OFFICE OF THE UNDER SECRETARY OF DEFENSE
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MAY 11 2009

PERSONNEL AND READINESS

MEMORANDUM FOR SECRETARY OF THE ARMY
SECRETARY OF THE NAVY
SECRETARY OF THE AIR FORCE
CHAIRMAN OF THE JOINT CHIEFS OF STAFF

SUBJECT: Public Health Emergency Management of the 2009 H1N1 Flu

Attached is an update on Department of Defense (DoD) activities in response to the 2009 H1N1 Flu. DoD Directive 6200.3, "Emergency Health Powers on Military Installations," May 12, 2003, provides policy on special command authorities in public health emergencies and activities of Public Health Emergency Officers (PHEOs). This Directive will be reissued as DoD Instruction, "Public Health Emergency Management," which is now in coordination. Additional relevant current policy is in DoD Instruction 6055.17, "DoD Installation Emergency Management Program," January 13, 2009.

The official DoD pandemic influenza (PI) Website, the DoD PI Watchboard (http://fhp.osd.mil/aiWatchboard/), provides updated information related to pandemic influenza and the 2009 H1N1 Flu outbreak. Additional information on pandemic influenza and the 2009 H1N1 Flu outbreak also can be found at www.pandemicflu.gov and http://www.cdc.gov/h1n1flu/guidance/.

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Gail H. McGinn
Performing the Duties of the
Under Secretary of Defense
(Personnel and Readiness)

DoD Public Health Emergency Management of the 2009 H1N1 Flu

Background

Public health emergencies such as pandemic influenza (PI) may result in surge requirements that overwhelm the response capacity, capability, and resources of both medical facilities and health care providers. Under these conditions, "situational standards of care" may be needed. Attachment 1 is an Assistant Secretary of Defense (Health Affairs) memorandum of September 1, 2008, that addressed prioritizing medical care delivery during pandemics and other public health emergencies. It includes guidelines on alternate standards of care in public health emergencies.

Circumstances suggesting a public health emergency as defined by the World Health Organization (WHO), the Centers for Disease Control and Prevention (CDC), and the Department of Defense (DoD), should be immediately reported through appropriate Service, Combatant Commander, and military medical channels in accordance with attachment 2, "Quarantinable Disease and Other Public Health Emergency Notification Routing Requirements." Circumstances suggesting a public emergency from other sources should be reported using the process described in CJCS Manual 3150.05c, "Joint Reporting Structure (JRS) Situation Monitoring Manual."

Responsibilities

As provided in DoD Directive 6200.3, the Secretaries of the Army, Navy, and Air Force, develop collaborative networks of installation/command Public Health Emergency Officers (PHEOs). These networks communicate locally and regionally with the federal interagency and the Geographic Combatant Commands with respect to the interactions with state, local, tribal, territorial, and host-nation governments.

The designation of a PHEO as required by DoD Directive 6200.3 should be accompanied by designation of an alternate PHEO and two trained Electronic Surveillance System for Early Notification of Community-based Epidemics (ESSENCE) users. Additional steps must ensure that public health emergency management is integrated into existing emergency preparedness and response plans and agreements for commands and installations (including DoD reservations such as the Pentagon). They must make certain that risk and crisis communications are executed by Public Affairs in coordination with all appropriate installation and command stakeholders. Groups and persons subject to quarantine or isolation shall obey the rules and orders established by the Commander.

Consistent with DoD Directive 6200.3 and DoD Instruction 6055.17, each military medical treatment facility (MTF) Commander/Officer in Charge will establish a National Incident Management System-compliant, comprehensive emergency management program that integrates all aspects of public health and medical planning. The MTF Commander will direct every healthcare provider or medical examiner to promptly report to the appropriate PHEO any circumstance suggesting a public health emergency. The

Commander also should identify key response personnel, authorize licensed but non-credentialed healthcare providers to provide care as necessary during emergencies, and ensure that MTF emergency management is integrated with existing emergency preparedness and response plans. The MTF Commander shall designate an emergency management team to prepare and execute their facility's response plan.

Consistent with DoD Directive 6200.3 and DoD Instruction 6055.17, the PHEO shall maintain situational awareness of public health and medical threats; provide advice to the Commander regarding the declaration of a public health emergency and the implementation of emergency health powers; ensure appropriate epidemiological investigation; recommend appropriate diagnosis, treatment, and prophylaxis of affected individuals or groups and populations in consultation with appropriate clinical staff; support Commanders in the integration of public health and medical preparedness with other installation/command emergency response planning and exercises; support preparedness for public health and medical surge capacity in collaboration with the MTF emergency management team; assist in risk communications; and coordinate with civilian state, local, tribal, and territorial or host-nation agencies and organizations regarding the above.

