THE ASSISTANT SECRETARY OF DEFENSE

WASHINGTON, D. C. 20301-1200

HEALTH AFFAIRS

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

SUBJECT: Policy for DoD Smallpox Epidemiological Response (SER) Teams

The recent anthrax attacks have shown the need for specialized medical response to bioterrorism agents. Should smallpox be used for a terrorist attack, its communicability from person to person could lead to substantial numbers of cases.

The Centers for Disease Control & Prevention (CDC), as the lead federal agency for medical response in the Federal Response Plan, has developed an Interim Smallpox Response Plan that includes the formation of Smallpox Response Teams at the federal, state, and local levels and provides specialized training for those teams. Using the CDC Smallpox Response Plan as a template, DoD developed the "DoD Smallpox Response Plan" that is currently in staffing for approval. The DoD plan is scheduled for final publication in September 2002. Attached is Appendix A-4 from the DoD Smallpox Planning Guidance, which outlines the Smallpox Response Team composition and functions.

I am aware the Services already have epidemiological response capabilities to respond to disease outbreaks that affect our personnel or installations, and that field epidemiological capabilities also exist in our deployable forces. DoD, however must have specially trained and designated Smallpox Epidemiological Response (SER) teams. The SER teams are key elements of both the CDC and DoD response plans, and provide one of the earliest ways to minimize an outbreak. These teams will have special training, coordinate across public health agencies, ensure proper epidemiological and medical response (e.g., early diagnosis, contact identification, treatment, etc.), and ensure implementation of appropriate disease control strategies. The teams will respond to any incidents known or suspected to be related to smallpox or other contagious disease outbreaks, either natural or deliberate, that may occur on DoD installations or during military operations. In addition, the teams will be able to provide assistance during incidents in the surrounding local communities and provide added DoD response capability in support of any request under the Federal Response Plan.

Because the SER teams are critical to responding to a smallpox incident, it is prudent to designate these teams now even as the draft plan is under review. Therefore, I

am asking each of the Services to create two SER teams per Service, each capable of responding to smallpox incidents. The Navy is tasked to provide a team for responding to incidents in/around Pacific Command (PACOM), and the Army is tasked to provide a team for responding to incidents in/around European Command (EUCOM). The other teams will be focused on incidents within the United States, but should have the capability to respond worldwide to support deployed forces and OCONUS installations, as well as provide military support to civil authorities. The Services shall ensure that the needed equipment and specialized initial and periodic training be given to these teams. Details regarding specialized training opportunities will be given later.

In addition to the six new teams discussed above, existing deployable field epidemiological teams (e.g., Theater Army Medical Laboratory (TAML); Air Force Preventive and Aerospace Medicine (PAM) Teams, Biological Assessment Teams (BAT), and Medical Rapid Response Force (MRRF); Navy Preventive Medicine-Medical Mobilization Augmentation Ready Teams (PM-MMART); Civil Support Teams (CSTs); and the Chemical-Biological Incident Response Force (CBIRF)) will also need to receive smallpox response training. The newly formed Smallpox Epidemiological Response Teams will be able to augment the field epidemiological teams in responding to any incidents that may occur during a contingency operation.

DoD SER teams should be comprised of 6-12 persons with the specialty mix and capabilities as described in the attached document (plus alternates). A "reach-back" capability for technical information, and the flexibility to task organize and augment with additional personnel as needed is critical. I urge coordination among the Military Departments, so teams are as uniform in structure and composition as possible. One of the DoD SER teams will need to be on call 24 hours/day and be deployable with equipment and supplies within 6-12 hours of notification. All team members (SER teams and Service field epidemiological teams) must be vaccinated against smallpox. Because smallpox vaccine is currently available only as an investigational new drug, only those who voluntarily accept vaccination can serve on the SER teams. Services should consider stabilizing team members for a minimum of 2 years to maximize training and vaccination resources.

A list of the teams, team members, and team contact information should be provided to this office not later than 4 weeks from the date of this memorandum. My point of contact is Colonel Benedict Diniega, (703) 404-4434.

William Winkenwerder, Jr., MD

Attachment:

Copy to:
Joint Staff (J-4 (HSSD)
Surgeon General, Army
Surgeon General, Navy
Surgeon General, Air Force
Director of Health and Safety, U.S. Coast Guard
Medical Officer, HQ, U.S. Marine Corps

DOD SMALLPOX PLANNING GUIDANCE

APPENDIX A-4
Characteristics of Smallpox Epidemiologic Response Teams ("Smallpox Epi-Teams").

