precautions, Contact Precautions, Droplet Precautions). For further guidance refer to the CDC Recommendations for Isolation Precautions in Hospitals.

(f) Describe the procedures to distribute basic needs materials and services during quarantine and/or isolation. Address food and water needs (consider unique nutritional requirements for ill personnel), shelter needs, social needs, religious requirements, and sanitary needs including laundry, bathing, and waste management requirements. Consider special requirements for contaminated laundry and waste.

(g) Describe the plan to secure and control access into and out of quarantine/isolation facilities.

(3) Other

(a) Outline the steps required for the dispersion of mission essential personnel to alternate housing facilities/shelters.

(b) Describe the procedure to implement social distancing measures to reduce the risk of person-to-person transmission of disease (e.g., minimize personal contact with others).

(c) Describe the process to limit ingress and/or egress to the installation or limit access to certain sectors of the installation. Consider who will be permitted access to and from the installation or sector.

(d) Identify non-essential installation facilities such as schools, commissaries, exchanges, gymnasiums, and movie theaters. Prioritize these facilities for closure or transition to quarantine/isolation facilities.

i. Public Health Crisis and Risk Communications

(1) Both the medical community and COMMSTRAT have responsibilities to communicate biological hazard information to select audiences on an ongoing basis and during a public health crisis. Amplified information and guidance regarding EPI are found in Chapter 2 of this Order.

(2) All means available should be used to communicate relevant, timely information across the affected community. Include both medical community and PA products in this attachment describing, at a minimum:

(a) Medical Community Public Health Crisis and Risk Communications. The medical community will coordinate risk communication plans and procedures with installation functional experts (e.g., Medical Situational Awareness in the Theater (MSAT)) as required.

1. Preparation and Pre-Event Communications

a. Include a plan to produce, coordinate, and disseminate materials to inform the installation population on biological threats, possible mitigation actions, and recommended readiness activities. Consider the following information:

(1) Overview of medical support available in the event of a biological incident. Items to address include mass prophylaxis, triage, and referral for specialty care through TRICARE resources, clinic capabilities, and support from local community medical facilities.

(2) Creation of flyers, website information, posters, and Command information materials that describe the health effects of biological hazards and agents and medical measures to mitigate risk.

(3) Medical facility contact information and reporting procedures.

(4) Biological-unique medical precautions that may occur including possible decontamination stations, quarantine, isolation, and ROM options.

(5) The need for all personnel and families to remain calm post-event and not panic. Medical personnel will expand services on base to meet requirements. The Medical Community is here to serve and support them.

(6) Psychological information regarding individuals' stress-related responses to biological incidents including what people should expect and best practice recommendations for mitigation.

(7) Importance of self-monitoring procedures during a biological incident, including reporting of personnel potentially exposed.

(8) Establish a telecommunications plan for hotlines and other services.

b. Coordinate with COMMSTRAT to ensure medical accuracy of counter-biological risk communications materials.

c. Support installation Unit Commanders Calls, as required, to provide general information on biological threats and anticipated installation response.

d. Create and maintain emergency notification rosters for appropriate national, SLTT, and local medical agencies (e.g., Federal Emergency Management Agency (FEMA), CDC, HN, United States Army Medical Research Institute of Infectious Diseases (USAMRIID), local hospitals, etc.).

2. Trans-Event Communications

a. Outline plan to keep installation population informed throughout a PHE.

(1) Biological agent of interest with associated symptoms, persons at risk, health impacts, and suggested actions.

(2) Expected incident/outbreak duration.

(3) Expected length of stay for quarantined and/or isolated personnel.

(4) P/ID principles and procedures.

(5) Appropriate protective equipment and medical self-treatments options.

(6) Mass prophylaxis plan execution.

(7) Triage plan.

b. Include procedures to notify personnel subject to quarantine and/or isolation.

c. Include procedures to notify families of those subject to quarantine and/or isolation.

d. Include procedures for the expeditious contact and notification of installation personnel. Consider the non-military base population (visitors, civilians, military family members, host-nationals).

e. Address unique communications requirements for forces transitioning through the installation.

f. Identify the numbers and specialties of medical personnel required to support the installation COMMSTRAT effort.

g. Include procedures to coordinate with COMMSTRAT ensure the accuracy of medical information in risk communications.

(b) Public Affairs (PA) Public Health Crisis and Risk Communications. Attach a risk communication plan that includes, at a minimum:

1. Preparation and Pre-Event Communications

a. Address requirements and procedures to educate COMMSTRAT personnel on crisis communications fundamentals for biological emergencies.

b. Identify activities, with associated themes and messages, to build installation and community confidence that the installation is prepared for a biological attack or naturally occurring disease outbreak. Consider:

(1) Media engagement activities

(2) Public briefings

(3) Commander’s calls

c. Establish a telecommunications plan for hotlines and other services.

2. Trans-Event Communications

a. Include emergency PA biological templates and/or notices that can be tailored based on key audience and the specifics of the crisis. Consider:

(1) Press releases

(2) Command Information products

(3) Public Service announcements

(4) Web content

(5) MWN (i.e., "Giant Voice/Little Voice", visual alert systems).

b. Outline procedures to coordinate information with installation medical experts to ensure the accuracy of information.

c. Outline procedures to track public requests for information.

d. Include procedures for the stand-up and sustainment of the PA Operations Center to support a PHE. Address number and expertise requirements for staffing.

e. Include installation procedures for public release of information during a biological event. Address expected media queries and releasable information and consider:

(1) Information regarding the cause of the event.

(2) Actions the installations is undertaking in response.

(3) Numbers of personnel affected.

(4) Potential impact on the local community.

(5) Recommended actions to mitigate the threat and reduce risk.

f. Include procedures for the activation and sustainment of a Media Operations Center to support a PHE. Address

numbers and expertise requirements for staffing. Address a plan to inform the affected population that the center is operational.

(1) Include procedures to initiate the Services Hotline. Address information content for dissemination during a PHE.

(2) Provide talking points to Services spokespeople as necessary.

(3) Refresh installation/unit leadership on biological Risk Communication procedures.

j. Transportation Support

(1) Describe the plan for the transport of samples and/or specimens to appropriate laboratories for presumptive and confirmatory Identification. Include personnel protection and transportation security requirements. Address anticipated timeline requirements. Address laboratory documentation and handling requirements.

(2) Address the transport of those subject to quarantine and/or isolation, medical personnel providing care, security personnel, and resupply requirements. Consider special requirements for the transport of exposed, symptomatic, and contagious personnel.

(3) Describe procedures for the transport of contaminated waste.

(4) Identify transportation requirements associated with contamination avoidance and decontamination activities.

k. Casualty Assistance. Describe procedures for the reporting of casualties, notification to next of kin, and rendering of casualty assistance to survivors.

l. Mortuary Affairs

(1) Describe procedures for handling remains that were exposed to biological agents or contamination. Address potential requirements to inter-biologically contaminated bodies using proper handling procedures.

(2) Identify agencies tasked to support MA such as chaplain, legal, etc.

m. Reporting Requirements. Identify requirements and procedures for the reporting of biological or pandemic events. Consider the development of pre-formatted or pre-addressed messages for OPREP-3 and Chemical, Biological, Radiological, Nuclear Warning and Reporting System (CBRNWRS). Consider developing templates with pathogen/toxin-

specific information for warning and notification messages in advance of an actual event. At a minimum, address:

(1) HHQ

(2) Lateral units

(3) Local public health officials

(4) Personnel potentially exposed to a pathogen (consider using DD Form 3112 (Personnel Accountability and Assessment Notification for a PHE).

n. Mental Health

(1) Describe procedures to identify and manage individuals who are psychological casualties.

(2) Identify the process and provide assistance to mitigate the psychological impact of quarantine/isolation on individuals.

o. Legal Considerations

(1) Address legal requirements for placing personnel in quarantine/isolation. Consider all installation populations to include civilians, military family members, and visitors on the base.

(2) Identify areas of the plan that require or recommend the involvement of judge advocates or legal advisors in decision-making or plan execution; include things such as treatment of civilian casualties, notification to different populations, etc.

p. Personnel Augmentation

(1) Identify a pool of medical augments; consider:

(a) Vaccine support

(b) Contact tracing

(c) Active monitoring of quarantine

(d) Isolation support

(2) Identify a pool of security augments; consider:

(a) Enforcement of quarantine and/or isolation

(b) Installation / command security

(3) Develop procedures to request augmentation through DoD or local, state, or federal agencies, as necessary.