Clinical Guidelines
Guidelines regarding the clinical management of patients with 2009 H1N1 Flu or influenza-like illness can be found at the DoD PI Watchboard, "Pandemic Influenza: Clinical and Public Health Guidelines for the Military Health System," located at http://fhp.osd.mil/aiWatchboard/preparedness_and_communication.jsp#dodpolicies

Laboratory Planning and Diagnostics
Respiratory samples for suspected cases of 2009 H1N1 Flu should be routed to the relevant state public health laboratory or other DoD-designated H1N1 testing activities (e.g., United States Air Force School of Aerospace Medicine, Naval Health Research Center). Additional testing sites and any changes in DoD respiratory specimen handling or routing will be announced on the DoD PI Watchboard. Public health laboratory confirmation of suspected cases should be pursued in accordance with current CDC and DoD guidance. As this outbreak evolves, laboratory confirmation may not be required for every clinically suspected case. Additional guidance regarding specimen collection, handling, shipping, and biosafety can be found on the CDC website at http://www.cdc.gov/h1n1flu/guidance/. Aliquots of original samples and culture material (if available) from all confirmed 2009 H1N1 positive samples should be maintained and forwarded to the Walter Reed Army Institute of Research, Division of Viral Diseases (301-319-9612) for full genome sequencing in collaboration with the CDC.

Notification Requirements
Confirmed cases of the 2009 H1N1 Flu are currently notifiable as a Public Health Emergency of International Concern. Attachment 2 is a template for public health

emergency notification that will be further refined in the DoD Instruction, "Public Health Emergency Management." Every DoD component identified in attachment 2 should ensure each of their specified reporting relationships are established and operational. Service Public Health Centers are required to report probable and confirmed cases of 2009 H1N1 Flu among active duty members and other beneficiaries to the Armed Forces Health Surveillance Center (AFHSC). AFHSC serves as the only authoritative DoD agency for comprehensive medical surveillance and reporting of rates of diseases and injuries among DoD Service members and beneficiaries outside of Service-specific reporting needs. The AFHSC reports health data directly to the Assistant Secretary of Defense (Health Affairs). AFHSC will modify reporting requirements (e.g., case definition(s), reporting times, and process, as necessary, and disseminate this information to the Services. More information on the AFHSC can be obtained at http://www.afhsc.mil

Antiviral Distribution and Use

The Assistant Secretary of Defense (Health Affairs) will authorize the release of part of DoD stockpiled antiviral medications so that the Military Health System will be prepared to rapidly respond to the threat of a confirmed PI throughout the entire range of military operations and health care settings. These supplies are reserved for use exclusively in the event of a declared pandemic. There are supplies of antivirals currently available within the MHS for use in treatment of seasonal influenza. At this time, DoD MTFs and military healthcare providers must dispense these antiviral medications based entirely on medical necessity. Guidelines regarding the appropriate use of antivirals for treatment and prophylaxis can be found in "Pandemic Influenza: Clinical and Public Health Guidelines for the Military Health System" located on the DoD PI Watchboard at http://fhp.osd.mil/aiWatchboard/preparedness_and_communication.jsp#dodpolicies

THE ASSISTANT SECRETARY OF DEFENSE
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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 (M&RA)
DIRECTOR, JOINT STAFF
DEPUTY ASSISTANT SECRETARY OF DEFENSE (C&PP)

SUBJECT: Department of Defense Policy for Prioritizing Delivery of Medical Care during Pandemics and Other Public Health Emergencies of National Significance

Public health emergencies of national significance such as an influenza pandemic will result in surge requirements that overwhelm the response capacity, capability, and resources of both medical facilities and health care providers. Under these conditions, alternate standards of care will be adopted, and difficult decisions regarding the allocation of limited resources will be required.

The Military Health System (MHS) will adopt the following framework for the delivery of medical care during pandemics and other public health emergencies and will incorporate it into all aspects of planning for these emergencies.

The MHS direct care system has two primary objectives. The first is to support the national security mission and the second is to provide care for TRICARE Prime and TRICARE Plus enrolled beneficiaries with Military Treatment Facility (MTF) primary care managers. Other objectives of the direct care system have lesser priority. It is DoD policy that MTF Commanders will fulfill both of these primary objectives. Under emergency conditions, the allocation of resources may not be based solely on medical necessity or risk, but also may be based on operational or other national security requirements, as directed by the President or Secretary of Defense. Some uniformed personnel, for example, may receive a higher level of care due to operational requirements, independent of their immediate medical risk. This does not preclude the responsibility to continue to care for beneficiaries enrolled with MTF primary care managers. These beneficiaries have an understandable expectation of continued access to their primary care.