1. Purpose. To describe the composition, capabilities, activation, and activities of Smallpox Epidemiologic Response Teams (Smallpox Epi-Teams) that would respond to any report of possible exposure or occurrence of cases of smallpox.

2. Background. Smallpox is unique as a bioterrorist weapon in its high case-fatality rate and ability to spread from person-to-person in an open society such as the United States. Routine vaccination of US military recruits against smallpox was intermittent after 1984 and discontinued in 1990. Routine vaccination of US civilians ceased in about 1972. Thus, susceptibility to smallpox is universal among children and young adults, and widespread among older adults (Appendix 7).

3. Assumptions.

a. Smallpox virus may be used in a terrorist attack against US civilian or military targets anywhere in the world. Such attacks may occur silently, with case appearance as the first evidence of such an attack. Other attacks may be associated with detectable events, in which case a suspicious substance and potentially exposed personnel would be the immediate issues of concern.

b. DoD will be expected to respond with its own resources to any such incidents that occur on its own installations in the United States or on other bases around the world. Some assistance may be possible from civilian authorities when an attack involves a community near a military installation. Civilian resources may be overwhelmed and civilian authorities will likely be unable to fully support activities on military installations.

c. In the event of an attack in the US that does not directly involve military installations, civilian resources may be overwhelmed and civilian authorities could call upon DoD resources to assist in providing response support.

d. In the event of an outbreak, early compilation of accurate information to confirm and define the scope of the problem will be a critical element in any response effort.

e. Early recognition and definition of a possible smallpox attack may be the deciding factor in how quickly the spread of disease can be contained.

4. Possible Scenarios.

a. There are several types of events that may occur:

(1) Reports of one or more clinical cases suspected to be smallpox.

(2) An incident occurs in which one or more people are exposed to a substance suspected to be smallpox.

b. There are several types of civilian-military interaction that may occur:

(1) Within the borders of the United States, an attack occurs that initially appears to involve only personnel and locations entirely on a military installation.

(2) Within the borders of the United States, an attack occurs that initially appears to involve only civilian personnel and locations outside of military installations.

(3) Within the borders of the United States, an attack occurs that initially appears to involve both civilian and military personnel or to involve locations both within and outside of military installations.

(4) Outside of the borders of the United States, an attack occurs that appears to involve military personnel or military installations.

(5) Outside of the borders of the United States, an attack occurs that appears to involve only US civilian personnel and locations outside of military installations (e.g., Embassies and their staffs).

5. Concept.

a. Depending on the nature of the attack, a DoD Smallpox Epi-Team may be assigned under the operational control of a Unified Command, a medical command authority of one of the US Armed Services (e.g., a regional medical command, Military Treatment Facility), or an installation commander. Alternatively, after a request from civilian authorities, the team could be assigned under the operational control of FEMA, CDC, state health officer, or other designated authority.

b. Number of Smallpox Epi-Teams. DoD will establish at least six teams, two from each Service, to provide the necessary global response capability to DoD. One or two will be located in the Pacific region, at least two in the United States, and one or two in Europe.

c. Smallpox Epi-Team Composition. Epidemiologic response teams will be trained with materials developed by the DoD and the CDC. Each full team will consist of approximately 6 to 12 members. DoD may field smaller teams with

sufficient capability where local support can be expected from host organizations or installations. Sufficient members will be identified to allow team function despite members taking personal leave. Team members will typically serve terms of 24 or more months. Teams will arrange for replacement of a portion of the team on an annual cycle, according to personnel turnover. The core members of the teams will typically include the following:

(1) Team leader (1 per team). A senior officer in the medical branch responsible for all activities of the team. This individual will serve as the lead coordinator with military and civilian authorities and oversee communication between the team and command-and-control elements.

(2) Operations officer or public-health advisor (1 to 2 per team). Medical Service Corps, Medical Corps, or other medical-branch officer with training in public health (e.g., community health nurses) who assists the team leader with communications, logistics, inter-agency coordination, mission tracking, reporting to high headquarters, vaccination activities, contact tracing, training, and related functions. Also serves as primary adviser for operations and disease-response activities, including recommendations for quarantine, isolation, and hospital infection control.

