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USNORTHCOM BRANCH PLAN 3560
PANDEMIC INFLUENZA AND INFECTIOUS DISEASE RESPONSE

References: See Annex AA

1. Situation.

a. General. The causative agents of biological incidents are microorganisms (or toxins produced or derived from them) which causes disease in humans, plants or animals. They can be grouped into subcategories of pathogens and toxins. Pathogens can be viral, bacterial, rickettsia, or parasitic and toxins are essentially chemical poisons produced by or extracted from living organism such as bacteria, fungi, or animals. Each type poses unique response and recovery challenges. While most causative agents are naturally occurring, their development for deliberate use and potential for accidental release are also concerns for incident.

(1) A catastrophic biological incident could threaten the Nation's human, animal, plant, environmental, and economic health, as well as America's national security. Such an event would demand a rapid and effective response in order to minimize loss of life and other adverse consequences associated with the incident and to thwart ongoing threats and follow-on attacks in the case of suspected criminal activity or terrorism. The potential for a large biological incident to impact the United States is real.

(a) Scenarios and response plans should consider multiple events with scalable response requirements from a local/regional event to a more widely distributed catastrophic event.

(b) Unique or novel pathogens are likely to defy conventional diagnostic and treatment tools which can result in rapid spread throughout the world, posing risk to national security.

(c) Novel contagious pathogens capable of human-to-human transmission via aerosol with high virulence for which no MCM exists may present the greatest challenge to response and recovery.

(d) Environmental shifts, disasters or other events can change disease patterns, raising the risk of a biological incident. Diseases can change; minor

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and sudden genetic shifts can transform existing pathogens, making routine outbreaks a source for potentially higher morbidity and/or mortality.

(e) Widespread and improper use of antibiotic, anti-viral, anti-malarial treatments or other medical countermeasures (MCM) are accelerating the emergence of drug-resistant pathogens that are unresponsive to available pharmaceutical interventions.

(f) Biological threats will continue to evolve through natural agent mutation, zoonotic spillover, amplification, spread of diseases, and intentional engineering.

(g) Complex transmission pathways, where a virulent pathogen moves between human and animal communities, require a high level of collaboration and coordination.

(2) The deliberate employment of biologicals as a weapon does exist. Both state and non-state actors have expressed interest. The response to the 2001 anthrax attacks in the United States demonstrated the difficulty of responding to a deliberate biological incident and reinforced the need for seamless interagency planning in advance of any deliberate incident.

(3) Unlike chemical and radiological hazards, biological incidents may take days to months to develop, and with certain causative bacteria and viruses may continue to spread from person-to-person. Also, there are limited detection/warning capabilities for biologicals which means that an outbreak/attack can go unrecognized and continue to spread before a clinical diagnosis is made. This will be exacerbated if there are limited or no assays by which to identify the organism and if the symptoms mimic naturally occurring endemic outbreaks (e.g., seasonal flu).

(4) Planning and preparedness for a biological incident requires unique considerations such as MCM. Roles and responsibilities of the public health and medical community and the emergency management community will intersect and need to be integrated with the operations community for mission assurance.

(5) A serious biological incident may diminish the capacity and ability of response entities to respond to the emergency. In addition, the risks to first responders and receivers posed by certain pathogens are high. The recovery from a biological incident may span months or even years based on the nature of the biological and its ability to transmit.

(6) Coordinated messaging and information that adheres to principles of risk communication, even in areas unaffected by the incident, are crucial to

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mitigating the impact of the incident and reducing panic and fear that might be associated with the event. Federal communications should include integrated web-based, telephonic, and graphic communications options. CDC will coordinate with key state governments to build a graphic interface designed to show outbreak cases, type of transmission, and risk assessment for future transmission with considered application of those factors to adjust overseas travel warnings. USNORTHCOM, should ensure its communications are coordinated with appropriate DOD elements (i.e., public affairs, OSD HA, DHA, etc) and consistent with other Federal government messaging. Early on in a response, consideration for a local outbreak or outbreaks need to factor in DOD installations working directly with their local civilian public health counterparts to develop risk communication messages.

b. Scope. This Branch Plan, Pandemic Influenza and Infectious Disease (PI&ID) Response to USNORTHCOM CONPLAN 3500-17, DSCA Response, provides the overarching planning guidance for USNORTHCOM response operations to an operationally significant infectious disease outbreak. This may encompass a spectrum ranging from a localized epidemic (outbreak likely to remain restricted to a limited geographical area – local or state level) to a pandemic (high potential for rapid continuous and global intercontinental spread). It is intended to address biological pathogens that adversely impact human health and threatens impact mission assurance due to adverse health effects to personnel, the US population, and/or impacts on freedom of movement. With the potential to overwhelm state and local resources, the lead federal agency (LFA), in this case the Department of Health and Human Services (HHS), deems that interagency support is or will be required. This Branch Plan supersedes and replaces USNORTHCOM CONPLAN 3591-09, Response to Pandemic Influenza, which focused singularly on pandemic (novel) influenza. This plan is developed in accordance with (IAW) the revised Department of Defense Global Campaign Plan for Pandemic Influenza and Infectious Disease (DOD GCP-PI&ID-3551-13), 15 October 2013 and incorporates insights from several recent outbreaks including the 2009 H1N1 Pandemic Influenza, 2012 Middle Eastern Respiratory Syndrome Coronavirus (MERS-CoV), 2013 H7N9 Avian Influenza, 2014 Ebola Virus Disease (EVD), and 2015 Zika Virus outbreaks.

c. Background. The potential impact of disease outbreaks on military operations is significant. There have been four influenza pandemics in recent history: 1918, 1957, 1968, and 2009. In the 1918 "Spanish Flu" pandemic, approximately one-third of the U.S. population was infected and 675,000 Americans died. Military fatalities from the Spanish Flu exceeded the total number of combat related fatalities from World War I (WWI). It is estimated the 1918 pandemic killed 2 percent of the world's population; the average life expectancy was reduced by 13 years. Influenza pandemics in 1957 ("Asian Flu") and 1968 ("Hong Kong Flu") killed tens of thousands of Americans and

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millions across the world. While the 2009 H1N1 pandemic was generally considered to be mild with approximately 60.8 million cases, over 274,000 related hospitalizations, and 12,469 deaths, it posed substantial challenges to theater security cooperation, forward-basing, and freedom of movement.

(1) Additionally, at least thirty emerging infectious diseases including Ebola Virus Disease (EVD), Severe Acute Respiratory Syndrome (SARS), H5N1 Avian Influenza (AI) and Nipah viruses have been discovered in the last thirty years. Throughout a PI&ID outbreak, US military forces must remain dominant across the full spectrum of military operations, preserving combat capabilities in order to engage adversaries around the world.

(2) In March of 2014, EVD was confirmed in the West African Nation of Guinea. While endemic only to this part of the world, the outbreak would eventually spread to 9 additional countries resulting in over 29,000 cases with 12,000 deaths in 20 months. In the US, it resulted in a non-Stafford act public health emergency.

(3) During recent outbreak responses, several different operational coordination mechanisms were utilized by the Federal government. Some operational or policy implementation matters were handled through the Presidential Policy Directive (PPD) 1; National Security Council System, others were coordinated with relevant stakeholders on an ad hoc basis, and still others were addressed by departments and agencies working largely on their own. This will likely be the norm in the future and will require flexibility on the part of USNORTHCOM during outbreak crisis action planning to adjust and engage with USG partners for coordination.

d. Disease of Operational Significance. For purposes of this plan, a disease of operational significance is an infectious disease (natural, accidental, or deliberate) likely to significantly impact the ability of the DOD to maintain mission assurance or result in significant increases in requests for DOD assistance. A disease of operational significance may create an environmental and global disaster (pandemic) with the potential of incapacitating upwards of 40% of the overall workforce. Consideration of scalable affects to the DOD workforce need to be evaluated in 5% increments from 5-40% to understand impacts from different infection rates of biologicals and for mission assurance and force health protection purposes. Similarly, efforts should be made to understand how impacts of varying levels of absenteeism would impact essential services. Beyond its primary negative effects, a disease of operational significance will have secondary and tertiary effects which will significantly threaten economic, political, and social stability of nations and regions.

(1) Characteristics of a disease of operational significance may include one of more of the following: new (novel) to humans; infects humans causing

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serious morbidity (illness) and mortality (death); easily transmissible among humans; able to spread globally (epidemic or pandemic) in a short period; severe enough (morbidity and mortality) to cause significant absenteeism (single parent, impact the family unit); limited or no natural protection or available MCM (force health protection).

(2) A disease of operational significance may impact USNORTHCOM's operating environment for up to 24 months. Impacts may include reduced access and Freedom of Maneuver (domestically and internationally) and reduced support from United States Government (USG)/Private Sector/other nations.

(3) The disease may occur in humans, animals, or plants.

(4) Existing health care capacities (ability to prevent, treat, and manage illness and the preservation of mental and physical well-being through services of medical and allied health) to respond to a disease outbreak will vary based on the type of disease e.g., greater capacity for non-sustained/low-level endemic diseases and lesser capacity for regional/pandemic diseases.

e. Policy and Planning Guidance. Also see base plan.

(1) Unified Command Plan (UCP). States that CDRUSNORTHCOM is responsible for synchronizing planning for DOD efforts in support of the U.S. Government response to PI&ID, and will do so in coordination with other combatant commands, the Services, and, as directed, appropriate U.S. Government agencies.

(2) Guidance for the Employment of the Force (GEF). Domestic civil authorities are adequately supported in preparing for, preventing, and mitigating, and responding to the consequences of catastrophic events (includes pandemic).

(3) Joint Strategic Capabilities Plan (JSCP). Directs GCCs to develop plans to mitigate and respond to the effects of PI&ID with their respective AORs. Also, directs coordination with relevant USG, NCO, and UN partners as appropriate.

(4) DOD Global Campaign Plan (GCP) for Pandemic Influenza and Infectious Disease (PI&ID)-3551-13 (DOD GCP-PI&ID-3551-13). Directs DOD departments, components, GCCs, and the military services to plan for supporting civil authorities and respond to an outbreak of an operationally significant disease (by definition includes pandemic disease). Ensures that DOD: supports USG-wide planning for PI&ID; is postured to support USG efforts to mitigate the effects of PI&ID to protect the nation's welfare; and is

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planning will be coordinated with the primary Federal agencies responsible for coordination with relevant domestic and international organizations. Planning should involve other USG departments and agencies, in particular for the GCCs; DOS, USAID, and HHS for foreign operations; and DHS, FEMA, USDA, HHS, and CDC for domestic operations, and account for the integration of USG and NGO efforts within each command's AOR. DOD's top priority: protection of U.S. forces and associated resources necessary to maintain readiness and conduct assigned missions in a PI&ID environment and continue performance of DOD's National Essential Functions.

(5) National Strategy for Pandemic Influenza. Guides national preparedness and response to an influenza pandemic, with the intent of (1) stopping, slowing or otherwise limiting the spread of a pandemic to the United States; (2) limiting the domestic spread of a pandemic, and mitigating disease, suffering and death; and (3) sustaining infrastructure and mitigating impact to the economy and the functioning of society.

(6) National Strategy for Pandemic Influenza Implementation Plan. Clarifies the roles and responsibilities of governmental and non-governmental entities, including Federal, State, local, and tribal authorities and regional, national, and international stakeholders, and provides preparedness guidance for all segments of society.

(7) DOD Implementation Plan for PI. Sets forth DOD guidance and addresses key policy issues for pandemic influenza planning. Guidance enables Combatant Commanders, Military Departments, and DOD agencies to develop plans to prepare for, detect, respond to, and contain the effects of a pandemic on military forces, DOD civilians, DOD contractors, dependents, and beneficiaries. Additionally, directs planning to address the provision of DOD assistance to civil authorities, both foreign and domestic, and to address considerations for key security concerns, such as humanitarian relief and stabilization operations that may arise as a result of a pandemic.

(8) National Strategy for Countering Biological Threats. Targeted to reduce biological threats by: (1) improving global access to the life sciences to combat infectious disease regardless of its cause; (2) establishing and reinforcing norms against the misuse of the life sciences; and (3) instituting a suite of coordinated activities that collectively will help influence, identify, inhibit, and/or interdict those who seek to misuse the life sciences. It complements existing policies, plans, and preparations to advance the U.S. Government's (USG) ability to respond to public health crises of natural, accidental, or deliberate origin.

(9) DOD Implementation Plan to the NSCBT. Outlines DOD roles and contributions to the National Strategy for Countering Biological Threats with

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three overarching areas of emphasis. First, to identify the baseline of activity that is already being done. Second, identify the gaps (authorities allowing additional efforts within existing resources) that exist. Third, the institutionalization of the effort across the DOD. USNORTHCOM and USSTRATCOM both play a role in achieving the objectives and sub-objectives outlined in the NSCBT due to their role as global synchronizers for PI&ID and Combating Weapon of Mass Destruction (CWMD), respectively. Neither USSTRATCOM nor USNORTHCOM is the lead for these objectives, but each command plans activities in support of the strategy.

(10) National Strategy for Biosurveillance. The Strategy's expressed goal is to achieve "a well-integrated national bio-surveillance enterprise that saves lives by providing essential information for better decision making at all levels." Core functions are to (1) scan and discern the environment, (2) identify and integrate essential information, (3) alert and inform decision makers, and (4) forecast and advise impacts. It sets forth the guiding principles, core functions and crosscutting enablers to implement a foundation for U.S. biosurveillance activities to enhance the nation's ability to detect, track, investigate and navigate incidents affecting human health.

(11) Department of Defense Mission Assurance Strategy. The strategic framework for mission assurance across DOD is organized along four pillars: (1) identify and prioritize critical missions, functions, and supporting assets, (2) develop and implement a comprehensive and integrated mission assurance risk management framework, (3) use risk-informed decision making to optimize risk management solutions, and (4) partnering to reduce risk – a shared responsibility.

f. Supporting Plans. USNORTHCOM addresses PI&ID strategic and operational requirements through the following series of connected plans:

(1) The USNORTHCOM Theater Campaign Plan (TCP) directs some of the Phase 0 operations, actions, and activities (OAAs) that are required to prepare for a PI&ID response and to support civil authorities in the Homeland. This includes building the PI&ID response capacity of both DOD and Allies and Partners.

(2) USNORTHCOM PI&ID Response branch plan directs the OAAs required to execute a Phase 1-5 PI&ID response. As described below, PI&ID Response branch plan aims to maintain mission assurance and provide Defense Support to Civil Authorities (DSCA) and/or Foreign Disaster Relief (FDR) as requested/directed.

(3) PI&ID DSCA response will be executed as a branch plan IAW USNORTHCOM CONPLAN 3500 DSCA Response (reference xx) and partner

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316 nation response will be executed through this branch and IAW CONPLAN 3729,
317 International Disaster Response (reference xx).

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319 (4) Should an operationally significant disease outbreak at any time be
320 determined as attributable, then the appropriate classified contingency
321 operation(s) described in Appendix 2, Combatting Weapons of Mass
322 Destruction (CWMD), to Annex C of the TCP may also be executed. Appendix 2
323 CWMD to TCP outlines the CONPLANS that direct the operations, actions, and
324 activities required to support civil authorities in preventing and responding to
325 the use of WMD in the Homeland.

326
327 (5) 3407 CBRN Prevent Plan supports USG law enforcement agencies in
328 preventing WMD (to include biologicals) entry into the US and search for WMD
329 when cued by intelligence.

330
331 (6) The Biological Incident Annex (BIA) to the Response and Recovery
332 Federal Interagency Operational Plans (FIOPs) includes the structure and
333 criteria for implementing an enhanced national-level operational coordination
334 procedures/mechanisms for a biological event.

335
336 (7) This CONPLAN is effective for planning upon receipt, and for
337 execution when directed.

338
339 g. Area of Concern.

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341 (1) Area of Responsibility (AOR). See Base Plan.

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343 (2) Area of Interest (AOI). USNORTHCOM's AOI includes the entire
344 globe, as operationally significant infectious disease could originate anywhere
345 in the world. USNORTHCOM will work with other Combatant Commanders,
346 Services, and Agencies, when a potential operationally significant infectious
347 disease is detected within the USNORTHCOM AOI but outside the
348 USNORTHCOM AOR. Within CONUS, USNORTHCOM's AOI extends to those
349 critical non-DOD events and infrastructure where the effects of infectious
350 disease may impact DOD operational capabilities or require DOD support for
351 protection or domestic incident management support.

352
353 (3) Operational Area (OA). See Base Plan.

354
355 (4) Area of Operations (AO). See Base Plan.

356
357 h. Deterrent Options.

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359 (1) Force Health Protection (FHP). Traditional deterrent options against
360 a disease do not directly apply. However, following FHP measures and public

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health guidelines published in FHP guidance and on key DOD and interagency (IA) websites (see examples at figure 1), can provide some deterrent/mitigation options. The FHP measures outlined in the DOD Global Campaign Plan (GCP) for PI&ID-3551-13 provide a unifying, synchronizing approach to preparedness, response, and recovery from an installation to GCC/Global perspective. Each level of command will utilize these FHP measures commensurate with baseline guidance (in the USNORTHCOM AOR by Service and/or USNORTHCOM) and the local situation (i.e., impacted area(s)). Some general deterrent options would include: annual/seasonal flu shots, washing hands frequently, cough etiquette, social distancing, etc.

(2) Diplomatic Flexible Deterrent Options. USG works with the Centers for Disease Control and Prevention (CDC), World Health Organization (WHO), the International Partnership on Avian and Pandemic Influenza, and through diplomatic contacts to strengthen international mechanisms to respond to an outbreak of influenza with pandemic potential. This includes support to WHO's doctrine of international response and containment published in 2009, which lays out the responsibilities of the international community and countries with human outbreaks, and includes provisions to develop and deploy critical resources needed to contain the virus.

(3) Military Flexible Deterrent Options. USNORTHCOM conducts targeted Theater Security Cooperation (TSC) and Building Partner Capacity (BPC) activities in coordination with other USG agencies to bolster and integrate Partner Nation (PN) capacity to respond to PI&ID, and to improve the interoperability and effectiveness of civilian and designated military critical responders. TSC and BPC activities in USNORTHCOM's AOR include Global Health Engagement activities such as medical readiness, training, and exercises. Further, TSC and BPC activities are designed to assure success by shaping perceptions and influencing behavior of both adversaries and allies. The prevention of the proliferation of disease causing agents which could result in accidental (e.g. misuse of life sciences) or deliberate release falls under the responsibility of USSTRATCOM's GCP-CWMD and/or CWMD and/ or Counterterrorism planning efforts for deterrent options.

i. Enemy/Threat. The most likely and significant threat (enemy) is a novel respiratory disease, particularly a novel influenza disease. A disease of operational significance (natural, accidental, or deliberate) will have rapid rates of transmission that will result in debilitating illness in military forces at levels significant enough to degrade combat readiness and effectiveness across multiple GCCs. An outbreak in a single community can quickly evolve into a multinational health crisis that causes millions to suffer, as well as spark major disruption to every facet of society. Disease characteristics may include high transmissibility or severity, and high likelihood of impact on force health protection due to limited or no natural protection or MCM. Additionally, it will

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significantly impact domestic civil authorities and partner nations to the degree that may result in significant requests for DOD support and/or secondary and tertiary effects that may require U.S. involvement. Consideration needs to be made in the planning phases to understand and plan for multiple scenarios where local, regional, and global impacts are likely to best prepare installations, the Services, and USNORTHCOM for preparedness and response activities and ensure a common operating picture. These scenarios include MERS-CoV (current transmission risks) for a local response, plague for a regional response, and a novel influenza for a global response (understanding that all of these events will begin at the local level).

(1) Enemy Center of Gravity (COG). The center of gravity of a pathogen is its ability to become operationally significant and spread from the point of emergence (i.e. diseases that have historically been operationally significant and those pathogens such as H5N1 avian influenza that may become operationally significant). An operationally significant disease can degrade readiness and effectiveness of the force through illness and related absenteeism, inhibit freedom of action through related restrictions (e.g., ports of debarkation/embarkation), and generate requests to assist partners with cascading impacts on critical infrastructure/key resources domestically and internationally.

(a) Critical Capabilities. An infectious disease with operationally significant characteristics can remain, in and of itself, relatively insignificant unless conditions exist to foster its contact with hosts and propagate spread. These conditions come from population and host, and environmental factors. Population and host factors that enable diseases are immunologically susceptible populations (little to no immunity), robust population mixing (developed social contact and mobility networks), availability of local, regional and global travel hubs/ports (e.g., international airport near point of emergence), poor personal hygiene practices, and limited access to health care or poor health care (limits ability to detect, diagnose and treat). Environmental conditions that enable diseases are crowded living/work conditions, vector/reservoir/ host interface (high exposure due to lack of preventive measures, location), poor sanitation (increases exposure opportunity), climate conducive to vector transmission, and high human/ animal interface.

(b) Critical Requirements. A crucial enabler for an infectious disease to become operationally significant, which differentiates it from other infectious diseases, is its characteristics. Characteristics more likely to be found in operationally significant diseases include: moderate/high pathogenicity /virulence, effective route(s) of transmission (airborne, waterborne/food-borne, vector-borne), effective reservoirs (e.g., animal, human, vector in which the pathogen lives and allows for transmission directly /indirectly), environmentally robust (long survival outside of a host), long

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shedding and contagious period (favors transmission), and adaptability and resistance to treatment/ countermeasures.

(c) Critical Vulnerabilities. The infectious disease is susceptible to pharmaceutical interventions that can immunologically and/ or prophylactically protect a host pre-exposure and/ or mitigate the effects of the disease post exposure. The disease is susceptible to non-pharmaceutical intervention measures such as disinfection, social distancing, hygiene practices, vector control, culling, and personal protective equipment (PPE) , which can hinder its ability to spread.

(2) National Strategic Threats. An operationally significant disease has serious national security implications for the United States. These national security implications may include severe economic, political, and social consequences both domestically and internationally. There will be competing interests for resources globally. Competition for, and scarcity of resources will include MCM (e.g. vaccines, antimicrobials, and antibody preparations), non-pharmaceutical MCM (e.g. ventilators, devices, personal protective equipment such as face masks and gloves), medical equipment, and logistical support. This will have a significant impact on the availability of the global workforce.

(a) While adversaries will also be susceptible, they may not be impacted in the same manner or at the same time as US and allied forces. The degree to which nations mitigate their own welfare and reintegrate individuals into society will have a considerable impact on those secondary and tertiary effects that pose potential problems to regional security. Key security concerns that could arise from the political, social, and economic instabilities include opportunistic aggression, opportunities for violent extremists to acquire weapons of mass destruction (WMD), reduced partner capacity during and after an outbreak, instability resulting from a humanitarian disaster, and decreased distribution and production of essential commodities.

(b) The prevalence of significant disease coupled with instability may result in reduced security capabilities, providing an opportunity for international military conflict, increased terrorist activity, internal unrest, political and/or economic collapse, humanitarian crises, and social change.

(3) Environmental Threats. A disease of operational significance may impact USNORTHCOM's operating environment for up to 24 months. Impacts may include reduced access and Freedom of Maneuver (domestically and internationally) and reduced support from United States Government (USG)/Private Sector/other nations.

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495 (4) Accidents/Misuse. The on-going evolution in life sciences
496 presents an inherent risk of misuse (or accidental release) of agents that have
497 similar characteristics as a naturally occurring PI&ID.
498

499 (5) Biological Hazard Binning Concept (BHBC). Currently, the DOD
500 and other US government agencies address biological hazards to the US and
501 global population based on individual biological hazards or diseases. This
502 approach requires planning, training, FHP guidance, and PPE to be focused on
503 individual biological hazards. To facilitate this approach for guidance and
504 planning purposes, USNORTHCOM groups biological hazards that will better
505 streamline and synchronize FHP and, possibly treatment to optimize DOD
506 asseets (personnel, capabilities, facilities, PPE, etc). Grouping biological
507 hazards within "bins" based on exposure / transmission routes and other
508 factors (availability of MCM/treatments, vaccines, etc) allows for a more
509 simplified planning and response approach, a more streamlined training
510 doctrine, more effective FHP guidance, and appropriate PPE recommendations.
511 Additionally, addressing biological hazards utilizing a BHBC approach would
512 be consistent with the current planning, training, and PPE approach for
513 chemical hazards CBRNE training models (i.e., MOPP levels).
514

515 (a) Framework. BHBC is broken into three main categories:
516 Contagious, Non-Contagious, and Plant/Animal. Under Contagious, there are 3
517 sub-categories: Contact, Respiratory, and Ingested. Under Non-Contagious,
518 there are 4 sub-categories: Contact, Respiratory, Ingested, and Vector Borne
519 (Table 1). See Table 2 for examples of disease categorized under BHBC.
520

521 1. The Contagious category contains biological hazards that
522 have sustainable person to person transmission.
523

524 2. The Non-contagious category contains biological hazards
525 where transmission is not sustainable from person to person.
526

527 3. The Plant/Animal category is for non-human diseases of
528 operational significance (e.g., may hinder mission assurance or result in a
529 request for DOD support to civil authorities).
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Biological Hazard Binning Concept (BHBC)			
Category	Contagious	Non-Contagious	Plant/Animal
Sub-Categories	Contact	Contact	
	Respiratory	Respiratory	
	Ingested	Ingested	
		Vector Borne	

Table 1, Biological Hazard Binning Concept

	Non-Contagious				Contagious			Others
Routes of Entry	Contact	Respiratory	Ingested	Vector Borne	Contact	Respiratory	Ingested	Plant/ Animal
Diseases	Poison Ivy	<u>Legionellosis</u>	Bacillus Ricin	Zika Dengue Malaria	Viral Hemorrhagic Fever	Novel Influenza SARS/ MERS-COV	Salmonella E. Coli <u>Shigella</u>	Avian Influenza Foot/ Mouth (FMD)
	Anthrax							
	<u>Glanders</u>				Smallpox Plague			

Table 2, Examples. Note: It is possible for a biological hazard to be in more than one sub-category if there is more than one route of transmission/exposure. (i.e. Anthrax, Glanders, etc.)

