Pandemic Influenza Tabletop Exercise for Military Installations

FACILITATOR'S GUIDE

11th Annual Force Health Protection Conference
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INTRODUCTION

An influenza pandemic presents several unique challenges. It has the potential to cause more death and illness than any other public health threat and to disrupt society on multiple levels. While the timing, nature, and severity of the next pandemic cannot be predicted with certainty, planning is imperative to lessen its impact. Mitigation of pandemic disease will require effective coordination across a broad spectrum of military, civilian government and nongovernmental entities. The most effective response plans will be flexible and interoperable with response partners, and will ensure performance of mission essential functions while protecting assigned military and civilian populations.

Beyond written plans, training exercises are critical to optimize response efforts. This tri-service exercise is the second of two pandemic influenza tabletop exercises developed by the Department of Defense – Global Emerging Infections Surveillance and Response System (DoD-GEIS) in coordination with the US Army Center for Health Promotion and Preventive Medicine (USACHPPM). An initial exercise for Public Health Emergency Officers (PHEOs) was conducted at the Force Health Protection (FHP) conference in August 2007.

This exercise in August 2008 at the FHP conference is a “train the trainer” event with the goal to equip PHEOs to execute an installation-level tabletop exercise on pandemic influenza at their respective installations. (The exercise for PHEOs to execute at their respective installations begins on page 3). Because an influenza pandemic is more than a public health and medical issue – one that will affect every sector of society -- the exercise for military installations focuses on engaging not only PHEOs but also other personnel at the installation level and surrounding community.

Additional information and guidance for facilitators appear in a text box throughout the Situation Manual (SITMAN) where appropriate.

Pandemic Influenza Tabletop Exercise for Military Installations

Facilitator's Guide to the Situation Manual

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Pandemic Influenza Tabletop Exercise for Military Installations

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Pandemic Influenza Tabletop Exercise

Exercise Goal and Objectives

Goal

The goal of this exercise is to prepare and equip military installations to respond to an influenza pandemic. Specific areas addressed include installation readiness, continuity of operations, and military-civilian coordination.

Objectives

The objectives of this exercise include the following:

- Identify strengths and gaps in the military installation response to a pandemic.
- Identify installation-specific, cascading second- and third-order consequences[1] of interventions and describe installation-level strategies for dealing with these consequences.
- Identify opportunities for enhanced coordination between military installations and civilian communities in pandemic influenza readiness and response.

[1] Cascading second- and third-order consequences are chains of effects that may arise because of the intervention and may require additional planning and intervention to mitigate. The term generally refers to foreseeable unintended consequences of intervention.

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Pandemic Influenza Tabletop Exercise

Overview

Focus and Scope

While acknowledging a global context, this exercise focuses on activities and events within the United States. Its scope is continental United States (CONUS)-based, fixed installations and does not include outside continental United States (OCONUS) installations, temporary bases, forward deployed or forces afloat. Consequently, this exercise will not cover issues of non-combatant evacuation operation (NEO), returning personnel overseas, or OCONUS military airlift operations. However, many issues delineated in this exercise have applicability for OCONUS-based installations.

While the focus is on CONUS-based installations, even within CONUS, military installations are diverse. They vary in components, resources, size, number and type of facilities, composition of work force, residential makeup (residing on the economy versus living on base), and mission. Some bases are primarily transport, others are logistical, and still others are training. If a particular question does not apply, then skip or adapt it for your installation.

While there are numerous important issues regarding pandemic influenza, this exercise does not aim to be comprehensive but rather to focus on three main objectives as previously outlined. Therefore, there are critical issues such as mortuary affairs, psychological consequences, economic ramifications of a pandemic, and other issues that are deliberately not covered for the sake of time.

While hypothetical, many elements of the scenarios are based on factual, real-life events that have occurred.

Exercise Format

This is a tabletop exercise that is intended to last approximately three to four hours with a facilitated discussion, breaks, and a “hotwash.” It consists of three scenarios that provide the storyline that drives discussion. Each scenario includes the following features:

- A fictitious time period

- A list of events that have occurred
- Data injects as appropriate
- A list of questions for discussion

Following the facilitated discussion, participants provide immediate feedback in a "hotwash" using Appendix 1 as a suggested framework where sustainment and short-term and long-term actions for improvement can be recommended and discussed.