(3) Epidemiologist (1 per team). Medical corps officer or other medical branch officer with advanced degree in epidemiology who serves as technical consultant and primary leader of investigation activities, medical surveillance, data collection, analysis, and definition of the scope of disease occurrence.

(4) Infectious-disease physician and/or dermatologist (1 to 2 per team). Serves as primary consultant in diagnosing and monitoring possible cases of disease. Also assists with diagnosis of adverse events after vaccination and monitors and analyzes vaccine safety data. Serves as the primary consultant on matters of infection control in medical facilities. An Infection Control Officer could fulfill some roles in this category.

(5) Laboratory scientist (1 per team). Medical service corps officer with laboratory expertise who advises team leader on specimen collection, handling, shipping, and related procedures. Serves as liaison with military and civilian laboratories to support the investigation and disease-control plan.

(6) Preventive-medicine, public-health, or environmental-health technician (1 to 2 per team). Provides logistical and administrative support to team, to meet requirements for equipment, supplies, transportation, meals, and quarters. As time allows, augments the activities of other team members, to assist in accomplishing critical tasks.

(7) Communication specialist (0 to 1 per team). Public affairs or medical branch officer or senior noncommissioned officer with excellent writing and

speaking skills and experience in media relations and risk communication. Serves as the communication link between the team and local health departments, press offices, and other outside agencies requesting information on team activities. In the absence of a specific member assigned to the team, the team will request local support from the host command.

(8) Occupational-medicine specialist (0 to 1 per team). An occupational-medicine physician who provides consultation and recommendations relating to protecting health-care workers, health department staff, emergency responders, and others with occupational risk in the outbreak.

(9) Community health nurse (0 to 1 per team). Community health nurse who provides expertise in performing case investigations, contact tracing, teaching, and home visits.

(10) Immunization technician (1 or more per team). A medic trained in screening for contraindications, vaccination, and management and reporting of adverse events after vaccination.

d. Smallpox Epi-Team Capabilities. Epi-Teams will be on-call to travel within 6 to 12 hours upon activation. The team will provide initial problem definition and assessment capabilities to senior authorities. After an initial in-brief with the host command authority, the team will complete an initial assessment within 24 hours and provide updates on assessment activities at least daily thereafter. The Smallpox Epi-Team will serve in the capacity of a field investigative team and will have at least the following capabilities:

(1) Confirm or refute the existence and number of smallpox cases.

(2) Confirm or refute the presence of a substance that may contain smallpox virus (subject to more definitive testing facilities elsewhere in the Laboratory Response Network).

(3) Upon confirmation of cases or an exposure, estimate the immediate threat of disease spread in the affected population.

(4) Serve as advisors to local authorities on immediate response activities, to include vaccination, quarantine, medical care, and safety precautions.

(5) Rapidly identify additional resources required to support response to an outbreak and coordinate an appropriate civilian or DoD response package.

(6) Administer smallpox vaccine.

6. Required Training and Preparation.

a. All team members will be vaccinated against smallpox.

b. All team members will attend smallpox training provided by the CDC and/or DoD. Examples include the DoD Emergency Preparedness Course, Health-Risk Communication Course, Combined Humanitarian Assistance Response Training.

c. All team members will be knowledgeable experts on the CDC Interim Smallpox Response Plan and Guidelines, as well as this DoD Smallpox Response Plan.

d. Teams will complete 1-day planning and practice sessions at least quarterly.

7. DoD Implementation.

a. Team development and support will be coordinated by the US Army Medical Department, as lead agent for the DoD Immunization Program for Biological Warfare Defense. Nonetheless, individual team composition and the various teams will be constituted and supported by each of the military Services. The Services and the Joint Staff will develop agreements to ensure that Unified Combatant Commands and other command authorities develop plans to support this response capability.

b. Prior planning and coordination with Unified Commands is critical to ensure that senior commanders know of and are prepared to request the Smallpox Epi-Team capability as needed. Also, hosting commands will provide the logistical, transportation, and other support requirements the team will need.

c. Initial team training and preparation will focus on the smallpox threat. However, as team capabilities mature, the team will develop expertise in responding to other bioterrorist events or to epidemics of contagious disease that result from natural, as well as deliberate, causes.