(b) **Planning.** BHBC will simplify planning needs by reducing the number of plans necessary to respond to different biological hazards. Importantly, planning based on the BHBC will cover emerging biological hazards. BHBC based plans should be able to provide the contextual backdrop to discussions with senior leaders about force response capabilities and force health protection protocols.

(c) **FHP.** BHBC allows for the development of a more streamlined CONOPS focused on several bins and response to the route of transmission vice countless specific individual biological hazards. Simplified training bins would allow for better retention and sustainability of training. Through better recall of the necessary steps for FHP and a decrease in potential confusion between specific responses for individual biological hazards, frontline units will be better prepared to respond in a bio-challenged environment, even if the exact biohazard is not immediately known. Specifics to a particular disease, when available, will help refine FHP.

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(d) PPE Framework (Appendix XX). BHBC, due to its nature of grouping biological hazards, provides a concept of response that can be standardized based on route of transmission of the biological hazard. The standardization afforded to the BHBC is ideal for the development of standardized PPE logistical packages that could be tiered based on the bin. This standardized PPE logistical packaging will reduce confusion, ordering errors, and unnecessary redundancy while at the same time improving efficiency of ordering, storage, movement and utilization. Utilizing BHBC would provide a tiered approach to PPE similar to MOPP levels for other portions of CBRNE training and familiarization.

j. Friendly. This branch plan, as part of CONPLAN 3500, provides concepts of operation for support to and coordination with the spectrum of potential response partners including Federal, State, local, tribal, territorial, and private sector entities. Several key organizations are listed below. A more comprehensive list is found under Appendix 4 to Annex A.

(1) Friendly Centers of Gravity.

(a) Strategic. USNORTHCOM's COG is its people (active duty, reserve, DOD civilians, DOD contractors, dependents, and beneficiaries). A significant global outbreak will degrade USNORTHCOM's ability to conduct assigned missions in the AOR and potentially cause absenteeism among its personnel within and outside the AOR. Infectious diseases in the military cause lost duty time; increase the burden to the health care system for diagnosis, treatment, and evacuation, and decrease combat readiness.

1. Critical Capability. The CCDR and other decision makers (both military and civilian) must have accurate and timely awareness of the situation across the area of interest (AOI) in order to prepare for and respond to operationally significant outbreaks. Crucial strategic enablers that sustain USNORTHCOM operations in before, during and after an outbreak: informed FHP policy decisions, biosurveillance, interagency global surveillance program coordination, laboratory confirmatory analysis, medical intelligence and reporting requirements (shared situational awareness (SA)); medical capabilities; stockpile of medical supplies; establishment/ identification of infrastructure to evaluate and treat infected persons; and authority to vaccinate and isolate/ quarantine select personnel.

2. Critical Requirement.

a. Global Surveillance Efforts. The World Health Organization (WHO) leads the international effort to detect, identify, and track the spread of pandemic influenza. Their Epidemic and Pandemic Alert and

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Response System (EPR) tie together multiple national and international capabilities, to include: the Global Outbreak Alert and Response Network (GOARN); the WHO's Global Influenza Surveillance and Response System (GISRS); and the U.S. Centers for Disease Control and Prevention (CDC) and the Department of Homeland Security's (DHS) National Biosurveillance Integration Center (NBIC).

b. DOD Surveillance Efforts. DOD sponsored surveillance efforts will be performed by numerous organizations including the DOD Global Emerging Infections Surveillance and Response System (DOD-GEIS), the Services' Public Health Centers, and the Naval Health Research Center (NHRC), as well as each DOD medical facility including shipboard medical facilities.

c. Pandemic Threat Surveillance and Intelligence Network. To be most effective, information and situational awareness must be shared across USG agencies and with international partners. NCMI, the Armed Forces Health Surveillance Branch (AFHSB), and other agencies are tasked with maintaining a network that collects, analyzes, and disseminates surveillance and intelligence information on outbreaks/ epidemics/ pandemics, the effects on populations and nations, and the actions being taken to prepare for and prevent, contain, respond to and recover from those effects. This network must work with other DOD and non-DOD organizations to better define and improve upon the current process for PI&ID surveillance.

3. Critical Vulnerabilities. Lack of communication and synchronization among partners and stakeholders, inability or unwillingness to share information/biosurveillance data, limited detection capabilities, and limited laboratory confirmatory testing. Military forces will be vaccinated/treated as soon as specific vaccine/pharmaceutical MCM becomes available.

(b) Operational. The ability to provide military support to USG domestic and international relief efforts in the AOR.

1. Critical Capability. Collaboration and communication amongst stakeholders, synchronized plans, constant policy updates to FHP measures, adherence of partner nations, the interagency and the DOD, to abide by IHR reporting requirements, shared real-time intelligence and SA, mandatory preventive care measures (including vaccinations), funding and access to MCM, personal hygiene educational campaigns, access to surge medical equipment, and PPE.

a. DOD readiness reporting. DOD global mission accomplishment requires organizations to provide timely reporting using

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existing systems (e.g., Defense Readiness Reporting System (DRRS)) that outline an accurate and timely assessment of the required forces to conduct missions and sustain DoD mission assurance.

b. DoD transportation. DoD global mission accomplishment requires the transportation infrastructure, both military and civilian to support movement of forces, resources and other assets in response to changes in priority despite systemic disruptions associated with an operationally significant disease outbreak environment.

c. Projection of forces. DoD global mission accomplishment requires the ability to properly position the requisite forces with the required numbers, skills, and materiel support within an appropriate C2 structure.

2. Critical Requirement.

a. Medical Threat Intelligence. USNORTHCOM must closely coordinate medical threat intelligence with the interagency (DHS NBIC, CDC, ect), U.S. Embassies and partner nations. Intelligence concerning PI&ID will involve information on locations and severity of outbreaks as well as actions being conducted by nations and organizations concerning PI&ID prevention and containment procedures. N-NC Medical Operations Center and the N-NC/J2 in collaboration with the NCMI, AFHSB, HHS/CDC, and DHS NBIC will be a key provider of both classified and unclassified medical intelligence to CDRUSNORTHCOM and to other designated USNORTHCOM subordinate organizations.

b. Medical Surveillance. Detection and surveillance of PI&ID is critical in determining mutations of the disease, its human-to-human transmissibility, geographic spread of the disease, and the impacts that it will have on affected populations. The front line surveillance source for early indications of virus mutation and human-to-human transmission will be local and international medical organizations or laboratories with operations in the affected nations and USG organizations like CDC, NCMI, AFHSB, and DHS NBIC. A USNORTHCOM Biological Threat Working Group composed of key reps from the N-NC/SG, J2, J5, S&T and the N/J3 must ensure it is closely tied to these front line resources as well as supporting organizations that will perform some of the more in-depth analysis and tracking of disease strains to make critical recommendations to the N2C2 and CDRUSNORTHCOM.

c. Trained, organized, and equipped units. Mission accomplishment requires the ability of units to retain the requisite number of trained personnel with adequate equipment and key classes of supply and/or adequate and responsive logistical support to execute assigned.

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d. Ability to prevent, inhibit or reduce disease agent transmission, mitigate effects of infection and illness, and regenerate and sustain the force. This includes comprehensive medical health care; force health protection (FHP) measures; proactive procurement; responsive, tailored logistic support; continuity of essential services (e.g., electricity, water, telecommunications, etc.); risk communication and public health education, implementation of non-pharmaceutical interventions, and continuity of operations planning.

3. Critical Vulnerability.

a. Deficiencies and vulnerabilities that threaten the friendly operational COG include: lack of USG-PN communication and synchronization among NGO and OGAs and stakeholders, lack of safe and effective vaccines and other MCM, lack of adequate infrastructure, medical equipment and hospital surge capacity, or PPE; inability or unwillingness to share information/biosurveillance data, limited detection capabilities, and limited laboratory confirmatory testing. Additionally, US personnel travel frequently and may become exposed to or transmit disease during the process of travel. Overreliance on rapid-testing kits due to limited laboratory capacity (rapid tests lack the accuracy of laboratory confirmation) may cause errors in disease reporting incidence and diagnostic results accurately. Medical systems may be overwhelmed by a dramatic increase in patient numbers. Staff availability may also be limited as medical personnel become infected.

b. Nefarious elements looking to exploit the unstable environment created by an operationally significant outbreak may adversely impact personnel and/ or operations.

c. Degradation of unit readiness to non-mission capable status due to disease impacts could be caused by the lack of effective vaccines, antibiotics, antivirals, education, and planning.

(2) USNORTHCOM, Components, and Subordinate Units. See Appendix 4 (Friendly Forces) to Annex A (Task Organization). All USNORTHCOM components and subordinate units are subject to participate in PI&ID response operations.

(3) Supporting Commands and Agencies/Departments. See Appendix 4 (Friendly Forces) to Annex A (Task Organization).

(4) Key Interagency Partners. See Appendix 4 to Annex A (Task Organization) for a detailed listing and description. The critical mission partners for PI&ID response are DHHS, CDC, USDA, and FEMA. State and

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local governmental public health agencies have primary responsibility and authority for public health response to biological incidents within their jurisdictions and can implement quarantine and movement restrictions that can vary from federal guidance issued by the Centers for Disease Control and Prevention (CDC).

Incident Type, Location	Lead Federal Authority
Response and Recovery (Consequence management for Human disease):	
a) Naturally occurring, domestic	a) HHS
b) Intentional, domestic	b) HHS
c) Naturally occurring, international*	c) DOS
d) Intentional, international*	d) DOS
Prevention and Protection (Crisis management):	
e) Domestic or foreign origin	e) FBI
Note: DHS/FEMA may be called upon to lead or provide supplemental operational coordination support for the primary authority during complex incidents.	

1. Department of Health and Human Services (HHS). HHS is the U.S. Government's (USG) principal agency for protecting the health of all Americans. The mission of HHS is to enhance the health and well-being of Americans by providing for effective health and human services and by fostering sound, sustained advances in the sciences underlying medicine, public health, and social services. HHS Declaration of Public Health Emergency Section 319 of the Public Health Services Act (PHSA) authorizes the Secretary of HHS to determine that a PHE exists, if the Secretary determines a disease or disorder presents a PHE or that a PHE, including significant outbreaks of infectious diseases or bioterrorist attacks, otherwise exists. This declaration authorizes the Secretary to take appropriate actions consistent with other authorities to respond to the emergency, temporarily suspend or modify certain legal requirements, and expend available funds in the PHE Fund to respond to the PHE. The Secretary has broad authorities to respond to a public health emergency, regardless of whether a formal PHE is declared.

2. U. S. Centers for Disease Control and Prevention (CDC). The CDC is an operational component of HHS that is responsible for the nation's health protection. The CDC's administration, scientists, and staff track diseases, research outbreaks, and respond to emergencies to protect the nation from health, safety, and security threats, both foreign and in the U.S.

3. Food and Drug Administration (FDA). The Food and Drug Administration (FDA) is an agency within the U.S. Department of Health and Human Services responsible for protecting the public health by assuring the safety, effectiveness, quality, and security of human and veterinary drugs,

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vaccines and other biological products, and medical devices. The FDA is also responsible for the safety and security of most of our nation's food supply.

a. FDA Emergency Use Authorization (EUA) authority allows FDA to help strengthen the nation's public health protections against CBRN threats by facilitating the availability and use of MCMs needed during public health emergencies.

b. Under section 564 of the Federal Food, Drug, and Cosmetic Act (FD&C Act), the FDA Commissioner may allow unapproved medical products or unapproved uses of approved medical products to be used in an emergency to diagnose, treat, or prevent serious or life-threatening diseases or conditions caused by CBRN threat agents when there are no adequate, approved, and available alternatives.

4. Department of Homeland Security. The Secretary of DHS is the principal federal official for domestic incident management. The Secretary is responsible for coordinating federal operations within the United States to prepare for, respond to, and recover from terrorist attacks, major disasters, and other emergencies, including biological incidents. DHS provides biosurveillance capabilities to detect an intentional aerosolized biological agent dispersion and to coordinate information sharing with federal partners on health-related threats to humans, animals, and plants. If an incident response progresses such that it requires multiagency participation, DHS will serve as the Incident Coordinator.

5. Federal Emergency Management Agency (FEMA). FEMA is an operational component of DHS that coordinates ESFs/RSFs) and funding support to impacted areas during disasters. For biological incidents, FEMA primarily manages coordinating centers, funding sources, non-medical supply resourcing, and supporting ESFs/RSFs.

6. United States Department of Agriculture (USDA). USDA serves as the USG's primary agency for the security and resilience in the commercial production of food and consequence management of outbreaks and/or attacks that may occur in animals used in the commercial production of food. The USDA, HHS, DHS, and the FBI collaborate through surveillance systems with states and private industries to protect the nation's food supply from terrorist threats and to prepare for and respond to catastrophic disasters.

7. Customs and Border Protection (CBP). For biological incidents suspected or detected inside or at U.S. borders or those individuals that may travel to the United States from abroad, CBP may detain and/or quarantine individuals until medical authorities have been alerted. CBP may deny entry to non-U.S. citizens who are suspected of being infected with a contagious disease.

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813
814 8. Department of State (DOS). As lead coordinating
815 agency for USG response to foreign nation and/or U.S Chief of Mission (COM)
816 requests for support, DOS is responsible for all communication and
817 coordination between the USG and other nations regarding consequence
818 management of a biological incident. DOS coordinates the U.S. support for
819 foreign countries in mitigation, preparedness, and response operations to a
820 biological incident that has the potential to adversely impact the United States
821 or U.S. interests. Additionally, when necessary DOS coordinates requests to
822 foreign countries for support of U.S. citizens located outside of the United
823 States, requesting support from foreign nations where necessary. As the
824 President's representative in a foreign country, the COM is responsible for the
825 security of all USG personnel and their families on official duty abroad and the
826 protection of private U.S. citizens. The COM is supported in security, health,
827 and crisis planning and risk management by consular, diplomatic security,
828 medical, and public affairs professionals and other subject matter experts on
829 the Emergency Action Committee. Through the Emergency Action Plan, DOS
830 and the U.S. Mission maintain formal processes for crisis management and
831 coordination at U.S. diplomatic posts for incidents that affect the Mission or
832 the host country, including biological incidents.
833

834 9. World Health Organization (WHO). World Health
835 Organization can declare a Public Health Emergency of International Concern
836 (PHEIC). A PHEIC is defined by the International Health Regulation (2005) as
837 any extraordinary public health event, whether biological, chemical, or
838 radiological that constitutes a public health risk to other countries through its
839 international spread and impact and potential to require a coordinated
840 international response. All countries notify potential PHEICs that they are
841 aware of to the WHO through their IHR National Focal Points; however, only
842 the Director-General of the WHO can determine whether an event constitutes
843 an actual PHEIC. In accordance with IHR the United States would have 48
844 hours to assess and determine whether a potential PHEIC notification should
845 be sent to the WHO. If the severity or impact of the biological incident poses a
846 significant threat (through international spread) or may require a coordinated
847 international response to contain, the Director-General of the WHO may
848 declare the event a PHEIC.
849

850 (5) Operational Contract Support. See Annex W.
851

852 (6) Multinational Forces. It can be reasonably anticipated that a
853 variety of organizations will either agree to or offer to participate in outbreak
854 response operations. USNORTHCOM forces supporting this plan should be
855 prepared to consider information sharing and coordination in a time sensitive
856 environment.
857

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UNCLASSIFIED//FOR OFFICIAL USE ONLYk. Assumptions.

(1) Full information about biological threats will not be immediately available and will take hours to days (pathogen identification), days to weeks (exposure areas/populations), or months (outbreak and secondary outbreak rates; lethality; susceptibility to countermeasures) to become known or apparent; Decisions will be required with incomplete information.

(2) The cause of a biological incident (e.g., intentional, accidental, or naturally occurring) may not be readily apparent; the possibility the incident was caused by a criminal act will be considered in the response.

(3) An infectious disease incident will include a wave of secondary infections well beyond the region of the incident.

(4) The size, scope, and/or complexity of an outbreak may overwhelm existing state and local capabilities and resources, causing significant strain on the whole community/USG.

(5) There is potential for pathogens to be resistant to existing MCM or for there to be no known MCM. As such, a vaccine or other MCM will not be available for distribution for a minimum of 6-9 month period once the disease is characterized and identified.

(6) Available, but limited MCM may fall short of the required demand due to a variety of factors (e.g., geographical variance in the severity of the outbreak, logistical issues, disruption to pharmaceutical production).

(7) Unique and unapproved or experimental therapies and diagnostic tests may need to be used after appropriate regulatory approval (e.g., Food and Drug Administration (FDA) Emergency Use Authorization (EUA)).

(8) The recall or activation of non-Active Duty personnel who work as first responders and medical specialists in their civilian employment could be counterproductive to a PI&ID response and may not be in the best interest of USNORTHCOM or the nation.

(9) USNORTHCOM will have some warning of PI&ID (disease of operational significance) before significant impacts occur and be able to conduct mitigating measures.

(10) Stockpiled MCM will not be immediately sufficient or entirely effective.

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(11) The Department of State's (DOS) remain/shelter-in-place policy will be followed unless other conditions (e.g., civil disturbance or political instability) force an evacuation. If a remain/shelter-in-place policy is not feasible, USNORTHCOM may be called upon to assist in the transportation of designated non-infected American citizens living abroad if deemed necessary.

(12) Medical facilities and resources (civilian and military) will be overwhelmed during peak periods of outbreak.

(13) USNORTHCOM, under applicable authorities, will be requested to provide some logistical support for international efforts.

(14) An outbreak will last between 6-12 weeks in one location with waves following for a period of 12-24 months.

(15) Countries with degraded medical capability will likely experience decreased stability and security.

(16) Due to the highly infectious nature of influenza and/ or infectious disease, efforts at containment will be only partially effective at preventing infection, but may reduce the speed of disease spread.

(17) Some nations will restrict transit of personnel.

(18) Implementation of COOP planning and COG activities is anticipated depending on the pathogen's impact on the workforce. Prioritization of capabilities will be necessary to balance competing missions and maximize efficiency. Depending on the nature of the disease, absenteeism could be 20-30% (or higher). This will stress primary military functions and missions and also critical civilian functions, which may require DOD support.

(19) Local commercial support (including commodities, services and contracted labor) to U.S. Forces within the AOR (Enduring Locations, Contingency Locations, etc.) will be degraded.

(20) Freedom of movement and freedom of action will be impacted due to localized restrictions undertaken to prevent further spread.

1. Limitations. See Base plan.

(1) Title 10 Army and Air Force military personnel shall not be employed to enforce or execute civil laws as stated in Title 18, Section 1385 (Posse Comitatus Act), (reference x), except as otherwise provided by law.

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(2) National Guard will normally respond in Title 32 or State Active Duty status. Consideration should be given to using a Dual Status Commander (Title 32 and Title 10 authority, see xxxx).

(3) Reserve Component mobilization authority, personnel, and time limitations are defined in Title 10, United States Code (USC.) 12301, 12302, 1203, and 12304 and normally require 30 day notification for mobilizations greater than 30 days. (reference x *Title 10, United States Code (USC), Sections 12301-12304, 12306, Statutes Affecting Reserve Components*)

(4) DOD forces/installations in the JOA will also be affected by the natural or man-made disaster, decreasing response capabilities.

m. Legal Considerations. See Base plan.

(1) The Federal Government has legal authority to prioritize distribution of vaccines and anti-virals (see ref. x, Title 42, USC, Sections 201 et seq., Public Health Services, Sections 264 et seq., Quarantines and Inspections, and Sections 5121 et. seq., Robert T. Stafford Disaster Relief and Emergency Assistance Act (as amended, April 2007).).

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

(3) DODD 6200.04 FHP. This Directive establishes policy and assigns responsibility for implementing FHP measures, on behalf of all military Service members during active and Reserve military Service, encompassing the full spectrum of missions, responsibilities, and actions of the DOD components in establishing, sustaining, restoring, and improving the health of their forces.

(4) Domestic law handbook [information on quarantine]

(5) Management of biologically contaminated human remains (B-CHR)

2. Mission. CDRUSNORTHCOM protects the force against pandemic influenza and operationally significant infectious disease outbreaks in order to execute assigned missions. When directed, USNORTHCOM conducts response operations within designated operational areas (OAs) to support civil authorities in response to an outbreak in order to save lives and minimize human suffering.

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990 3. Execution.
991

992 a. Concept of Operations. The purpose of USNORTHCOM's branch plan is
993 to delineate DOD and CDRUSNORTHCOM policy for the employment of military
994 resources in support of PI&ID preparation and response operations. It assigns
995 responsibilities for carrying out this policy within USNORTHCOM's AOR. This
996 guidance will enable USNORTHCOM and its subordinate commands to develop
997 plans to prepare for an operationally significant outbreak and to mitigate and
998 respond to the effects of the outbreak on USNORTHCOM forces, civilians,
999 contractors, dependents, and beneficiaries.

1000
1001 (1) Commander's Intent.

1002 (a) Purpose. To maintain mission assurance, mitigate the effects of
1003 the disease, and when requested, execute PI&ID related Defense Support of
1004 Civil Authorities (DSCA) and Foreign Disaster Response (FDR) operations in the
1005 USNORTHCOM Area of Responsibility (AOR).

1006 (b) Method. USNORTHCOM's mission and end-state will be
1007 achieved in six phases through the execution of the operations, actions and
1008 activities (OAAs) listed below (see Figure 1). In general terms USNORTHCOM
1009 adopts an active, layered defense with respect to a disease of operational
1010 significance. Our first line of defense consists of Phase 0 – activities aimed at
1011 both the preparation and rehearsal of comprehensive and synchronized plans,
1012 and building internal and international capacity of partner nations and
1013 militaries in coordination with the International Health Community (IHC), and
1014 United States Government (USG) agencies. These activities will mitigate the
1015 risk associated with a significant outbreak and reduce the requirement for
1016 USNORTHCOM support. If an outbreak of operational significance does occur,
1017 USNORTHCOM Phase 1-5 actions balance CDRUSNORTHCOM's efforts
1018 between Mission Assurance, DSCA and FDR lines of effort. USNORTHCOM will
1019 rapidly implement appropriate Force Health Protection (FHP) measures and
1020 PI&ID related education to protect the force, and will posture to rapidly provide
1021 DSCA and FDR as required. Unless otherwise directed by Secretary of Defense
1022 (SecDef) or President of the United States (POTUS), Mission Assurance will take
1023 priority.

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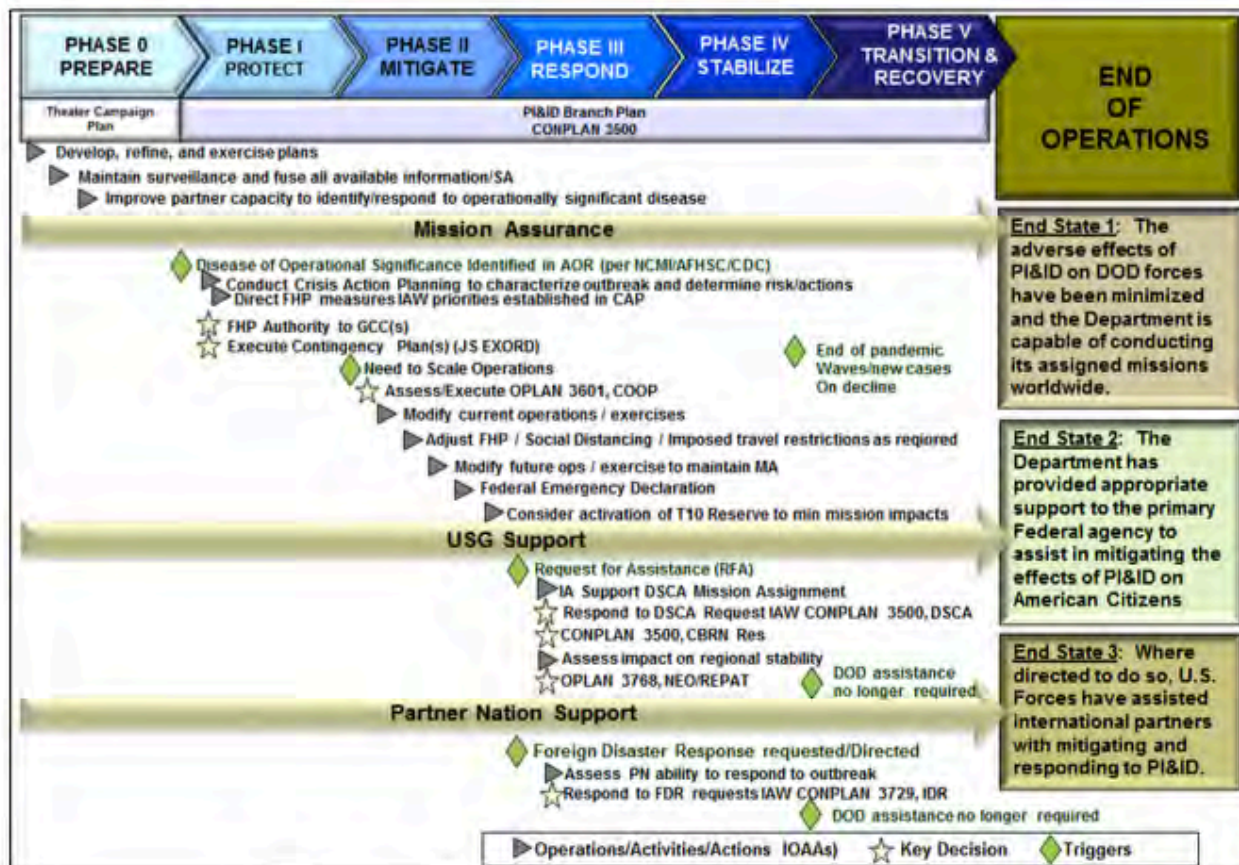


Figure 1, PI&ID Response Concept of Operations

(c) End State. The adverse effects of PI&ID on USNORTHCOM forces have been minimized and USNORTHCOM is capable of conducting its assigned missions. USNORTHCOM has provided adequate support to civil authorities to assist in mitigating the effects of the outbreak, such that further DOD support is no longer required. See Figure 1.a., Objectives/Effects by Phase.