5. Pandemic and Infectious Disease (P/ID). This Annex should provide detailed procedures, information, and guidance to prepare for and respond to a public health crisis (i.e., pandemic influenza). Develop this Annex IAW applicable GCC/Service component supporting pandemic plans, and other applicable HHQ guidance. The pandemic annex must undergo periodic updates, applicable AOR plans, and other HHQ policy and guidance. When available, lessons learned from exercises and real-world events should be incorporated into the plan.

a. References. List applicable pandemic-specific references required for the planning and execution of installation pandemic response.

b. Situation

(1) Threat

(a) Background on the Pandemic Threat. Include background information from applicable CONPLAN and applicable AOR plans.

(b) Potential impact of a pandemic on the Marine Corps.

(c) Potential impact of a pandemic on Marine Corps forces in the AOR.

(d) Potential impact of a pandemic on the Installation.

(2) Key Assumptions. Outline major planning assumptions used in pandemic response and/or preparedness.

(a) Include assumptions from the DoD FCP-P&ID.

(b) Include any additional assumptions from the applicable GCC CONPLAN.

(c) Include any additional assumptions from the applicable Service Component supporting plan.

(d) Command/Installation level planning factors. Identify specific planning factors, taken from key assumptions and HHQ guidance that were used in developing the installation plan.

c. Mission. Outline the purpose and goals of the installation pandemic preparedness and response. Ensure the mission is synchronized with the DoD Global Pandemic CONPLAN and applicable COCOM/Service Component pandemic plans.

d. Execution

(1) Concept of Operations. Describe the general methodology the installation will follow to prepare for and respond to a pandemic outbreak.

(a) Commanders Intent. The commander's intent is a broad vision, stated succinctly of how the commander intends to conduct the operation, and must state Purpose, Method, and desired End State.

1. Purpose. Outline the "why" of the command or installation pandemic plan.

2. Method. Outline, in general terms, how the commander visualizes achieving success with the plan.

3. End State. Outline the expected outcome environment for the command/installation based on the successful execution of the plan.

4. Objective(s). Describe the overarching objectives guiding the development and implementation of the command/installation plan.

5. Priority Effects List. Outline the identified priority effects to achieve the commanders' objectives. At a minimum, the following priority effects will be included:

a. Effect 1: Virus does not impair key population. The virus does not adversely impact active-duty military personnel and their family members, DoD civilians, mission essential DoD contractors such that overall command and/or installation readiness falls below established thresholds. Factors influencing absenteeism in a PHE environment include member illness, concern for families, etc. Of particular concern is the loss of special skill sets required to sustain critical command/installation missions. An included nested effect requires prioritization of installation personnel for FHP measures to ensure the virus does not impair the operational readiness of units.

b. Effect 2: The pandemic virus does not degrade command/installation critical capabilities beyond that required for mission accomplishment. Personnel and forces are adequate in number, sufficiently healthy, and possess the requisite training/skill sets to perform all assigned critical missions.

c. Effect 3: Virus does not degrade the execution of critical command/installation capabilities or supporting infrastructure. The pandemic virus does not command/installation critical capabilities and supporting infrastructure enough to prevent forces from being deployable, sustainable, and available to protect the nations vital interests, as directed. Command/installation

critical capabilities and supporting infrastructure are not degraded to compromise mission assurance or mission execution. Degradation does not prevent expedient reconstitution of command/installation assets.

d. Effect 4: Installation, HHQ, federal, and SLTT partners synchronize planning, response, and communication. In support of DoD objectives, commands and/or installations synchronize efforts with HHQ, federal, SLTT partners in responding to and mitigating the impact of a public health crisis. Installation response measures, taken in concert with local communities, will aggressively protect personnel and gain time for the implementation of additional measures. The installation will harmonize its strategic and risk communications with HHQ. The installation maintains freedom of action to conduct assigned critical missions.

(2) Phasing Structure. Identify the various phasing structures that affect command/installation pandemic/PHE preparedness and response.

(a) Shape Phase (0). Include a description of Phase 0.

1. Commanders Intent. Include commanders' intent for Phase 0 from applicable GCC or service component pandemic plans.

a. Timing. Describe when this phase will occur and how the installation will determine the need to be in this phase. Include guidance on what drives the change from Phase 0 to Phase 1. Additionally, establish decision points or conditions to elevate HPCON (i.e., HPCON 0 to HPCON A).

b. Phase Objectives and Desired Effects. Include information from HHQ plans, as required. Outline installation objectives and desired effects for Phase 0.

c. Key Tasks. Identify key installation tasks for Phase 0. Consider identifying an OPR for each task and reference section in the installation plan that outlines the details for task accomplishment. Based on HHQ guidance, the following tasks will be included as a minimum. Supplement as required based on AOR plans and installation commander guidance.

(1) Identify and train a primary and alternate (at a minimum) PHEO per references (c) and (i).

(2) Establish/maintain communications with federal, SLTT, HN, military, and public health officials and/or providers and other agencies/organizations, as appropriate.

(3) Conduct routine health surveillance to enhance situational awareness (e.g., determine baseline and normal

perturbations). Include guidance on what drives the change from Phase 0 to Phase 1. Establish decision points or conditions to elevate HPCON (e.g., HPCON 0 to HPCON A).

(4) Model, develop, review, and evaluate installation FHP plans and mitigation measures (including HPCON status, ROM, quarantine, isolation, social distancing, directly observed therapy/treatment protocols for antiviral medications and risk communication).

(5) Identify installation requirements for essential supplies (e.g., IPE, PPE) and personnel.

(6) Review legal/policy issues relating to installation pandemic response.

(7) Conduct Emergency Medical Services (EMS)/first responder coordination, planning, and exercise.

(8) Perform screening and testing for contagious diseases and other respiratory pathogens.

(9) Incorporate veterinary assets with the surveillance and response activities associated with avian outbreaks, as applicable.

(10) Identify any pandemic/PHE-unique modifications required for the installation incident command and response structure.

(d) Protect Phase (1). Include a description of Phase 1.

1. Commanders Intent. Include commanders' intent for Phase 1 from applicable GCC or Service component PI plans.

a. Timing. Describe when this phase will occur and how the installation will determine the need to be in this phase. Include guidance on what drives the change from Phase 1 to a subsequent phase (0 or 2).

b. Phase Objectives and Desired Effects. Include information from HHQ plans, as required. Outline installation objectives and desired effects for Phase 1.

c. Key Tasks. Identify key installation tasks for Phase 1. Consider identifying an Office of Primary Responsibility (OPR) for each task and reference section in the installation plan that outlines the details for task accomplishment. Based on HHQ guidance, the following tasks will be included as a minimum. Supplement as required based on AOR plans and installation commander guidance.

(1) Refine, expand, evaluate, and exercise existing plans, guidance, and programs, to include FHP measures (HPCONs), to evaluate and identify PPE requirements, targeted layered containment and/or mitigation strategies, potential logistical gaps or excesses, and potential disconnects within and among the installation, HHQ, and SLTT partners.

(2) Acquire, maintain, and rotate sufficient supplies and materials needed to maintain a health force (i.e., food, potable water, fuel, etc.) during a pandemic.

(3) Assess the availability of vaccines, antivirals, antibiotics, supplies, and equipment and report shortfalls or gaps to HHQ.

(4) Hold pandemic or PHE educational and informational sessions for health/medical and other response personnel.

(5) Develop plans and procedures for the receipt, transport, storage, security, and distribution of PPE, pre-pandemic vaccines (when available), antivirals, antibiotics, supplies and equipment.

(6) Conduct daily public health surveillance, and communications/reporting routines, including monitoring of suspected person-to-person transmission cases, as applicable. Elevate HPCON based on threat conditions, as appropriate, (i.e., HPCON A to HPCON B).

(7) Develop and conduct awareness information and/or education targeting installation populace.

(8) Identify alternate treatment facilities.

(9) Identify alternate quarantine and isolation facilities.