Ground Rules

The following are ground rules for play during the exercise:

1. You are playing yourself (PHEOs play PHEOs, Commanders are Commanders, administrative personnel are administrative personnel, etc.).
2. This is a "no fault" exercise; the intent of this exercise is not to assign blame. Be honest regarding your installation's level of preparedness.
3. You are not making official policy statements for your unit, organization, facility, or installation.
4. Differing viewpoints, even professional disagreements, are expected and encouraged. To allow open and frank discussion, the after action report (AAR) will not reference individual respondents.
5. All participants are encouraged to contribute to the discussion without regard to rank or position.
6. To ensure completion of this exercise within the designated time, facilitators will hold to strict time management of the discussions.

Force Health Protection Conference
Pandemic Influenza Tabletop Exercise

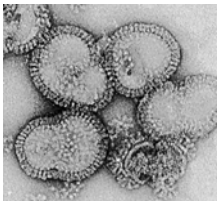
Background Scenario

Topic: WHO Officials Declare Onset of Influenza Pandemic

Dates: October 2008 – 18 January 2009

Events:

- Beginning in October 2008, human-to-human spread of a novel influenza virus H7N3 has been detected in several Southeast and South Asian countries. These cases have occurred in numerous small clusters among family members within these countries. No human cases of H7N3 infection have occurred in the United States. The present global influenza situation is characterized as World Health Organization (WHO) Phase 4, US Government (USG) Stage 2, DoD Phase 2.



Avian influenza virus H7N3

- Insert Data Inject: WHO Phases/USG Stages/DoD Phases

- In late December 2008, the WHO confirms the first known human case of H7N3 infection in northwest, rural Pakistan. The case was a veterinarian who had helped cull chickens during an avian influenza outbreak. Within five days, three of the veterinarian's brothers, all of whom had close contact with the veterinarian, became ill. In total, four cases of H7N3 infection were identified, of whom three were laboratory confirmed by WHO. Two brothers died and two fully recovered. WHO confirms the family cluster as human-to-human transmission. Within the next several days, additional epidemiologically-linked cases of human infection with H7N3 virus develop in three towns in northwest Pakistan, approximately 100 kilometers from Islamabad. These larger clusters of human-to-human spread suggest that the virus is becoming increasingly better adapted to infect humans. Subsequently, on 26 December 2008, WHO declares Pandemic Phase 5. No human cases of H7N3 infection have occurred in the United States. The present global influenza situation is characterized as WHO Phase 5, USG Stage 2, DoD Phase 3.

- A fifth brother (of the veterinarian) who lives in New York attended the funerals of his two brothers in Pakistan. While there, he was potentially exposed to H7N3 virus through household contact. Delayed notification to public health officials leads to the international travel of this fifth brother back to the U.S. During the 22-

hour return flight from Pakistan through London, where he changes airplanes, to New York he becomes ill with fever, cough, and malaise. Upon returning to New York, he seeks medical attention for his illness and informs his family physician about his recent travel to Pakistan. The physician, trained in public health, immediately notifies the Health Officer of her local health department, who in turn, notifies the New York State Epidemiologist. The State Epidemiologist alerts the Centers for Disease Control and Prevention (CDC). The suspected case is medically evaluated, tested for influenza, treated with antiviral drugs, and placed in an isolation room at a nearby hospital. Laboratory results (RT-PCR and culture) indicate positive H7N3 infection.

- WHO, CDC, and other health officials are rapidly investigating possible contacts, including airplane passengers, and instituting quarantine (in home, hospital, or other facility), post-exposure prophylaxis with antiviral drugs and laboratory testing of suspected cases.

- International efforts at containing the spread of the virus are unsuccessful. By 6 January 2009, eight additional human cases of H7N3 infection who are epidemiologically linked (by airplane exposure) to the Pakistani brother from New York appear in the United States in eight different states.

- National and local media are reporting the cases and following the public health investigations closely.