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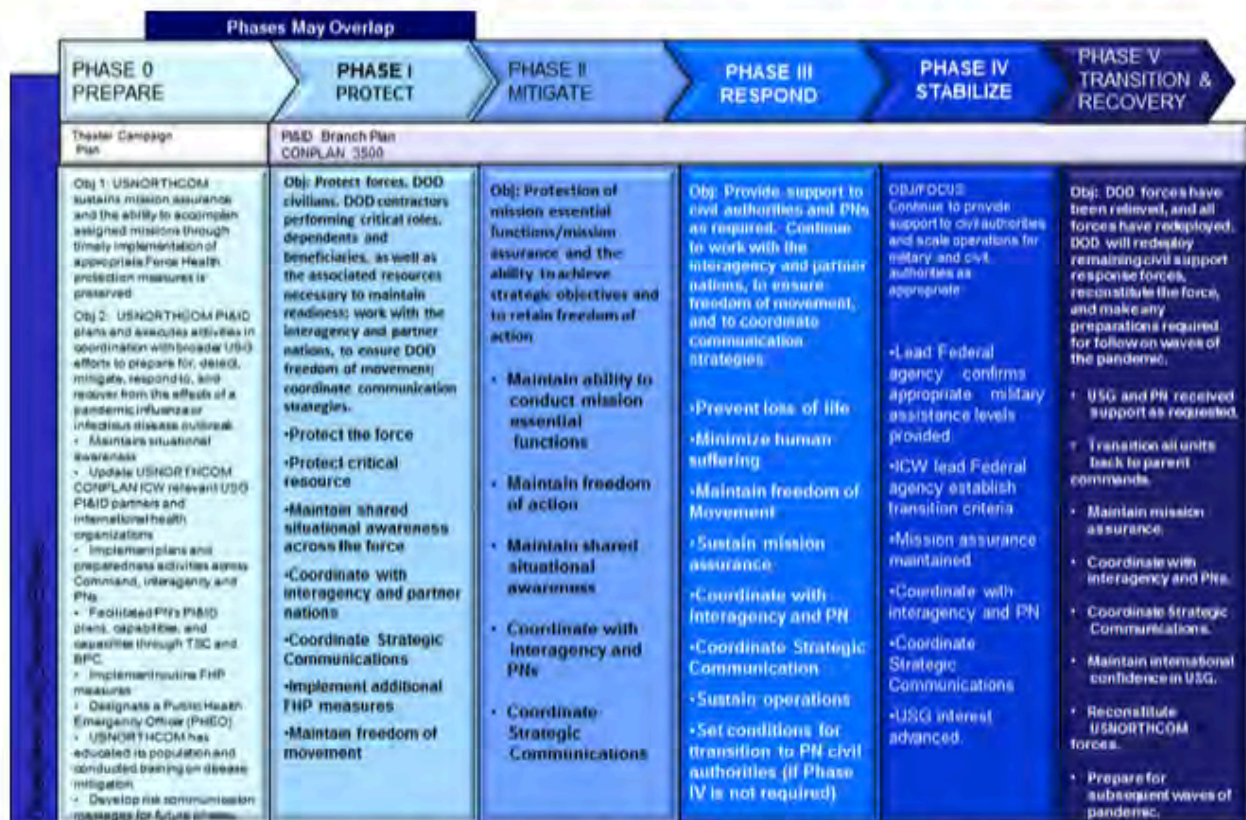
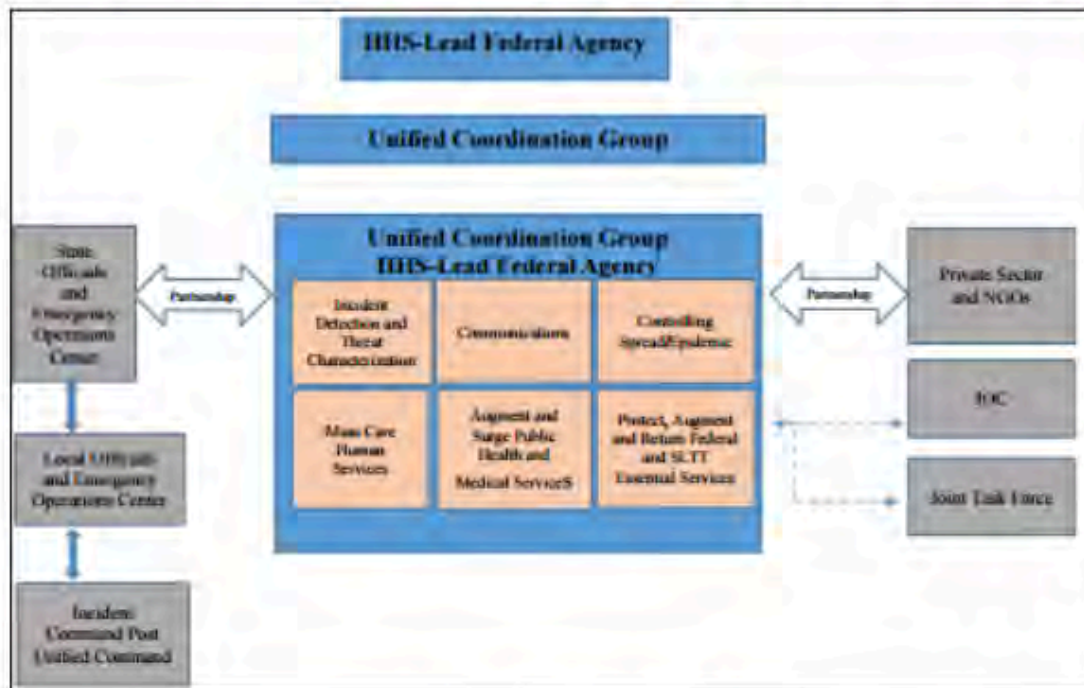


Figure 1.a., PI&ID Response Objectives & Effects by Phase

(2) General. There are multiple ways in which an outbreak can unfold depending on the nature and type of disease (respiratory, contact, etc) and its location(s). As such, response will vary and therefore multiple USG response plans exist (i.e., Biological Incident Annex (BIA) to the Response and Recovery Federal Interagency Operational Plans (FIOP), Interagency Crisis Action Plan for H7N9/MERS-CoV, etc). The USNORTHCOM response must be informed by, and nested with these plans.

(3) Unified Coordination. The purpose of unified coordination is to integrate and synchronize the response and recovery activities of relevant federal departments and agencies. Early and rapid unified coordination of federal government resources is imperative at the outset of a biological incident and can occur along a spectrum of activities. The LFA is responsible for determining the relevant departments and agencies required for participation in unified coordination and the level of unified coordination needed. This may be required independent of any formal declarations. In the early stages of an incident, unified coordination may be as simple as formalized communications with minimal staffing between departments and agencies (e.g., weekly meetings).

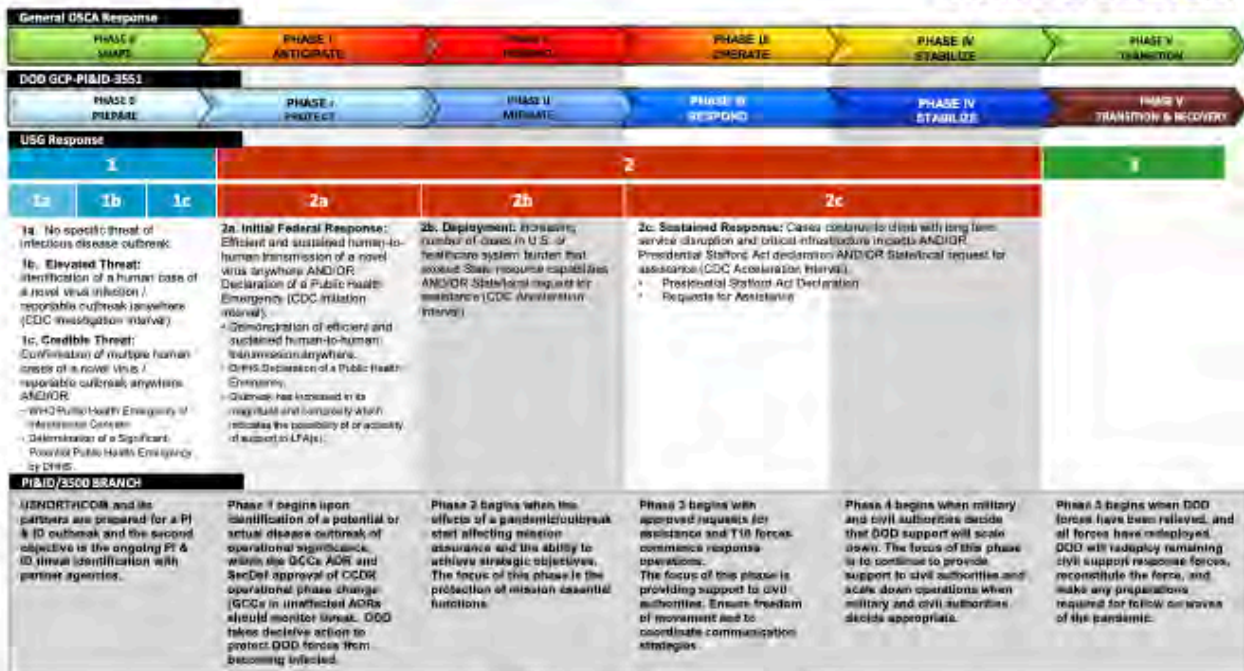
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Note: This figure represents a local level and may occur in those jurisdictions significantly affected by a large-scale biological incident. The UCG develops appropriate national-level response actions to such incidents while overseeing implementation of those response actions aimed ultimately at providing effective federal support to affected SLTT. The same operational areas/capabilities are identified, involving federal support to affected states/territories as well as private sector and to NGOs, but in addition, the UCG can maintain situational awareness of local incident command, JOCs, and/or joint task force functions. Given the wide variety of potential biologic scenarios, flexibility in implementation is critical.

(4) In general terms, the following figure depicts a crosswalk of related DoD and Interagency plans phasing:

Phase Crosswalk



(5) USNORTHCOM Phasing. Phasing follows the DOD GCP-PI&ID and is synchronous with CONPLAN 3500 and USG DSCA response phasing. USNORTHCOM will accomplish this operation in six phases: Phase 0 – Prepare, Phase 1 – Protect, Phase 2 – Mitigate, Phase 3 – Respond, Phase 4 – Stabilize and Phase 5 – Transition & Recovery.

(a) Phase 0 – Prepare (Steady State).

1. Commander's Intent. USNORTHCOM is prepared for continued operations in the event of an operationally significant outbreak at local, regional, or throughout the AOR. USNORTHCOM integrates planning efforts with the interagency and PNs. The priority of effort is engaging partners, medical intelligence/biosurveillance situational awareness, and development/synchronization of strategic communication. Secondary efforts are focused on plan development, synchronization, COOP planning, and promulgation of information to educate the USNORTHCOM community on PI & ID.

2. Timing. This phase is ongoing.

3. Objectives and Effects. The first objective is USNORTHCOM and its partners are prepared for a PI & ID outbreak and the second objective is the ongoing PI & ID threat identification with partner agencies. Desired effects are: DOD, USNORTHCOM, interagency, state, tribal,

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local, and international partners synchronize planning, response, and communications; USNORTHCOM, interagency, state, tribal, local, and international partners mitigate spread of virus.

4. Risk.

a. Lack of awareness will most likely result in a larger percentage of the population (including USNORTHCOM personnel) being exposed to, and potentially infected by a pathogen. Due to the delay in implementation of containment and mitigation measures (FHP), a degradation in the civil and defense sectors' ability to sustain essential functions may ensue.

b. Any lack of partner nation capacity/ capability could degrade its ability to detect and respond to an outbreak and increase the likelihood of a foreign assistance requirement; possibly including USNORTHCOM support.

c. Lack of integrated planning with the interagency community will negatively impact the timeliness and effectiveness of the USNORTHCOM response.

5. Execution. Activities and operations executed during this phase are considered Steady-State Operations and will be executed as part of USNORTHCOM's TCP and are supported by subordinate Service Components and Selected Defense Agencies. These activities will continue through all phases. Phase 0 ends when a potential or actual disease of operational significance has been identified (assessed by NCMI and/or CDC and/or AFHS as posing a high risk to the US and/or DOD population) in the AOR that triggers SECDEF approval to change phases, receipt of an approved DOD MA, and/or JCS EXORD ordering execution of this branch plan.

(b) Phase 1 – Protect.

1. Commander's Intent. USNORTHCOM sustains mission assurance through timely implementation of appropriate FP and FHP measures (both pharmaceutical and non-pharmaceutical, education and training) to protect personnel and maintain the associated resources necessary to ensure readiness. USNORTHCOM works with the interagency and partner nations to ensure DOD freedom of movement and coordinate communication strategies.

2. Timing. Phase 1 begins upon determination that a potential or actual disease of operational significance has been identified (assessed by NCMI and/or CDC and/or AFHS as posing a high risk to the US and/or DOD population) in the AOR and triggers SECDEF approval of CDRUSNORTHCOM's decision to transition from Phase 0 to Phase 1 (GCCs in

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unaffected AORs will monitor situation and transition when deemed appropriate), or upon receipt of an approved DOD MA, and/or JCS EXORD ordering execution of this branch plan. This phase ends when the effect of the disease begins to impact mission assurance and the ability to achieve essential functions, mission, or strategic objectives (transition to Phase II), or the outbreak (infection rate) is on the decline and no additional risk is expected (transition to Phase 5).

3. Objectives and Effects. The objective for this phase is the protection of U.S. forces, DOD civilians, DOD contractors, dependents and beneficiaries, as well as the associated resources necessary to maintain readiness, and to work with the interagency and partner nations to maintain DOD freedom of action to conduct assigned missions within the AOR. The priority of effort is engaging partners, medical intelligence/biosurveillance situational awareness, and development/synchronization of strategic communication. Secondary efforts are focused on plan development, synchronization, COOP planning, and promulgation of information to educate the USNORTHCOM community on PI & ID. USNORTHCOM is postured to take more significant actions should the impact of the Disease of Operational Significance further increase.

4. Risk.

a. Significant absenteeism of USNORTHCOM personnel, whether due to illness, fear, or primary care giver requirements, will degrade operations.

b. Divergent strategic communication will lead to confusion and loss of confidence in USG/DOD.

c. Lack of awareness may lead to incorrect application of resources/capabilities (medical-counter-measures, surge medical capability, etc.)

5. Execution. Actions taken in this phase include: maintaining situational awareness; modifying current operations/exercises and implementing Force Protection (FP) conditions and Force Health Protection (FHP) measures IAW crisis action planning (CAP) (FOC/Threat Assessment Group Recommendations/OPT Planning); influencing implementation of common FHP measures through service/component Surgeons (vaccination, social distancing, increased hygiene protocols etc) based on USNORTHCOM priorities determined through CAP until GCC FHP authority is granted to CDRUSNORTHCOM for the AOR; implementing focused education regime for personnel with supporting info messages to families; reviewing, rehearsing, and executing containment strategies (social distancing, isolation, travel

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restrictions) found in HOI 10-170 and COOP Plans; prepositioning key supplies, and preparation for implementation of appropriate restrictions. CDR USNORTHCOM will request PI&ID FHP authority from JS for all DOD elements and personnel within the AOR (per DODD 6400.02, CDRs have overall responsibility for FHP for forces assigned or attached to their command). Success in this phase is defined as keeping forces intact and maintaining mission assurance. See Figure 2.

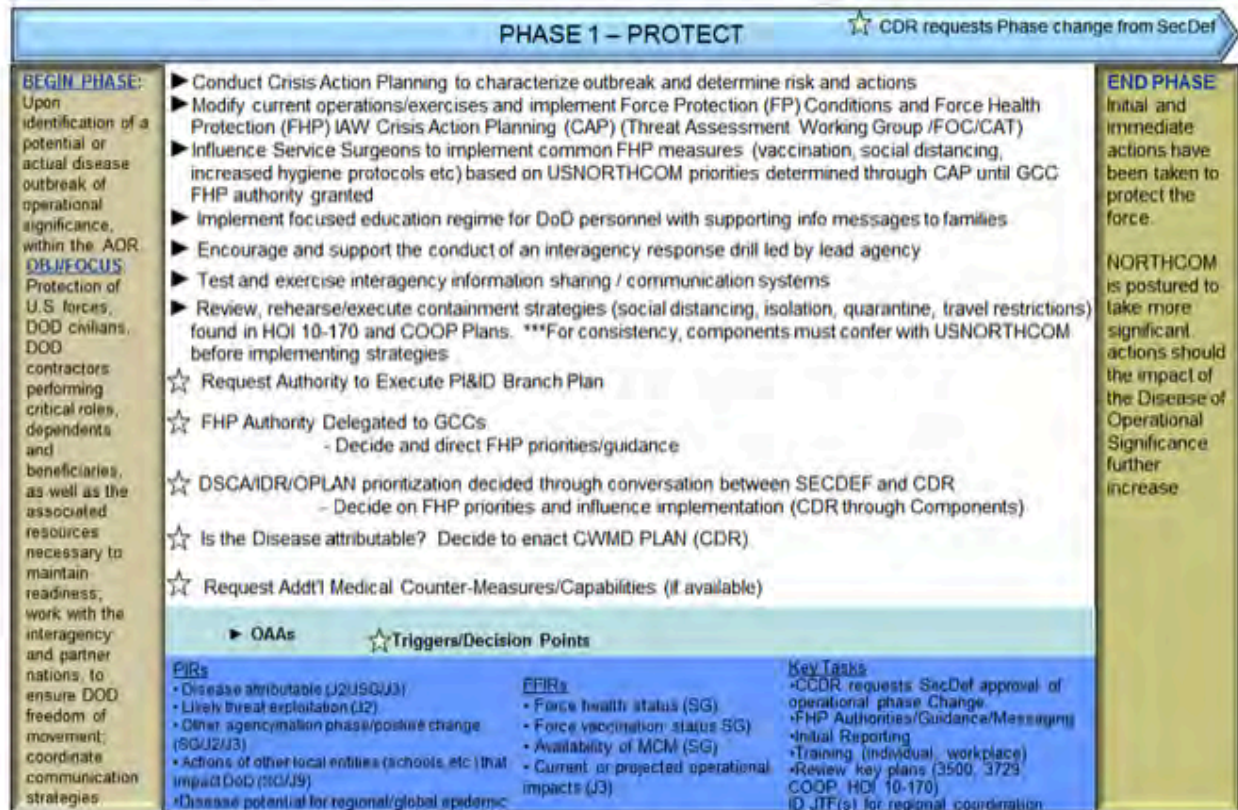


Figure 2, PI&ID Response Phase 1 - Protect

(c) Phase 2 – Mitigate.

1. Commander's Intent. The Command will support USG efforts in responding to effects of disease geographically. Priority of effort is on preparations to ensure freedom of action to conduct assigned missions in the face of an impending operationally significant disease event. Secondary effort is coordination with stakeholders IOT maintain situational awareness and ensure appropriate contracts, requirements, and agreements are in place. USNORTHCOM is postured to maintain mission assurance.

2. Timing. This phase begins when the effects of an outbreak start affecting mission assurance / ability to achieve essential

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functions and/or strategic objectives. This phase ends when significant protective and mitigating actions have been taken and USNORTHCOM remains postured to maintain mission assurance, conduct HD, and respond to USG requests for support. USNORTHCOM, upon receipt of an approved request for assistance will either transition to Phase III or if the infection rate is on the decline and no further pandemic waves are expected will transition to Phase 5.

3. Objectives and Effects. USNORTHCOM takes more significant actions to further protect the force in order to maintain mission assurance: modify current ops/exercises and implement FP Conditions and FHP measures IAW CAP recommendations, ensure QRFs/RRFs and DSCA/IDR responders are appropriately vaccinated / protected (if available), coordinate with IA for anticipated requirements from DOD, BPT Deploy JTF(s), USNORTHCOM components take measures to protect the USNORTHCOM population in the localized region(s) while maintaining freedom of action to conduct assigned missions. USNORTHCOM remains postured to conduct HD and to respond to DSCA and FDR requests for support.

4. Risk.

a. Mission essential functions may be degraded if non-mission essential operations are not re-prioritized/curtailed.

b. Restrictions on freedom of action will degrade world-wide missions and ability to project forces.

5. Execution. Actions taken in this phase involve directing more specific FP and FHP measures to ensure the disease does not degrade USNORTHCOM capabilities and supporting infrastructure that would prevent forces from being able to deploy, be sustained, and protect U.S. vital interests within the AOR. In particular, measures are taken to ensure disease transmission from human-to-human is inhibited through non-pharmaceutical and pharmaceutical intervention, bio-surveillance monitoring and timely sharing of information. Other key OAAs include preparing DSCA and IDR response forces to deploy if requested and authorized IAW CONPLAN 3500 and 3729 respectively. This phase may also include the decision to execute USNORTHCOM's Continuity of Operations Plan (ref xxxx). See Figure 3.

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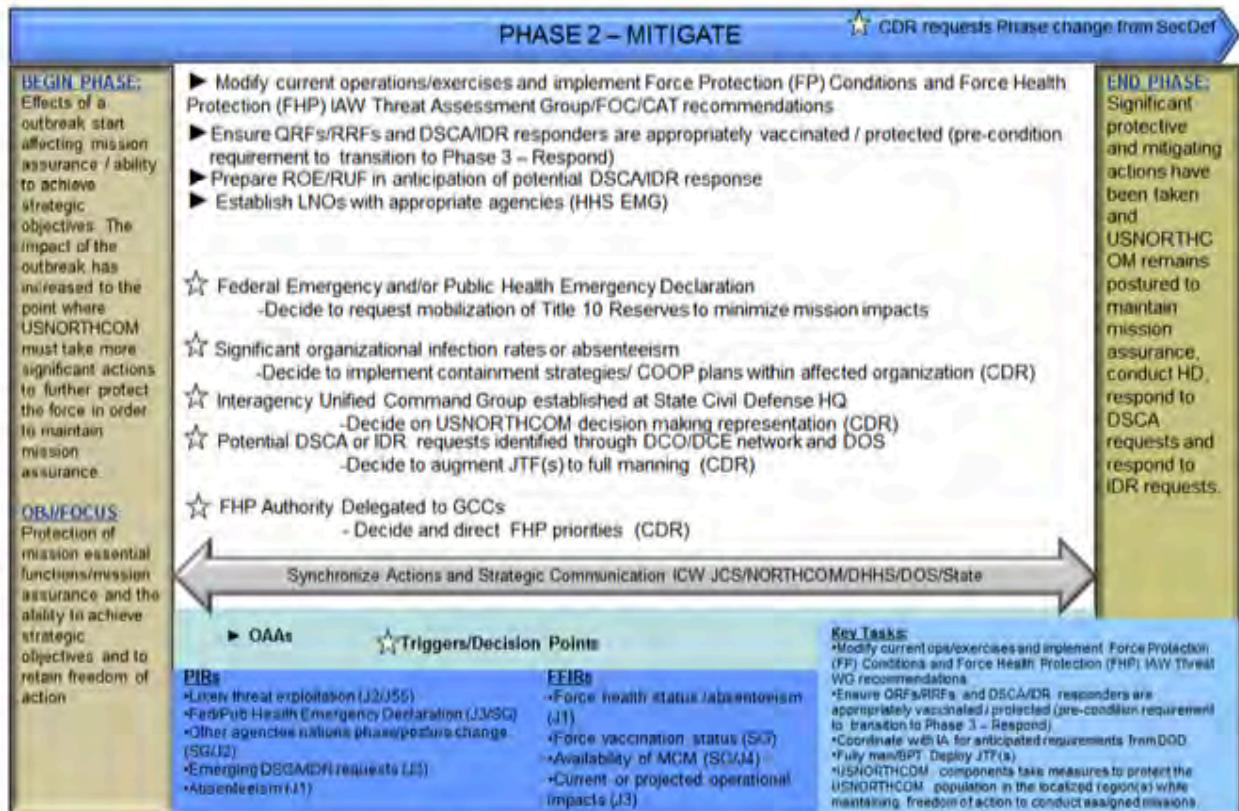


Figure 3, PI&ID Response Phase 2 - Mitigate

(d) Phase 3 – Respond.