Commanders of MTFs are directed to make public health emergency plans to meet surge requirements related to the two primary missions. Commanders will make arrangements that ensure that the minimum level of care provided to all enrolled beneficiaries is, at the very least, comparable to local community standards in the context

HA POLICY: 08-010

of the public health emergency. Such arrangements may include special work schedules, increased use of reserve component members, intermittent employees, reemployed annuitants, contractor personnel, and volunteers, and coordination with the TRICARE managed care support contactor. Planning to ensure for the smooth transition of care for MTF-enrolled patients by non-DoD providers, to the extent that is necessary, must be accomplished well in advance of emergency conditions and the agreed-upon arrangements clearly communicated to all enrolled beneficiaries. Determination of critical personnel, rather than blanket policies affecting all Service members in an area of responsibility, will help meet the two seemingly conflicting objectives affecting mission requirements and beneficiary care. This will require a critical analysis at local levels of what represents a critical role. To fully manage expectations and appropriately educate the beneficiary population on the emergency response plan relating to access to care, it is imperative that risk communication messages and products include instructions pertaining to where to receive care in the event of a public health emergency.

As in any mass casualty event, when resources are inadequate, the adoption of altered community standards of care will be required. In non-deployed settings, the standard of care, at the very least, should be comparable to local civilian community standards. In many settings, the standard of care may exceed that of the local civilian community. In deployed settings, the altered standard of care will not necessarily mirror that of the host nation but will be based on available assets and requirements consistent with preexisting medical triage practice.

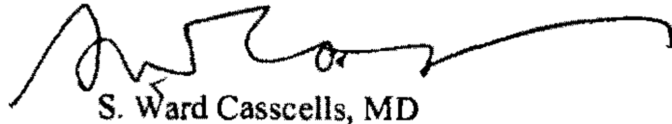
When all available resources are insufficient to meet the health care needs of beneficiaries in a public health emergency, the MHS shall use the limited resources to achieve the greatest good for the greatest number. Under these circumstances, "good" is defined as lives saved and suffering alleviated. In an environment of insufficient resources, MHS commanders shall not require expenditure of resources if treatment likely would prove futile or if a disproportionate amount of assets would be expended for one individual at the cost of many other lives that otherwise could be saved. MHS commanders are to ensure the most competent medical authority is available, at the lowest level of command possible, to make medical judgments of this nature.

Decisions involving triage for care and the allocation of medical supplies also must take into account the values of personal rights and fairness to all. Critical mission requirements may require allocation of resources based on operational rather than medical risk. MTFs will provide care to their enrolled populations as noted previously. Other eligible beneficiaries are expected to seek care at the facilities where they routinely receive primary care. MTF commanders must communicate regularly and clearly on the resource limitations that exist at their facilities to maximize the communities' effective response to a public health emergency. Access to MTF care will comply with the

beneficiary group priority list at 32 CFR 199.17. However, availability of care is always subject to mission requirements directed by the President or Secretary of Defense.