(10) Verify and test surveillance reporting networks and procedures and confirm/update points of contact.

(e) Mitigate Phase (2). Include a description of Phase 2.

1. Commanders Intent. Include commanders' intent for Phase 2 from applicable GCC or service component PI plans.

a. Timing. Describe when this phase will occur and how the installation will determine the need to be in this phase. Include guidance on what drives the change from Phase 2 to a subsequent phase (1 or 3), including HPCON elevation.

b. Phase Objectives and Desired Effects. Include information from HHQ plans, as required. Outline installation objectives and desired effects for Phase 2.

c. Key Tasks. Identify key installation tasks for Phase 2. Consider identifying an OPR for each task and reference section in the installation plan that outlines the details for task accomplishment. Based on HHQ guidance, the following tasks will be included as a minimum. Supplement as required based on AOR plans and installation commander guidance.

(1) Prepare to receive DoD-established stockpiles. Ensure adequate security to prevent loss or pilferage.

(2) Prepare to provide mass immunization and care for potentially large numbers of personnel.

(3) Prepare to implement targeted layered containment and mitigation measures to include possible quarantine, when directed.

(4) Prepare to screen service-members and/or military family members and AMCITS from outside the geographic containment area engaged in early return to the United States, as applicable.

(5) Enhance/expand ongoing public health surveillance and communications and reporting routines, to include monitoring of suspected person-to-person transmission cases. Consider elevating HPCON level based on increased threat/conditions, as appropriate, (i.e., HPCON A or HPCON B).

(6) Develop, plan, and test the process to deliver essential goods to personnel assigned to quarantine or isolation, as necessary.

(7) Issue public information notice to continue and expand public education, in addition to providing updates on HPCON and protective measures associated with them.

(8) Develop and provide mandatory country-specific FHP briefs to evaluate needs and issue PPE and antivirals to forces deploying from and to high-risk locations currently in Phase 3 or Phase 4.

(9) Conduct redeployment medical screening of all forces and personnel returning from a Phase 3 or Phase 4 afflicted area, as appropriate.

(10) Establish coordination and crisis response structures. Ensure coordination with HN and SLTT partners.

(11) Continue issuing public information notices and conduct public education on plans and individual/military family preparedness and response, including updates on HPCON status.

(12) Plan for alternate service delivery strategies and activities when social distancing measures or local ROM orders are enacted, (e.g., on-line, VTC conferencing, telephone, chat services, drive-through, PPE and hand washing and sanitizing capabilities in all facilities, etc.).

(13) Register requirements through medical supply chain/TLAMMs for projected vaccines, antivirals, antibiotics, supplies, and equipment.

(14) Exercise and coordinate with TLAMMs to validate procedures for the receipt, transport, storage and management, security, and distribution of PPE, antivirals, antibiotics, and vaccines.

(f) Respond Phase 3. Include a description of Phase 3.

1. Commanders Intent. Include commanders' intent for Phase 3 from applicable GCC or Service component pandemic plans.

a. Timing. Describe when this phase will occur and how the installation will determine the need to be in this phase. Include guidance on what drives the change from Phase 3 to a subsequent phase (2 or 4), to include changes in HPCON levels.

b. Phase Objectives and Desired Effects. Include information from HHQ plans, as required. Outline installation objectives and desired effects for Phase 3.

c. Key Tasks. Identify key installation tasks for Phase 3. Consider identifying an OPR for each task and reference section in the installation plan that outlines the details for task accomplishment. Based on HHQ guidance, the following tasks will be included as a minimum. Supplement as required based on AOR plans and installation commander guidance.

(1) Provide comprehensive exposure surveillance for all forces deploying in support of operations or conducting response and mitigation at home installations. Exposure surveillance will be employed to conduct retrospective analysis to improve the FHP of future operations, prepare and protect potential areas that have

not been impacted, and support follow-up medical care to previously deployed forces.

(2) Conduct initial occupational and environmental health and VAs. Assessments should identify additional occupational/environmental health and safety requirements, as necessary.

(3) Be prepared to modify the response based on declaration of outbreak severity, per issued PHE declarations and elevated HPCON levels. Consider elevating HPCON level based on increased threat/conditions, as appropriate, (HPCON B or HPCON C).

(4) Conduct screening of personnel, including transitioning forces. Direct ROM, quarantine, or isolation, as appropriate.

(5) Implement appropriate targeted layered containment measures.

(6) Consider implementation of COOP or restructure workforce (i.e., shift assignments, telework, etc.), based on specific threat.

(7) Implement specific self-reporting and reporting procedures.

(8) Implement medical screening for all forces returning from countries suspected of person-to-person transmission, to include obtaining contact history and conduct febrile screening.

(9) Finalize and review guidance and/or SOPs for implementation of social distancing measures, ROM, quarantine and/or isolation.

(10) Be prepared to activate EOCs and/or watch centers (partial or full) to perform enhanced monitoring and reporting to ensure situational awareness, and monitoring of preparations and other actions. Identify and train personnel required to staff an EOC, watch center or MTF 24-hour hotline.

(11) Complete inventories and mobilization of medical supplies, food, water, and infection control supplies (to support in-hospital care, alternate care, ROM, quarantine, and isolation facilities).

(12) Be prepared to implement procedures for the receipt, transport storage and/or management, security and distribution of PPE, vaccines (when available), antivirals, antibiotics, supplies and equipment.

(13) Increase liaison between command and/or installation, and local public health, law enforcement, first responders, MTFs, hospital response, senior military leaders (i.e., GCC, service, installation) and local civilian political leaders.

(14) Review and be prepared to implement social distancing and ROM measures in coordination with local authorities (i.e., locally issued reduced or ROM orders).

(15) Prepare for GCC AOR-wide infection control through education and notifications regarding measures affecting public transportation, air travel, public gatherings, and facility closures or reduced access.

(16) Validate list of essential personnel; prepare to disseminate related notification documents.

(17) Be prepared to implement revised access procedures by use of DoD identification card scanners to limit person-to-person contact.

(18) Be prepared to issue PPE IAW CDC and HHQ guidance.

(19) Be prepared to implement SITREPs , reporting up chain of command, per established policy.

(g) Stabilize Phase (4). Include a description of Phase 4.

1. Commanders Intent. Include commanders' intent for Phase 4 from applicable GCC or Service component pandemic plans.

a. Timing. Describe when this phase will occur and how the installation will determine the need to be in this phase. Include guidance on what drives the change from Phase 4 to a subsequent phase (3 or 5), to include changes in HPCON levels.

b. Phase Objectives and Desired Effects. Include information from HHQ plans, as required. Outline installation objectives and desired effects for Phase 4.

c. Key Tasks. Identify key installation tasks for Phase 4. Consider identifying an OPR for each task and reference section in the installation plan that outlines the details for task accomplishment. Based on HHQ guidance, the following tasks will be included as a minimum. Supplement as required based on AOR plans and installation commander guidance.

(1) During Health Protection Condition (HPCON) B or Health Protection Condition (HPCON) C conditions

(a) Declare a PHE.

(b) Initiate active surveillance cases.

(c) Continue to expand and increase public awareness, to include HPCON level status, including but not limited to preparations and intent of increased ROM or social distancing measures.

(d) Be prepared to notify of impending cancellations or suspension of non-essential events or services, or alternate availability and/or access to essential goods and services.

(e) Continue notification regarding preparations and intent to implement increased social distancing measures, ROM, and quarantine and isolation.

(f) Based on recommendations by international health organizations, the CDC and/or DOS global travel warnings, implement travel restrictions or ordered departure from affected or potentially affected areas located outside the United States.

(g) Direct appropriate social distancing on all forms of mass transit IAW DoD, Service-level and/or HHQ guidance).

(h) Limit or reduce military flights to/from regions designated safe. Conduct preflight screening for febrile respiratory illness including temperature and other signs or symptoms of illness. Screen arriving and departing passengers. Require infection control during air travel.

(i) Restrict use of commercial air unless necessary to meet mission requirements.

(j) Direct social distancing on all modes of transportation and minimize travel within cities and/or to-from affected areas located inside the United States and its territories.

(k) Quarantine asymptomatic exposed individuals and be prepared to isolate and treat sick personnel.