- The US Navy Ship (USNS) Mercy is scheduled to deploy from San Diego to Southeast Asia in 48 hours. The Senior Medical Officer is reporting dozens of crew members reporting influenza-like symptoms, and requesting guidance on how to deal with the issue of antiviral drugs, and what to do if an outbreak occurs on the ship while underway. Several corpsmen are requesting Tamiflu® (oseltamivir), not only for themselves but also for family members. The Commanding Officer of the USNS Mercy has expressed concern about the deployment, and is also requesting guidance on what to do in the event of an outbreak on the ship.

- By 14 January 2009, human outbreaks of H7N3 influenza are reported throughout Indonesia, Vietnam, Thailand, Malaysia, Philippines, India, Bangladesh, Pakistan and the United States. WHO reports a total of 290 laboratory confirmed cases, 174 of whom have died (60% case fatality rate).

- Insert Data inject: WHO Cumulative Case Counts

- Due to mounting evidence of efficient and sustained person-to-person transmission of H7N3 virus, on 18 January 2009, WHO officials declare the onset of an influenza pandemic (WHO Phase 6, USG Stage 5, DoD Phase 4).

- The U.S. Department of Health and Human Services (HHS) prepares a press release. In coordination with HHS, the DoD, through the Office of the Assistant Secretary of Defense for Public Affairs (ASD(PA)), provides public affairs guidance to Combatant Commands (COCOMs).

- The Pentagon has scheduled a video-teleconference with the Secretary of Defense, the Chairman of the Joint Chiefs of Staff, and the Assistant Secretary of Defense for Health Affairs within the next several hours to address this rapidly developing situation.

Data Injects:

1. WHO phases/USG stages/DoD Phases

2. WHO Cumulative Case Counts

Data Inject # 1: Pandemic Influenza Categories: USNORTHCOM Response Phases, US Federal Government Response Stages, and WHO Phases
(Mock document prepared for Force Health Protection Pandemic Influenza Tabletop Exercise, 11 August 2008)

USNORTHCOM Response to Pandemic Influenza Phases (Response, Virus and Geography Driven)		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 pandemic risk)
PANDEMIC PERIOD					
4	Receipt of information of a highly lethal pandemic influenza virus is spreading globally from human-to-human signaling a breach in containment and failing interdiction efforts.	3	Widespread human outbreaks at multiple locations overseas	6	Pandemic influenza 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 fro subsequent waves		

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Data Inject #2: WHO Cumulative Case Counts.
(Mock document prepared for Pandemic Influenza Tabletop Exercise, 11 August 2008)

World Health Organization

Cumulative Number of Confirmed Human Cases of Influenza A/(H7N3) Reported to WHO

14 January 2009

Country	2008*		2009**		Total	
	cases	deaths	cases	deaths	cases	deaths
Bangladesh	3	2	3	2	6	4
India	3	1	14	8	17	9
Indonesia	27	17	29	23	56	40
Malaysia	6	3	10	6	16	9
Pakistan	24	14	34	19	58	33
Philippines	9	6	19	10	28	16
Thailand	32	22	21	11	55	35
United States	0	0	9	4	9	4
Viet Nam	36	19	11	7	49	28
Total	140	84	150	90	290	174

Total number of cases includes number of deaths.
WHO reports only laboratory-confirmed cases.
All dates refer to onset of illness.

* Beginning in October 2008

** Confirmed cases to date

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Exercise Assumptions

- Disease is efficiently spread between people, and containing the spread of an influenza pandemic is not feasible.

- A known effective vaccine will not be available for at least six months after the pandemic strain of influenza virus is identified. Once available, it will require up to two doses of vaccine (30 days apart) to build peak immunity. Immunity requires 1-2 weeks after vaccination, and the level of immunity reached upon vaccination is about 40%.

- The current pre-pandemic vaccine stockpile of 2.6 million doses will not be effective since the current stockpile is for an H5N1 strain of virus. Pre-pandemic H7 vaccine is currently not available.

- Installations have limited supply of antiviral medications but can request access to the DoD antiviral stockpile.

