DEPARTMENT OF THE NAVY
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OPNAV INSTRUCTION 3500.41

From: Chief of Naval Operations

Subj: PANDEMIC INFLUENZA POLICY

Ref: (a) CJCS Planning Order (PLANORD) of 14 Nov 05 (NOTAL)
(b) Strategic Planning Guidance (SPG), Fiscal Years 2008-2013, of 1 Mar 06 (NOTAL)
(c) CDRUSNORTHCOM Concept Plan (CONPLAN) 3551-09, Pandemic Influenza, of 23 Mar 09 (NOTAL)
(d) National Strategy for Pandemic Influenza Implementation Plan of May 06
(e) DoD Implementation Plan for Pandemic Influenza of May 06
(f) CDRUSNORTHCOM CONPLAN 3591-09, Pandemic Influenza, of 13 Aug 09 (NOTAL)
(g) CDRUSNORTHCOM Global Synchronization Planning Directive (NOTAL)
(h) CJCS PLANORD of 20 Apr 07 (NOTAL)
(i) DoD Directive 6200.3 of 12 May 03
(j) DoD Directive 6200.04 of 9 Oct 04
(k) CNO WASHINGTON DC 101814Z Nov 05
(l) CNO WASHINGTON DC 182335Z Dec 02
(m) BUMEDINST 6220.12B
(n) CNO WASHINGTON DC 141910Z Nov 05 (NOTAL)
(o) OPNAVINST F3100.6H, Chapter 4, Section I (NOTAL)
(p) SECNAVINST 3030.4B
(q) OPNAVINST 3030.5A
(r) SECNAV M-5210.1
(s) SECNAV M-5214.1

Encl: (1) List of Acronyms

1. Purpose. To issue policy, identify responsibilities, and set forth standards for pandemic influenza (PI) planning within the Navy.

2. Organization of Instruction. The Navy's PI instruction is separated into the following six sections: purpose, situation, mission, execution, administration and logistics, and command and control (C2). The situation section covers the background, higher level guidance, impact, threat, and planning assumptions of an influenza pandemic. The mission section describes the Navy's primary responsibility during a pandemic. The execution section provides a detailed list of responsibilities for Navy component commands to meet in order to comply with the Navy's PI instruction. The last two sections provide detailed information on administrative and logistics and C2 authorities during an influenza pandemic.

3. Situation

a. General

(1) An epidemic is a widespread disease attacking or affecting many individuals in a given community and/or population. A pandemic is a worldwide, global outbreak of disease (e.g., a novel influenza virus), which has the potential to be catastrophic. In light of current concerns, the focus of this planning effort is PI.

(2) Current models estimate that an influenza pandemic may cause 30 to 40 percent work absenteeism and the deaths of two hundred thousand to two million people in the United States.

(3) The 1918 PI outbreak had a detrimental effect on the U.S. military's ability to prosecute World War I. More troops died as a result of the disease than died of combat-related injuries. One of the lessons learned from the 1918 Pandemic was that the Army Staff's failure to act on advice from the Army Surgeon General had devastating effects. Spread of the disease was increased in troops due to close quarters and transit time from Continental United States (CONUS) to the European Continent. In the face of a future pandemic, advance planning will establish lines of authority, support and coordination to provide for the protection, and continuing operability of the force.

b. Higher Level Guidance

(1) Reference (a) directed combatant commanders (CCDRs) to conduct execution-level planning for Department of Defense (DoD) response to an influenza pandemic. The planning order

directs CCDRs to address force health protection (FHP) and defense support of civil authorities in each geographic combatant commander's (GCC) area of responsibility (AOR), as well as support to humanitarian assistance/disaster relief (HA/DR) operations to prepare and respond to the effects of an influenza pandemic.

(2) Reference (b) directed Commander, United States Northern Command (CDRUSNORTHCOM) and the other CCDRs to develop individual plans to respond to an influenza pandemic. Chairman of the Joint Chiefs of Staff Instruction (CJCSI) 3110.01F, Joint Strategic Capabilities Plan Fiscal Year 2006, of 1 September 2006 (superseded by CJCSI 3110.01G) directed CDRUSNORTHCOM to prepare a concept plan (CONPLAN) to synchronize worldwide planning to mitigate and contain the effects of an influenza pandemic. Reference (c) directly supports references (d) and (e) for PI. It is designed to coordinate the DoD PI planning effort and synchronize the decentralized execution of the GCCs' theater campaign CONPLANs as the supported commanders. The functional CCDRs, Services, and DoD Agencies are supporting commanders or agencies. Reference (f) outlines overarching guidance for mitigating and containing the effects of a PI. Specific tasks, based on the task list in reference (e), are listed in reference (g).

(3) Preparing and responding to PI will require an active, layered defense. This active, layered defense is global, and integrates U.S. capabilities seamlessly in the forward regions of the world, the approaches to the U.S. territory, and within the United States. It is a defense in depth which includes assisting partner countries to prepare for and detect an outbreak, respond, and manage the key second-order effects that could lead to an array of challenges. The top priority is the protection of DoD forces, comprised of the military, DoD civilians, and contractors performing critical roles, as well as the associated resources necessary to maintain mission readiness and the ability to meet our strategic objectives. Priority consideration is given to protect the health of DoD beneficiaries and dependents. Reference (e) assigns tasks to primary and supporting offices within the Department of Defense to accomplish tasks specified in reference (d). The Department of the Navy will incorporate references (c) and (f) tasks appropriate to their respective geographical and functional responsibilities in their planning efforts.