(l) Enforce general infection control measures during public transportation, air travel, and at public gatherings. Utilize personal antimicrobial hand sanitizer when soap and hot water hand-washing facilities are not accessible or unavailable.

(m) Conduct enhanced medical screening for personnel with symptoms at the entrance into key installation facilities.

(n) Establish screening checkpoints at command and/or installation entry points.

(o) Establish screening checkpoints at key areas such as commissaries, dining facilities, and essential public gatherings at random points at nonessential areas such as exchanges.

(p) Implement new or enhanced installation access procedures by requiring use of DoD identification card scanners to limit person-to-person contact. Consider enhanced random security measures that align with elevated FPCON levels.

(2) During Health Protection Condition (HPCON) C or Health Protection Condition (HPCON) D conditions

(a) Declare PHE.

(b) Full activation of EOCs and operations centers.

(c) Cancel/suspend all nonessential events and public gatherings.

(d) Continue quarantine and isolation procedures. Ensure enforcement on quarantine and isolation personnel assigned to these categories. Be prepared to adjust guidelines for workspaces or facilities.

(h) Transition and Recover Phase 5. Include a description of Phase 5.

1. Commanders Intent. Include commanders' intent for Phase 4 from applicable GCC or Service component pandemic plans.

a. Timing. Describe when this phase will occur and how the installation will determine the need to be in this phase. Include guidance on what drives a change from Phase 5 to a previous phase (0 or 4), to include a reduction of HPCON level.

b. Phase Objective and Desired Effects. Include information from HHQ plans, as required. Outline installation objectives and desired effects for Phase 5.

c. Execution. Insert applicable execution summary information from HHQ plans. Supplement, as required, to include installation specific information.

d. Key Tasks

(1) Expect gradual return to normal operations as situation dictates (1st outbreak has passed).

(2) Evaluate effectiveness of FHP measures for use in future pandemics.

(3) Assess feasibility of easing/reversing phases back to normal FHP status and measures.

(4) When feasible, rescind PHE declaration.

(5) Continue to monitor and assess for resurgence of virus.

(6) Be prepared to re-implement FHP measures as required.

(7) Document lessons learned and adjust installation level plans accordingly, in anticipation of a resurgence of the pandemic.

(8) Conduct recovery and reconstitution operations.

7. Roles and Responsibilities. The roles and responsibilities contained in this format are not all inclusive. However, the included information has been specifically directed by HHQ P/ID guidance and policy; therefore, the following information must be included:

a. Installation Commander

(1) Ensure the PI Annex to the installation plan is synchronized and includes AOR-specific requirements as directed by the GCC and HHQ.

(2) As directed by the GCC, be prepared to provide health service support to indigenous civilians on an emergency basis, or resource permitting, when community/host nation medical infrastructure is insufficient to support its population and no other alternatives are available to relieve pain and suffering.

(3) Develop guidance for allocating scarce installation medical resources during mass casualty events.

(4) Be prepared to provide installation medical assets to support contingency operations as directed by the GCC.

(5) Ensure appropriate installation personnel meet pre- and post-deployment FHP measures.

(6) Ensure installation PHE planning, training, and exercise activities are conducted in conjunction with SLTT jurisdictions to the

maximum extent possible. Conduct a minimum of one (1) pandemic/PHE exercise (i.e., table-top exercises).

(7) Be prepared to implement targeted layered containment and mitigation measures to include possible quarantine and/or isolation.

(8) Ensure installation pandemic/PHE planning and response procedures are supported by sufficient C2 capabilities.

(9) Establish appropriate HPCON framework during an all-hazard emergency to communicate specific health protection measures to the affected population, to include individuals working in, residing on, or visiting the installation. The HPCON framework can include any authorized FHP measures that may be applicable to the emergency and should be coordinated with other affected installations to ensure consistent messaging across installations and Services. Authority to establish appropriate HPCONs does not require coordination or approval by HHQ.

(10) Where operationally feasible, establish policies for adopting flexible worksites (e.g., telework) and flexible work hours (e.g., staggered shifts) in the event of a pandemic.

(11) Ensure installation mission essential functions are adequately addressed in the plan and that specific are outlined in the DoD implementation plan for pandemics are covered.

(12) Establish orders for succession for key leadership positions. Ensure personnel identified to fill key positions are adequately trained to fill the position and ensure recall rosters are up to date.

(13) Ensure that FHP measures and Public Health Emergency Management (PHEM) are integrated into existing installation and command continuity, emergency preparedness, and response plans and agreements.

b. Public Health Emergency Officer (PHEO). During plan development and in all phases, provide commanders with estimates on health and environmental threats associated with public health emergencies, and recommend countermeasures and training for personnel.

(1) Coordinate appropriate veterinary service support for pandemic operations.

(2) Coordinate FHP measures and resource requirements with Service, GCC and HHQ pandemic planners.

(3) During exercises and training, evaluate FHP measures and HPCONs, PPE requirements, targeted layered containment strategies, and

mitigation strategies for completeness and synchronization with HHQ guidance and policy.

(4) Provide guidance and advice on the elevation or reduction of HPCONs and associated protective health measures. Coordinate and synchronize HPCONs with MTFs.

c. Coordinating Instructions

(1) Personnel suspected of having infectious disease will be masked and isolated as soon as recognized.

(2) Personnel suspected of having been exposed will be masked and quarantined as soon as recognized.

(3) Personnel known to have positive test results will observe established social distancing and self-isolation protocols.

d. Administration and Logistics. Identify how key installation organizations and/or tenant activities are to be supported and what support must provide for themselves or to others in a PHE environment.

e. Command and Control (C2). Identify any installation relationships (both internal and external) that are unique to the installation response in a PHE environment.

f. Delegation of Authority

(1) Establish delegations of authority to ensure all installation personnel know who has authority to make key decisions in a COOP situation.

(2) Outline which installation positions must be at least three deep to account for the expected high rates of illness and absenteeism. Identify personnel, by position rather than name, to backfill these positions.

g. Orders of Succession. Establish and order of succession for key installation leadership positions. Identify the orders of succession by position or title, rather than name, and ensure they are at least three deep per key position.

h. Tabulations. The installation pandemic/PHE Annex will contain tabulations that generally align with the Annexes in the DoD FCP-P&ID and supporting GCC PI CONPLANS. Where appropriate, PI tabulations may reference information from the installation preparedness plan. Installations may include additional tabs as desired, or as directed by HHQ plans.

APPENDIX F

Sample Written Declaration of a Public Health Emergency (PHE)

[Letterhead]

[Date]

MEMORANDUM FOR ALL SUBORDINATE COMMANDS AND TENANT UNITS

SUBJECT: Declaration of a Public Health Emergency (PHE) on [Installation Name]

I have been notified by my Public Health Emergency Officer (PHEO) of a possible public health situation on our installation involving {*agent/disease name or description of the qualifying incident*} that requires immediate action. Based on the PHEOs recommendations and the results of a preliminary investigation, I am declaring a PHE in accordance with DoD Instruction (DoDI) 6200.03, "Public Health Emergency Management (PHEM) Within the DoD," and {*applicable Service Inst*ruction}. This declaration will automatically terminate 30 days from the date of this memorandum unless it is renewed and re-reported or terminated sooner by me or a senior commander in the chain of command.

The installation PHEO {*and public health personnel*} are hereby directed to identify, confirm, and control this PHE utilizing all the necessary means outlined in DoDI 6200.03 and {*applicable Service Instruction*}. To implement my direction, the PHEO may issue guidance that affects installation personnel and property, and other individuals working, residing, or visiting this installation (e.g., steps to protect personnel health, closing base facilities, restricting movement, or implementing quarantine for select individuals). We will establish the Health Protection Condition (HPCON) level framework that will provide specific actions specific to this emergency that each person should take to protect his or her health.

The installation command and the PHEO will coordinate activities and share information with {*list which of the following are applicable to the current situation: federal, State, local, tribal, territorial, and/or host nation. For overseas commands, replace "Federal, State, and local" with "host nation"*} officials responsible for public health and public safety to ensure our response is appropriate for the PHE. Shared information may include personally identifiable health information only to the extent necessary to protect the public health and safety, as permitted by existing privacy laws and regulations.