DoD established and continues to add to, a stockpile of Tamiflu® and Relenza® that remain within the control of the ASD(HA). Following ASD(HA) release of antiviral medications from this stockpile, the Joint Chiefs of Staff (JCS) and affected commanders of combatant commands (CCDRs) will apportion these medications to the Services for use within CONUS. In addition, DoD established an additional supply of Tamiflu® that is stored and maintained at MTFs at a supply level equal to 10% of a population at risk. Authority to release this supply of Tamiflu® is vested in the Services, for CONUS MTFs (*Policy for Release of the Department of Defense Antiviral Stockpile During an Influenza Pandemic*, 10 August 2007).

- Installations have limited ability to conduct laboratory testing to confirm H7N3 infection. The ability of installations to screen suspect cases will vary and will primarily depend on personnel resources.

- Installations have limited supplies of personal protective equipment.

- Non-pharmaceutical measures will be the main method of control, including but not limited to:
  1. Population movement restrictions,
  2. Social distancing (adults and children),
  3. Personal protection (masks, hand hygiene, etc.)

- Additional cases will occur in all COCOMs.
- States will request DoD [and National Guard] support to civil authorities.
- The Posse Comitatus Act[2] remains in effect.
- Existing federal, state, and local laws and regulations apply.
- The DoD mission in a pandemic is to maintain defense of the homeland while assisting U.S. Government efforts to limit the long-term impact of an influenza pandemic on the U.S.

[2] The Posse Comitatus Act restricts participation of the military in domestic law enforcement activities under many circumstances. National Guard forces operating under state rather than federal service, and federal troops (including active-duty military and federalized National Guard) pursuant to the presidential power to quell domestic violence are exempt from this Act.

Force Health Protection Conference
Pandemic Influenza Tabletop Exercise

Scenario #1

Topic: Influenza Pandemic Arrives on Military Installation

Dates: 24 January 2009 –31 January 2009

Events:

- By the last week of January 2009, cases of H7N3 infection are identified in the National Capital Region with a total of 25 laboratory-confirmed cases in Northern Virginia alone.

- Local clinics and emergency rooms are already overwhelmed due to seasonal influenza and concern of pandemic influenza by the “worried well."

- On 30 January, an outbreak of H7N3 is reported among the Headquarters Command Battalion and their family members at the Fort Myer military installation[3] in Virginia. Ten patients are initially seen at the Andrew Rader Health Clinic but later transported to Virginia Hospital Center for inpatient medical care. Calls from concerned family members, active duty soldiers, and civilians are overwhelming the Clinic. Many callers living on and off the installation demand antiviral drugs while others report additional influenza-like illness.

Andrew Rader Clinic at Fort Myer

- Triage sites outside the Clinic (such as alternative care sties) at Fort Myer are activated to separate cases from the general population presenting at Andrew Rader Health Clinic, and 24/7 triage operations begin. Routine clinical care is curtailed.

- On 31 January, the Fort Myer Installation Commander declares a public health emergency and immediately reports the declaration through the chain of

[3] Fort Myer is home to the U.S Army IMOCM (Installation Management Command) Northeast Region and the Army’s Headquarters Command Battalion. It primarily provides logistical and personnel support for law enforcement, contingency, ceremonial, information management and customer support operations in support of soldiers, family members, retirees and veterans within the National Capital Region. The installation provides outpatient services only as it does not have a hospital or emergency room. The Andrew Rader Health Clinic does not normally operate 24/7.

command to the Secretary of Defense. The PHEO also reports the declaration through the medical chain of command to the Army Surgeon General and to the Assistant Secretary of Defense for Health Affairs, as well as to civilian public health authorities (HHS/CDC, Virginia Department of Health, and the Arlington County Health Department). At the same time, the Commander activates the garrison Emergency Operations Center (EOC).

Department of Defense Directive (DoDD) 6200.3, *Emergency Health Powers on Military Installations*, 12 May 2003, authorizes a commander to declare a public health emergency on one or more military installations under his command and provides instructions for reporting such a declaration.