1. Commander's Intent. Provide approved support to civil authorities and PNs as required. Ensure freedom of action to conduct assigned missions and protect key personnel.

2. Timing. This phase begins upon receipt of approved requests for DSCA (see reference - CONPLAN 3500) and/or FDR (CONPLAN 3729) and/or the decision to deploy Title 10 response capabilities. This phase ends when mission assurance is maintained for all assigned missions and forces have been deployed to support authorized Federal military DSCA and/or FDR response operations.

3. Objectives and Effects. Taking broader measures to protect the USNORTHCOM population while maintaining the freedom of action to conduct assigned missions as authorized the Secretary of Defense and requested by the Lead Federal Agency which is in direct support to USG's efforts to delay or halt a pandemic wave or infectious disease. Coordinate with interagency and partner nation to prevent loss of life, minimize human suffering, maintain public confidence, coordinate strategic communication, and sustain operations.

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4. Risk.

a. Failure to provide support to domestic PI&ID response may lead to loss and/or suffering in affected nation(s).

b. Failure to provide support to PNs may lead to instability and require future and more significant U.S. involvement.

c. Failure to provide support could erode domestic and international confidence in USG and fail to advance U.S. interests.

5. Execution. Provide support to civil authorities and PNs as required responding to DSCA and FDR requests IAW CONPLAN 3500 and CONPLAN 3729 respectively, while continuing to maintain appropriate FP and FHP measure. Continue to work with the interagency and partner nations to ensure freedom of movement and to coordinate communication strategies. Monitor threat actors, whether traditional or asymmetric, domestic or international, and ensure they are deterred or prevented from exploiting actual or perceived weaknesses created by the PI&ID environment. See Figure 4.

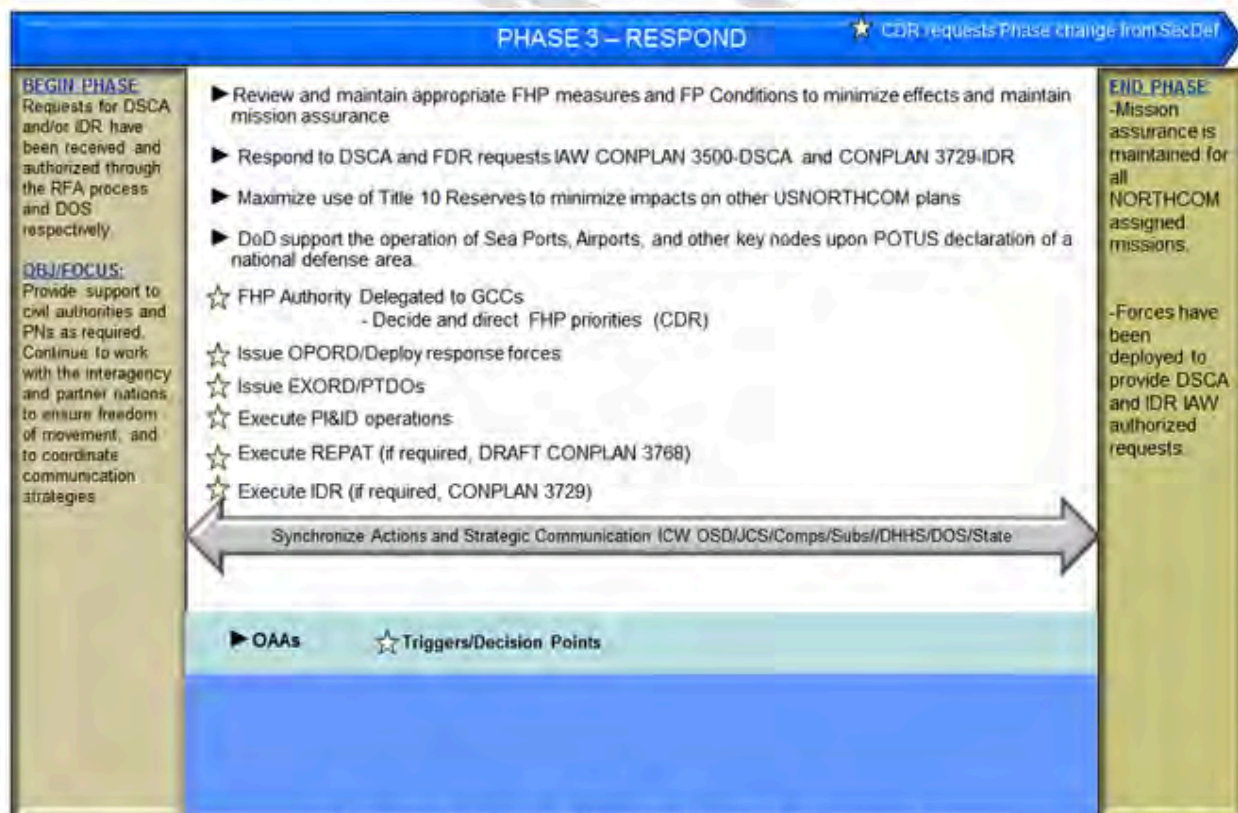


Figure 4, PI&ID Response Phase 3 - Respond

(e) Phase 4 – Stabilize.

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1271 1. Commander's Intent. As the LFA and/or DOS (USAID /
1272 OFDA) determines DOD support is no longer required, USNORTHCOM will
1273 begin to scale down military support/ operations as appropriate.

1274 2. Timing. Phase IV begins when military and civil
1275 authorities determine that DOD support can begin to scale down. Phase IV
1276 ends when all authorized DSCA and IDR requests have been responded to and
1277 domestic and international agencies have the capacity to respond without
1278 continued USNORTHCOM support.

1279 3. Objectives and Effects. USNORTHCOM continues to
1280 protect the force with appropriate FHP measures and maintains mission
1281 assurance. In consultation with the interagency and partner nation lead
1282 federal agencies establishes transition criteria and validates appropriate
1283 military assistance levels while remaining vigilant for possible follow on waves
1284 of the disease outbreak.

1285 4. Risk.

1286 a. USNORTHCOM, due to the effects of the disease on
1287 its personnel and resources, may not have the capacity to effectively support
1288 the USG/PN with the support required.

1289 b. Failure to provide timely/adequate assistance to PN
1290 will result in additional human deaths and suffering and could erode
1291 confidence in DOD and possibly the USG.

1292 c. Failure to adequately support USG lead federal
1293 agency could negatively impact relations between DOD and interagency and/or
1294 PNs.

1295 5. Execution. Review and maintain appropriate FHP
1296 measures and FP Conditions to minimize effects and maintain mission
1297 assurance. Continue to provide approved DSCA and IDR operations and define
1298 transition criteria with interagency and PNs and scale down operations when
1299 military and civil authorities decide appropriate. See Figure 5.
1300
1301
1302
1303

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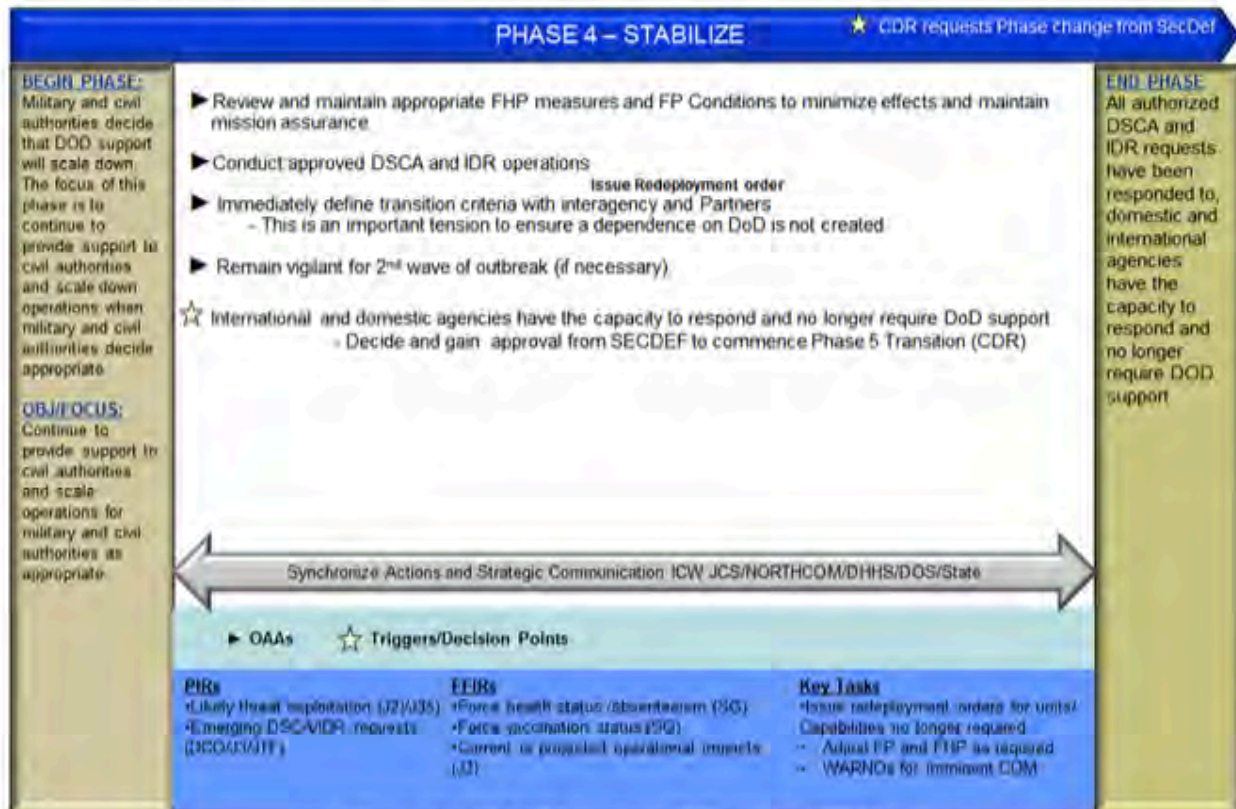


Figure 5, PI&ID Response Phase 4 - Stabilize

(f) Phase 5 – Transition and Recover.

1. Commander's Intent. Redeploy response forces, reconstitute the force, and make any preparations required for follow on waves of the outbreak/event.

2. Timing. Phase V begins when DSCA and IDR response forces have commenced re-deployment to home locations. This phase ends when DSCA and IDR response forces have returned to home locations, have been reconstituted, and returned to original C2 arrangements and/or the disease is no longer of operational significance.

3. Objectives and Effects. The first objective for this phase is the reconstitution of USNORTHCOM assets. The second is to support all efforts to establish conditions that require a return to a previous phase: Disease does not impair key population, preclude operations, negate critical capabilities or supporting infrastructure; USNORTHCOM, interagency, and international partners synchronize planning, response, and communications; and traditional and emerging threats do not exploit a PI&ID environment. Lessons learned are identified and plans are updated accordingly.

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4. Risk. The failure to reconstitute the force in time for subsequent outbreak waves will negatively impact the ability of USNORTHCOM to maintain mission assurance and support domestic and international partners.

5. Execution. The focus of this phase is transition from support to domestic and international operations to redeploying the forces to homes stations for reconstitution and preparation for subsequent outbreak waves. USNORTHCOM conducts force recovery operations and as directed will support efforts to re-establish normal support conditions with key partners. Additionally, USNORTHCOM will continue to work with the interagency and PNs, to ensure freedom of movement, and to coordinate strategic communications, conduct AARs from previous operations and update plans accordingly. Success in this phase is defined as: USNORTHCOM and assets returned to Steady-State Operations. See figure 6.

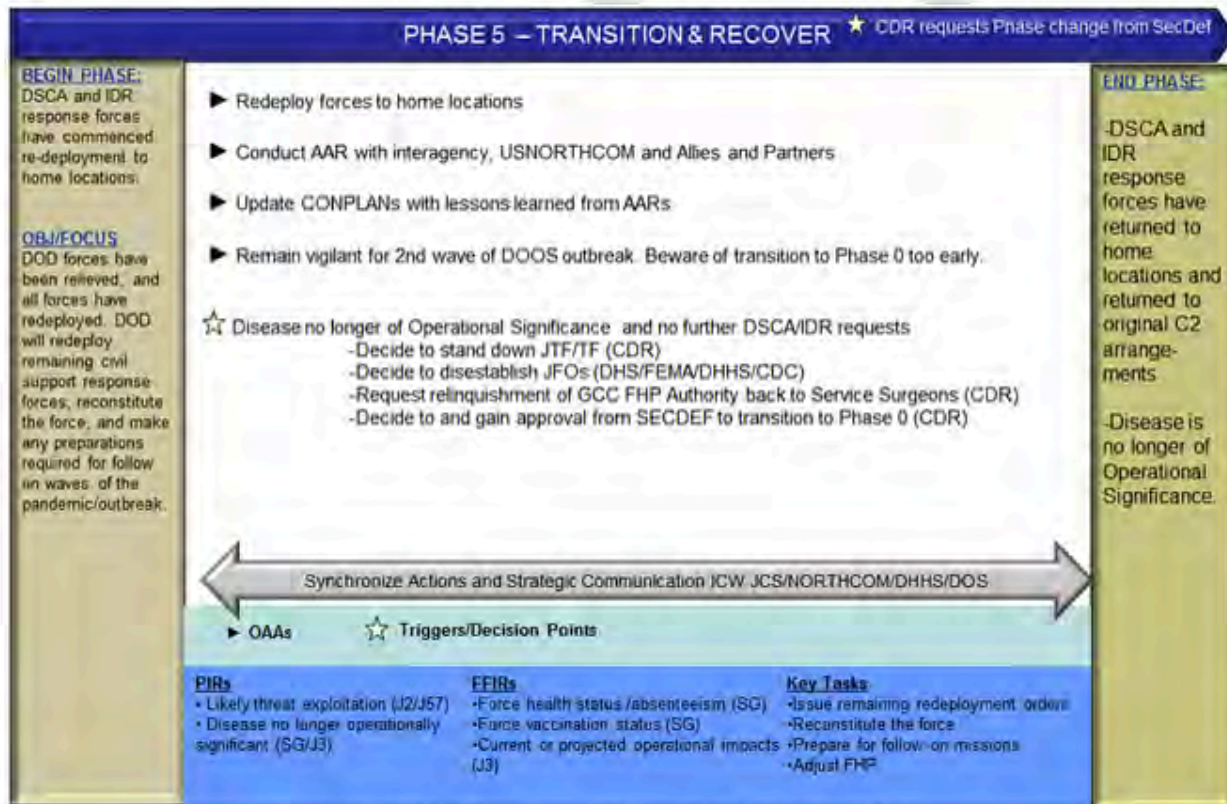


Figure 6, PI&ID Response Phase 5 – Transition & Recover

b. Tasks. Refer to the Base Plan and the CJCS DSCA EXORD, for more details.

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(a) Director of Personnel, N-NC/J1. See Base plan and Headquarters Operating Instruction (HOI) 10-170 (reference, ??)

1. Provide planning representation to crisis action planning and boards, centers, cells, and working groups as required.

2. Keep command apprised of existing and emerging OPM guidance as related to operationally significant disease outbreaks. Make available current and subsequent updates to personnel policies and procedures, relative to operationally significant disease outbreaks, for command-wide dissemination via PA developed platforms and command J14 portal.

3. Provide personnel accountability, monitor casualty reporting and maintain accountability of command Individual Medical Readiness (IMR) related to operationally significant disease outbreak.

4. Establish processes for NORAD and USNORTHCOM and its subordinates to have ready access to information on locations and availability of high demand/low density personnel assets relevant to PI&ID (mission assurance).

(b) Director of Intelligence, N-NC/J2. See Enclosure B (Intelligence) to this PI&ID Response Branch Plan.

1. Develop and recommend PIRs as part of CDR's CCIR to provide timely intelligence and open-source reporting in support of this plan and adjust accordingly base on specific disease threats.

2. Task/coordinate theater and request national intelligence collection and other support per Enclosure B to support planning and operations.

3. Coordinate with N-NC/SG for the monitoring of disease occurrence in the AOR. Collaborate annually to identify "top five" potential disease of operational significance for the USNORTHCOM AOR and update Enclosure B to this branch plan accordingly.

(c) Director of Operations, NC/J3.

1. IAW the Battlestaff Standard Operating Procedures (BSOP) establish the USNORTHCOM Future Operations Center (FOC) to conduct crisis action planning in support of this branch plan and lead directorate for Crisis Action Planning and execution in support of PI&ID operations.

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1392 2. Develop and recommend FFIRs as part of CCDR's CCIR to
1393 provide timely critical status updates on friendly forces IOT aid CCDR decision-
1394 making.

1395
1396 3. Recommend decisions for Commander's approval in
1397 support of the established operation order as necessary.

1398
1399 4. Conduct Critical Infrastructure Protection (CIP) and Anti-
1400 terrorism FP planning with Service component commands and other agencies
1401 as necessary to support response.

1402
1403 5. ICW SG and J2, maintain and coordinate theater level all
1404 domain situational awareness for the emergence and spread of a disease of
1405 operational significance in the USNORTHCOM AOI, trends, events, and
1406 activities through all phases ICW components and other USNORTHCOM
1407 elements and staffs.

1408
1409 6. In coordination with PA, lead the development of a
1410 Strategic Communication framework from which guidance is provided and
1411 coordinate activities and internal messaging within USNORTHCOM and
1412 external with other Unified, Sub-Unified commands, Components, Direct
1413 Reporting Units and USG agencies as required.

1414
1415 7. Establish N2C2 communication with USG, other GCCs,
1416 international and between interagency partners including partnering nation
1417 emergency operations centers. Identify preferred unclassified collaboration
1418 tools for information sharing. Promote, contribute to, and coordinate PI&ID
1419 situational awareness efforts with components, other USG organizations, allies
1420 and partners.

1421
1422 8. ICW SG, prioritize FHP to reduce degradation of priority
1423 capabilities and implement force posture, FP, FHP and containment strategies
1424 to minimize exposure of Joint Forces in disease environments.

1425
1426 9. Act as primary USNORTHCOM point of contact for Lead
1427 Federal Agencies (primarily DHHS and FEMA).

1428
1429 10. Notify JS/OSD of phase changes and FHP guidance
1430 changes.

1431
1432 11. Advise CDRUSNORTHCOM, who exercises TACON (for
1433 FP) authority for DOD elements, on personnel and facilities located within the
1434 AOR to ensure effective FP of DOD forces under all operating conditions and
1435 environments.

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12. ICW J5, SG, and Service Components, facilitate the identification, prioritization, and protection planning of Defense Critical Infrastructure (DCI) in accordance with and synchronized with the AOR pandemic strategy. Act as the Office of Primary Responsibility (OPR) for DCI related concerns.

13. ICW J2/JIOC and SG, prepare threat warning(s) and notify travelers in affected areas.

14. BPT establish and lead crisis action planning and develop an EXORD that implements and directs Phase 1-5 OAAs in response to a disease of operational significance in the USNORTHCOM AOR.

15. Ensure HQ USNORTHCOM, subordinate, and component Continuity Of Operations Plan (COOP) activities enable mission assurance in an operationally significant disease environment when PI&ID effects and associated FHP measures degrade mission capabilities. Key differences from normal COOP activities are that mission related impacts will likely be primarily to the work force and secondarily to infrastructure. The plan must consider the ability to accomplish the mission with a severely degraded workforce due to PI&ID related impacts including but not limited to absenteeism, travel restrictions, containment strategies, and second and third order effects of the disease(s).

16. BPT execute USNORTHCOM CONPLAN 3500, DSCA Response should a PI&ID related DSCA request be received.

17. BPT execute the USNORTHCOM CONPLAN 3729 should a PI&ID related FDR request be received.

18. BPT conduct/support DOD NEO/Repatriation or early return of dependents.

18. Determine command and control relationships with key partner nations and regions.

19. Support all efforts to contain the disease geographically

20. Refine COOP PLAN and include operationally significant disease, social distancing, restriction of movement procedures, medical/logistical support, continuity of operations, mission accomplishment, and support to higher. Identify 2nd and 3rd order effects of PI & ID on ability to conduct COOP, support assigned/attached forces/missions, and ability to provide Force Health Protection (ICW w SG).

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(d) Director of Logistics, N-NC/J4.

1. Maintain an updated logistics sustainability analysis for this branch plan.

2. ICW Service Components, plan, coordinate, and manage theater and operational logistics for USNORTHCOM PI&ID operations.

3. ICW DLA, maintain SA on USNORTHCOM critical supplies for PI&ID (PPE, vaccine, antivirals, etc). ICW SG, maintain Joint Medical Asset Repository (JMAR) visibility.

4. ICW Service Components and DLA identify critical supplies, goods, or services that require priority delivery from industry/suppliers to ensure COOP and sustainment of key populations.

5. BPT coordinate large-scale logistics operations to maintain flow of critical supplies to military base installations in the AOR if a disease of operational significance results in interruption of commercial transportation and/or trade.

6. BPT establish vaccine acquisition and distribution networks that acquire vaccine directly from the manufacturers and distribute them to USNORTHCOM components using USNORTHCOM logistics networks.

7. Maintain visibility on US and international airports and seaports that are considered strategic and that may be restricted due to an operationally significant disease outbreak ICW with USTRANSCOM, identify alternatives to ensure freedom of movement for DOD forces into/out of the USNORTHCOM AOR.

8. Assess sustainment stock levels, and mitigate any shortfalls necessary to meet the logistical requirements associated with a significant PI & ID event.

9. ICW J3 BPT implement prioritized medical material distribution plan, to include enroute security, for PI & ID vaccines, anti-virals, and other medical materiel consistent with J3 operational priorities and forces available.

10. BPT coordinate with NDDOC/AMC/USTRANSCOM for MILAIR or commercial air return of dependents/pets to home of record and potentially infected DOD personnel and/or AMCITs from OCONUS.

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1526 11. ICW N-NC/SG, BPT establish and/or support
1527 appropriate outbreak related medical operations IAW Health and Human
1528 Services (HHS) guidelines and screening criteria at aeromedical evacuation (AE)
1529 hubs and Aerial Ports of Debarkation (APOD)/Sea Ports of Debarkation (SPOD).
1530

1531 (e) Director of Strategy, Policy, and Plans, N-NC/J5.
1532

1533 1. Submit a strategic assessment to SECDEF as part of its
1534 yearly Campaign Assessment describing the Command's progress toward
1535 achievement of the GEF prioritized PIID end states via TCP annual assessment.
1536

1537 2. Coordinate PI&ID related policy issues with N-NC/J52,
1538 OSD, and Joint Staff respectively.
1539

1540 3. Maintain this branch plan in a "living state" to CONPLAN
1541 3500 and as a supporting plan to the DOD GCP-PI&ID-3551 and adjust as
1542 guidance or changes to the environment dictate. Coordinate required policy
1543 adjustments with OSD and required authorities and planning support with the
1544 Joint Staff.
1545

1546 4. In the designated DOD Global Synchronizer for PI&ID
1547 role, coordinate the revision and review of GCC, SVC, and select DA supporting
1548 plans to the DOD GCP-PI&ID-3551.
1549

1550 5. Develop and execute USNORTHCOM led global synch
1551 conferences and planning efforts for GCP 3551.
1552

1553 6. Coordinate with component commands to review
1554 supporting plans and planning activities in a recurring information sharing
1555 forum.
1556

1557 7. N-NC/J59, Security Cooperation Division.
1558

1559 a. ICW SG coordinate Phase 0 health engagements
1560 across the USNORTHCOM AOR. Engagements shall align with planning
1561 guidance from the TCP and shall build the capacity for partner nations and
1562 partner nation militaries to reduce susceptibility to diseases and mitigate the
1563 effects of operationally significant outbreaks should one occur.
1564

1565 b. Establish Phase 0 - Security Cooperation and
1566 Partner Activities (SCPA) priorities and incorporate planning and opportunities
1567 into annual TCP, Theater Security Cooperation Annex (Annex P, TCP).
1568

1569 c. Work with target nation militaries to assess existing
1570 laboratory capacity, rapid response teams and portable field assay testing

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equipment. ICW international military partners develop solutions for identified national and regional military gaps.

(g) Director, Cyberspace Operations, N-NC/J6.

1. Provide Command, Control, Communications, and Computer (C4) systems planning to enable a common operating picture by mapping/fusing extant information flows and resources to fulfill C2 and C4 requirements in support of mission execution.

2. Establish plans to ensure communication with all PI&ID response elements to include liaisons with DoS, international organizations and partner nations.