Any person who refuses to obey or otherwise violates an order during this declared PHE may be detained. Those not subject to military law

may be detained until civil authorities can respond. Violators of procedures, protocols, provisions, or orders issued in conjunction with this PHE may be charged with a crime under the Uniform Code of Military Justice and under Section 271 of Title 42, United States Code (U.S.C.). Pursuant to Section 271 of Title 42, U.S.C., violators are subject to a fine up to $1,000 or imprisonment for not more than one year, or both.

[Signature]

APPENDIX G

Sample Written Notice of Quarantine

[LETTERHEAD]

[Date]

MEMORANDUM FOR INDIVIDUALS SUBJECT TO QUARANTINE

FROM: {Installation Commander}
TO: [Recipient]

Subject: NOTICE OF QUARANTINE

In response to a declared Public Health Emergency (PHE) on {*installation name*}, this is a formal notice that as the installation commander, I am ordering your quarantine. I am providing you with the following directions and information regarding the quarantine.

{*Name, identifying information or other description of the individual, group of individuals or geographic location subject to the order. Brief statement of the facts warranting the quarantine.*} [SEE NOTE]

{*Symptoms of the subject disease and a course of treatment. Instructions on the disinfecting or disposal of any personal property. Precautions to prevent the spread of the subject disease.*}

{*Conditions for termination of the order. Specified duration of quarantine. The place or area of quarantine. Rules for the quarantine. Requirements for contact with non-quarantined individuals.*}

Any individual subject to quarantine has the right to contest the reason for quarantine. Information supporting an exemption or release can be provided to me or one of my designated representatives. I (or a designated representative) will review the information provided, in consultation with public health, medical, and legal personnel, for a final determination on the need for quarantine. The total time from submission to response will not exceed 24 hours.

Procedures for the declaration of a PHE, quarantine, and the actions prescribed above are found in Department of Defense Instruction 6200.03, "Public Health Emergency Management (PHEM) Within the DoD," and {applicable Service Instruction}. It is DoD and {*Military Service*} policy that military installations, property, and personnel and other individuals working or residing on military installations will be protected under applicable legal authorities against communicable diseases associated with biological warfare or terrorism or other PHE. Violators of procedures, protocols, provisions, or orders detailed in this memorandum may be charged with a crime under

Section 271 of Title 42, United States Code (U.S.C.), and subject to punishment of a fine up to $1,000 or imprisonment for not more than one year, or both. A wide range of professionals are working hard to bring this situation to a resolution that supports your health and the safety of the general public.

[Signature]

Attachment: Declaration of Public Health Emergency

NOTE: This document will contain PII upon entering a name, identifying information or medical information and must be marked and handled as Controlled Unclassified Information (CUI).

APPENDIX H

Sample Written Notice of Isolation

[LETTERHEAD]

[Date]

MEMORANDUM FOR INDIVIDUALS SUBJECT TO ISOLATION

FROM: {Installation Commander}
TO: [Recipient}

SUBJECT: Notice of Isolation

Due to your diagnosis of {*specify communicable disease of concern*}, this is a formal notice that as the installation commander, I am ordering your isolation. I am providing you with the following directions and information regarding the isolation.

{*Name, identifying information or other description of the individual, group of individuals or geographic location subject to the order. Brief statement of the facts warranting the isolation*.} [See NOTE]

{*Symptoms of the subject disease and a course of treatment. Instructions on the disinfecting or disposal of any personal property. Precautions to prevent the spread of the subject disease*.}

{*Conditions for termination of the order. Specified duration of isolation. The place or area of isolation. Rules/requirements for the isolation, such as no unapproved contact with non-isolation or protocols for individuals entering isolation premises.*

Any individual subject to isolation has the right to contest the reason for isolation. Information supporting an exemption or release can be provided to me or one of my designated representatives. I (or a designated representative) will review the information provided, in consultation with public health, medical, and legal personnel, for a final determination on the need for isolation. The total time from submission to response will not exceed 24 hours.

Procedures for the declaration of isolation and the actions prescribed above are found in Department of Defense Instruction 6200.03, "Public Health Emergency Management (PHEM) Within the DoD," and {applicable Service Instruction}. It is DoD and {*Military Service*} policy that military installations, property, and personnel and other individuals working or residing on military installations will be protected under applicable legal authorities against communicable diseases of public health concern.

Violators of procedures, protocols, provisions, or orders detailed in this memorandum may be charged with a crime under Section 271 of Title

42, United States Code (U.S.C.), and subject to punishment of a fine up to $1,000 or imprisonment for not more than one year, or both.

A wide range of professionals are working hard to ensure you receive the highest quality medical care and are released from isolation as soon as possible. These actions are necessary to safeguard the health of your loved ones and ensure the safety of the general public.

[Signature]

Attachment: Declaration of Public Health Emergency

NOTE: This document will contain PII upon entering a name, identifying information or medical information and must be marked and handled as Controlled Unclassified Information (CUI).

APPENDIX I

PANDEMIC PHASES

DoD FCO-P&ID Phases	Marine Corps Synchronization Phases	CDC Interval	HPCON
Phase 0 Prepare	**Prepare** Phase 0	**Investigation**	**HPCON 0** Normal **DOS Travel Advisory** Level 1 **CDC Travel Health Notice** Level 1
Phase 1 Elevated Threat	**Protect** Phase 1	**Recognition**	**HPCON A** Report of unusual health risk or disease (HEALTH THREAT) **DOS Travel Advisory** Level 2 **CDC Travel Health Notice** Alert 2
Phase 1 Elevated Threat **Phase 2** Respond	**Phase 1** Protect **Phase 2** Respond	**Initiation**	**HPCON B** Outbreak or heightened exposure of risk. **DOS Travel Advisory** Level 2 **CDC Travel Health Notice** Alert 2

Phase 2 Respond	**Phase 3** Respond	**Initiation** Acceleration (Peak established transmission)	**HPCON C** High morbidity epidemic or contamination and sustained transmission. **DOS Travel Advisory** Level 2 **CDC Travel Health Notice** Alert 2 or Warning Level 3 **HPCON D** High morbidity epidemic or contamination and widespread transmission. **DOS Travel Advisory** Level 4 **CDC Travel Health Notice** Warning 3
Phase 3 Transition/Recover	**Phase 4** Stabilize **Phase 5** Transition and Recover	**Deceleration** **Preparation**	**HPCON** Appropriate HPCON level set based on conditions in the environment. **DOS Travel Advisory** (As appropriate for conditions) **CDC Travel Health Notice** (As appropriate for conditions)