- A hotline is established for people with influenza symptoms to call for advice.
- Outpatient visits to the Clinic are rapidly increasing and many of these require transport to the off-post Northern Virginia Hospital Alliance. There is concern among health care staff about reporting to work due to fear of becoming infected by ill patients and leaving their families.
- TRICARE clinics have no available appointments, and family members have contacted the local media complaining of being turned away. Local civilian hospitals are reporting lines of people wanting antiviral drugs.
- Insert Data Inject: DoD Antiviral Prioritization Tiers

Long lines of patients wait for care in the out-patient clinic

Prioritization and use of antiviral medications will vary depending on both the disease severity and the supply of antiviral medication. High severity is defined as a case fatality ratio $\geq$1% consistent with the pandemic severity index category 4 and 5. Low severity is defined as a case fatality ratio < 1% consistent with pandemic severity index categories 1-3. Guidance regarding which matrix (see data inject) should be employed will be posted on the DoD Watchboard (www.dod.mil/pandemicflu) (*Policy for Release of Department of Defense Antiviral Stockpile during an Influenza Pandemic*, 10 August 2007). There are three potential antiviral strategies: treatment, outbreak prophylaxis, and post-exposure prophylaxis. With a few exceptions, antiviral medications should not be used for outbreak prophylaxis (*Addendum to Policy for Release of the Department of Defense Antiviral Stockpile during an Influenza Pandemic*, 4 April 2008).

Data Injects:

1. DoD Antiviral Prioritization Tiers

Questions for Discussion

1. Does your installation have a written pandemic influenza response plan and has it been exercised? What is the date of the plan? When was it last reviewed? Does your plan detail how personnel, equipment, and resources will be used to support mission critical tasks and emergency response activities?

> Annex C, Force Health Protection in *Department of Defense Implementation Plan for Pandemic Influenza*, August 2006, requires installations to develop comprehensive pandemic influenza preparedness and response plans, and to exercise such plans.

2. How has your installation ensured that tenant commands (if applicable) will implement pandemic influenza plans in accordance with your installation plan?

3. Who has your installation commander designated as the Public Health Emergency Officer (PHEO)?

> DoDD 6200.3, 12 May 2003 charges installation commanders to designate a PHEO, "who shall be a senior health professions military officer or DoD civilian employee affiliated with the command of the commander or of a higher level or associated command…The PHEO should be the Command Surgeon, local equivalent, hospital commander, or other senior leader with experience and training in functions essential to effective public health emergency management."

4. How will your installation recognize the first cases of a novel influenza virus infection in your MTF?

> This question has to do with influenza surveillance. Influenza A viruses other than the currently circulating H1 and H3 subtypes should be considered as potentially pandemic if detected in humans. Enhanced surveillance should be conducted during the introduction, initial spread, and first waves of a pandemic. The most intense testing will be necessary during the early stages of a pandemic, when detecting the introduction of the virus into a state or community is the primary goal. Laboratory staff should anticipate shipping a large number of specimens in a very short time, especially during the early stages of a pandemic (*Pandemic Influenza: Clinical and Public Health Guidelines for the Military Health System*, May 2007).

5. How will your installation manage or limit ingress and egress to prevent the spread of influenza to and from your base?

Close the gates? Limit access? Free access with social distancing and personal protective measures? Other?

6. How will your installation communicate essential information with your various constituent groups (active duty personnel, families, tenant commands, general public, etc.)? Who communicates the public affairs message?

Annex E, Public Affairs in *Department of Defense Implementation Plan for Pandemic Influenza*, August 2006 provides guidance on public affairs for the DoD in an influenza pandemic.

7. What is the plan to address an increased surge of patients, increased demand for antiviral drugs, and intensive care requirements? How does this surge capacity plan address potentially scarce resources and related ethical considerations?

Reference *Pandemic Influenza: Clinical and Public Health Guidelines for the Military Health System*, May 2007.

8. Has your installation identified essential personnel, and critical infrastructure that would be needed to support base operations?

Annex D, Continuity of Operations/Continuity of Government in *Department of Defense Implementation Plan for Pandemic Influenza*, August 2006 provides guidance on continuing DoD mission essential functions and services.

9. Has your installation established standardized policies for inventory, mobilization, dispatch, tracking, and recovery of resources to be utilized in the event of a pandemic?