3. Develop and test Social Distancing/Telework plans ISO mission critical and support functions (phase 0/1).

4. Coordinate the synchronization of the cyberspace domain and provide decision makers and mission partners with the processes and architecture that facilitate relevant, accurate, and timely information in order to achieve decisive levels of shared and accessible knowledge.

(h) Director of Joint Training and Exercises, N-NC/J7.

1. Support branch plan with the overall exercise program that delineates the planning, execution, and assessment of joint training and is consistent with the Commander's training vision.

2. ICW NC/J3, N-NC/J5, and N-NC/SG, determine exercise requirements for CONPLAN 3500, PI&ID Branch Plan, and assist in developing appropriate mechanisms to exercise the plan within existing Joint Exercise Program and service component events.

3. As required, establish linkages with interagency (DHHS/CDC/FEMA) PI&ID exercise programs.

(i) Director of Requirements, Analysis, and Resources, N-NC/J8.

1. Synchronize ongoing USNORTHCOM PI&ID assessments and analyze plan maintenance activities. Capture capability requirements and shortfalls and integrate with appropriate DOD programmatic activities.

2. Advocate for PI&ID resources through the Planning, Programming, Budget and Execution (PPBE), Integrated Priority List (IPL) and

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Joint Capabilities Integration Development System (JCIDS) processes when directed by CDRUSNORTHCOM.

3. Assist in the alignment of security cooperation activities (that will be used to achieve CONPLAN Phase 0 end states) with TCP All Hazards Sub-campaign IMOs, and assist in the development of a framework to monitor and assess the performance of these through the TCP assessment. In coordination with the J55, review changes or modifications needed to the TCP and produce a strategic assessment as required.

(j) Director of Interagency Coordination, N-NC/J9.

1. Facilitate USNORTHCOM interface and information sharing with interagency partners, specifically DHHS, the LFA for Medical and Public Health response.

2. ICW N-NC/SG, N-NC/J4, and N-NC/J59, establish Phase 0 - SCPA priorities and incorporate PI&ID planning and IMOs into the TCP.

3. Support pandemic Surveillance and Detection through consolidation, documentation and reporting of USG agency, International organizations, NGOs and private sector surveillance and detection programs.

4. ICW the N-NC/SG and established BSOP procedures, monitor and report, as necessary, PI&ID related results of USG infectious disease surveillance programs: Global Disease Detection (GDD), Field Epidemiology Training Program (FETP), Integrated Disease Surveillance and Response (IDSR), and Global Emerging Infections Surveillance and Response System (GEIS).

(k) Staff Judge Advocate (N-NC/JA).

1. Support the conduct of PI&ID response operations IAW Appendix 4 to Annex E-Legal.

2. Monitor USNORTHCOM PI&ID activities and advise CDRUSNORTHCOM and JTF or MILFOR Commander of legal/regulatory implications on current and planned activities, policies, and procedures through all operational phases.

3. Provide guidance to component commands and JTFs on handling of IDPs, refugees, modification to SROE, treatment of civilian casualties and any additional requested items through all operational phases.

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4. Coordinate with N-NC/J4 and N-NC/J9 to confirm that diplomatic clearances, over flight, basing rights, access agreements and facility/ equipment usage authorizations have been requested and obtained to the extent possible.

(l) Public Affairs, N-NC/PA.

1. Educate key audiences on the importance of preparation in the event an operationally significant disease is identified (during Phases 0 through II), develop fact sheets or other general information on USNORTHCOM outbreak preparation and mitigation activities ICW N-NC/SG for distribution to various target groups, including professional and community groups. Ensure national consistency of locally produced fact sheets and ensure N-NC PA does not message ahead of local, state, and federal messaging when inappropriate to do so.

2. Monitor public affairs teams deployed ISO outbreak operations.

3. Act as focal point of all CDRUSNORTHCOM public announcements concerning foreign outbreak efforts. Prepare public affairs guidance, as required.

4. Coordinate for the dispatch of news stories and photographs with the Office of the Assistant SECDEF (Public Affairs) for release to national and local media as well as USNORTHCOM command/internal information media.

5. Refine themes and messages for communication activities (protect, mitigate, respond, and stabilize).

a. DoD's first priority is focused on protecting the force and sustaining DoD mission assurance.

b. Education and understanding will enhance preparedness.

c. Preparedness is essential to mitigate effects of an outbreak.

d. During an outbreak, the protection of DoD personnel and their families is a high DoD priority.

e. Openness and communication among mission partners will enhance preparedness for an outbreak.

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f. Adverse effects of PI – ID on DoD forces will be minimized and DoD is capable of conducting its assigned missions worldwide.

g. The Department is capable of providing appropriate support to the primary Federal agency to assist in mitigating the effects when requested and directed.

h. When directed to do so, US forces are capable of assisting international partners to mitigate and respond to PI – ID.

(m) Command Surgeon, N-NC/SG.

1. Monitor disease occurrence in the AOR. ICW J2, DIA/NCMI, and AFHSB utilize medical intelligence, environmental surveillance, health surveillance, and early warning system efforts to identify, monitor, and track the emergence and spread of a disease of operational significance in the USNORTHCOM AOI. This includes analysis and evaluation of the environment, and prioritization of regional threats based on epidemiology, infrastructure, and potential for operational impact. This work is to be done in collaboration with DOD components and other international and federal agencies (WHO, DHS/NBIC, and HHS/CDC, etc.).

2. IAW DODI 6200.03 (Public Health Emergency Management within the Department of Defense) reporting requirements for Biological Events to include USNORTHCOM.

3. IAW DODD 6200.04 (Force Health Protection) develop and promulgate FHP guidelines for assigned/attached forces and/or AOR (either upon receipt of JS EXORD granted AOR authority, or ICW JS Surgeon and SVC Surgeons) to ensure baseline FHP is being met. Protect forces and preserve operational readiness through FHP education and training on the operationally significant threats, personal protective measures, MCM, non-medical therapeutics treatment, prophylaxis, and personnel protective equipment (PPE). As required, recommend implementation of FHP protocols.

3. Establish priorities for immunization/prophylaxis against operationally significant disease outbreaks (particular attention to Novel Influenza).

4. Assess USNORTHCOM force health preparedness status.

5. Update recommendations for prophylaxis and treatment with antivirals/MCM (if available).

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1749 6. Assess effectiveness of treatment and infection control
1750 measures in the AOR.

1751
1752 7. Ensure IMR addresses and includes the administration of
1753 prophylaxis for personnel traveling to affected areas.

1754
1755 8. ICW the NC/J3 coordinate medical requests for public
1756 health and preventive medicine assistance with the USG lead.

1757
1758 9. ICW the N-NC/J4 coordinate medical aspects of patient
1759 evacuation.

1760
1761 10. Coordinate medical assets as required and monitor
1762 medical support requirements during an operationally significant disease
1763 outbreak.

1764
1765 11. Synchronize and coordinate DOD medical activities
1766 with local, interagency, partner nation and NGO/IO medical activities.

1767
1768 12. ICW N-NC/J59 coordinate Phase 0 health engagements
1769 across the USNORTHCOM AOR. Engagements shall align with planning
1770 guidance from the TCP and shall build the capacity for partner nations and
1771 partner nation militaries to reduce susceptibility to diseases and mitigate the
1772 effects of operationally significant outbreaks should one occur.

1773
1774 13. Coordinate with JS and the OSD to develop theater
1775 stockpiles and for access to and release of the DOD stockpile of MCM/PPE,
1776 through Office of the Assistant Secretary of Defense for Health Affairs (ASD-HA)
1777 and Joint Staff IAW existing policies and guidelines.

1778
1779 14. BPT to establish priorities for allocation and distribution
1780 of FHP materials. Authorize and direct the distribution of MCM and other
1781 stockpiled assets to installations within the USNORTHCOM AOR.

1782
1783 15. ICW Component Surgeons, identify the requirement for
1784 components to develop, maintain, and coordinate (for non-medical
1785 support/requirements) installation-level medical response plans to include
1786 evaluation and prioritization of medical requirements and to estimate medical
1787 capabilities and surge capacities.

1788
1789 16. Develop and execute a theater distribution and tracking
1790 plan for medications, vaccines, ventilators, and other medical
1791 supplies/equipment in coordination with USTRANSCOM, Defense Logistics
1792 Agency (DLA), N-NC/J4, Single Integrated Medical Logistics Management
1793 (SIMLM), and Theater Lead Agent for Medical Materiel (TLAMM).

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1794
1795 17. Ensure awareness of bed capacity across respective
1796 AORs. Obtain surge capacity data with National Disaster Medical System
1797 (NDMS) partners, as applicable, on a recurring basis, while also pursuing ways
1798 to incorporate community/PN efforts that are not included in this data.
1799

1800 18. Coordinate with USTRANSCOM and NDMS service
1801 coordinators, as applicable, in patient movement planning efforts.
1802

1803 19. ICW N-NC/J4, BPT establish and/or support
1804 appropriate outbreak related medical operations IAW Health and Human
1805 Services (HHS) guidelines and screening criteria at aeromedical evacuation (AE)
1806 hubs and Aerial Ports of Debarkation (APOD)/Sea Ports of Debarkation (SPOD).
1807

1808 20. ICW the JS Surgeon and Service Surgeons, ensure
1809 DoD/Service guidance and clinical practice guidelines specific to the outbreak
1810 event are adequate and being disseminated.
1811

1812 (n) Deputy Chief of Staff for Communications Synchronization, N-
1813 NC/ CSSC. Support the conduct of PI&ID response operations IAW Annex Y-
1814 Communications Synchronization and Annex C-Operations.
1815

1816 (o) Director, Office of the Command Chaplain, N-NC/HC.
1817

1818 1. Provide and coordinate religious support to the Command
1819 and authorized DOD personnel, in order to ensure the free exercise of religion
1820 for forces conducting PI&ID response operations IAW Appendix 6 (Chaplain
1821 Activities) to Annex E-Personnel.
1822

1823 2. USNORTHCOM/HC establishes theater religious support
1824 (RS) policy, provides RS to the Command, and coordinates RS activities of
1825 subordinate commands and joint task force(s) for all phases of PI&ID
1826 operations.
1827

1828 3. RSTs provide RS to authorized DOD personnel during all
1829 phases of PI&ID operations. Service components and JTFs provide religious
1830 support to service personnel through assigned RSTs.
1831

1832 4. CDRUSNORTHCOM will employ strategic communication
1833 and public information plans in coordination with civil authorities in order to
1834 mitigate fear and miscommunication. Chaplains will contribute to this mission
1835 by advising the command on the impact of religion during operationally
1836 significant disease outbreak operations.
1837

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1838 5. Establish guidelines for pastoral care in a reduction
1839 contact environment.

1840
1841 (p) Director, Washington Office, (N-NC/WO). As the situation
1842 dictates and in response to the CDR's requirements, the N-NC/WO Director
1843 deploys appropriate representation to DOD and non-DOD operations centers
1844 that may include, but are not limited to: DHHS Secretary's Operations Center
1845 (SOC), FEMA National Operations Center (NOC).

1846
1847 (2) USNORTHCOM Components. See Base plan Component Tasks.

1848
1849 (a) Commander, - Air Forces Northern (CDRAFNORTH).

1850
1851 1. Conduct planning and develop supporting plan(s) for
1852 PI&ID response that at a minimum:

1853
1854 a. Detail actions for mission assurance, USG support,
1855 and PN support operations.

1856
1857 b. Submit supporting plan to USNORTHCOM J5.
1858 Provide supporting planback-brief to USNORTHCOM leadership.

1859
1860 2. IAW Annex J and the base plan, BPT to be designated as
1861 a CDR-DOD Title 10 HQs overall operational level commander to execute C2
1862 and synchronize efforts to provide DOD support within the affected area
1863 and/or provide forces IAW Global Force Management (GFM) guidance to
1864 conduct operations in support of directed efforts to respond to a PI&ID event.

1865
1866 3. As directed in the USNORTHCOM TCP and TSC Annex,
1867 and in consultation with N-NC/SG, N-NC/J4, and N-NC/J59, coordinate and
1868 conduct Phase 0 health engagements across the USNORTHCOM AOR IOT build
1869 the capacity for partner nations and partner nation militaries to reduce the
1870 host nation's susceptibility to diseases and mitigate the effects of an
1871 operationally significant outbreak should one occur.

1872
1873 4. BPT lead, or participate in, responses in the AOR as
1874 directed ISO the Lead Federal Agency (DHHS and/or FEMA) efforts in affected
1875 areas of operational significance.

1876
1877 5. IAW DODI 6200.03 (reference x.), and ICW N-NC/SG,
1878 protect assigned forces and preserve operational readiness through education
1879 and training on the PI&ID threat, personal protective measures, prophylaxis,
1880 and PPE. As required, implement FP/FHP measures to protect forces, families
1881 and readiness.

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6. Monitor for potential operationally significant outbreaks (N-NC/SG, NCMI, Center for Disease Control, WHO) to establish and maintain situational awareness.

7. Coordinate public affairs messages with USNORTHCOM on activities that will impact USNORTHCOM AOR in order to ensure synchronization of CDRs communications strategy.

8. As required, monitor and report to USNORTHCOM health of forces assigned/attached to USNORTHCOM IOT support situation awareness/understanding and support requisite decision points IAW Annex R.

9. As required, report status to USNORTHCOM of installations/bases/posts in USNORTHCOM AOR to support situational awareness and anticipate capabilities IAW Annex R.

10. Advise CDRUSNORTHCOM on the impact of PI on the operational status of Service installations in the NC AOR IOT provide SA to CDRUSNORTHCOM.

11. Serve as the USNORTHCOM designated theater JFACC. BPT provide theater support to CDRUSNORTHCOM and localized support for established JTF(s), the JFLCC (to include the DCO), or other components as designated in conducting PI&ID operations in the USNORTHCOM AOR. Coordinate with JFLCC, JFMCC, and Alaskan Command (ALCOM) JFACC (11th Air Force).

12. BPT rapidly establish theater airlift of international relief supplies, USNORTHCOM assets and/or other assets into countries affected by PI&ID outbreak. Conduct planning and take actions during Prepare Phase to establish necessary agreements, or if unable, at least lay the groundwork for such agreements, in order to rapidly establish operations during Mitigate and/or Respond Phase. Coordinate with N-NC/J4 (NDOC) and USTRANSCOM as required. Assume limited or no PN support would be available to support operations.

(b) Commander, - U.S. Army North (CDRUSARNORTH).

1. Conduct planning and develop supporting plan(s) for PI&ID response that at a minimum:

a. Detail actions for mission assurance, USG support, and PN support operations.

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1927 b. Submit supporting plan to USNORTHCOM J5.
1928 Provide supporting plan back-brief to USNORTHCOM leadership.
1929

1930 2. IAW Annex J and the base plan, BPT to be designated as
1931 a CDR-DOD Title 10 HQs overall operational level commander to execute C2
1932 and synchronize efforts to provide DOD support within the affected area
1933 and/or provide forces IAW Global Force Management (GFM) guidance to
1934 conduct operations in support of directed efforts to respond to a PI&ID event.
1935

1936 3. As directed in the USNORTHCOM TCP and TSC Annex,
1937 and in consultation with N-NC/SG, N-NC/J4, and N-NC/J59, coordinate and
1938 conduct Phase 0 health engagements across the USNORTHCOM AOR IOT build
1939 the capacity for partner nations and partner nation militaries to reduce the
1940 host nation's susceptibility to diseases and mitigate the effects of an
1941 operationally significant outbreak should one occur.
1942

1943 4. BPT lead, or participate in, responses in the AOR as
1944 directed ISO the Lead Federal Agency (DHHS and/or FEMA) efforts in affected
1945 areas of operational significance.
1946

1947 5. IAW DODI 6200.03 (reference x.), and ICW N-NC/SG,
1948 protect assigned forces and preserve operational readiness through education
1949 and training on the PI&ID threat, personal protective measures, prophylaxis,
1950 and PPE. As required, implement FP/FHP measures to protect forces, families
1951 and readiness.
1952

1953 6. Monitor for potential operationally significant outbreaks
1954 (N-NC/SG, NCMI, Center for Disease Control, WHO) to establish and maintain
1955 situational awareness.
1956

1957 7. Coordinate public affairs messages with USNORTHCOM
1958 on activities that will impact USNORTHCOM AOR in order to ensure
1959 synchronization of CDRs communications strategy.
1960

1961 8. As required, monitor and report to USNORTHCOM health
1962 of forces assigned/attached to USNORTHCOM IOT support situation
1963 awareness/understanding and support requisite decision points IAW Annex R.
1964

1965 9. As required, report status to USNORTHCOM of
1966 installations/bases/posts in USNORTHCOM AOR to support situational
1967 awareness and anticipate capabilities IAW Annex R.
1968

1969 10. Advise CDRUSNORTHCOM on the impact of PI on the
1970 operational status of Service installations in the NC AOR IOT provide SA to
1971 CDRUSNORTHCOM.

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1972
1973 11. Serve as the USNORTHCOM designated theater JFLCC.
1974 BPT provide theater support to CDRUSNORTHCOM and localized support for
1975 established JTF(s) or other components as designated in conducting PI&ID
1976 operations in the USNORTHCOM AOR. Coordinate with JFMCC, JFACC, and
1977 ALCOM.

1978
1979 12. BPT source additional JTFs headquarters upon
1980 identification of force requirements and as requested by USNORTHCOM and
1981 directed by SecDef IOT ensure HQ elements rapid availability to support
1982 potential USG efforts in multiple regions.

1983
1984 (c) Commander, U.S. Navy North (COMUSNAVNORTH).

1985
1986 1. Conduct planning and develop supporting plan(s) for
1987 PI&ID response that at a minimum:

1988
1989 a. Detail actions for mission assurance, USG support,
1990 and PN support operations.

1991 b. Submit supporting plan to USNORTHCOM J5.
1992 Provide supporting plan back-brief to USNORTHCOM leadership.

1993
1994
1995 2. IAW Annex J and the base plan, BPT to be designated as
1996 a CDR-DOD Title 10 HQs overall operational level commander to execute C2
1997 and synchronize efforts to provide DOD support within the affected area
1998 and/or provide forces IAW Global Force Management (GFM) guidance to
1999 conduct operations in support of directed efforts to respond to a PI&ID event.

2000
2001 3. BPT lead, or participate in, responses in the AOR as
2002 directed ISO the Lead Federal Agency (DHHS and/or FEMA) efforts in affected
2003 areas of operational significance.

2004
2005 4. IAW DODI 6200.03 (reference x.), and ICW N-NC/SG,
2006 protect assigned forces and preserve operational readiness through education
2007 and training on the PI&ID threat, personal protective measures, prophylaxis,
2008 and PPE. As required, implement FP/FHP measures to protect forces, families
2009 and readiness.

2010
2011 5. Monitor for potential operationally significant outbreaks
2012 (N-NC/SG, NCMI, Center for Disease Control, WHO) to establish and maintain
2013 situational awareness.

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2015 6. Coordinate public affairs messages with USNORTHCOM
2016 on activities that will impact USNORTHCOM AOR in order to ensure
2017 synchronization of CDRs communications strategy.

2018
2019 7. As required, monitor and report to USNORTHCOM health
2020 of forces assigned/attached to USNORTHCOM IOT support situation
2021 awareness/understanding and support requisite decision points IAW Annex R.

2022
2023 8. As required, report status to USNORTHCOM of
2024 installations/bases/posts in USNORTHCOM AOR to support situational
2025 awareness and anticipate capabilities IAW Annex R.

2026
2027 9. Advise CDRUSNORTHCOM on the impact of PI on the
2028 operational status of Service installations in the NC AOR IOT provide SA to
2029 CDRUSNORTHCOM.

2030
2031 10. Identify major seaports which are considered strategic
2032 junctures for major military deployments, access preparedness and response
2033 capabilities.

2034
2035 11. BPT rapidly establish movement of international relief
2036 supplies, USNORTHCOM assets and Sea Port of Embarkation / Debarkation
2037 SPOE/SPOD operations in countries affected by PI&ID outbreak. Assume
2038 limited PN support would be available for port operations.

2039
2040 12. BPT resupply ships for long-term sequester. Coordinate
2041 for resupply for ships for at least 45 days.

2042
2043 13. BPT cancel ports visits or utilize alternate major
2044 seaports that are considered strategic junctures for major military
2045 deployments, access preparedness and response capabilities.

2046
2047 14. Consider re-routing vessels and aircraft where countries
2048 prohibit arrival or alternatives to provision of sovereign information required to
2049 preserve and protect health.

2050
2051 15. Serve as the USNORTHCOM designated theater JFMCC.
2052 BPT provide theater support to CDRUSNORTHCOM and localized support for
2053 established JTF(s), the JFLCC, or other components as designated in
2054 conducting PI&ID operations in the USNORTHCOM AOR. Coordinate with
2055 JFLCC, JFACC, and ALCOM.

2056
2057 (d) Commander, U.S. Marine Forces North (COMMARFORNORTH).
2058

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2059 1. Conduct planning and develop supporting plan(s) for
2060 PI&ID response that at a minimum:

2061 a. Detail actions for mission assurance, USG support,
2062 and PN support operations.

2063 b. Submit supporting plan to USNORTHCOM J5.
2064 Provide supporting planback-brief to USNORTHCOM leadership.

2065 2. IAW Annex J and the base plan, BPT to be designated as
2066 a CDR-DOD Title 10 HQs overall operational level commander to execute C2
2067 and synchronize efforts to provide DOD support within the affected area
2068 and/or provide forces IAW Global Force Management (GFM) guidance to
2069 conduct operations in support of directed efforts to respond to a PI&ID event.

2070 3. As directed in the USNORTHCOM TCP and TSC Annex,
2071 and in consultation with N-NC/SG, N-NC/J4, and N-NC/J59, coordinate and
2072 conduct Phase 0 health engagements across the USNORTHCOM AOR IOT build
2073 the capacity for partner nations and partner nation militaries to reduce the
2074 host nation's susceptibility to diseases and mitigate the effects of an
2075 operationally significant outbreak should one occur.

2076 4. BPT lead, or participate in, responses in the AOR as
2077 directed ISO the Lead Federal Agency (DHHS and/or FEMA) efforts in affected
2078 areas of operational significance.

2079 5. IAW DODI 6200.03 (reference x.), and ICW N-NC/SG,
2080 protect assigned forces and preserve operational readiness through education
2081 and training on the PI&ID threat, personal protective measures, prophylaxis,
2082 and PPE. As required, implement FP/FHP measures to protect forces, families
2083 and readiness.

2084 6. Monitor for potential operationally significant outbreaks
2085 (N-NC/SG, NCMI, Center for Disease Control, WHO) to establish and maintain
2086 situational awareness.

2087 7. Coordinate public affairs messages with USNORTHCOM
2088 on activities that will impact USNORTHCOM AOR in order to ensure
2089 synchronization of CDRs communications strategy.

2090 8. As required, monitor and report to USNORTHCOM health
2091 of forces assigned/attached to USNORTHCOM IOT support situation
2092 awareness/understanding and support requisite decision points IAW Annex R.

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2103 9. As required, report status to USNORTHCOM of
2104 installations/bases/posts in USNORTHCOM AOR to support situational
2105 awareness and anticipate capabilities IAW Annex R.
2106

2107 10. Advise CDRUSNORTHCOM on the impact of PI on the
2108 operational status of Service installations in the NC AOR IOT provide SA to
2109 CDRUSNORTHCOM.
2110

2111 11. BPT serve as the USNORTHCOM designated theater
2112 JFLCC and provide theater support to CDRUSNORTHCOM and localized
2113 support for established JTF(s) or other components as designated in
2114 conducting PI&ID operations in the USNORTHCOM AOR. Coordinate with
2115 JFMCC, JFACC, and ALCOM.
2116

2117 (e) Commander, Special Operations Command North
2118 (CDRSOCNORTH).
2119

2120 1. As directed in the USNORTHCOM TCP, TSC Annex, and
2121 in consultation with the N-NC/SG, N-NC/J4, and N-NC/J59, coordinate and
2122 conduct Phase 0 health engagements across the AOR IOT build the capacity for
2123 partner nations and partner nation militaries to reduce the host nation's
2124 susceptibility to diseases and mitigate the effects of a PI&ID outbreak should
2125 one occur.
2126

2127 2. BPT lead, or participate in, PI&ID responses in the AOR
2128 as directed ISO the Lead Federal Agency (DHHS, FEMA or USAID/OFDA) and
2129 international efforts in affected areas in response to a disease of operational
2130 significance.
2131

2132 3. IAW DODI 6200.03 (reference x.), and ICW N-NC/SG,
2133 protect assigned forces and preserve operational readiness through education
2134 and training on the PI&ID threat, personal protective measures, prophylaxis,
2135 and PPE. As required, implement FP/FHP measures to protect forces, families
2136 and readiness.
2137

2138 4. Serve as the Joint Special Operations Component
2139 Commander (JFSOCC) in the USNORTHCOM AOR. BPT execute C2 of SOF
2140 supporting PI&ID operations.
2141

2142 (f) Commander, Alaskan Command (CDRALCOM).
2143

2144 1. Conduct planning and develop supporting plan(s) for
2145 PI&ID response that at a minimum:
2146

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a. Detail actions for mission assurance, USG support, and PN support operations.

b. Submit supporting plan to USNORTHCOM J5. Provide supporting plan back-brief to USNORTHCOM leadership.