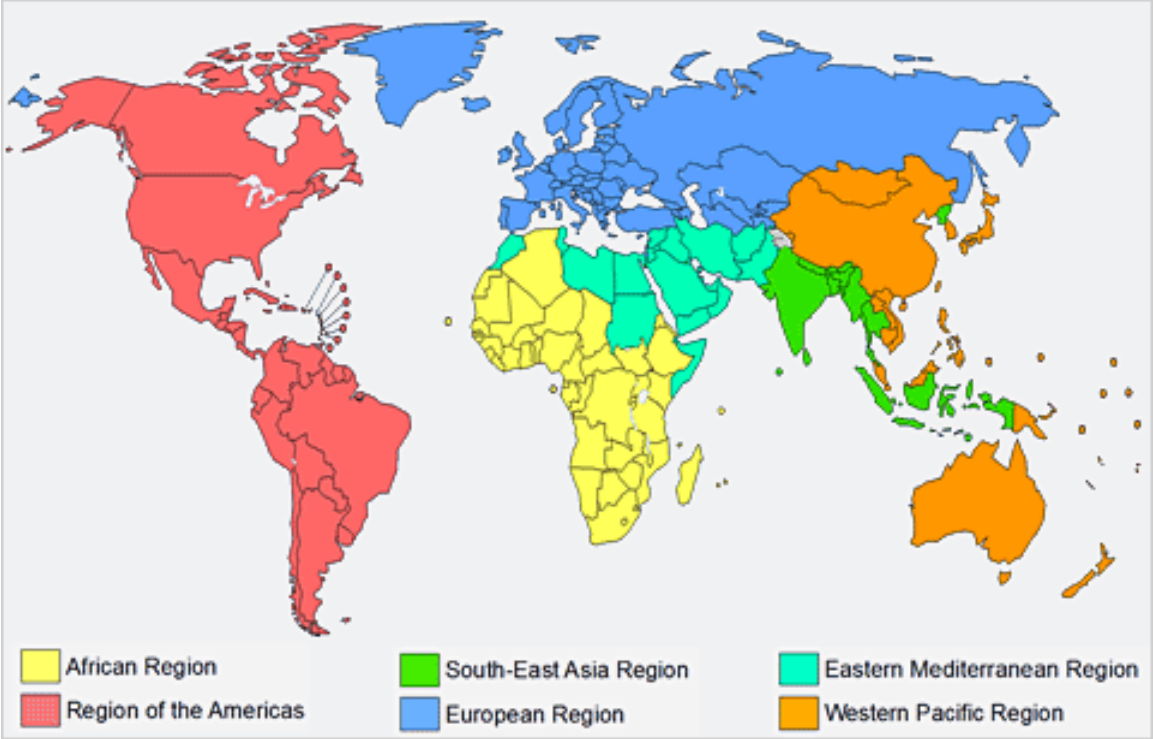
APPENDIX J

Centers for Disease Control and Prevention (CDC) Pandemic Intervals

Interval 1	**Investigation** of cases of a novel virus infection in humans.	When novel viruses are identified in people, public health actions focus on targeted monitoring and investigation. This can trigger a risk assessment of the virus, which is performed to evaluate if the virus has the potential to cause a pandemic.
Interval 2	**Recognition** of increased potential for ongoing transmission of a noel virus.	When increasing numbers of human cases of a novel illness are identified and the virus has the potential to spread from person-to-person, public health actions focus on control of the outbreak, including treatment of sick persons.
Interval 3	**Initiation** of a pandemic wave.	A pandemic occurs when people are easily infected with a novel virus that can spread in a sustained manner from person-to-person.
Interval 4	**Acceleration** of a pandemic wave.	Acceleration is the upward epidemiological curve as the novel virus infects susceptible people. Public health actions may focus on the use of appropriate Non-Pharmaceutical Interventions (NPIs) in the community (e.g., social distancing, facility closures), as well the use of medications (e.g., antivirals) and vaccines, if available.
Interval 5	**Deceleration** of a pandemic wave.	Deceleration occurs when cases consistently decrease. Public health actions include continued vaccination, monitoring of virus circulation and illness, and reducing the use of NPIs.
Interval 6	**Preparation** for future pandemic wave.	When the pandemic has subsided, public health actions include continued monitoring of pandemic virus activity and preparing for additional waves (resurgence) of infection. It is possible that a second wave could have higher severity than the initial period. A pandemic is declared ended when enough data shows the virus, worldwide, is similar to seasonal influenza.

APPENDIX K

World Health Organization (WHO) Regions



APPENDIX L

Glossary of Acronyms and Abbreviations

AAR	After Action Reports
AFHSD	Armed Forces Health Surveillance Division
AMCIT	American Citizen
AMRID	Army Medical Research Institute of Infectious Diseases
APHEO	Assistant Public Health Emergency Officer
APOD	Aerial Port of Debarkation
AO	Area(s) of Operation
AOR	Area(s) of Responsibility
ASD	Assistant Secretary of Defense
BCP	Body Composition Program
BUMED	United States Navy Bureau of Medicine
C2	Command and Control
C4	Command, Control, Communication and Computers
CCA	Contamination Control Area
CBRN	Chemical, Biological, Radiological and Nuclear
CBRNWRS	Chemical, Biological, Radiological, Nuclear Warning and Reporting System
CCDR	Combat Commander
CCIR	Commanders Critical Information Requirements
CCMD	Combatant Command
CDC	Centers for Disease Control and Prevention
CDR	Command Recruiting Program
CFR	Code of Federal Regulations
CFT	Combat Fitness Test
CG, MCRC	Commanding General, Marine Corps Recruiting Command
CG, TECOM	Commanding General, Training and Education Command
CJA	Command Judge Advocate
CMC	Commandant of the Marine Corps
CONPLAN	Concept Plan
COMMARFORRES	Commander, Marine Forces Reserve
COMMCICOM	Commander, Marine Corps Installations Command
COMMSTRAT	Communications Strategy
COOP	Continuity of Operations
CUI	Controlled Unclassified Information
DC, CD&I	Deputy Commandant, Combat Development and Integration
DC, I	Deputy Commandant, Information
DC, I&L	Deputy Commandant, Installations and Logistics
DC, M&RA	Deputy Commandant, Manpower and Reserve Affairs
DC, PP&O	Deputy Commandant, Plans, Policies, and Operations
DC, P&R	Deputy Commandant, Programs and Resources
DHA	Defense Health Agency
DHS	United States Department of Homeland Security
DIA	Defense Intelligence Agency
DIRLAUTH	Direct Liaison Authority

DLA	Defense Logistics Agency
DNA	Deoxyribonucleic Acid
DoD FCP-P&ID	Department of Defense Functional Campaign Plan for Pandemics and Infectious Disease
DoD	Department of Defense
DON/AA	Department of the Navy/Assistant for Administration
DON	Department of the Navy
DOS	United States Department of State
DRMD	Directives and Records Management Division
DSCA	Defense Support of Civil Authorities
DST	Decision Support Template
EHP	Emergency Health Powers
ELT	Entry-Level Training
EM	Emergency Management
EMS	Emergency Medical Services
EMWG	Emergency Management Working Group
EOC	Emergency Operations Center
EPI	Emergency Public Information
FEMA	Federal Emergency Management Agency
FGA	Fourth Generation Agents
FHP	Force Health Protection
FMF	Fleet Marine Force
FPCON	Force Protection Condition
GCC	Geographic Combatant Command
GFM	Global Force Management
GFMAP	Global Force Management Allocation Plan
GSAF	Global Situational Awareness Facility
GS	Global Security
HD	Homeland Defense
HHQ	Higher Headquarters
HHS	United States Department of Health and Human Services
HN	Host Nation
HPCON	Health Protection Condition
HQBN	Headquarters Battalion
HQMC	Headquarters, United States Marine Corps
HS	Health Services
IA	Interagency
IHR	International Health Regulations
IMO	Intermediate Military Objective(s)
INDOPACOM	Indo-Pacific Command
IPE	Individual Protective Equipment
IRA	Immediate Response Authority
JOA	Joint Operations Area
JSROI	Joint, Reception, Staging, Onward Movement, And Integration
JTR	Joint Travel Regulations
LIC	Low Intensity Conflict
LIMFAC	Limiting Factors
LSE	Large Scale Exercise

MA	Mission Assurance / Mortuary Affairs
MAA	Mutual Aid Agreement
MARCORLOGCOM	Marine Corps Logistics Command
MARFOR	Marine Forces
MARFORCYBER	Marine Corps Cyber Command
MARFORNORTH	Marine Forces North
MARFORRES	Marine Forces Reserve
MASCAL	Mass Casualty
MCCDC	Marine Corps Combat Development Command
MCCLL	Marine Corps Center for Lessons Learned
MCM	Medical Countermeasures
MCICOM	Marine Corps Installations Command
MCO	Marine Corps Order
MCRC	Marine Corps Recruiting Command
MCSC	Marine Corps Systems Command
METL	Mission Essential Task List
MHS	Military Health System
MOA	Memorandum of Agreement
MOPP	Mission-Oriented Protective Posture
MOS	Military Occupational Specialty
MOU	Memorandum of Understanding
MPF	Military Prepositioning Forces
MPP	Master Projection Plan
MSAT	Medical Situational Awareness in the Theater
MTF	Military Treatment Facility
MWN	Mass Warning and Notification
NARA	National Archives and Records Administration
NCMI	National Center for Medical Intelligence
NEO	Noncombatant Evacuation Operation
NFP	National Focal Point
NGO	Non-Governmental Organizations
NIMS	National Incident Management System
NMCC	National Military Command Center
NORAD	North American Air Defense
NPI	Non-Pharmaceutical Intervention
OCONUS	Outside the Contiguous United States
OPM	Office of Personnel Management
OPREP-3	Operations Event/Incident Report
OPR	Office of Primary Responsibility
OSD	Office of the Secretary of Defense
PA	Public Affairs
PCS	Permanent Change of Station
PDHA	Pre-deployment Health Assessment
PFT	Physical Fitness Test
PHA	Periodic Health Assessment
PHE	Public Health Emergency
PHEIC	Public Health Emergency of International Concern
PHEM	Public Health Emergency Management
PHEO	Public Health Emergency Officer