Data Inject #3: DoD Memorandum on Antiviral Prioritization Tiers.
(Mock document prepared for Force Health Protection Pandemic Influenza Tabletop Exercise, 11 August 2008)

THE ASSISTANT SECRETARY OF DEFENSE
1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

MEMORANDUM FOR ASSISTANT SECRETARY OF THE ARMY (M&RA)
ASSISTANT SECRETARY OF THE NAVY (M&RA)
ASSISTANT SECRETARY OF THE AIR FORCE (M&RA)
DIRECTOR, JOINT STAFF

SUBJECT: Antiviral Prioritization Tiers

Because the supply of both Tamiflu® and Relenza® are limited and replenishment may not be possible, prioritization guidelines are necessary. The following prioritization matrix lists the priority for the use of antivirals in four differing conditions depicting high and low supply with high and low disease severity and should be used as a general guide. The categories of personnel in each block are listed highest to lowest priority from top to bottom of each matrix block, respectively. Guidance regarding which matrix should be employed will be based on the current supply status and disease characteristics and will be posted on the DoD Watchboard (www.dod.mil/pandemicflu) as needed.

Matrix for Varying Disease Severity and Antiviral Capacity			
		Antiviral Drug Supply	
		Low	**High**
Pandemic Severity	**High**	SCF (T, P or PEP) CF (T) HP (T) AF (T) OF (T) F (T) B (T)	HP (T) SCF (T, P or PEP) CF (T, P or PEP) AF (T, P or PEP) OF (T, P or PEP) F (T or PEP) B (T or PEP)
	Low	HP (T) SCF (T, P or PEP) CF (T) AF (T) OF (T) F (T) B (T)	

AF	Alert Forces	OF	Operational Forces
B	Beneficiaries	P	Prophylaxis (Outbreak or Operational)
CF	Critical Forces	PEP	Post Exposure Prophylaxis
F	Forces	SCF	Select Critical Forces
HP	Hospitalized Patients	T	Treatment

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Pandemic Influenza Tabletop Exercise

Scenario #2

Topic: Continuity of Operations on Installations

Dates: 31 January 2009 – 7 February 2009

Events:

- Upon declaration of a public health emergency on 31 January, the Fort Myer Installation Commander, in consultation with the PHEO, implements emergency powers including a series of non-pharmaceutical interventions (NPI) at the installation. These include:

  - Isolation of ill, combined with use of antiviral treatment as available and indicated;
  - Quarantine of household members in homes with ill persons, combined with antiviral prophylaxis if effective, feasible, and in sufficient quantity;
  - Closure of schools and the child development center at the installation;
  - Closure or cancellation of large gatherings on base including restaurants, gyms, bowling alley, worship services, and other events;
  - Restriction of movement, including limiting ingress and egress to and from the installation; and
  - Activation of telecommuting by non-essential personnel.

Empty classroom

- By 7 February, several "downstream" (i.e., 2nd and 3rd order) installation-level effects of implementing the above measures are visible. Over two dozen military police are ill and placed under isolation. Their absence has attenuated security at the installation gate and restricting access to the installation has become a problem. In addition, there is an insufficient number of well personnel to continue guarding the Tomb of the Unknown Soldier and to conduct military funerals at the Arlington National Cemetery.

- Closure of the Installation's schools and child development center has resulted in interruption of education, students congregating at the Army Community Service

center and at the Post Exchange, and work absenteeism from parents staying home. In turn, worker absenteeism has resulted in reduced supplies of food on the shelves at the Commissary, as well as reduced pharmacy, clerical, technical support, and custodial services throughout garrison.

Near empty shelves at the Commissary

- The civilian community outside of Fort Myer is also experiencing severe staff shortages and is having trouble finding manpower, especially for essential services such as EMS, fire, police, utilities, sanitation, and transportation.

Questions for Discussion

1. At what point, if any, will your installation close DoD schools and child development centers, cancel public events, limit access to the Post Exchange and Commissary? At what point will you lift these restrictions?

CONUS installation commanders are authorized, upon the recommendation of the PHEO, to implement emergency health powers on their installations in order to protect military and civilian personnel and property such as movement restrictions, individual protection and social distancing strategies (including unit shielding, ship sortie, cancellation of public gatherings, drill, training, etc.). DoD personnel and beneficiaries living off-base should comply with local community containment guidance with respect to activities not directly related to the installation (DoDD 6200.3, 12 May 2003; *Department of Defense Implementation Plan for Pandemic Influenza*, August 2006).