(4) Reference (h) designated CDRUSNORTHCOM as the lead CCDR responsible for planning and synchronizing the DoD global response to an influenza pandemic, in conjunction with CCDRs, Services, and DoD Agencies.

(5) United States Government (USG) stages are trigger points that reflect geography driven triggers tied to when potential Federal responses will take effect. These stages are outlined in diagram 1.

(6) World Health Organization (WHO) phases reflect virus driven trigger points. The WHO has defined six phases, before and during an influenza pandemic, that are linked to the characteristics of a new influenza virus and its spread through the population. This characterization represents a useful starting point for discussion about Federal Government actions, and true to its international acceptance, links overseas DoD networks to partner nation understanding of the virus. These phases are outlined in diagram 1.

(7) The DoD Global CONPLAN to synchronize planning for PI phases.

(a) Reference (c), the CCDR, Service and DoD Agency plans will be synchronized to follow a six-phased construct. The six phases are shape, prevent, contain, interdict, stabilize, and recover. Each plan developed under reference (c) construct must describe the process for enabling a transition back and forth between phases as multiple waves occur. As stated in the coordinating instructions of CDRUSNORTHCOM's CONPLAN, a CCDR must consult with the Secretary of Defense (SecDef) prior to declaring a phase change within AOR.

(b) Diagram 1 aligns the critical elements of the WHO and the USG (see diagram 1) to align portions of these plans with reference (c), as appropriate. Reference (c) phases, depicted on the left of this diagram, is the phase structure that the Department of Defense will use in their planning efforts. The six phases are detailed in references (c) and (f). Since WHO phase definitions may change often, visit the following for current WHO phases: http://www.who.int/csr/disease/avian_influenza/phase/en/index.html.

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

Diagram 1

c. Potential Impact of a PI on the United States Navy

(1) Overall. The potential 30 to 40 percent absenteeism projected by current models (due to illness, caring for the sick, or unwillingness to risk exposure) would have tremendous impact on the Navy's ability to execute current plans. It can be assumed that military movements will be constrained and host countries may limit or prevent freedom of movement or transit of sick personnel through their country. Navy plans must focus on remaining dominant across the full spectrum of military operations, preserving combat capabilities in order to engage adversaries in any theater around the world.

(2) Environment. The Navy must view PI 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 impacts of an influenza pandemic across the nation and the world will limit support usually provided by the Federal Government and Department of Defense to nations, states and communities, especially when balanced with protection of military capabilities through FHP.

(3) Personnel. Large portions of the overall Navy population may contract the (influenza) virus over the lifespan of the pandemic. Competing demands for low-density units (e.g., medical, mortuary) will decrease the range of options available for support. Limited civilian and military medical care options for military forces and their dependents (both CONUS and (outside the Continental United States (OCONUS)) will increase the stress upon the Navy.

(4) Transportation. There will likely be a significant reduction in transportation capacity affecting Navy acquisition/distribution capabilities. Civil aviation support to strategic deployment will be reduced. Interstate transport of material and equipment to aerial ports or sea ports of Debarkation (APOD/SPOD) and international land crossings may decrease. Access to goods OCONUS may be reduced. Therefore, Navy assets may be asked to offset private sector shortfalls at ports, in transportation, or providing security. Movement restrictions imposed by national, state or local public health/medical personnel, or national policies, to slow the spread of a PI may have the potential to impact operations.

d. Threat

(1) The primary characteristics of the threat during an influenza pandemic are the virus's ability to reproduce within a host, its relatively indiscriminate attack rate, its ability to mutate quickly, and its ability to easily transmit from human-to-human. The high transmissibility and rapid onset of severe morbidity can result in large numbers of people becoming sick or absent simultaneously.

(2) Impact of the primary threat may cause political, social, and economic instability as well as the degradation of 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 U.S. and allied forces. The degree to which countries can mitigate morbidity and mortality during an influenza pandemic will have a considerable impact on military force capabilities. Countries with more advanced and robust health care systems will be better able to mitigate many of the PI effects.

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

e. Planning Assumptions

(1) Pandemics travel in waves; not all parts of the world will be affected at the same time or affected to the same degree (i.e., multiple waves).

(2) An influenza pandemic outbreak will last between 6 to 12 weeks in one location, with multiple PI waves following for a period of 12 to 24 months.

(3) A vaccine (PI specific strain) will not be available for distribution for a minimum of 4 to 6 months after the laboratory confirmation of sustained human-to-human PI transmission. Foreign manufacturers are not expected to support U.S. demand. Prioritization will be required.

(4) Developed countries will be quicker in preparing for, detecting, and responding to outbreaks than less developed countries.

(5) Some coalition partners, allies and host nation (HN) governments will request military assistance and training from the USG for PI preparedness, surveillance, detection, and response.

(6) International and interstate transportation will be restricted to contain the spread of the virus.

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

(8) If an influenza pandemic starts outside the United States, it will enter the United States at multiple locations and spread quickly to other parts of the country.

(9) PI in the United States will result in 30 to 40 percent of the population being absent, 3 percent of those infected being hospitalized, and a case fatality rate of 0.2 to 2.0 percent over the course of the pandemic.

(10) A layered mix of voluntary and mandatory individual, unit, and installation-based public health measures, such as limiting public gatherings, closing schools, social distancing, personal hygiene measures, and masking can limit transmission and reduce illness and death if implemented before or at the onset of the event. Quarantine, isolation, and other movement restrictions are essential for a successful containment operation.

(11) State, local, and tribal jurisdictions will be overwhelmed and unable to provide or ensure the provision of essential commodities and services.