PHM	Public Health Measures
PII	Personally Identifiable Information
PI	Pandemic Influenza
PME	Professional Military Education
POC	Point of Contact
POD	Points of Dispensing
POE	Point Of Embarkation
POTUS	President of the United States
PPE	Personal protective equipment
P/ID	Pandemic and Infectious Disease
PTP	Pre-deployment Training Program
PUI	Person(s) Under Investigation
RA	Reserve Affairs
RC	Reserve Component
REL	Chaplain of the Marine Corps
REPAT	Repatriation
RFA	Request for Assistance
RFF	Request for Forces
ROM	Restriction of Movement
RSS	Receipt, Staging, and Storage
RTW	Return-to-Work
SECDEF	Secretary of Defense
SIP	Shelter-In-Place
SIR	Serious Incident Reports
SITREP	Situation Report
SJA	Staff Judge Advocate
SLTE	Service-Level Training Exercises
SLTT	State, Local, Tribal and Territorial
SNS	Strategic National Stockpile
SO	Special Operations
SOFA	Status of Forces Agreement
SOP	Standard Operating Procedure
SPOD	Seaport of Debarkation
SROE	Standing Rules of Engagement
SRUF	Standing Rules for the Use of Force
TAD	Temporary Additional Duty
TCP	Theater Campaign Plan
TECOM	Training and Education Command
TPFDD	Time Phase Force Deployment Data
T&R	Training and Readiness
UN	United Nations
USAMRIID	United States Army Medical Research Institute of Infectious Diseases
U.S.C.	United States Code
USDA	United States Department of Agriculture
USG	United States Government
USNORTHCOM	United States Northern Command
USMC	United States Marine Corps
VA	Vulnerability Assessment

VAERS	Vaccine Adverse Event Reporting System
WG	Working Group
WHO	World Health Organization
WMD	Weapon of Mass Destruction
WTI	Weapons and Tactics Instructor (Course)
WRM	War Reserve Material

APPENDIX M

Glossary of Terms and Definitions

NOTE: The following terms and definitions are offered for the purposes of this Order and includes user-specific and subject matter focused definitions and are not universally accepted DoD and Joint Staff terms and definitions. The terms and definitions serve as a central resource to promote understanding and de-conflict terminology nuances.

Asset. Person, structure, facility, information, material, or process that has value.

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

Contamination Control Area (CCA). An area in which chemically contaminated IPE is removed; personnel, equipment, and supplies are decontaminated to allow processing between a toxic environment and a toxic free area; and personnel exiting a toxic free area may safely don IPE.

Crisis. Incident or situation involving a threat to the United States, its citizens, military forces, or vital interests that develops rapidly and creates a condition of such diplomatic, economic, or military importance that commitment of military forces and resources is contemplated to achieve national objectives (JP 3-0).

Crisis Management. Measures, normally executed under federal law, to identify, acquire, and plan the use of resources needed to anticipate, prevent, and/or resolve a threat or an act of terrorism (JP 3-28).

Decision Point. A point in space and time when the commander or staff anticipates making a key decision concerning a specific course of action (JP 5-0).

Decisive Point. Key terrain, key event, critical factor, or function that, when acted upon, enables commanders to gain a marked advantage over an enemy or contribute materially to achieving success (JP 5-0).

Detector Alarm Trigger. Events refer to the discovery of a biological event via a positive test from a detection device, laboratory report from environmental samples, or a positive food/water sample indicating that a biological agent is present in the environment. Detectors are not a foolproof method of indicating the presence of biological agents due to the sensitivity limitations of the devices and the possibility of false negatives/positives. Positive results via detector may permit discovery of a biological event prior to the onset of symptoms.

Disaster. Any incident, natural or manmade, that causes significant loss of life or personal injury, severe population disruptions, major interference with the orderly functioning of government, or significant damage to property, the economy, or the Environment.

Disease of Operational Significance. An infectious disease (natural, accidental, or deliberate) likely to significantly impact the ability of DOD to maintain mission assurance or likely to result in significant increases in requests for DOD assistance. The disease may occur in humans, animals, or plants. Disease characteristics may include high transmissibility or severity, and high likelihood of impact on FHP due to limited or no natural protection or MCM.

Disease Surveillance. An epidemiological practice by which the spread of disease is monitored in humans, animals, and plants to establish patterns of progression.

Emergency. Any incident, whether natural or manmade, that requires responsive action to protect life or property.

Emergency Management (EM). The managerial function charged with creating the framework within which communities reduce vulnerability to hazards and cope with disasters.

Emergency Operations Center (EOC). The distinctive location at which the coordination of information and resources to support incident management (on-scene operations) activities normally take place. An EOC may be a temporary facility or may be in a more central or permanently established facility, perhaps at a higher level of organization within a jurisdiction. EOCs may be organized by major functional disciplines (e.g., fire, law enforcement, medical services), by jurisdiction (e.g., federal, state, local, tribal, territorial, other Services, private or HN), or by some combination thereof.

Emergency Responder. Emergency responders are defined as personnel who respond to an incident after first responders to expand C2 or perform support functions. Medical emergency responders are follow-on medical teams dispatched to the scene in support of the first responders, as well as non-clinical medical teams requested by the incident commander, such as a mass casualty event response team provided by the MTF.

Endemic. A disease prevalent in or restricted to a particular region, community, or group of people.

Epidemic. A disease effecting or tending to affect a disproportionately large number of individuals within a population, community, or region at the same time.

Evacuation. (1) Removal of a patient by any of a variety of transport means from a theater of military operation, or between HS capabilities, to prevent further illness or injury, providing additional care, or providing disposition of patients from the military health care system (JP 4-02); (2) The clearance of personnel, animals, or material from a given locality (JP-3-68); (3). The ordered or authorized departure of noncombatants from a specific area by the Department of State, Department of Defense, or appropriate military commander (JP 3-68).

First Responder. First responders are defined as personnel who immediately respond to an incident to provide initial C2, save lives, stabilize the incident, and suppress and control hazards.

Force Health Protection (FHP). Measures to promote, improve, or conserve the behavioral and physical well-being of Service members to enable a healthy and fit force, prevent injury and illness, and protect the force from health hazards (JP 4-02).

Hazard. A condition with the potential to cause injury, illness, or death of personnel; damage to or loss of equipment or property, or mission degradation (JP 3-33).

Health Surveillance. The regular or repeated collection, analysis, and interpretation of health-related data and the dissemination of information to monitor the health of a population and to identify potential health risks, thereby enabling timely interventions to prevent, treat, reduce, or control disease or injury, which includes occupational and environmental health surveillance and medical surveillance subcomponents (JP 4-02).

Host Nation (HN). A nation which receives forces and/or supplies from allied nations and/or North Atlantic Treaty Organization to be located on, to operate in, or to transit through its territory (JP 3-57).

Health Protection Condition (HPCON) level. A framework to inform personnel of specific health protection actions recommended in response to an identified health threat, stratified by the scope and severity of the threat (DODI 6200.03).

Individual Protective Equipment (IPE). In nuclear, biological, and chemical warfare, the personal clothing and equipment required to protect an individual from biological and chemical hazards, and some nuclear effects (JP 1-02).

Incident. An occurrence, caused by either human action or natural phenomena, that requires action to prevent or minimize loss of life or damage to, loss of, or other risks to property, information, and/or natural resources (JP 3.28).

Installation. All DoD facilities, activities, reservations, and enduring bases, worldwide across all commands and organizations at multiple echelons, including government-owned facilities and facilities operated by contractors by DoD, and non-DoD activities operating on DoD installations; includes locations supporting contingency operations per service guidance (DoDI 6055.17).

Intermediate Military Objective(s) (IMO). Operational activities that directly and materially contribute to achieving a desired end state; or establish key conditions within the environment; accomplished through measurable tasks.