Guidance from the Centers for Disease Control and Prevention suggests the primary trigger for initiating use of non-pharmaceutical interventions (NPI) be the arrival and transmission of pandemic virus. This trigger is best defined by a laboratory-confirmed cluster of infection with a novel influenza virus and evidence of community transmission (i.e., epidemiologically linked cases from more than one household). Total duration of implementation of NPI will depend on the severity of the pandemic and the total duration of the pandemic wave in the community. Communities should be prepared to maintain NPI for up to 12 weeks in a severe pandemic. (*Interim Pre-pandemic Planning Guidance: Community Strategy for Pandemic Influenza Mitigation in the United States*, February 2007).

2. What is your installation's policy for adopting flexible worksites (e.g., telecommuting) and flexible work hours (e.g., staggered shifts)? Do you have the infrastructure necessary for mass telecommuting?

> Department of Defense Instruction 1035.01, 3 April 2007 establishes an overarching policy governing telework (also known as telecommuting) within the DoD. *Department of Defense Civilian Human Capital Guide for Pandemic Planning*, September 2007 http://www.cpms.osd.mil/disasters/docs/HRPIGuide2007.pdf provides guidance on telework during a pandemic. A joint website from the Office of Personnel Management (OPM) and the General Services Administration (GSA) www.telework.gov provides information to agencies, managers, and employees about how to effectively implement telework programs and arrangements.

3. How will your installation address the needs (medical, food, supplies, etc.) of those who are placed in isolation or quarantine?

4. In what other ways might these respective NPI measures disrupt *installation-level operations*?

5. What strategies could be employed to maintain continuity of operations in the face of:
    a. Disruptions to access of goods and services?
    b. School and day care closures?
    c. Reduced staffing?
    d. Restrictions in movement?

> Annex D, Continuity of Operations/Continuity of Government, "DoD Implementation Plan for Pandemic Influenza," August 2006 provides guidance on continuing DoD mission-essential functions and services. Elements of a viable continuity of operations plan (COOP) include among other elements: identification of essential functions; pre-established delegations of authority; orders of succession; alternate operating facilities; the identification, protection, and availability of vital records and databases; and employee issues.

6. If active duty personnel are ordered sequestered to base, where will they be housed and do you have the resources to support them? How will care for dependent children living off base be provided?

7. For installations that serve as a basic training center, how will your installation handle accession and training of recruits if NPI (e.g., adult social distancing measures) are implemented?

Force Health Protection Conference
Pandemic Influenza Tabletop Exercise

Scenario #3

Topic: Coordination of Military-Civilian Response

Dates: 31 January – 18 February 2009

Events:

- By mid-February, essentially all counties in the National Capital Region are reporting heavy pandemic influenza activity. CDC has tabulated over 500 cases of H7N3 influenza in Northern Virginia.

- Fort Myer attempts to coordinate with Arlington County Health Department for reporting and management of influenza cases, particularly those DoD beneficiaries and civilian contractors living on the economy. However, due to the overwhelming deluge of media requests and calls from concerned individuals, the telephones are overloaded.

- As cases mount in the National Capital Region, demand spikes for antiviral drugs. Internet and cable media outlets fan rumors in the National Capital Region that politicians and military leaders are receiving far higher priority than the "average citizen" in the face of limited supplies.

- Similarly, conspiracy theories emerge on various blogs that military researchers have already developed a working H7N3 vaccine, but that the vaccine's existence has not yet been disclosed to the general public due to concerns for a "run on limited supplies".

- The Fort Myer emergency notification system (Public Address System; Blast FAX; Channel 3 – a local television station and other local media) is used to inform the community at Fort Myer and its adjacent civilian community of the status of the pandemic, individual protective measures, and actions taken to mitigate the pandemic. The Fort Myer Public Affairs Officer consults with its counterparts at the Arlington County Health Department in responding to media queries and to ensure consistency of messages.