(12) DoD reliance on "just-in-time" procurement will compete adversely with U.S. and foreign civilian businesses for availability of critical supplies.

(13) DoD Title 10 Reserve Component forces will need to be quickly mobilized to provide surge capabilities, especially in the areas of transportation, C2, communications, engineering, logistics, force protection, maintenance, aviation, and security. (See Service tasking.)

(14) The Department of State (DOS) Shelter-in-Place policy will be followed unless other conditions (e.g., civil disturbance or political instability) force an evacuation. If a shelter-in-place policy is not feasible, the Department of Defense will be called upon to assist in the transportation of American citizens living abroad if deemed necessary.

(15) DOS will request DoD support for selective non-combatant evacuation (NEO) of designated non-infected individuals from areas abroad experiencing outbreaks. This will only be conducted after all other methods of extraction have been exhausted by DOS and only when directed by Secretary of Defense. As stated in reference (e), this will only cover areas experiencing outbreaks (outbreaks being defined in reference (d) as an epidemic limited to a localized area).

(16) Department of Defense will support security and possibly staffing of national critical infrastructure at all levels (e.g., air traffic control, security for national critical infrastructure, etc.).

(17) Navy can expect requests from International Agency (IA) partners to support civilian mortuary affairs operations.

(18) Susceptibility to the PI virus will be universal.

(19) The influenza incubation period (time from exposure to signs and symptoms of disease) is typically 2 days. Persons who become infected may shed the virus and can transmit infection for one-half to one day before the onset of illness. Viral shedding and the risk of transmission will be greatest during the first 2 days of illness.

(20) National Guard forces, minus those subject to the needs of national security (e.g., chemical biological radiological nuclear and high yield explosives, Consequence Management Response Force) units called to Title 10 status, will remain in place to provide support to the governors of the individual States.

(21) OCONUS operational commitments will continue at current levels through the next several years, and troop rotations will be impacted.

(22) There will be no increase in overall programmed DoD force structure.

(23) Military treatment facilities will potentially be overwhelmed by DoD patients, dependents and beneficiaries, necessitating outsourcing and alternate care facilities after outsourcing. DoD treatment of military personnel and other beneficiaries may be prioritized, with changes in priorities and altered standards of medical care during an influenza pandemic.

(24) HN support to U.S. forces will be impacted by an influenza pandemic at a rate proportional to the impact of an influenza pandemic on the HN's general population.

(25) DOS/United States Agency for International Development will request support from Department of Defense to provide HA/DR support to the international community.

(26) Some military movements, basing, over flight, and support to coalition operations may be restricted by other countries. If DOS is going to request DoD support for NEO operations, DOS will obtain diplomatic clearances and country access required for military support of NEO operations.

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

(28) A significant reduction in civilian transportation capacity could affect DoD acquisition and distribution.

(29) An influenza pandemic environment will minimize the patient evacuation effectiveness of the National Disaster

Medical System (NDMS) due to limited movement and a wide range of pandemic impact (see annex Q, appendix 2 of reference (c)).

4. Mission. To protect and preserve the operational effectiveness of our forces throughout the globe. In addition, attempt to prevent/inhibit an overwhelming epidemic within the Navy by providing sufficient personnel, equipment, facilities, materials, and pharmaceuticals to care for Navy forces, civilian personnel, dependents, and beneficiaries (including contractors overseas).

5. Execution

a. General. Success in an influenza pandemic environment will depend greatly on how well the installation level PI plans are written, exercised, and executed. Echelon II commands will develop PI instructions that address all key tasks for each phase defined in reference (c) and appropriate Navy component command (NCC) PI plans. Echelon II commands will direct their components to develop installation PI plans using appendix 32 and annex C of reference (c). Installation level plans will be reviewed by the Navy Judge Advocate General to ensure plans comply with annex E, appendix 4, of reference (c) and appropriate laws.

b. SecDef Decision Support Template (DST). The DST is a graphic record of the PI operation along the phased timeline and is illustrated in reference (c). The DST depicts nine key SecDef GCCs' strategic decision points and timelines associated for the movement of forces, capabilities or critical supplies and the flow of the operation, and other key items of information required to execute a specific course of action. The DST includes the anticipated time period and critical information required by the Secretary of Defense in conjunction with the execution of reference (c). Each decision and its applicable DoD objectives, priority effects, and commanders critical information requirements (CCIRs) are amplified and linked in appendix 28 of reference (f). The DST and its associated decision framework will assist the CCDRs and Chairman of the Joint Chiefs of Staff to identify and analyze the applicable decision CCIRs in order to take timely action against the PI threat or staff the applicable decision up to the Secretary of Defense for approval. Supporting PI plans will need to incorporate these SecDef decisions within their decision

support process. The SecDef DST and appendix 28 of reference (f) are provided to Navy commanders for situational awareness of the strategic level decisions that will impact CCDRs during an influenza pandemic event and require SecDef briefings by the Chief of Naval Operations (CNO). As a Title X force provider, these references will be used to develop CNO level decisions that affect the Navy's overall mission. It is paramount that echelon II and III commanders understand the SecDef DST and can articulate events at their commands that may impact overall Navy readiness. Key CNO decisions by phase:

(1) Phase 0 - Realign essential supplies.

(2) Phase 1 - Allocate resources for PI planning.

(3) Phase 2 - Distribute and preposition antivirals, personal protective equipment (PPE) and medical treatment equipment for containment.

(4) Phase 3 - Targeted release of antivirals.

(5) Phase 4 - Close entry level training facilities/ movement of Service members at their projected rotation date (PRD).