Intelligence Warning Trigger. Events occur when a commander receives convincing information (unanalyzed) or intelligence (analyzed information) indicating that a biological event (naturally occurring or unintentional) is imminent. Information and intelligence from multiple sources (e.g., the public, military intelligence, national intelligence institutions in a host country, etc.) can provide advance warning of a biological event.

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

Jurisdiction. A range or sphere of authority. Public agencies have jurisdiction at an incident related to their legal responsibilities and authority. Jurisdictional authority at an incident can be political or geographical (e.g., federal, state, local, tribal, territorial, other Services, private or HN partnerships boundary lines) or functional (e.g., law enforcement, public health).

Mass Casualty (MASCAL) incident. Any number of human casualties produced across a period that exceeds available medical support capabilities (JP 4-02).

Medical Countermeasures (MCM). Regulated pharmaceutical products and interventions use to combat the effects of chemical, biological, radiological, or nuclear incidents.

Military Treatment Facility (MTF). A facility established for the purpose of furnishing medical and/or dental care to eligible personnel.

Mitigation. Activities providing a critical foundation in the effort to reduce injuries and the loss of life and property from natural and/or manmade disasters by avoiding or lessening the impact of a disaster.

Morbidity. The state of being ill, diseased, or injured or the incidence or prevalence of illness or injury in a population.

Mortality. The incidence of death in a population; an important indicator of the gravity of a disaster.

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

Non-Pharmaceutical Intervention (NPI). Protective measures including public education, respiratory etiquette, the avoidance of shaking hands, and the wearing of respirators. NPI also includes "social distancing" measures, avoiding close contact with other persons outside the home, discouraging congregations of people in public settings, and closing schools and businesses. NPI include other measures to limit the spread of infection such as isolating persons who are ill and quarantining persons who have had recent contact with persons suspected of exposure or patients confirmed to be ill.

Outbreak. An epidemic that has spread to human populations across a large geographic area. Pandemics are widespread occurrences of an infectious disease across several countries, or worldwide, affecting an exceptionally high portion of the population, as opposed to an epidemic which may be limited to a defined area.

Pandemic. A widespread occurrence of an infectious disease affecting or attacking the population of a whole country, region, continent, or the globe.

Pathogen. A bacterium, virus, or other microorganism that can cause disease.

Patient Under Investigation (PUI). Person who has signs or symptoms consistent with a pandemic virus or infectious disease of operational significance and has exposure history to an affected community. This person has been clinically evaluated and has a pending laboratory test.

Personal Protective Equipment (PPE). Those items worn by personnel to prevent transmission of infectious organisms or by a patient to reduce the spread of an infectious microorganism (e.g., surgical mask, exam gloves, etc.)

Preparedness. The range of deliberate, critical tasks and activities necessary to build, sustain, and improve the operational capability to prevent, protect against, respond to, and recover from domestic incidents. Preparedness is a continuous process. Preparedness involves efforts at all levels of government and coordination among government, private-sector, and Non-Governmental Organizations (NGO)

to identify threats, determine vulnerabilities, and identify required resources. Within NIMS, preparedness is operationally focused on establishing guidelines, protocols, and standards for planning, training and exercises, personnel qualification and certification, equipment certification, and publication management.

Prevention. Actions to avoid an incident or to intervene to stop an incident from occurring. Prevention involves actions to protect lives and property. It involves applying intelligence and other information to a range of activities that may include such countermeasures as deterrence operations; heightened inspections; improved surveillance and security operations; investigations to determine the full nature and source of the threat; public health and agricultural surveillance and testing processes; immunizations, isolation, or quarantine; and, as appropriate, specific law enforcement operations aimed at deterring, preempting, interdicting, or disrupting illegal activity and apprehending potential perpetrators and bringing them to justice.

Public Health Emergency (PHE). An occurrence or imminent threat of an illness or health condition that may be caused by a biological incident, man-made or naturally occurring; the appearance of a novel or previously controlled or eradicated infectious agent or biological toxin; natural disaster; chemical attack or accidental release; radiological or nuclear attack or accident; or high-yield explosives that poses a high probability of a significant number of deaths, severe or long-term disabilities, widespread exposure to an infectious or toxic agent, and healthcare needs that exceed available resources (DoDI 6200.03).

Public Health Emergency of International Concern (PHEIC). An extraordinary public health event as declared by the Director of the WHO that constitutes a public health risk to other countries through the international spread of the health hazard and potentially requires a coordinated international response (DoDI 6200.03).

Quarantine. The physical separation and non-punitive confinement of an individual or groups of individuals, who are or may have been exposed to a contagious or possibly contagious disease, and who do not show signs or symptoms of a contagious disease, from non-quarantined individuals, to prevent or limit the transmission of the disease to non-quarantined individuals.

Recovery. The development, coordination, and execution of service and site-restoration plans; the reconstitution of government operations and services; individual, private-sector, nongovernmental, and public assistance programs to provide housing and to promote restoration; long-term care and treatment of affected persons; additional measures for social, political, environmental, and economic restoration; evaluation of the incident to identify lessons learned; post incident reporting; and development of initiatives to mitigate the effects of future incidents.

Resource(s). The forces, materiel, and other assets or capabilities apportioned or allocated to incident response operations. Resources are described by kind and type and may be used in operational support or supervisory capacities at an incident or at an EOC.

Response. Activities that address the short-term, direct effects of an incident. Response includes immediate actions to save lives, protect property, and meet basic human needs. Response also includes the execution of emergency operations plans and of mitigation activities designed to limit the loss of life, personal injury, property damage, and other unfavorable outcomes. As indicated by the situation, response activities include applying intelligence and other information to lessen the effects or consequences of an incident; increased security operations; continuing investigations into nature and source of the threat; ongoing public health and agricultural surveillance and testing processes; immunizations, isolation, or quarantine; and specific law enforcement operations aimed at preempting, interdicting, or disrupting illegal activity, and apprehending actual perpetrators and bringing them to justice.

Restriction of Movement (ROM). Limiting people's movement to prevent or limit the transmission of a communicable disease, including limiting ingress and egress to, from, or on a military installation, isolation, or quarantine.

Risk Management (RM). A continual process or cycle where risks are identified, measured, and evaluated; countermeasures are then designed, implemented, and monitored to see how they perform, with a continual feedback loop for decision-maker input to improve countermeasures and consider tradeoffs between risk acceptance and risk avoidance (DoDI 6055.17).

Sentinel Casualties Trigger. Refers to the medical community's detection of a biological warfare or infectious disease event by assessing trends in medical symptoms among personnel reporting to MTFs, or the diagnosis of an index case. Response actions based on a sentinel casualty may begin well into the disease progression cycle. Monitoring domestic livestock, wildlife or pets for unexplained illness or death may be useful in identifying a biological event.

Shelter-In-Place (SIP). The use of a structure and its indoor atmosphere to temporarily separate individuals from a hazardous outdoor atmosphere.

Social distancing. Methods to reduce the frequency and closeness of contact between people and/or animals.

Strategic National Stockpile (SNS). Large quantities of medicine and medical supplies, maintained by the CDC, to protect the American public if there is a PHE (terrorist attack, pandemic outbreak,

earthquake, or other national disaster) severe enough to cause local supplies to be depleted.

Threat. Natural or manmade occurrence, individual, entity, or action that has or indicates the potential to harm life, information, operations, the environment, and/or property.

Tribal. Referring to any Indian tribe, band, nation, or other organized group or community as defined in section 450b of Title 25 of the U.S.C., including any Alaskan Native Village as defined in or established pursuant to the Alaskan Native Claims Settlement Act (43 U.S.C.A. and 1601 et seq.), that is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

Virus. An infection or disease cause by a virus.

Vulnerability. The characteristics of a system that cause it to suffer a definite degradation (incapability to perform the designated mission) as a result of having been subjected to a certain level of effects in an unnatural (manmade) hostile environment (JP 3-60).

Weapons Events. Refers to attacks by a weapon system(s), such as theater ballistic missile(s), artillery, or observed attacks employing other delivery means such as an aerosol sprayer device. Where intelligence has assessed a biological weapon capability, it is reasonable to initially react to weapons events if they could contain biological agents.

Zoonotic (disease). Diseases transmissible under natural conditions from vertebrate animals to humans.