2. IAW Annex J and the base plan, BPT to be designated as a CDR-DOD Title 10 HQs overall operational level commander to execute C2 and synchronize efforts to provide DOD support within the ALCOM JOA to conduct operations in support of directed efforts to respond to a PI&ID event.

3. BPT lead, or participate in, responses in the AOR as directed ISO the Lead Federal Agency (DHHS and/or FEMA) efforts in the ALCOM JOA.

4. IAW DODI 6200.03 (reference x.), and ICW N-NC/SG, protect assigned forces and preserve operational readiness through education and training on the PI&ID threat, personal protective measures, prophylaxis, and PPE. As required, implement FP/FHP measures to protect forces, families and readiness.

5. Monitor for potential operationally significant outbreaks (N-NC/SG, NCMI, Center for Disease Control, WHO) to establish and maintain situational awareness in the ALCOM JOA.

6. Coordinate public affairs messages with USNORTHCOM on activities that will impact ALCOM JOA in order to ensure synchronization of CDRs communications strategy.

7. As required, monitor and report to USNORTHCOM health of forces assigned/attached to ALCOM IOT support situation awareness/understanding and support requisite decision points IAW Annex R.

(g) Commander, Joint Force Headquarters National Capital Region (CDR JFHQ-NCR).

1. Conduct planning and develop supporting plan(s) for PI&ID response that at a minimum:

a. Detail actions for mission assurance, USG support, and PN support operations.

b. Submit supporting plan to USNORTHCOM J5. Provide supporting plan back-brief to USNORTHCOM leadership.

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2. IAW Annex J and the base plan, BPT to be designated as a CDR-DOD Title 10 HQs overall operational level commander to execute C2 and synchronize efforts to provide DOD support within the JFHQ-NCR JOA to conduct operations in support of directed efforts to respond to a PI&ID event.

3. BPT lead, or participate in, responses in the AOR as directed ISO the Lead Federal Agency (DHHS and/or FEMA) efforts in the JFHQ-NCR JOA.

4. IAW DODI 6200.03 (reference x.), and ICW N-NC/SG, protect assigned forces and preserve operational readiness through education and training on the PI&ID threat, personal protective measures, prophylaxis, and PPE. As required, implement FP/FHP measures to protect forces, families and readiness.

5. Monitor for potential operationally significant outbreaks (N-NC/SG, NCMI, Center for Disease Control, WHO) to establish and maintain situational awareness in the JFHQ-NCRJOA.

6. Coordinate public affairs messages with USNORTHCOM on activities that will impact JFHQ-NCR JOA in order to ensure synchronization of CDRs communications strategy.

7. As required, monitor and report to USNORTHCOM health of forces assigned/attached to JFHQ-NCR IOT support situation awareness/understanding and support requisite decision points IAW Annex R.

(3) Joint and Service Force Providers (JFPs). The Joint Staff J3 serves as the primary joint force coordinator for conventional forces and in this capacity provides recommended global sourcing solutions and associated force sourcing risk assessments for SecDef approval. When directed by SecDef, the Joint Staff sources conventional forces and resources to assist civil authorities within the USNORTHCOM AOR. CDRUSSOCOM is the joint force provider for SOF.

(4) Services.

(a) Ensure all MTFs:

1. Review plans/infection control procedures
2. Coordinate with local health officials for PH guidance during outbreaks
3. Conduct facility gap analysis (surge resources)

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2237 4. Validate Tamiflu and PPE stock levels.

2238 5. BPT leverage medical and public health surge capacity.

2239
2240
2241 6. Report shortfalls of staff and supplies through
2242 installation commanders.

2243
2244 (b) Ensure Installation Commanders:

2245
2246 1. Plan for supply and resupply in a PI&ID environment
2247 where they will be subject to prolonged COOP execution and shelter-in-place
2248 policy, restricted transportation capabilities, and shortages of critical supplies.

2249
2250 2. Update PI&ID plans to address operationally significant
2251 disease.

2252
2253 (c) Services are responsible for coordinating FHP actions (e.g.,
2254 movement restrictions, appropriate staffing of medical facilities, isolation) with
2255 USNORTHCOM to ensure minimal impact to operations in the AO. Assigned
2256 personnel will fall under the FHP actions of the JTF/TF Commander.

2257
2258 (5) Geographic Combatant Commands. Geographic Combatant
2259 Commanders (GCCs) are the supported commanders within their respective
2260 AORs. All other combatant commanders are supporting commanders for PI&ID
2261 response operations. When directed by the SecDef, GCCs are supporting
2262 CCDRs to CDRUSNORTHCOM for PI&ID operations in the USNORTHCOM OA.
2263 SecDef will set priority of effort.

2264
2265 (6) CDRUSSTRATCOM.

2266
2267 (a) When directed by the SecDef, CDRUSSTRATCOM supports
2268 designated supported Combatant Commanders by ensuring the conduct of
2269 assigned missions and by making recommendations on the allocation of
2270 intelligence, surveillance and reconnaissance (ISR) assets during operations in
2271 a global PI&ID environment. Additionally, USSTRATCOM will oversee the
2272 deployment of strategic, high priority assets to ensure Continuity of Operations
2273 (COOP) and will synchronize global CWMD planning efforts in accordance with
2274 UCP responsibilities as they relate to biological threats.

2275
2276 (b) When directed by the SecDef, CDRUSSTRATCOM supports
2277 CDRUSNORTHCOM by conducting space operations, space control support
2278 and Nuclear Weapons Control during PI operations in the USNORTHCOM OA
2279 and managing FHP and deployment of strategic, high priority assets to ensure
2280 COOP. USSTRATCOM, through the Center for Combating Weapons of Mass
2281 Destruction (SCC-WMD), will provide situational awareness and planning

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support upon request. Situational awareness support includes the biological (BIO) common operational picture

(7) CDRUSTRANSCOM. When directed by the SecDef, CDRUSTRANSCOM employs strategic common-user air, land, and sea transportation for deployment and redeployment of forces engaged in contingency response operations in a global PI&ID environment. Additionally CDRUSTRANSCOM provides air refueling assets and air evacuation assets for patient movement as required.

(8) Chief, National Guard Bureau (CNGB).

(a) Exchange daily SITREPs with the NORAD-USNORTHCOM Command Center on National Guard activities in the USNORTHCOM AOR.

(b) Share COP information concerning National Guard forces responding to a PI&ID event in a State status or Title 32 status to the NORAD-USNORTHCOM Command Center, to include forces responding under EMAC.

(c) Coordinate with USNORTHCOM and subordinate headquarters with integrating/synchronizing Federal and non-Federal military planning, response, deployment/redeployment and transition efforts.

(d) Coordinate with USNORTHCOM for liaison with the CDRUSNORTHCOM designated TF/JTF to avoid on-site duplication of missions, ensure unity of effort, and share force protection and COP information.

(9) Supporting Defense Agencies. As directed by SecDef, provide the following resources and/or capabilities:

(a) Defense Threat Reduction Agency (DTRA). Provide support and technical advice to assist with developing scenarios to prepare for and models for operationally significant outbreaks in concert with USG and public/private counterparts.

1. Provide support and technical expertise to PI&ID operations to include 24 hours a day/7 days a week technical reach back assistance to federal, state and local agencies.

2. Provide deployable planning, technical support and consequence management teams as required.

3. Provide CBRNE (specifically disease) modeling as requested.

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4. Leverage Cooperative Biological Engagement Program to strengthen partner nation's capabilities for biosurveillance, early detection, diagnostic and reporting, and biological safety and security for Especially Dangerous Pathogens (EDP).

(b) National Geospatial Intelligence Agency (NGA). Provide geospatial intelligence (GEOINT) to include imagery, imagery intelligence, and geospatial information and service products data and associated services in support of PI&ID contingency response operations for USNORTHCOM as directed.

(c) Defense Information Systems Agency (DISA). Ensure USNORTHCOM, supporting commands and agencies receive timely and effective command, control, communications, computers, and intelligence (C4I) support, and other support as required.

(d) Defense Logistics Agency (DLA). Coordinate with USNORTHCOM and Service components for subsistence, clothing, individual equipment, petroleum, construction materials, personal demand items, medical materials and repair parts support. Provide integrated material management and supply support for all DLA managed material. Provide property and hazardous material (HAZMAT) disposal services. Provide USNORTHCOM visibility over general support to a LFA per interagency agreement that is not directly providing DSCA. Execute DSCA within the USNORTHCOM AOR ISO CDRUSNORTHCOM.

(e) Defense Intelligence Agency (DIA), National Center for Medical Intelligence (NCMI). Provide support to USNORTHCOM PI&ID missions to include: situational awareness, disease impact characterization assessments, disease operational risk assessments, and dynamic threat assessment. If information is unclassified results should be consolidated with and distributed by AFHSB (or other appropriate Defense Health Agency or SG office) to allow maximum dissemination with USNORTHCOM stakeholders and integrate FHP recommendations from DHA and elsewhere (see annex B).

c. Coordinating Instructions.

(1) Planning should involve other USG departments and agencies, including but not limited to DHHS, CDC, FEMA, and USDA for domestic operations DOS, USAID/OFDA, and HHS for foreign operations, and account for the integration of USG and NGO efforts within the AOR.

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

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

(3) Military, DOD civilian and contract personnel will deploy in accordance with NORAD and USNORTHCOM Instruction 44-163, Individual Medical Readiness, and FHP guidance per Department of Defense Instruction (DoDI) 6025.19, Individual Medical Readiness (IMR), and DoDI 6490.03, Deployment Health.

(4) All strategic communications and public affairs messaging will be consistent with ASD(PA) and ASD (HD&ASA) guidance which will support the overall USG messaging.

(5) This document is effective for planning upon receipt and for execution upon notification. Subordinate plan revisions are due NLT 60 days following approval of the plan.

(6) CDRUSNORTHCOM will notify the SECDEF of phase changes, and coordinate requirements with Joint Staff.

(7) CJCSI 3121.018, Standing Rules of Engagement/Standing Rules for the Use of Force for U.S. Forces are in effect until superseded by competent authority.

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

(9) DIRLAUTH is granted for subordinate coordination with external organizations and agencies, as appropriate. However, the chain of command must maintain accurate awareness of what external coordination is taking place to ensure an overall unified effort and consistency of policy implementation. Subordinate organizations must keep this headquarters informed of these external coordination.

(10) Commander's Critical Information Requirements (CCIRs).

(a) Priority Intelligence Requirements (PIR). See Annex B.

1. PIR 1: What are the efforts of international partners, countries or organizations to detect, mitigate or respond to an infectious disease outbreak of operational significance (epidemic or of pandemic potential)? (OPR: DIA/NCMI)

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2. PIR 2: Identify the new or novel influenza virus or other respiratory pathogen (emerging or engineered) with pandemic potential. (OPR: DIA/NCMI)

3. PIR 3: Has an infectious disease of operational significance (epidemic or of pandemic potential) been detected in or introduced into a geographic area where there is little or no assessed population immunity? (OPR: DIA/NCMI)

4. PIR 4: Provide medical intelligence analysis concerning the health and medical threat implications of a pandemic caused by either influenza or another emerging respiratory pathogen. (OPR: DIA/NCMI)

5. PIR 5: What are the foreign governments' political, military, medical and social responses to infectious disease outbreaks? (OPR: JIOC-N)

6. PIR 6: Will a state, non-state or transnational actor take advantage of the PI&ID situation? (OPR: JIOC-N)

(b) Friendly Force Information Requirements (FFIR).

1. Are Force Health Protection capabilities available?
2. Have DOD personnel been potentially exposed to disease?
3. Is operational Readiness affected?
4. Requirements for possible NEO/ Repat support?
5. Civil unrest another GCC—NC AOR?
6. Effects to Mission Assurance?
7. Are key population and critical staff absenteeism rates above normal?
8. Are priority missions not being performed?
9. What is the status and adequacy of essential supplies?
9. Localized public health measures implemented?
10. What is the health status of the force?

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11. Are RFAs for domestic/international support?
12. Are critical infrastructure/operations being impacted?
13. Have key partner nation/s readiness been impacted?
14. Change in disease behavior?
15. FHP guidance issued by another GCC?
16. Introduction with section of indigent population?
17. Exposed US Citizen returning to CONUS?

(11) Decision Support Framework.

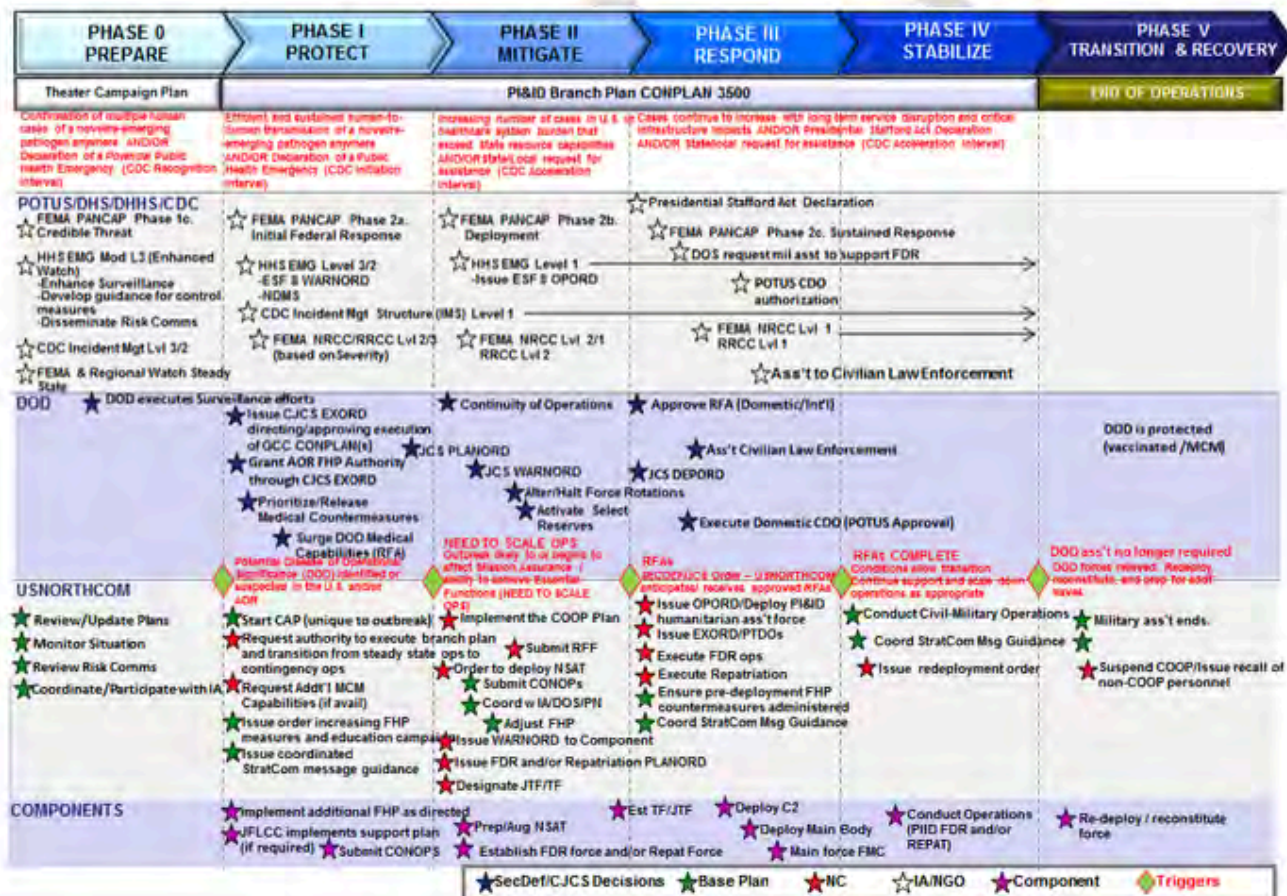


Figure 7, PI&ID Response Decision Support Framework

4. Administration and Logistics.

- a. Concept of Support. The concept of logistics for PI&ID operations, to

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include deployment, sustainment, and combat service support (CSS) efforts will be flexible and tailored to support the mission requirements. At the tactical level, support will be provided, to the extent possible, using the designated BSI (or multiple installations) as the hub supporting JTF/TF operations. See Annex D for more detail.

b. Logistics. See Base Plan and Annex D. The principle materiel requirements for a PIID event include specially formulated influenza vaccine, antiviral drugs, ventilators and personal protective equipment. The DOD will coordinate its purchases of antiviral drugs and influenza vaccine through the Defense Supply Center Philadelphia. The DOD has begun to stockpile Tamiflu, which is used to prevent and treat influenza and believed to be effective against pandemic influenza (PI). Stockpiles are not released to the Services or Geographical Combatant Commanders, but remain within the control of the Assistant Secretary of Defense (Health Affairs) (ASD (HA)), and may be transported to different locations depending on the overall risk and mission. The ASD (HA) is vested with the authority to release all or a portion of the stockpile to JCS and/ or the Services after PIID event is confirmed.

c. Personnel. See Annex E.

d. Public Affairs. See Annex F. A comprehensive information campaign should begin immediately for USNORTHCOM and the US interagency to build cooperation to with regard to the PI&ID risk. Objectives of this information campaign should include building awareness and encouraging. Populations in and around affected areas must be educated on the characteristics of the threat, personal protective measures, and government plans to respond to outbreaks. Appropriate responses and compliance to instructions by civilian populations in affected areas will be essential to the ability to successfully mitigate outbreak impacts. The public information campaign to support education on the threat and appropriate actions is a critical element of an effective comprehensive partnership effort to combat the risk of PI&ID.

e. Meteorological and Oceanographic (METOC) Operations. Refer to USNORTHCOM Theater Campaign Plan - Annex H.

f. Geospatial Information and Services. See Annex B.

g. Medical Services. See Enclosure B to this Branch Plan. During PI&ID operations, medical and public health needs will be significant factors. The National Disaster Medical System (NDMS), which includes DOD coordination with participating non-Federal fixed hospitals and DOD provided patient evacuation, will provide Federal-level medical response when applicable and able. A pandemic or large scale operationally significant disease environment will reduce the effectiveness of NDMS. Therefore, NDMS will not be used for

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movement of influenza patients and will be of limited functionality in the event of a mass casualty event requiring patient movement/regulation from an area impacted by another disaster. Other DOD medical capabilities external to NDMS should be requested if it is determined necessary to augment or sustain the NDMS/local response in order to save lives and minimize human suffering. The time sensitive nature of the requirements necessitates early and rapid interagency coordination to be effective. Restrictions on the use of military medical stockpiles and on the military immunizing civilians may need to be addressed in mission planning. JFHQ-State accessing Strategic National Stockpile resources through respective state health departments is encouraged.

5. Command and Control.

a. Command. See Base Plan and Annex J.

(1) Command Relationships. See Base Plan and Annex J.

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

(3) Succession of Command. See Base Plan and Annex A.

b. Command, Control, Communications, and Computer (C4) Systems. See Annex K.

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General, USAF
Commander

Enclosures

A -- Intelligence
B -- Medical
C -- TBD
D -- TBD

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ENCLOSURE A TO TAB D PI&ID RESPONSE BRANCH PLAN TO APPENDIX 1
TO ANNEX C TO USNORTHCOM CONPLAN 3500 – 14
INTELLIGENCE

References:

- a. (U) DIA/NCMI, Defense Intelligence Study DIA-16-1405-629.B, "Dynamic Threat Assessment 3551: Pandemic Influenza", 3 Jun 2014 (S//REL TO USA, FVEY)
- b. (U) DIA/NCMI, Defense Intelligence Reference Document DIA-16-1204-533, "Evaluating the Operational Impact of Emerging Infectious Diseases in the U.S. Military", 26 Apr 2012 (U)
- c. (U) CJCSM 3150.01B, "Joint Reporting Structure General Instructions", 16 Jun 2008 (U)
- d. (U) DIA, Defense Intelligence Agency Instruction 5240.400, "Information Security Program", 2 Apr 2014 (U)
- e. (U) DIA/NCMI DI-1812-1533-09 "Warning Assessment for Pandemic influenza", 28 April 2009 (U)

1. Situation.

a. Characteristics of the Operational Environment (OE). See Annex B to CONPLAN 3500.

(1) Physical Areas and Factors. See Annex B to CONPLAN 3500.

(2) Information Environment. See Annex B to CONPLAN 3500.

(3) Systems Perspective. See Annex B to CONPLAN 3500.

b. Crisis Environment.

(1) DIA assesses with high confidence that any highly contagious infectious disease resulting in near simultaneous debilitating illness across multiple geographic commands will, at a minimum, negatively impact the availability of U.S. military personnel for duty. Novel respiratory diseases with a short incubation period, such as influenza viruses, pose the most likely

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2638 pandemic threat. An influenza pandemic is a global event that affects all
2639 populations to varying degrees, and transmission can occur in waves over
2640 many months. DIA assesses that a pandemic, which would entail a multiyear
2641 new operating environment, will give rise to political, social, and economic
2642 instabilities that could, in turn, lead to opportunistic aggression, increased
2643 terrorist activity, internal unrest, political/economic collapse, humanitarian
2644 crises, and dramatic social change, especially when coupled with high
2645 morbidity and mortality.

2646
2647 (2) Although novel influenza viruses currently pose the most likely
2648 pandemic threat, any pathogen that has a short incubation period and is
2649 readily transmissible among an almost universally susceptible population has
2650 the potential to become a pandemic.

2651
2652 (3) Initial recognition, identification and characterization of an
2653 emerging or re-emerging pathogen can take several weeks or possibly months,
2654 during which time regional and/or global movement of infected individuals will
2655 occur, thereby facilitating disease spread.

2656
2657 (4) Mitigating morbidity and mortality will define how a country will
2658 emerge post-pandemic. Even the most industrialized countries will have
2659 insufficient hospital beds, specialized equipment such as mechanical
2660 ventilators, and pharmaceuticals readily available to adequately treat their
2661 populations during a clinically severe pandemic. The degree to which countries
2662 can mitigate morbidity and mortality and affect messaging during a pandemic
2663 and reintegrate recovering people back into society will have considerable
2664 impact on the magnitude of secondary and tertiary economic, political,
2665 security and social effects.

2666
2667 (5) The top concerns for emerging/re-emerging infectious diseases of
2668 operational significance and diseases with pandemic potential in the
2669 USNORTHCOM AOR are depicted in the table listed below. The top five
2670 priorities, in no particular order, are highlighted in orange. The prioritization
2671 and content is based on our assessment using NCMI's "Evaluating the
2672 Operational Impact of Emerging Infectious Diseases in the U.S. Military" (ref b),
2673 "Guide to Emerging Infectious Disease Threats" (linked to ref a) and CDC's
2674 Category A agents and diseases listing. See CDC's site at
2675 <http://emergency.cdc.gov/agent/agentlist-category.asp> for more information
2676 on categories.

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Pathogen/Agent/Disease	Pathogen Characteristics	Population/Host Factors	Environmental Factors
Avian Influenza A Virus (H7N9)	<ul style="list-style-type: none"> - H2H transmissible, but not sustained at this time - Mutation tendencies of the virus may enable sustained H2H transmission and trigger a potential pandemic 	Treatment with antivirals; no vaccine currently available; social interactions will contribute to spread if the virus mutates to enable sustained H2H transmission	If a mutation enables sustained H2H transmission, then crowded living conditions will contribute to the spread of the disease
Corona Virus	<ul style="list-style-type: none"> - H2H transmissible; however, no sustained H2H transmission with MERS-CoV - Corona virus infections common around the world; exceptions are MERS-CoV and SARS-CoV - Specific host unknown 	No specific treatment or vaccine	For MERS-CoV: close contact such as care-giver situation increases exposure to virus and illness
Plague (Yersinia pestis)	<ul style="list-style-type: none"> - Several forms: Pneumonic (H2H transmissible), Bubonic (most common, not H2H) and Septicemic (not H2H) - Early identification and treatment of pneumonic plague is essential 	No human immunity; treatment available; no vaccine; social interactions and travel patterns contribute to increased spread of bacteria	Crowded living conditions favorable to spread of pneumonic plague

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Viral hemorrhagic fevers (filoviruses [Ebola, Marburg] and arenaviruses [Lassa, Machupo])	<ul style="list-style-type: none"> - H2H transmissible - Various hosts (animal/rodent, insect and human); host for ebola and Marburg unknown 	No human immunity; supportive therapy, no specific treatment	Crowded living conditions, vector exposure and poor sanitation/ infection control will contribute to spread
Smallpox (variola major)	<ul style="list-style-type: none"> - H2H transmissible - Humans are only natural host - Host is usually debilitated once contagious; most contagious once rash on tongue and in mouth appears 	No specific treatment; vaccine available, however, routine vaccination stopped because disease was considered eradicated;	Crowded living conditions favorable for spread of smallpox
Dengue hemorrhagic fever	<ul style="list-style-type: none"> - Not H2H - Mosquito is primary vector - Localized or regional epidemic possible 	No specific treatment, frequently requires hospitalization	Areas with high mosquito population are favorable to transmission
Chikungunya	<ul style="list-style-type: none"> - Not H2H- Food/waterborne- <p>May lead to localized or regional epidemics</p>	No specific treatment	Areas with high mosquito population are favorable to transmission

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West Nile encephalitis	<ul style="list-style-type: none"> - Not H2H - Mosquito is primary vector - 70-80% of infected persons are asymptomatic - Less than 1% develop severe illness, such as encephalitis or meningitis - Regional epidemic possible 	Persons with certain medical conditions are at higher risk of serious illness; no specific treatment or vaccine	Areas with high mosquito population are favorable to transmission
Yellow Fever	<ul style="list-style-type: none"> - Not H2H - Mosquito is primary vector - Localized or regional epidemic possible 	No specific treatment; vaccine available; yellow fever patients should be hospitalized for supportive care and close observation	Areas with high mosquito population are favorable to transmission
Anthrax (Bacillus anthracis)	<ul style="list-style-type: none"> - Not possible to result in pandemic - Not H2H transmissible - Contact with/exposure to spores required to become ill; inhaled, ingested or contact through open wound (cutaneous) 	No human immunity; treatment available	Person-to-person transmission has been reported through cutaneous anthrax, where discharge from skin lesions may be infectious

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Botulism (Clostridium botulinum toxin)	<ul style="list-style-type: none"> - Not possible to result in pandemic - Not H2H transmissible - Foodborne, infant or wound botulism - 3-5% fatality rate 	No human immunity; antitoxin available	<ul style="list-style-type: none"> - Foodborne botulism due to improper food handling - Most wound botulism cases are associated with black-tar heroin injection
Tularemia (Francisella tularensis)	<ul style="list-style-type: none"> - Not H2H transmissible - Infection through animal and insect hosts, or through inhaled bacteria 	No human immunity; treatment available; vaccine under review	Crowded living conditions and proximity to animals may cause low level to regional epidemics
Cholera (Vibrio cholerae)	<ul style="list-style-type: none"> - Not H2H - Food/waterborne - May lead to localized or regional epidemics 	Treatment with rehydration and antibiotics;	Poor sanitation levels, to include food and water contamination, will increase risk of exposure and spread
Hantavirus Pulmonary Syndrome	<ul style="list-style-type: none"> - Not H2H- Host in rodent population 	No specific treatment; supportive care	Exposure to areas with active rodent inhabitation increases chances of exposure to virus

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(6) A PI&ID-related crisis would severely threaten NORAD or USNORTHCOM missions if the disease were to impact continuity of government, command and control, indications and warning capabilities or critical response forces.

c. Friendly.