(6) Phase 5 - Re-open entry level training facilities/ movement of Service members at PRD.

c. Responsibilities

(1) Director, Operations and Plans (OPNAV (N31))

(a) Coordinate and synchronize the Navy's PI plans and policy.

(b) Develop and maintain service level PI instruction and ensure it is synchronized with reference (c). At a minimum, this plan will provide the necessary guidance to enable the development of installation-level plans that ensure FHP and Continuity of Operations (COOP) per references (i) and (j).

(c) Assist Service Components in synchronizing support plans with CCDRs.

(d) Coordinate with CDRUSNORTHCOM to ensure that guidance and installation plans are developed, updated, and synchronized with reference (c).

(e) In conjunction with Chief of Information, communicate/disseminate common public affairs (PA), themes, and messages consistent with Assistant Secretary of Defense (Health Affairs), Assistant Secretary of Defense (Homeland Defense and Americas' Security Affairs) and Assistant Secretary of Defense (Health Affairs) guidance, National and DoD policy and guidance.

(f) Review plans every 6 months in accordance with reference (f), with an emphasis on refinements necessary due to significant changes in strategy, risk and/or tolerance of risk, assumptions, U.S. capabilities, enemy and/or adversary intent or capabilities or resources.

(g) Provide daily situation reports as directed by the Joint Staff.

(h) Establish reporting procedures for NCCs and ensure Navy compliance with references (c) and (f).

(i) Identify personnel, equipment or logistical shortfalls immediately to the Joint Staff; components should report through their component commander.

(j) Prioritize mission essential U.S. Forces for vaccinations.

(2) Commander, Navy Installations Command (CNIC)

(a) Plan, coordinate and synchronize all Navy installation PI plans, to include the Navy extended community (such as, civilian workforce, contractors, retirees, etc.). PI plan execution and response will be conducted at the regional and installation level under the operational direction of the respective NCCs.

(b) Execute the NCC specific resource requirements for Navy regional manning, training, and equipping requirements.

(c) Provide training and equipping resources for Navy regions on protective measures against the [threat viral subtype] strain.

(d) Maintain COOP in an influenza pandemic environment, including provisions for increased staff, emergency training of volunteer staff, and/or second or third order effects.

(e) Ensure installation-level plans, as a minimum, contain the following sections: references, tasked organizations, situation, threat, key assumptions, mission, execution, administration, logistics, and C2, and the appropriate annexes listed in reference (f).

(f) Ensure installation plans include potential second and third order effects of a pandemic, incorporate FHP measures by phase, include personal protective measures (PPM), and are shared across Service Components, as necessary.

(g) Submit resource requirements, as directed, within 180 days of reference (c) approval considering the following common framework: biennial installation planning conferences, biennial installation PI table top planning exercises, and biennial installation coordination visits.

(h) In conjunction with the Naval Supply Systems Command and Defense Logistics Agency (DLA), identify critical commodities, goods or services that require priority delivery from industry/suppliers to ensure COOP and sustainment of key populations.

(i) Coordinate with private sector and other government organizations to promote efforts to assure continuity of Defense critical assets, and, thus, ensure availability of sufficient military capability to execute the national military strategy during an influenza pandemic.

(j) Exercise plans biennially in coordination with the NCC to include other DoD Components and the IA, including state, local and international organizations.

(k) Report costs during all phases of a pandemic for the ultimate reimbursement from the primary agency.

(l) Identify resource shortfalls as directed to ensure execution of phases 0 and 1 and to begin preparation for remaining phases.

(m) Develop religious support plans as specified in appendix 6 to annex E of reference (f).

(n) Per references (k) and (l), ensure that Navy regional commanders monitor and coordinate arrangements for visits to the United States by foreign sovereign immune vessels to ensure respect for the sovereign immune status of those vessels. Official U.S. policy for foreign sovereign immune vessels visiting the United States is to accord these vessels the same sovereign immunity that the United States claims for its sovereign immune vessels. This privilege includes, in relevant part, not requiring these vessels to provide either a crew list or any form of liberty log for those persons debarking the sovereign immune vessel in U.S. ports.

(o) Prioritize mission essential U.S. Forces for vaccinations.

(3) Chief of Navy Reserve (CNO (N095))

(a) In conjunction with Chief of Naval Operations, Director Augmentation (OPNAV (N313)) and Assistant Secretary of the Navy (Manpower and Reserve Affairs), establish guidelines for the recall of Navy Reserve personnel regarding call-up of reserves for emergency response during an influenza pandemic.

(b) Monitor Reserve Component readiness and training policies for domestic and overseas PI preparedness.

(c) Review Reserve Component forces semi-annually to determine which personnel would not be available for activation given an influenza pandemic situation 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 skill sets, and specifically addresses the impact on anticipated PI operations. Results of these analyses will be shared with Joint Staff, Joint Forces Command and Service Headquarters (HQ).

(d) Prioritize mission essential U.S. Forces for vaccinations.

(4) Bureau of Medicine and Surgery (BUMED)

(a) Plan, coordinate, and synchronize all medical treatment facilities (MTFs) PI plans. MTF PI plan execution and response will be conducted at the Navy Medical Region (NAVMEDREG) and local MTF level in support of operational direction of the respective NCC.

(b) Direct NAVMEDREGs to be the supporting commander to the respective Navy region and NCC for operational execution of PI response.

(c) Develop FHP program elements consistent with the FHP measures aligned by phase and any supplemental CCDR FHP guidelines.

(d) Ensure threat medical surveillance is provided in support of Service activities, facilities, and key population.

(e) Provide FHP and community mitigation guidance to affected regions.