- On February 18, the Fort Myer Installation Commander authorizes DoD active duty forces to provide support to local civil authorities. Consequently, troops begin managing traffic control points, patrolling shopping centers to prevent looting, transporting patients, and delivering food to patients placed in home isolation. In addition, they augment security forces at various Points of Distribution (PODs) for assets from the Strategic National Stockpile (SNS).

Active duty soldier assists civilian authorities with transport of supplies

Questions for Discussion

1. How has your installation coordinated with state and local civilian public health to ensure local DoD access to antiviral drugs from the Strategic National Stockpile?

> CONUS MTFs will receive some antiviral medications through the SNS for use in the general beneficiary population per the interagency agreement between the Department of Health and Human Services and the DoD, *Support of Contingency Medical Material Requirements*, dated 5 May 2005. Antiviral therapy for the general beneficiary population should be comparable to that of the local civilian population. PHEOs should coordinate with both state and local public health authorities to ensure that this process is anticipated (*Policy for Release of the Department of Defense Antiviral Stockpile During an Influenza Pandemic*, 10 August 2007).

2. What specific support does your installation anticipate being asked to provide to civilian authorities? How equipped are you for these anticipated tasks?

> The *Department of Defense Implementation Plan for Pandemic Influenza*, August 2006 identifies “installation support to civilian agencies” as one of 19 critical planning categories. However, during an influenza pandemic, DoD’s capability to protect the Nation and conduct civil support operations will be severely limited. Protecting the Nation will remain the first priority. Providing support to civil authorities is a secondary priority and will be provided within available capabilities (USNORTHCOM CONPLAN 3591, 17 December 2007).
>
> The Posse Comitatus Act and DoDD 5525.5 prohibit the use of DoD forces for direct law enforcement unless an exception to it exists. DoD lacks legal authority to restrict the movement of civilians in the civilian community. DoD forces cannot enforce isolation, quarantine and containment operations or otherwise enforce the law during civil unrest situations unless the President of the United States asserts his authorities under the Constitution, and directs DoD employment in accordance with existing law and regulations (USNORTHCOM CONPLAN 3591, 17 December 2007).

3. How will your installation ensure coordination and consistency of risk communication messaging with the civilian sector? How will your installation manage information in the face of potential rumors or other misconceptions among installation personnel, families and members of the general public?

4. What relationships has your installation forged to date with the civilian community for pandemic influenza planning and response? Are there additional civilian agencies/institutions with which your installation has not yet engaged in planning efforts? If so, which ones, and how might these relationships be established?

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Pandemic Influenza Tabletop Exercise

Conclusion

The initial outbreak of the pandemic upon the installation and surrounding community lasts eight weeks (until the last week of March 2009). During this period, 20 percent of the installation's military and civilian personnel become ill, as do 40 percent of their children. Due to illness and other factors, including childcare, there is a 40 percent rate of workforce absenteeism at the installation. Approximately half of those who become ill seek outpatient medical care. This wave of the pandemic results in the deaths of two percent of installation personnel and family members. A second pandemic wave, lasting three months, hits the installation 10 weeks after the termination of the initial outbreak wave (mid-June 2009). This second wave exerts similar rates of illness, absenteeism, and mortality upon the installation as the first.

During these successive pandemic waves, a pandemic vaccine is not yet available due to development and supply limitations. Antiviral medications are in limited supply and must be triaged according to existing DoD protocols.

Extended school closures and disruption of installation functioning remain significant ongoing challenges. The multiple waves of the pandemic also exert a significant toll on the mental health of installation employees and their families, with increased rates of anxiety and depression observed. Elevated rates of post-traumatic stress disorder can be expected in the longer term aftermath of the pandemic.

Nationally, the pandemic of 2009-2010 results in 9.9 million hospitalizations, and 1.9 million deaths among the U.S. population of approximately 300 million. Rates of hospitalizations and deaths at the installation are roughly proportionate to those of the U.S. population as a whole.

In the aftermath of the pandemic, the installation must address longer-term recovery phase challenges, including economic, functional, and psychosocial impacts on its community.

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Pandemic Influenza Tabletop Exercise

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Appendix 1. Breakout Group Due Out

Sustain: Activities to continue

1.

2.

3.

Quick Fix: Gaps to address within 6 months

1.

2.

3.

Improve: Gaps to address long term

1.

2.

3.