(1) The primary responsibility for DOD medical intelligence analysis and dissemination concerning the health and medical threat and implications of PI&ID resides with the Defense Intelligence Agency (DIA) primarily through the National Center for Medical Intelligence (NCMI). NCMI will provide intelligence warning of diseases with pandemic potential and provide intelligence assessments of potential impact, implications, outlook and opportunities associated with the spread of a disease with pandemic potential. NCMI will also provide intelligence warning and finished all source medical intelligence analysis regarding foreign emerging/re-emerging infectious diseases of operational significance to the Combatant Commanders, the DOD, and the U.S. government as a whole. NCMI will provide information regarding foreign medical capability to plan for, report, identify and respond to PI&ID threats.

(2) HHS and CDC will be the primary source of reporting on PI&ID threats within the US homeland.

(3) JIOC-N will be responsible for supporting assessments of key second and third order impacts of the PI&ID on AOR countries, as specified in the Unified Command Plan. These assessments are addressed through PIRs 5 and 6.

d. Legal Considerations. See base plan.

2. Mission. JIOC-N supports USNORTHCOM in operations to prepare for, detect, mitigate, respond to, and recover from the effects of a pandemic influenza or infectious disease outbreak of operational significance in order to sustain assigned missions and provide support to primary Federal agencies and international partners to protect the Nation's interests. JIOC-N, ICW the Department of Defense Intelligence Community (DOD IC) works with interagency and international partners to provide Indications and Warning (I&W) of PI and infectious diseases of operational significance, track global disease spread, monitor secondary and tertiary effects of PI&ID on state and non-state actors and assure mission readiness to continue key DOD intelligence functions during a PI&ID environment.

3. Execution.

a. Concept of Intelligence Operations.

(1) DOD IC works as part of an interagency and international effort to provide early detection of infectious diseases with pandemic potential and operational significance. Early detection gives international organizations, U.S. Government (USG), and partner nations the opportunity to respond to and mitigate the effects of PI&ID. The Defense Intelligence Agency (DIA) in collaboration with JIOC-N and DOD IC provide indications and warning of diseases with pandemic potential to facilitate force health protection, analysis and assessments of secondary and tertiary effects, situational awareness of partner nation actions and responses, and synchronize DOD national intelligence support operations in response to PI&ID and in support of USG efforts as requested and authorized. This plan is linked to certain biological warfare (BW) aspects of USSTRATCOM GCP-CWMD, and certain terrorist use of BW of USSOCOM CONPLAN 7500, DOD Campaign Plan for the Global War on Terrorism. A biological attack (see GCP-CWMD, PIR #6) may be initially indistinguishable from a naturally occurring infectious disease outbreak and will require the same suite of public health and medical responses. Even a small, unexplained PI&ID outbreak could require a great deal of epidemiologic and forensic investigation to distinguish between a naturally occurring event, an accident or a deliberate attack. Regardless, the intelligence required to support FHP measures and PI&ID contingency branch plans will be the same. If epidemiologic and forensic investigations reveal the outbreak is due to a deliberate release by a terrorist organization, refer to contingency branch plans to CONPLAN 7500.

(2) JIOC-N, ICW the intelligence community, other GCCs' JIOCs and DOD Agencies, interagency and international partners, contributes to the situational awareness of pathogens and infectious diseases which may result in a pandemic or increased demands for civil support in the USNORTHCOM AOR.

(3) Maintaining situational awareness of PI&ID spread allows the DOD IC to monitor secondary and tertiary impacts of PI&ID, with focus on political, military, economic, social, infrastructure and information (PMESII) impacts. Accurate assessments of secondary and tertiary impacts provide important context to ongoing activities of both state and non-state actors and are important for USG decision-making. JIOC-N, in collaboration with other GCC and Functional Combatant Command (FCC) JIOCs and DOD Agencies, monitor secondary and tertiary impacts of PI&ID with emphasis on potential for regional instability, and the resultant impacts on mission assurance and strategic objectives.

(4) Faced with potential manning shortfalls during a pandemic or infectious disease situation, the JIOC-N sustains mission assurance to continue key intelligence functions. The emergence of PI&ID will likely have

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significant impact on JIOC-N personnel available for duty, with upwards to 40% absentee rates among all segments of the population. JIOC-N will prioritize essential intelligence functions and develop redundancies and discontinue non-essential functions.

b. Tasks.

(1) Priority Intelligence Requirements (PIRs). PIRs 1 to 3 are steady state requirements, and PIRs 4 to 6 are contingency requirements. See Exhibit 1 to Enclosure B (classified) for a baseline of information requirements:

(a) PIR 1: What are the efforts of international partners, countries or organizations to detect, mitigate or respond to an infectious disease outbreak of operational significance (epidemic or of pandemic potential)? (OPR: DIA/NCMI)

(b) PIR 2: Identify the new or novel influenza virus or other respiratory pathogen (emerging or engineered) with pandemic potential. (OPR: DIA/NCMI)

(c) PIR 3: Has an infectious disease of operational significance (epidemic or of pandemic potential) been detected in or introduced into a geographic area where there is little or no assessed population immunity? (OPR: DIA/NCMI)

(d) PIR 4: Provide medical intelligence analysis concerning the health and medical threat implications of a pandemic caused by either influenza or another emerging respiratory pathogen. (OPR: DIA/NCMI)

(e) PIR 5: What are the foreign governments' political, military, medical and social responses to infectious disease outbreaks? (OPR: JIOC-N)

(f) PIR 6: Will a state, non-state or transnational actor take advantage of the PI/ID situation? (OPR: JIOC-N)

(2) Intelligence Tasks.

(a) Defense Intelligence Agency (DIA).

1. DIA – Directorate for Analysis (DIA/DI). DI will provide analytical assessments of:

a. General information on foreign military capabilities, transportation systems, information infrastructure and communications, environmental factors, economy, culture, and social issues

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that might affect the ability of USNORTHCOM to conduct military operations, provide humanitarian or medical support or to respond militarily to crises that threaten U.S. interests.

b. Emerging political, military, cultural, social or economic crises due to PI&ID.

c. Any evidence of efforts by foreign governments or other actors to exploit disease outbreaks, including efforts to actively use pathogens as a weapon.

d. Surveillance of PI&ID conducted IAW interagency cooperation, non-government organizations and scientific institutions operating in conjunction with USG efforts.

2. DIA – National Center for Medical Intelligence (DIA/NCMI). DIA/NCMI will provide intelligence warning of diseases with pandemic potential and provide intelligence assessments of potential impact, implications, outlook and opportunities associated with the spread of a potentially pandemic disease. NCMI will also provide intelligence warning and finished all source medical intelligence analysis regarding foreign emerging/re-emerging infectious diseases of operational significance to the USNORTHCOM, the DOD, and the U.S. government as a whole. NCMI will provide information regarding foreign medical capability to plan for, report, identify and respond to PI&ID threats. NCMI will provide analytical assessments of:

a. The accuracy and reliability of foreign reporting on extent and severity of PI&ID outbreaks and factors which would influence reporting accuracy including adequacy of reporting systems or efforts to suppress information.

b. The capability of foreign countries to respond to outbreaks including treatment facilities, medical staff, vaccination, antivirals and other medications used, medical infrastructure, and quarantine efforts.

(b) NRO. Provide reconnaissance support IAW USG laws to support PI&ID monitoring.

(c) DTRA. DTRA will provide PI&ID situational awareness and contribute to global situational awareness tool. DTRA may also leverage the Cooperative Biological Engagement Program to strengthen state capabilities for surveillance, and early detection for animal and human pandemic influenza.

(d) USSTRATCOM. Provide situational awareness on CWMD threats, including biological threats.

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(e) JIOC-N.

1. Steady state tasks. During Phase 0 (Prepare), J25P will be the directorate's primary point of contact for supporting PI- and ID-related activities and monitoring. J23 will be the lead for preparing for crisis support.

a. Establish and maintain relationship with SG and J9 to ensure information sharing across the command as appropriate for the unique USNORTHCOM AOR. (OPR: J25P)

b. ICW NCMI and NORAD and USNORTHCOM SG and J9, develop AOR specific PI&ID analysis and evaluation of the environment and prioritization of regional threats based on epidemiology, infrastructure and potential enemy capabilities, intentions and COAs. Include potential impact on PMESII systems on our partners and priority countries. (OPR: J25P)

c. Assist SG and J5 in identifying the top five priorities for emerging/re-emerging infectious diseases of operational significance and diseases with pandemic potential in our AOR. (OPR:J25P)

d. JIOC-N will coordinate PI-ID-specific collection and production requirements with JS J25 in support of the PIRs specified in Exhibit 1 to Enclosure B. Information sharing requirements will be coordinated with J25S. (OPR: J25P; OCR: J23)

e. Develop appropriate interagency and international relationships and communications pathways to share PI&ID intelligence. (OPR: J25P)

f. BPT continue mission essential intelligence functions during a pandemic. (OPR: J23; OCRs: J21, J22, J24, J25P)

g. Coordinate with DIA efforts to provide indications and warning for emergence of PI&ID. Participate in PI Community of Interest, hosted by JS/J25. (OPR: J25P)

h. BPT support USG efforts as requested and authorized. (OPR: J23; OCR: J25P)

2. Contingency tasks. JIOC-N will transition to crisis support operations IAW the NORAD-USNORTHCOM intelligence operating instruction when CDR NORAD-USNORTHCOM considers moving to Phase 1 (Protect). At this point, J25P will transition into a supporting role to J23, who

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will then coordinate intelligence support to the command, IAW PIRs 4 through 6.

a. ICW NCMI, provide intelligence warning and analysis regarding foreign emerging/re-emerging infectious diseases of operational significance and diseases with pandemic potential. (OPR: J23; OCR: J25P)

b. Provide intelligence analysis to support evaluating the operational impact of emerging infectious diseases, as per ref b, and assessments concerning the health threat and implications, outlook and opportunities associated with the spread of a potentially pandemic disease. Information on transmissibility and severity are vital in determining the appropriate type of FHP measures to ensure DOD forces are ready and capable of supporting USG and partner nation efforts to mitigate a PI&ID outbreak and manage second and third order effects. (OPR: J23; OCR: J25P)

c. Monitor PMESII aspects of affected areas to provide early warning of instability, opportunistic aggression, indications of military conflict, increased terrorist activity, reduced partner nation capacities, internal unrest, political or economic collapse, and humanitarian crises. (OPR: J23; OCR: J25P)

d. Maintain situational awareness of partner nation actions and responses, if not provided in a collaborative manner through medical or operational channels. Accurate information on partner nation responses will provide context to the impact of the disease on partner capabilities and potential vulnerabilities. (OPR: J23; OCR: J25P)

e. Support lead agencies as requested and authorized. (OPR: J23; OCR: J25P)

(3) Orders to Subordinate Units. See Annex B to CONPLAN 3500.

(4) Requirements to Higher and Supporting Organizations.

(a) Defense Intelligence Agency (DIA).

1. DIA – Directorate for Analysis (DIA/DI). Provide analytical assessments of:

a. General information on foreign military capabilities, transportation systems, information infrastructure and communications, environmental factors, economy, culture, and social issues that might affect the ability of USNORTHCOM to conduct military operations,

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provide humanitarian or medical support or to respond militarily to crises that threaten U.S. interests.

b. Emerging political, military, cultural, social or economic crises due to PI&ID.

c. Any evidence of efforts by foreign governments or other actors to exploit disease outbreaks, including efforts to actively use pathogens as a weapon.

d. Surveillance of PI&ID conducted IAW interagency cooperation, non-government organizations and scientific institutions operating in conjunction with USG efforts.

2. DIA – National Center for Medical Intelligence (DIA/NCMI).

a. Provide intelligence warning of diseases with pandemic potential and provide intelligence assessments of potential impact, implications, outlook and opportunities associated with the spread of a potentially pandemic disease.

b. Provide intelligence warning and finished all source medical intelligence analysis regarding foreign emerging/re-emerging infectious diseases of operational significance to the USNORTHCOM, the DOD, and the U.S. government as a whole.

c. Provide information regarding foreign medical capability to plan for, report, identify and respond to PI&ID threats. NCMI will provide analytical assessments of:

i. The accuracy and reliability of foreign reporting on extent and severity of PI&ID outbreaks and factors which would influence reporting accuracy including adequacy of reporting systems or efforts to suppress information.

ii. The capability of foreign countries to respond to outbreaks including treatment facilities, medical staff, vaccination, antivirals and other medications used, medical infrastructure, and quarantine efforts.

(b) NRO. Provide reconnaissance support IAW USG laws to support PI&ID monitoring.

(c) DTRA. DTRA will provide PI&ID situational awareness and contribute to global situational awareness tool. DTRA may also leverage

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the Cooperative Biological Engagement Program to strengthen state capabilities for surveillance, and early detection for animal and human pandemic influenza.

(d) USSTRATCOM. Enable DOD's ability to provide global CWMD situational awareness, including biological threats.

c. Collection. See Appendix 12 to Annex B to CONPLAN 3500.

(1) Signals Intelligence (SIGINT). See Appendix 2 to Annex B to CONPLAN 3500.

(2) Geospatial Intelligence (GEOINT). See Appendix 12 to Annex B to CONPLAN 3500. Imagery intelligence can be used prior to the onset of a pandemic to establish a baseline essential to detecting and determining abnormal activity. After a potential onset of a pandemic, imagery can be used to confirm unusual activity, providing insight into foreign responses to the spread of disease and potential follow-on impacts. Imagery reports will be shared with Service component commands, U.S. Country Teams and the national intelligence community.

(3) Human Intelligence (HUMINT). See Appendix 5 to Annex B to CONPLAN 3500.

(4) Measurement and Signature Intelligence (MASINT). See Appendix 8 to Annex B to CONPLAN 3500.

(5) Counterintelligence (CI). See Appendix 3 to Annex B to CONPLAN 3500.

(6) Open Source Intelligence (OSINT). OSINT collection manager receives, validates and manages OSINT collection requirements and coordinates tasking for DNI's Open Source Center (OSC). Note: Within N-NC, local OSINT research and production requirements are internally tasked through the RFI process managed by J25, Mission Support.

(7) ISR. See Appendix 15 to Annex B.

d. Processing and Evaluation. See Annex B.

e. Analysis and Production. See Appendix 13 to Annex B to CONPLAN 3500.

(1) All Source Intelligence Analysis and Production. DIA, through NCMI, is the Responsible Analytical Center (RAC) for medical intelligence analysis and production concerning a pandemic, in collaboration with JIOC-N

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and other GCCs/FCCs and DOD IC. NCMI will provide intelligence warning of diseases with pandemic potential and provide intelligence assessments of the implications, outlook and opportunities associated with the spread of a potentially pandemic disease. NCMI will also provide intelligence warning and finished all source medical intelligence analysis regarding foreign emerging/re-emerging infectious diseases of operational significance to the Combatant Commanders, the DOD, and the U.S. government as a whole. NCMI will provide information regarding foreign medical capability to plan for, report, identify and respond to PI&ID threats.

(2) General Reporting. Information pertinent to the PIRs as outlined in Exhibit 1 to Enclosure B to Tab D to Appendix 1 to Annex C to CONPLAN 3500 will be reported using established reporting procedures and in accordance with Appendix 13 to Annex B to CONPLAN 3500.

f. Dissemination and Integration. As the RAC, DIA/NCMI is responsible for dissemination of medical intelligence products concerning the emergence of a pandemic virus OCONUS, in collaboration with GCCs/FCCs and DOD IC. Products are posted at <https://www.ncmi.dia.smil.mil/subject/epi.php> for easy access. JIOC-N, in collaboration with DOD IC, is responsible for dissemination of products assessing key second and third order impacts of the pandemic on AOR countries. See Appendix 14 to annex B to CONPLAN 3500.

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

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

(3) Information will be classified according to source and content. Sensitive medical reporting with potential to cause damage to national security should be brought before an original classification authority prior to release. Refer to Defense Intelligence Agency Instruction DIAI 5240.004, Information Security Program for classification policy and guidelines.

g. Coordinating Instructions.

(1) Review current DIA/NCMI Warning Assessment for Pandemic influenza for PI and ID indicators.

(2) Review current DIA Dynamic Threat Assessment 3551 for situational awareness.

(3) Participate in Pandemic Influenza and Infectious Disease conferences and biennial table top exercises hosted by NORAD-USNORTHCOM or Joint Staff (JS) when scheduled.

(4) Familiarization with USSTRATCOM CGP-CWMD.

(5) Familiarization with USSOCOM CONPLAN 7500.

(6) Disclosure of Intelligence / Releasability to Partner Nation Forces. Guidelines for foreign disclosure of intelligence information are provided by NORAD-USNORTHCOM FDO IAW National Disclosure Policy. These guidelines are specific to an operation and will vary considerably based on the nations participating and the nature of the operation. Defense Intelligence Community organizations and JIOC-N should to the maximum extent possible write intelligence reports for the widest possible release, preferably at the REL FVEY level. When appropriate, Emergency Dissemination Authority (EDA) may be obtained through NORAD-USNORTHCOM Commander or FDO.

4. Administration and Logistics.

a. Shortfalls and Limiting Factors. J2 has accepted risk in this mission area. There are no analysts dedicated to this mission set on a full-time basis.

b. Mitigation. J25P will provide planning and operational support for PI- and ID-related issues during Phase 0. During crisis, coordination of intelligence support will transition to J23, and J25P assumes a supporting role. This transition of support and associated responsibilities will be exercised in small group training scenarios and TTX when available.

c. Miscellaneous. Role of J23 is codified in the intelligence operating instruction.

d. Logistics. See base plan.

e. Reporting. See Annex R.

5. Command and Control.

a. Command Relationships. See base plan.

b. Communications. See base plan.

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3137 General, USAF
3138 Commander

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3141 Exhibit
3142 1—Priority Intelligence Requirements (PIRs) (classified)

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HEADQUARTERS, U.S. NORTHERN COMMAND
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ENCLOSURE B TO TAB D PI&ID RESPONSE BRANCH PLAN TO APPENDIX 1
TO ANNEX C TO USNORTHCOM CONPLAN 3500 – 14
MEDICAL

1. Medical PPE Options in Response to PI&ID

(a) To mitigate risks to DoD medical personnel operating in environments with infectious diseases of operational concern, this plan establishes a medical PPE framework to expand the scope of current DoD PPE guidance beyond pandemic influenza (PI) and EVD medical responses to a wider range of PI&IDs. The medical PPE framework is based on the U.S. Centers for Disease Control and Prevention Healthcare Infection Control Practices Advisory Committee “2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings.” It consists of two parts: 1) four PPE levels for diseases, each addressing a category of diseases defined by characteristics of the infection and condition and modes of transmission, and 2) a list of PPE items designated for each PPE level to protect body parts of concern (surface exposure areas/routes). The levels of protection offered by the recommended PPE ranges from least to most protective (Level I to IV) based on various exposure and disease variables.

(b) It is important for the N-NC Components to develop training and logistical arrangements compatible to the PPE levels defined in this plan to ensure smooth expansion of medical PPE guidance from individual diseases to disease levels. In particular, the Military Services must analyze and determine appropriate types and quantities of PPE for each level and efficient distribution methods, in terms of centralized or fixed-facility based stockpiles. Military medical treatment facilities should conduct hazard vulnerability analyses and undergo the associated PPE selection process in an infectious disease outbreak incident response, as the hazards in each work environment can be unique and their characteristics must be evaluated accordingly. Additional policy and guidance will be provided as needed to enable comprehensive, responsive, and effective disease prevention and medical care to DoD personnel.

(c) Medical PPE Levels and Options. Below is a brief description of varying levels of PPE ensembles to protect healthcare workers (HCWs). Tables 1 and 2 provide additional information on the medical PPE levels and PPE options, respectively.

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(1) For treatment of some contagious diseases (e.g., common cold and seasonal influenza) or non-contagious diseases (e.g., anthrax and tularemia), Level I PPE will provide sufficient protection to HCWs from possible infection. This level of PPE can also be used for zoonotic or plant diseases as a way to contain the spread and thus control the associated economic loss.

(2) Levels II and III PPE recommendations focus on primary modes of transmission with Level II PPE being designed to protect against droplet and contact transmission and Level III PPE intended to protect against airborne transmission (i.e., inhalation hazards (aerosols)). Consideration should also be given to medical procedures that may aerosolize fluids and particles from contact diseases and create inhalation hazards. For example, if a patient with a viral hemorrhagic fever is undergoing intubation, bronchoscopy, or other medical procedures that can aerosolize the virus, HCWs should use PPE at Level III or higher.

(3) Level IV PPE offers the highest level of protection to its users by protecting all routes of entry into the human body, i.e. contact, inhalation, and ingestion. Level IV PPE is suitable for diseases with undetermined modes of transmission or due to suspected deliberate release. In cases where patients are affected by diseases that are highly contagious; have high case-fatality ratios (CFRs); or may result in severe, persistent, recurrent, or irreversible morbidity, etc., use of Level IV PPE and other disease containment measures should be considered to protect HCWs and other patients. Another factor to consider during the PPE selection process for an infectious disease outbreak incident response is the availability of MCM, e.g. vaccines and therapeutic regimens. The lack of MCM for diseases such as severe acute respiratory syndrome (SARS), EVD, and Middle East respiratory syndrome should be considered to determine whether HCWs use PPE with the highest level of protection.

Table 1. Medical PPE Levels and Disease Conditions/Characteristics

Medical PPE Levels	Disease Conditions/Characteristics	Examples Of Diseases
Level I	Non-Contagious and Some Contagious Disease	Anthrax, tularemia, ricin and some contagious disease (e.g., common cold and seasonal influenza)
Level II	Contact and droplet hazards by body fluids only (limited aerosol risk)	Viral hemorrhagic fevers
Level III	Airborne and/or droplet hazards that may require elements of airborne precautions for aerosol-generating procedures	PI, tuberculosis, smallpox, pneumonic plague
Level IV	Diseases with undetermined modes of transmission or require precautions (airborne and droplet) addressing factors such as a high CFR or severe morbidity, lack of MCM, and other factors	Novel influenza, SARS, EVD due to suspected deliberate release with undetermined modes of transmission, EVD undergoing aerosolizing activities; e.g., childbirth, dialysis, etc.

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Table 2. Medical PPE Options.