(f) Maintain COOP in a PI environment. Prioritize mission essential U.S.. Forces for vaccinations.

(g) In conjunction with DLA, identify critical medical supplies, goods or services that require priority delivery from industry/suppliers to ensure COOP and sustainment of key population.

(h) Exercise plans biennially in coordination with CDRUSNORTHCOM.

(i) Conduct exercises and rehearsals with other DoD Components and IA (state, local and international) organizations.

(j) Report costs during all phases for the ultimate reimbursement from the primary agency.

(k) Identify resource shortfalls to Office of Secretary of Defense, as applicable, to ensure execution of phases 0 and 1 and to begin preparation for remaining phases.

(l) Collect data daily at each point of care. Points of care include established MTFs, operational units with organic medical capability, and any non-medical facility designated or re-missioned for use as an alternate care/treatment facility. Data collection and reporting processes and requirements will surge during a pandemic. Commanders must assure their access to surveillance information and adequate staff and resources to conduct effective surveillance.

(m) Coordinate health service support planning and execution through respective surgeons general, including appropriate GCC coordination and cross-leveling of medical assets and capabilities.

(n) Initiate immunization of military units once a licensed vaccine is available and supplies and distribution are adequate. Department of Defense will direct the immunization program via DoD issuances and its executive agent, Military Vaccine (MILVAX) Agency. BUMED will provide service implementation guidance in support of DoD guidance.

(o) Ensure DoD laboratories that are Laboratory Response Network (LRN) reference laboratories will conduct rule in/rule out testing for the pandemic virus per LRN guidance.

(p) Public health emergency officers (PHEOs) will advise Service chiefs, surgeons general, and commanders, and coordinate the FHP portion of PI preparation and response efforts with GCC PHEOs.

(q) Provide Service medical assets to support PI contingency operations as directed by the GCC.

(r) Ensure any adverse events are tracked and reported following vaccine and/or antiviral administration in accordance with existing policies and guidelines, including GCC command surgeons among report addressees.

(s) Ensure all MTFs perform daily influenza like illness surveillance and trend analysis in accordance with DoD policy to monitor for evidence of an emerging pandemic. Ensure appropriately trained public health or preventive medicine professionals monitor Electronic Surveillance System for the Early Notification of Community-based Epidemics (ESSENCE) at each military installation. Installations without qualified personnel to monitor ESSENCE must coordinate with a nearby installation, regional medical HQ, or the Service-specific surveillance hub to ensure coverage. All will report significant medical events (disease outbreaks) to the Navy's Medical Event Reporting System, MERS, as directed per reference (m).

(t) Be prepared to establish and/or support appropriate PI related medical operations in accordance with Department of Health and Human Services (HHS) guidelines and screening criteria at aeromedical evacuation hubs and APODs/SPODs.

(u) Identify MTFs receiving antivirals and vaccine by unit identification code.

(v) In accordance with service doctrine, include medical material management and biomedical maintenance as a Service responsibility until each GCC Single Integrated Medical Logistics Management, SIMLM, or any successor system, is established.

(w) In coordination with CNIC, preposition or have ready access to a 10-day supply of approved antivirals and other essential medical supplies to support the key populations at each installation. The population supported will be determined and prioritized by the Services, Service Components, and installation commanders.

(x) Ensure adequate supply and sourcing of materiel. The following are recommended PPE for responding to an influenza pandemic: face shields/protective goggles, disposable gloves for clinical use (small, medium and large), reusable gloves for cleaning, hair cover, high efficiency particulate air filter respirator (N-95) for medical staff and others coming into

contact with PI patients, disposable surgical masks for patients, disposable long-sleeved gowns, and disposable plastic aprons. See annex Q of reference (f).

(y) Meet the respective hospital bed requirements as computed by the Joint Medical Analysis Tool, JMAT, or estimated based on population at risk and severity risk and projected affected population factors.

(z) Ensure healthcare facilities are prepared for administrative measures for the detection of PI, preventing its spread and managing its impact on the facility and staff.

(aa) Build on the existing preparedness and response plans for bioterrorism events, Severe Acute Respiratory Syndrome, and other infectious disease emergencies.

(ab) Incorporate planning suggestions from state, local, and HN health departments, and other local and regional healthcare facilities and response partners.

(ac) Measure compliance with response procedures (e.g., infection control practices, case reporting, patient placement and healthcare worker illness surveillance).

(ad) Review and update inventories of supplies that will be in high demand during an influenza pandemic.

(ae) Review procedures for the receipt, storage, and distribution of assets received from federal stockpiles.

(af) Include mechanisms for periodic reviews and updates.

(ag) To the extent feasible, ensure medical evaluation for patients suspected of having PI will include routine evaluation to determine influenza type (i.e., type A or not type A) and applicable laboratory and radiological evaluation as required.

(ah) Ensure occupational environmental health survey assessments are conducted as appropriate.

(ai) Ensure Service activities are coordinated through Armed Forces Health Surveillance Center.

(aj) Ensure PHEOs, while under BUMED operational control, forward health surveillance data to Armed Forces Health Surveillance Center.

(ak) Develop guidance for allocating scarce medical resources during mass casualty events.

(al) Establish medical C2 architecture.

(am) Identify and coordinate medical credentialing requirements as required.

(an) Support HHS in the global effort by, among other things, conducting medical and laboratory surveillance and diagnostic testing through DoD members of the LRN, and by participating in the Food and Drug Administration Vaccines and Related Biologic Products Advisory Committee and the Center for Disease Control Advisory Committee on Immunization Practices as influenza vaccine recommendations are formulated.

(ao) Ensure awareness of bed capacity across respective AORs. Obtain surge capacity data with NDMS partners, as applicable, on a recurring basis, while also pursuing ways to incorporate community/HN efforts that are not included in this data.

(ap) Coordinate with United States Fleet Forces Command (USFFC), Pacific Fleet Command (PACFLT), United States Transportation Command (USTRANSCOM), and NDMS service coordinators, as applicable, in patient movement planning efforts.

(aq) In coordination with CNIC, USFFC and PACFLT, incorporate exercises and training to evaluate FHP measures for completeness and to determine/evaluation of gaps (i.e., determine need for altered FHP requirements and potential disconnects) within and among DoD, USG, and other governmental and non-governmental organizations.

(ar) Review and evaluate existing MTF PI plans, guidance, and programs to include PPM, identification of PPE

requirements, targeted layered containment, and community mitigation strategies. Provide guidance to MTFs on modifying standards of care to respond to possibility that system may be overwhelmed.

(as) In coordination with CNIC, prepare to provide mass immunization and care.

(at) In coordination with CNIC, USFFC, and PACFLT recommend screening, isolation, and quarantine strategy options for personnel leaving affected regions.

(au) In coordination with National Center for Medical Intelligence (NCMI), employ exposure surveillance to conduct retrospective analysis in order to improve the FHP of future operations, prepare/protect potentially non-impacted areas, and support follow-up medical care to previously deployed forces.

(av) Be prepared to quickly augment clinical staff of MTFs overwhelmed with influenza patients.

(aw) Ensure that public health and disease outbreak emergency response policies, plans, procedures, and guidelines are supported by sufficient C2 capabilities and other equipment to respond properly to disasters, public health emergencies, and disease outbreaks.

(ax) Maintain continuity of care operations in an influenza pandemic environment including provisions for increased staff, emergency training of volunteer staff, and/or second or third order effects.

(ay) Provide training and equipping resources for Navy medicine regions on protective measures against the [threat viral subtype] strain.

(az) Develop religious support plans as specified in appendix 6 to annex E of reference (f).

(5) NCCs

(a) Develop FHP program elements consistent with the FHP measures aligned by phase and any supplemental CCDR FHP guidelines.

(b) Maintain COOP in a PI environment.

(c) Re-deploy and reconstitute the PI response forces between PI waves.

(d) In conjunction with DLA, identify critical supplies, goods or services that require priority delivery from industry/suppliers to ensure COOP and sustainment of key population.

(e) Exercise plans biennially in coordination with appropriate CCDR.

(f) Conduct exercises and rehearsals with other DoD Components and the IA, including state, local, and international organizations.

(g) Capture costs during all phases for the ultimate reimbursement from the primary agency.

(h) Identify resource shortfalls to Chief of Naval Operations, Director Antiterrorism/Force Protection (OPNAV (N314)), as applicable, to ensure execution of phases 0 and 1 and to begin preparation for remaining phases. Keep USFFC and PACFLT informed.

(i) Properly position forces with the required numbers, skills, and materiel support to respond and meet the projection of forces in the changing PI environment.

(j) Develop and evaluate existing PI plans, guidance, and programs to include PPM, identification of PPE requirements, targeted layered containment, and community mitigation strategies.

(k) Ensure that public health and disease outbreak emergency response policies, plans, procedures, and guidelines

are supported by sufficient C2 capabilities and other equipment to respond properly to disasters, public health emergencies, and disease outbreaks.

(l) Develop religious support plans as specified in appendix 6 to annex E of reference (f).

(m) Ensure compliance with U.S. sovereign immunity and related policies regarding provision of crew lists and other information of military and non-military personnel on board U.S. sovereign immune vessels to foreign governments as outlined in references (k), (l) and (n). Early engagement with the U.S. embassy country team for the HN is essential to resolving potential difficulties in a timely manner.

(n) Prioritize mission essential U.S. Forces for vaccinations.

(6) Naval Facilities Engineering Command

(a) Maintain COOP in a PI environment.

(b) In coordination with CNIC and BUMED, maintain essential utilities and facility services, and provide contingency engineering support as tasked

(c) Prioritize mission essential U.S. Forces for vaccinations.

(7) Naval Supply Systems Command

(a) Maintain COOP in a PI environment.

(b) In coordination with CNIC and DLA, and within the confines of existing policy and law, develop and execute region sustainment plans with the installations to begin identifying sufficient quantities of critical PPE to ensure mission assurance during a PI response. These plans should include the purchase, storage, management, and distribution of identified PPE.

(c) Prioritize mission essential U.S. Forces for vaccinations.

(8) Defense Intelligence Agency/NCMI

(a) Maintain COOP in a PI environment.

(b) Per reference (f), provide intelligence information on the OCONUS spread of PI and the latest information on the nature of the threat, current mutative state, personnel, and casualty information.

(c) Prioritize mission essential U.S. Forces for vaccinations.

6. Administration and Logistics

a. Concept of Logistics Support for PI operations, to include deployment, sustainment, and combat service support (CSS) efforts, will be flexible and tailored to support the mission requirements.

b. Logistics. The CCDR's NCCs are responsible for administrative, logistical, medical, and communication support for forces employed in PI operations. Component commanders will comply with respective Service instructions, existing plans, agreements, and legal authorities. DLA, Defense Contract Management Agency, USTRANSCOM, and other government/Defense Agencies will continue to provide the logistics backbone in the Joint operating agreements to include: supply, maintenance, transportation, civil engineering, health services and other CSS to DoD forces. Efforts must be directed at leveraging the existing infrastructure, contracts, and support relationships with civilian services through innovative information coordination and management, business practices, contracting, and operating procedures. A coordinated effort to match prioritization of effort and resources with each operational phase is essential to the success of providing PI support.