PPE	Protected Body Parts	Types Of Hazards Protected Against	Level IV	Level III	Level II	Level I
Coverall Suits ¹	Body	Contact (Blood/Body Fluids)	X			
Gown	Body	Contact (Blood/Body Fluids)	X	X	X	
Apron	Body	Contact (Blood/Body Fluids)	X			
Scrubs, Top	Body	Contact (Blood/Body Fluids)	X	X	X	X
Scrubs, Bottom	Body	Contact (Blood/Body Fluids)	X	X	X	X
Filtering Facepiece Respirator ²	Face/Respiratory Tract	Inhalation (Aerosolized Droplets)	X	X		
Surgical Masks	Face/Respiratory Tract	Contact (Blood/Body Fluids)			X	X
Face Shield	Face/Respiratory Tract	Contact (Blood/Body Fluids)	X	X	X	
Goggles	Face	Contact (Blood/Body Fluids)	X	X	X	
Full-facepiece air purifying respirator (APR) or powered air purifying respirator (PAPR) ³ , or helmet/hood PAPR	Face/Respiratory Tract	Inhalation (Aerosolized Droplets)	X			
Helmet/hood PAPR	Face/Head/Neck	Contact (Blood/Body Fluids)	X			
Surgical Hood or Head/Neck Cover	Head/Neck	Contact (Blood/Body Fluids)	X	X	X	
Shoes	Foot	Contact (Blood/Body Fluids)	X	X	X	X
Boot Covers	Foot	Contact (Blood/Body	X		X	

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		Fluids)				
PVC Boots	Foot	Contact (Blood/Body Fluids)	X			
Hand Sanitizer	Hand	Contact (Blood/Body Fluids)	X	X	X	X
Duct Tape	Hand	Contact (Blood/Body Fluids)	X			
Nitrile Gloves ⁴	Hand	Contact (Blood/Body Fluids)	X	X	X	X

Notes:

1. Coverall suits are acceptable although not an ideal alternative to gowns and aprons. The ease of donning and doffing of gowns and aprons make them preferred options for body protection, considering the risk of cross-contamination is low when the donning and doffing of PPE is simple.
2. National Institute for Occupational Safety and Health-certified filtering facepiece respirators with appropriate filter designation (e.g., N95) may be used in conjunction with face shield or goggles, and surgical hood or head/neck cover. This combination of respiratory protection and other protective equipment and clothing is an acceptable alternative to full-facepiece APRs or PAPRs with surgical hood or head/neck covers, or helmet/hood PAPRs in cases where precautions warrant respiratory, face, and head and neck protection.
3. PAPR unit includes cartridge(s), charger, breathing tube, and battery.
4. Double gloves must be used in cases of viral hemorrhagic fevers (e.g., EVD).

EXHIBIT 1 BIOLOGICAL DETECTION TO ENCLOSURE B TO TAB D PI&ID RESPONSE BRANCH PLAN TO APPENDIX 1 TO ANNEX C TO USNORTHCOM CONPLAN 3500 – 14 MEDICAL

Biological Agent Detection is defined as identification of a biological pathogen of concern. There are numerous ways in which initial detection could occur, including presentation of disease in humans or animals (domestically or internationally), detection through syndromic surveillance, alerts from environmental surveillance systems or international partners, and normal operations and surveillance efforts conducted by law enforcement or other departments and agencies. **Details are provided in Appendix 3: Support and Coordination Elements.** Table X provides examples of some potential sources of initial information with follow-on verification processes. It should be noted that in some instances, detection can predictably occur after the outbreak/incident is well underway resulting in numerous infections prior to initial detection.

Source of Information	Examples of Initial Intelligence Received	Verification Processes	Methods of Information Sharing
Individual practitioner or healthcare facility laboratory	<ul style="list-style-type: none"> Suspected sentinel case reported through local public health Confirmed sentinel case reported through local public health 	<ul style="list-style-type: none"> Private sector, LRN, or CDC laboratory confirmation may be required 	HAN, NPIC, COCA
Individual facility, local or state health department surveillance systems	<ul style="list-style-type: none"> Influx of patients with similar symptoms indicating potential new disease pathogen 	<ul style="list-style-type: none"> Private sector, LRN, or CDC laboratory confirmation may be required Epidemiologic investigation to confirm patterns of similarity 	HAN, NPIC, COCA
Identification of novel or atypical pathogen in federal, SLTT, or private sector laboratory	<ul style="list-style-type: none"> Individual not originally suspected but "surprise" diagnosis received through secondary testing 	<ul style="list-style-type: none"> Private sector, LRN, or CDC laboratory confirmation may be required 	HAN, NPIC, COCA, NPHIC, PACL, NBIS Protocol
Novel emerging or reemerging infection reported under international health	<ul style="list-style-type: none"> New pathogen or pathogen of concern evolving in a situation in which spread to 	<ul style="list-style-type: none"> Multiple international partners as well as international 	HAN, NPIC, COCA, NPHIC, PACL, NBIS protocol

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Source of Information	Examples of Initial Intelligence Received	Verification Processes	Methods of Information Sharing
regulations from overseas source	United States is possible	assistance provided by USG	
Zoonotic outbreak identified by private sector, SLTT, or federal providers or laboratories	<ul style="list-style-type: none"> Zoonotic pathogen identified in an animal population with potential for causing concerning human disease 	<ul style="list-style-type: none"> USDA, CDC, SLTT, NAHLN, or private sector laboratory confirmation all possible 	HAN, NPIC, COCA, NPHIC, PACL, NBIS Protocol
Law enforcement intelligence	<ul style="list-style-type: none"> Credible threat of deployment of pathogen of concern 	<ul style="list-style-type: none"> Law enforcement investigations paired with public health expertise 	LES Bulletin, NSC/Deputies Committee Process, NICCL
Public media	<ul style="list-style-type: none"> Announced release of pathogen of concern 	<ul style="list-style-type: none"> Multiple entities/processes at various levels potentially involved 	NSC/DC Process, NICCL, follow on HAN, NPIC, COCA, NPHIC, PACL
BioWatch or other environmental sampling	<ul style="list-style-type: none"> Pathogen of concern detected in environment leading to a BioWatch Actionable Result or BAR 	<ul style="list-style-type: none"> BioWatch has internal verification processes and may conduct additional sampling If another environmental sample, may require USG support to SLTT sample to verify 	BioWatch National Conference Call, NSC/Deputies Committee Process, NICCL, follow on HAN, NPIC, COCA, NPHIC, PACL, NBIS Protocol

Incidents involving biological pathogens occur regularly but usually do not rise to the level of requiring the coordination of multiple federal agencies and departments. Notification, coordination, and collaboration efforts are ongoing, occurring as part of regular public health activities.

A critical initial consideration regarding any identified pathogen is whether or not it is contagious. Contagious diseases capable of person-to-person spread or spread between people and animals significantly alter the approach to response at all levels. In addition, there are various methods of spread, and degrees of infectivity, viability, and virulence which may not be known initially.

**EXHIBIT 2 NOTIFICATION METHODS TO ENCLOSURE B TO TAB D PI&ID RESPONSE
BRANCH PLAN TO APPENDIX 1 TO ANNEX C TO USNORTHCOM CONPLAN 3500 – 14
MEDICAL**

The following table (see FEMA BIA) lists examples of information sharing processes with descriptions of when they are utilized. For purposes of this annex, notification is most appropriately utilized to describe the process in which the LFA “notifies” interagency partners when unified coordination is required. HHS maintains predesignated points of contact among the interagency but may also request DHS/FEMA to assist with obtaining appropriate Department and Agency representation during initial unified coordination efforts.

Information Sharing Process	Description
BioWatch National Conference Call	Occurs within 2 hours of the BAR declaration and after the local jurisdictional BioWatch Advisory Committee (BAC) call. It begins with a summary of laboratory testing data and a summary of the current local situation by the BAC chair and other local public health, law enforcement, and emergency management representatives to provide situational awareness of follow-on activities and potential requests for assistance from other Federal Agencies (DHS, CDC, FBI, EPA, or the Strategic National Stockpile (SNS)) and a decision regarding the next conference call time.
Clinician Outreach and Communication Activity (COCA)	Provides timely, accurate, and credible information to clinicians related to emergency preparedness and response and emerging public health threats. COCA fosters partnerships with national clinician organizations to strengthen information-sharing networks before, during, and after a PHE.
National Security Council Deputies Committee (NSC) Process	Coordination can occur for a biological incident through the process outlined in PPD-1. The NSC is the President's principal means for coordinating the implementation of national security policy. The Principals Committee is the senior interagency forum for national security policy issues. The Deputies Committee is responsible for day-to-day crisis management. Interagency Policy Committees manage the development and implementation of policy.
Health Alert Network (HAN)	CDC's primary method of sharing public health information with public information officers, federal and SLTT-area public health practitioners, clinicians, and public health laboratories. There are jurisdictional HAN programs from 50 states and the District of Columbia, 8 territories as well as Chicago, Los Angeles, and New York City metropolitan areas.
HHS Public Affairs Conference Line (PACL)	Provides a conference line to allow telephone connectivity for public affairs staff supporting Emergency Support Function (ESF) #8. This conference line provides HHS public affairs personnel to work from dispersed sites during the crisis yet be able to receive guidance or direction or to provide information to those needing it.
National Incident Coordination Conference Line (NICCL)	While DHS traditionally leads the NICCL for transmission and exchange of critical and timely incident information among federal authorities, HHS, when needed, can coordinate communications information related to the public health and medical aspects of a response, particularly in a public health-specific emergency such as a pandemic disease.
National Public Health Information Coalition (NPHIC)	Leverages a network of state and local public health communicators to exchange information and increase the likelihood of consistent messaging and communication activities between federal and SLTT-area governments regarding the emergency and its impact on health.
National Biosurveillance Integration System (NBIS) Protocol	Mechanism to bring federal NBIS partners together on a short-notice teleconference to share information on a potentially significant biological incident. It can be initiated at the request of any NBIS partner and is an example of a unique capability of the National Biosurveillance Integration Center (NBIC) that helps enable national biosurveillance integration. The Protocol is activated when a situation meets one or more of the threshold criteria and is requested by a NBIS agency.
National Response Center (NRC)	As a part of the National Response System, the NRC is the sole national point of contact for reporting all oil, chemical, radiological, biological, nuclear, and etiological discharges

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3312 EXHIBIT 3 LABORATORY NETWORKS IN THE US TO ENCLOSURE B TO TAB D
3313 PI&ID RESPONSE BRANCH PLAN TO APPENDIX 1 TO ANNEX C TO USNORTHCOM
3314 CONPLAN 3500 – 14
3315 MEDICAL

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Lab Network	Description
LRN	Provides analytical support informing public health assessments of the potential for human illness associated with exposure and the scope of associated risk. The LRN also provides for definitive testing of both environmental and clinical samples, as well as limited supporting analysis of food samples that may be implicated as part of epidemiological investigations associated with incident response to cases of human illness.
ERLN	Provides consistent analytical capabilities, capacities, and quality data in a systematic, coordinated response. ERLN integrates capabilities of existing public sector laboratories with accredited private sector labs to support environmental responses. EPA's ERLN is solely dedicated to the testing of environmental samples.
NAHLN	Nationally coordinated network and partnership of federal, state, and university-associated animal health laboratories. NAHLN laboratories provide animal health diagnostic testing, methods research and development, and expertise for education and extension to detect biological threats to the nation's animal agriculture, thus protecting animal health, public health, and the nation's food supply.
NPDN	Provides a cohesive, distributed system to quickly detect and identify pests and pathogens of concern. NPDN laboratories immediately report their findings to appropriate responders and decision makers. To accomplish this mission, the NPDN has invested in diagnostic laboratory infrastructure and training, developed an extensive network of first detectors through education and outreach, and enhanced communication among public agencies and stakeholders responsible for responding to and mitigating new outbreaks.
FERN	Integrates the nation's food-testing laboratories at the federal and SLTT levels into a network that is able to respond to emergencies involving biological, chemical, or radiological contamination of food. The FERN structure is organized to ensure federal and state inter-agency participation and cooperation in the formation, development, and operation of the network.

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3320 EXHIBIT 4 LIST OF VACCINES LICENSED FOR IMMUNIZATION AND DISTRIBUTION
3321 IN THE US TO ENCLOSURE B TO TAB D PI&ID RESPONSE BRANCH PLAN TO
3322 APPENDIX 1 TO ANNEX C TO USNORTHCOM CONPLAN 3500 – 14
3323 MEDICAL
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3325 <http://www.fda.gov/BiologicsBloodVaccines/Vaccines/ApprovedProducts/ucm093833.htm>
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EXHIBIT 2 LIST OF LICENSED BIOLOGICAL PRODUCTS IN THE US TO ENCLOSURE
B TO TAB D PI&ID RESPONSE BRANCH PLAN TO APPENDIX 1 TO ANNEX C TO
USNORTHCOM CONPLAN 3500 – 14

MEDICAL

<http://www.fda.gov/BiologicsBloodVaccines/ucm133705.htm>

**ENCLOSURE C TO TAB D PI&ID RESPONSE BRANCH PLAN TO APPENDIX 1 TO
ANNEX C TO USNORTHCOM CONPLAN 3500 – 14
IDENTIFICATION OF BIOLOGICAL INCIDENTS**

Source of Information	Examples of Initial Intelligence Received	Verification Processes	Methods of Information Sharing
Individual practitioner or healthcare facility lab	<ul style="list-style-type: none"> Suspected sentinel case reported through local public health Confirmed sentinel case reported through local public health 	<ul style="list-style-type: none"> Private sector, LRN, or CDC laboratory confirmation may be required 	HAN, NPIC, COCA
Individual facility, local or state health department surveillance systems	<ul style="list-style-type: none"> Influx of patients with similar symptoms indicating potential new disease pathogen 	<ul style="list-style-type: none"> Private sector, LRN, or CDC laboratory confirmation may be required Epidemiologic investigation to confirm patterns of similarity 	HAN, NPIC, COCA
Identification of novel or atypical pathogen in federal, SLTT, or private sector laboratory	<ul style="list-style-type: none"> Individual not originally suspected but “surprise” diagnosis received through secondary testing 	<ul style="list-style-type: none"> Private sector, LRN, or CDC laboratory confirmation may be required 	HAN, NPIC, COCA, NPHIC, PACL, NBIS Protocol
Novel emerging infection reported under IHR from overseas source	<ul style="list-style-type: none"> New pathogen or pathogen of concern evolving in a situation in which spread to United States is possible 	<ul style="list-style-type: none"> Multiple international partners as well as international assistance provided by USG 	HAN, NPIC, COCA, NPHIC, PACL, NBIS protocol
Zoonotic outbreak identified by private sector, SLTT, or federal providers or laboratories	<ul style="list-style-type: none"> Zoonotic pathogen identified in an animal population with potential for causing concerning human disease 	<ul style="list-style-type: none"> USDA, CDC, SLTT, NAHLN, or private sector laboratory confirmation all possible 	HAN, NPIC, COCA, NPHIC, PACL, NBIS Protocol
Law enforcement	<ul style="list-style-type: none"> Credible threat of deployment of pathogen 	<ul style="list-style-type: none"> Law enforcement investigations paired 	LES Bulletin, NSC/Deputies

Source of Information	Examples of Initial Intelligence Received	Verification Processes	Methods of Information Sharing
intelligence	of concern	with public health expertise	Committee Process, NICCL
Public media	<ul style="list-style-type: none"> Announced release of pathogen of concern 	<ul style="list-style-type: none"> Multiple entities/processes at various levels potentially involved 	NSC/DC Process, NICCL, follow on HAN, NPIC, COCA, NPHIC, PACL
BioWatch or other environmental sampling	<ul style="list-style-type: none"> Pathogen of concern detected in environment leading to a BioWatch Actionable Result or BAR 	<ul style="list-style-type: none"> BioWatch has internal verification processes and may conduct additional sampling If another environmental sample, may require USG support to SLTT sample to verify USPS has a robust program on mail-borne biological threats 	BioWatch National Conference Call, NSC/Deputies Committee Process, NICCL, follow on HAN, NPIC, COCA, NPHIC, PACL, NBIS Protocol

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3343 ENCLOSURE D TO TAB D PI&ID RESPONSE BRANCH PLAN TO APPENDIX 1 TO
 3344 ANNEX C TO USNORTHCOM CONPLAN 3500 – 14
 3345 BIOLOGICAL COMMUNICATION RESOURCES

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Information Sharing Process	Description
BioWatch National Conference Call	Occurs immediately following the local jurisdictional BioWatch Advisory Committee (BAC) call and begins with a summary by the BAC chair of the current situation, follow-on actions, requests for federal assistance from the various agencies (DHS, CDC, FBI, EPA, or the SNS) and a decision regarding the next conference call time.
Clinician Outreach and Communication Activity (COCA)	Provides timely, accurate, and credible information to clinicians related to emergency preparedness and response and emerging public health threats. COCA fosters partnerships with national clinician organizations to strengthen information-sharing networks before, during, and after a PHE.
National Security Council (NSC) Deputies Committee Process	Coordination can occur for a biological incident through the process outlined in Presidential Policy Directive 1. The NSC is the President's principal means for coordinating the implementation of national security policy. The Principals Committee is the senior interagency forum for national security policy issues. The Deputies Committee is responsible for day-to-day crisis management. Interagency Policy Committees manage the development and implementation of policy.
Health Alert Network (HAN)	CDC primary method of sharing public health information with public information officers, Federal and SLTT-area public health practitioners, clinicians; and public health laboratories. There are jurisdictional HAN programs from 50 states and the District of Columbia, 8 territories, as well as Chicago, Los Angeles, and New York City metropolitan areas.
HHS Public Affairs Conference Line (PACL)	Provides a conference line to allow telephone connectivity for public affairs staff supporting ESF #8. This conference line provides HHS public affairs personnel to work from dispersed sites during the crisis yet be able to receive guidance or direction or to provide information to those needing it.
National Incident Coordination Conference Line (NICCL)	While DHS traditionally leads the NICCL for transmission and exchange of critical and timely incident information among federal authorities, HHS, when needed, can coordinate communications information related to the public health and medical aspects of a response, particularly in a public health specific emergency such as a pandemic disease.
National Public Health Information Coalition (NPHIC)	Leverages a network of state and local public health communicators to exchange information and increase the likelihood of consistent messaging and communication activities between federal and SLTT-area governments regarding the emergency and its impact on health.
NBIS Protocol	Mechanism to bring federal NBIS partners together on a short-notice teleconference to share information on a potentially significant biological incident. It can be initiated at the request of any NBIS partner and is an example of a unique capability of the NBIC that helps enable national biosurveillance integration. The Protocol is activated when a situation meets one or more of the threshold criteria and is requested by a NBIS agency.
Epidemiologic Data	Sources of information may include clinical, epidemiologic, and laboratory data from different sources such as providers/private sector, local, state, and federal public health.

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GLOSSARY

Aerosol. A mixture of small droplets of liquid or small particles dispersed as a fine mist, fog, or cloud.

Biological Agent

1. (DOD) A microorganism (or a toxin derived from it) that causes disease in personnel, plants, or animals or causes the deterioration of materiel. Source: JP 3-11.

2. (CFR) Any microorganism (including, but not limited to, bacteria, viruses, fungi, or protozoa), or infectious substance, or any naturally occurring, bioengineered, or synthesized component of any such microorganism or infectious substance, capable of causing: (1) Death, disease, or other biological malfunction in a human, an animal, a plant, or another living organism; (2) Deterioration of food, water, equipment, supplies, or material of any kind; or (3) Deleterious alteration of the environment. Source: 7 CFR Part 331

Biological Hazard. (DOD) An organism, or substance derived from an organism that poses a threat to human or animal health. Source: JP 3-11
Biological warfare. The employment of BW agents to produce casualties in personnel or animals, or damage to plants or materiel; or defense against such employment.

Biological weapon. Biological agent loaded into a munition (e.g., missile warhead, aerosol sprayer). The term biological weapon is often erroneously used to describe a biological agent. (Biological Agent + Munition = Biological Weapon). DHS, Key Planning Factors for Response to Bio Attack

Biosurveillance. Process of active data-gathering with appropriate analysis and interpretation of biosphere data that might relate to disease activity and threats to human or animal health – whether infectious, toxic, metabolic, or otherwise, and regardless of intentional or natural origin – in order to achieve early warning of health threats, early detection of health events, and overall situational awareness of disease activity

Communicable Disease. An illness due to a specific infectious agent or its toxic products that arises through transmission of that agent or its products from an infected and/or affected individual, animal, or a reservoir to a susceptible host, either directly or indirectly through an intermediate animal host, vector, or the inanimate environment. Communicable diseases spread from one person to another or from an animal to a person. The spread often happens via airborne viruses or bacteria, but also through blood or other bodily fluid. The terms infectious and contagious are also used to describe communicable disease.

Contagious. 1. Of or relating to contagion. 2. Transmissible by direct or indirect contact; communicable. 3. Capable of transmitting disease; carrying a disease.

Contagious Disease. See communicable disease.

Emerging infectious disease. Any previously unknown communicable illness or any previously controlled contagion whose incidence and prevalence are suddenly rising. In recent years, some emerging (and re-emerging) infections have been bovine spongiform encephalopathy (mad cow disease), Ebola hemorrhagic fever, cholera, plague, hemolytic uremic syndrome caused by *Escherichia coli* 0157:H7, drug-resistant strains of enterococcus, the human immunodeficiency virus, SARS, and antibiotic-resistant organisms, among many others.

Force health protection (FHP). All measures taken by commanders, supervisors, individual Service members, and the military health system to promote, protect, improve, conserve, and restore the mental and physical well-being of Service members across the range of military activities and operations. These measures enable the fielding of a healthy and fit force, prevention of injuries and illness and protection of the force from health hazards, and provision of medical and rehabilitative care to those who become sick or injured anywhere in the world.

Immunization. The process of rendering an individual immune to specific disease causing agents. Immunization most frequently refers to the administration of a vaccine to stimulate the immune system to produce an immune response (i.e., active immunization). That process may require weeks to months and administration of multiple doses of vaccine. Passive immunization occurs with administration of antibodies to provide prompt but relatively short term immunity.

Infectious Disease. Disease resulting from the presence and activity of a pathogenic microbial agent.

Infectious Disease (of Operational Significance). "An infectious disease (natural, accidental, or deliberate) likely to significantly impact the ability of DOD to maintain mission assurance or likely to result in significant increases in requests for DOD assistance. The disease may occur in humans, animals or plants. Disease characteristics may include: high transmissibility or severity, and high likelihood of impact on force health protection due to limited or no natural protection or medical countermeasures." JSCP

Medical countermeasures. Includes both biologic and pharmaceutical medical countermeasures (e.g. vaccines, antimicrobials, and antibody preparations),

non-pharmaceutical medical countermeasures (e.g. ventilators, devices, personal protective equipment such as face masks and gloves), and public health interventions (e.g. contact and transmission interventions, social distancing, and community shielding) to prevent and mitigate the health effects of biological agents. (Office of Science and Technology Policy, White House)

Medical countermeasure dispensing. The ability to provide medical countermeasures (including vaccines, antiviral drugs, antibiotics, antitoxin, etc.) in support of treatment or prophylaxis (oral or vaccination) to the identified population in accordance with public health guidelines and/or recommendations. (CDC Public Health Preparedness Capabilities, Mar 2011)

Mission Assurance. 1. The ability to achieve strategic objectives (reference (c)).
2. A process to protect or ensure the continued function and resilience of capabilities and assets—including personnel, equipment, facilities, networks, information and information systems, infrastructure, and supply chains—critical to performance of DOD mission-essential functions (MEFs) in any operating environment or condition. (DOD Mission Assurance Strategy and will be incorporated into DODD 3020.40).

Non-pharmaceutical Intervention. Non-technical measures (e.g., social distancing, isolation, quarantine, personal protective equipment) to prevent illness and death due to an attack.

Pathogen. An organism (i.e., viruses, bacteria) that infects its host and causes disease.

Personal Protective Equipment. Equipment (e.g., gloves, respirators, hazardous material suits, etc.) that helps protect responders from being exposed and infected by a biological agent.

Pharmaceutical Intervention. Medical supplies (e.g., vaccines, medicines, diagnostics and other tools) that can be used to prevent illness or death in a population targeted by an attack (also referred to as medical counter measures – MCM).

Pandemic (Influenza). “A worldwide epidemic when a new or novel strain of influenza virus emerges in which humans have little or no immunity, and develops the ability to infect and be passed between humans.”

Implementation Plan for the National Strategy for Pandemic Influenza

PI&ID includes influenza viruses and other highly transmissible diseases that are novel or new, with the following characteristics: 1) easily transmissible among humans, 2) global (rapid local/regional) spread in a short period of time (such as a season), and 3) broad susceptibility among the majority of the human population. *GEF*

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3488 **Re-Emerging Disease.** Any condition, usually an infection, that had decreased
3489 in incidence in the global population and was brought under control through
3490 effective health care policy and improved living conditions, reached a nadir,
3491 and, more recently, began to resurge as a health problem due to changes in the
3492 health status of a susceptible population

3493 Examples Cholera, dengue, diphtheria, malaria, tuberculosis

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3495 **Strategic National Stockpile (SNS).** The Federal cache of pharmaceuticals,
3496 vaccines, medical supplies, equipment, and other items established to augment
3497 local supplies of critical medical countermeasures that may be needed for a
3498 public health emergency or disaster. The SNS is managed by the CDC and
3499 includes (1) the 12-Hour Push Packages positioned in strategically located,
3500 secure warehouses ready for immediate deployment to a designated site within
3501 12 hours of the federal decision to deploy SNS assets, (2) SNS-managed
3502 inventory, and (3) vendor-managed inventory (to increase efficiency and reduce
3503 cost of stockpiling). SNS holdings are supplied to state and local jurisdictions
3504 at their request upon federal authorization. The statutory mission of the SNS is
3505 to provide for the emergency Stockpile (SNS) health security of the United
3506 States (42 USC 247d-6b(a)). (DHHS PHEMCE Strategy, 2012)