(1) Civil Engineering. See annex D of reference (f).

(2) Environmental Considerations. Significant environmental actions are not expected in support of DoD PI operations. Commanders are responsible to employ environmental practices that minimize adverse impacts to human health and the environment as follows. All DoD forces employed in PI operation will be briefed on their responsibilities for protection of our

environment. During all phases of operations, strategies will be developed to avoid, reduce or eliminate negative impacts on the environment. Emergency exemptions may be needed for disposal of contaminated and hazardous material.

(3) Environmental Responsibilities. Department of Defense will be in support of a primary agency. Environmental responsibilities remain with the primary agency. However, this does not release Department of Defense from responsibility to plan and conduct operations in a manner responsive to environmental considerations. Timely response in crisis circumstances may make it necessary to take immediate action without preparing the normal environmental planning documents. Close coordination with local, state, federal agencies, and HNs during operations is needed to avoid negative environmental consequences. DoD's goal is compliance with all applicable laws.

(4) Environmental Conditions and Transfer to Civil Authorities. Documenting conditions and actions as soon as possible before, during, and after operations will facilitate resolution and closure of environmental issues. An active environmental review of DoD operations should be accomplished to identify possible environmental issues before a negative impact occurs. Environmental impacts will be addressed as soon as possible once operations have stabilized. DoD forces should direct efforts to properly identify, contain, document, and transfer environmental issues to civil authorities as soon as possible.

(5) Personnel. Upon SecDef direction, Commander, United States Joint Forces Command will source Joint Staff validated requirements and notify the CCDRs of augmentee information and arrival dates. The designated C2 HQ will be responsible for coordinating the Joint Reception Center, maintaining accountability of deployed DoD personnel, and reporting personnel information.

(6) PA. Proactive communication efforts are essential prior to and during a pandemic. Early dissemination of information and aggressive PA (educational) programs support the USG's effort to prevent/inhibit or mitigate the spread of the virus, and instill confidence in the key population. Successful communications will lead to reduced fear and panic at the onset

of a pandemic. It is imperative that Navy speak with one voice and ensure the themes and messages from HHS are nested in subordinate plans. The Office of the Assistant Secretary of Defense (Health Affairs) is overall responsible for coordinating the DoD PA response by providing PA's guidance to CCDRs, Services, and DoD Agencies. Delegation of release authority to the CCDR, Services, and DoD Agency PA office and, in turn, the appropriate C2 HQ, is allowed in support of this plan. Installation level plans should utilize annex F of reference (f) for specific guidance.

(7) Medical Services. During PI operations, maintenance of the medical and public health infrastructure will be a significant challenge. Department of Defense has a critical role at the national level in fulfilling its National Response Plan responsibilities and an equally critical role at the installation level. Commanders, working through their respective PHEOs, should consider using the full spectrum of their resources to assist local governments in providing essential services to their citizens. DoD medical capabilities should be requested if it is determined necessary to augment or sustain the local response in order to save lives and minimize human suffering. The time sensitive nature of the requirements necessitates early and rapid IA coordination to be effective. Restrictions on the use of military medical stockpiles and provisions of direct military care to civilians by military personnel may need to be addressed in mission planning.

7. Command and Control. Per the CJCSI 3110.01F (superseded by CJCSI 3110.01G), CDRUSNORTHCOM is the lead CCDR for planning and synchronizing reference (c), until directed otherwise. GCCs will have command for execution within respective AORs.

a. Command Relationships

(1) CDRUSNORTHCOM is the supported commander for the synchronization of Global PI planning. CCDRs, Services, and Defense Agencies are supporting commands/departments/agencies for coordination and synchronization of Global PI planning.

(2) GCCs are the supported commanders within their respective AORs. All other component commanders are supporting commanders for PI response operations.

(3) The Department of the Navy is a supporting organization, and its PI plans will conform to GCC plans in case of conflict.

(4) OPNAV (N31) will coordinate and synchronize the Navy's PI plans and policy.

(5) All NCCs supporting GCCs are responsible for PI planning and execution in their GCC's AOR. NCCs are responsible to inform USFFC and PACFLT on all man, train, and equip issues. All echelon II commanders are supporting commanders to their respective NCC wherein located for pandemic influenza planning and execution.

(6) USFFC and PACFLT retain responsibility to train and equip the force on protective measures against virus strains. USFFC is the supported commander, and PACFLT is the supporting commander for all units administrative control to PACFLT operating in the CDRUSNORTHCOM AOR, with respect to addressing training and equipping shortfalls. PACFLT will keep USFFC informed of uncorrected deficiencies.

b. Reporting Requirements

(1) All Navy echelon II commands will report outbreaks of PI per reference (o), including BUMED and the Navy and Marine Corps Public Health Center (NMCPHC).

(2) CCDR's reporting guidance will apply within respective AORs.

(3) Deputy Chief of Naval Operations, Operations, Plans and Strategy (CNO (N3/N5)) guidelines on classification pertaining to operational readiness information will not change due to the onset of an influenza pandemic.

(4) Echelon II commanders shall utilize annex K of reference (f) to ensure an effective communication strategy has been developed and is ready to be exercised during a PI event.

(5) Submit Operational Report (OPREP) 3 Navy Blue to chain of command, to include Office of the Chief of Naval Operations (OPNAV), USFFC, PACFLT, BUMED, and NMCPHC, if an outbreak will significantly impact the command's operational

ability to perform its mission. Commanders will report degradations in unit operational readiness and adverse impacts to mission accomplishment caused by a PI outbreak via the Defense Reporting Requirement System (DRRS)/Status of Resources and Training System (SORTS).

Note: It is not required nor desired that commanders report each case of suspected or confirmed viral strain infection via situational report/OPREP.

(6) Medical reporting:

(a) The NMCPHC at Portsmouth, Virginia, will be the central point of contact for receipt on pandemic pathogen data from ships, shore installations and deployable units. NMCPHC will also provide regular reports, as required, on Navy-wide pandemic pathogen status to OPNAV via electronic mail (e-mail) to the CNO battle watch. All units with non-secure Internet protocol router (NIPRNET) access will be required to use the Navy Disease Reporting System Internet (NDRSI) for reporting influenza and other notifiable diseases. NDRSI is a Web-based reporting system and commands will be required to obtain an account at: http://www-nmcphc.med.navy.mil/preventive_medicine/reportingtools.aspx.

(b) For further information on NDRSI, contact the NDRSI helpdesk via e-mail at ndrs@nehc.med.navy.mil or by calling 757-953-0954. Units without NIPRNET access may report using alternate methods or tools as described in reference (e). The return to routine disease reporting does not alter the continuing requirement for submission of weekly disease non-battle injury data. All lab confirmed cases must also be reported by medical event reports to NMCPHC. Submit other reports in accordance with immediate superior in command requirements.

c. COOP

(1) In accordance with references (p) and (q), all Secretary of the Navy offices and OPNAV echelon I and echelon II organizations are required to have a COOP program and supporting plan. Continuity planning facilitates the performance of mission essential functions (MEFs) during all-hazards emergencies or other situations that may disrupt normal

operations. Traditional COOP planning efforts focuses on a component's ability to accomplish their MEFs while deferring remaining functions for up to 30 days.

(2) During COOP execution, key personnel are relocated away from the impacted area to an emergency relocation site in order to continue the component's MEFs utilizing either pre-positioned records or remote access capabilities to vital systems. PI presents a different environment in which Navy components may be forced to operate. The traditional concept of COOP, relocating to a readied alternate site, may no longer be a viable option. In addition, the estimated duration of the pandemic dictates that Navy components will be required to perform more than just MEFs during this period. Previously deferred functions may have to be prioritized and performed by significantly diminished staffs. Existing COOP programs have to be expanded to incorporate this prioritization of effort, hence changing work procedures in a PI environment. Approaches such as alternate work schedules and alternate locations, tele-work, cross training of employees, job sharing, social distancing, and devolution will all need to be considered and adopted as appropriate to the component's situation and functional responsibilities.

(3) In anticipation of a potential occurrence of a PI outbreak, components should review and modify current COOP plans to ensure their ability to continue operations during a PI event is not compromised.

(4) Due to the unique USFFC responsibilities delineated in SECNAVINST S3030.5, DON HQ Continuity of Operations Plan, USFFC should be copied on all PI reports made to the CNO.

8. Records Management. Records created by this instruction, regardless of media and format, must be managed in accordance with reference (r).

9. Reports. Reporting requirements within this instruction are exempt from report control symbols per reference (s).

SAM J. LOCKLEAR III
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LIST OF ACRONYMS

Acronym	Meaning
AOR	Area of Responsibility
APOD	Aerial Ports of Debarkation
BUMED	Bureau of Medicine and Surgery
C2	Command and Control
CCDR	Combatant Commander
CCIR	Commanders Critical Information Requirement
CDRUSNORTHCOM	Commander, United States Northern Command
CJCSI	Chairman, Joint Chiefs of Staff Instruction
CNO	Chief of Naval Operations
CNIC	Commander, Naval Installations Command
CONPLAN	Concept Plan
CONUS	Continental United States
COOP	Continuity of Operations
CSS	Combat Service Support
DLA	Defense Logistics Agency
DoD	Department of Defense
DOS	Department of State
DR	Disaster Relief
DRRS	Defense Reporting Requirement System
DST	Decision Support Template
ESSENCE	Early Notification Community-based Epidemics
FHP	Force Health Protection
GCC	Geographic Combatant Command
HA	Humanitarian Assistance
HHS	Department of Health and Human Services
HN	Host Nation
HQ	Headquarters
JMAT	Joint Medical Analysis Tool
IA	International Agency
LRN	Laboratory Response Network
MEF	Mission Essential Function
MILVAX	Military Vaccine
MERS	Medical Event Reporting System
MTF	Medical Treatment Facility
NAVMEDREG	Navy Medical Region
NCC	Navy Component Commander
NCMI	National Center for Medical Intelligence
NDMS	National Disaster Medical System
NEO	Non-Combatant Evacuation
NIPRNET	Non-Secure Internet Protocol Router

NMCPHC	Navy and Marine Corps Public Health Center
NOC	Navy Operations Center
NDRSI	Navy Disease Reporting System Internet
OCONUS	Outside the Continental United States
OPNAV	Office of the Chief of Naval Operations
OPREP	Operational Report
PA	Public Affairs
PACFLT	Pacific Fleet Command
PHEO	Public Health Emergency Officer
PI	Pandemic Influenza
PPE	Personal Protective Equipment
PPM	Personal Protective Measure
PRD	Projected Rotation Date
SecDef	Secretary of Defense
SIMLM	Single Integrated Medical Logistics Management
SORTS	Status of Resources and Training System
SPOD	Sea Ports of Debarkation
USFFC	United States Fleet Forces Command
USG	United States Government
USTRANSCOM	United States Transportation Command
WHO	World Health Organization