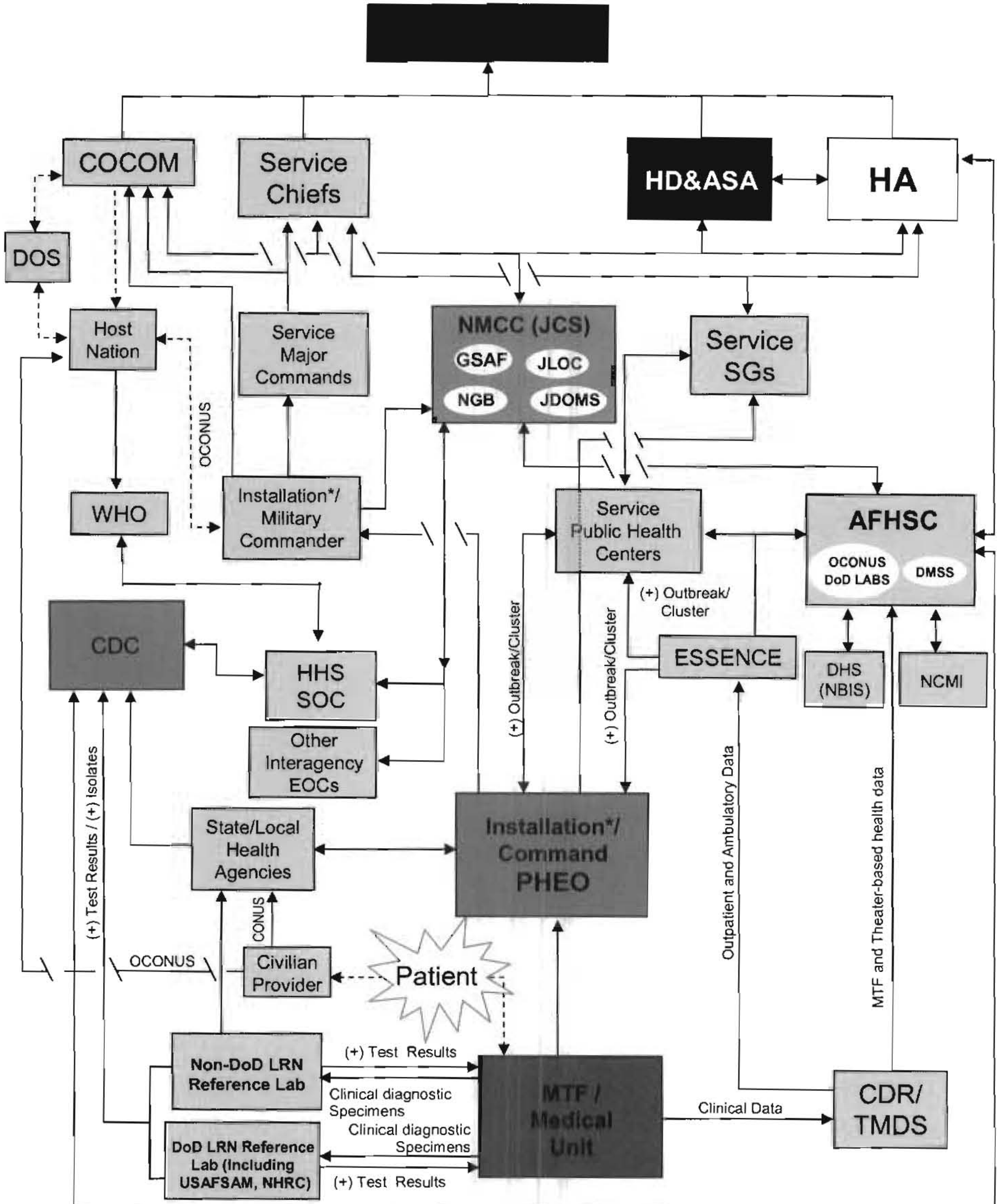
Commanders and health care providers throughout DoD need to engage in ongoing planning and decision-making consistent with this general policy and responsive to changing local conditions. They must effectively communicate those decisions to each other and the community before emergencies, as well as during emergencies when conditions change. Conditions affecting decisions include, but are not limited to, availability of health care providers and resources such as pharmaceuticals, ventilators, and hospital beds, all in the context of evolving disease characteristics on target and at-risk populations. A decision made in one area may not be appropriate for another due to conditions such as population demographics, susceptibility, capacity, and resources. A discussion of planning challenges, including ethical issues, is in the Agency for Healthcare Research and Quality document "Mass Medical Care with Scarce Resources" (2007) (www.ahrq.gov/research/mce/).

All levels of command and health care providers will incorporate these principles in developing their pandemic response plans and in determining the allocation of limited medical resources.



S. Ward Casscells, MD

Quarantinable Disease and Other Public Health Emergency Notification Routing Requirements



* This includes DoD reservations such as the Pentagon

AFHSC	Armed Forces Health Surveillance Center
CDC	Centers for Disease Control & Prevention
CDR	Clinical Data Repository
CoCOM	Combatant Command
CONUS	Continental United States
DHS	Department of Homeland Security
DMSS	Defense Medical Surveillance System
DOS	Department of State
EOC	Emergency Operations Center
ESSENCE	Electronic Surveillance system for the Early Notification of Community-Based Epidemics
GSAF	Global Situational Awareness Facility
HA	Assistant Secretary of Defense for Health Affairs
HD&ASA	Assistant Secretary of Defense for Homeland Defense and Americas' Security Affairs
HHS SOC	Department of Health & Human Services, Secretary's Operations Center
JCS	Joint Chiefs of Staff
JDOMS	Joint Director of Military Support
JLOC	Joint Logistics Operation Center
LRN	Laboratory Response Network
MTF	Medical Treatment Facility
NBIS	National Biosurveillance Integration System
NCMI	National Center for Medical Intelligence
NGB	National Guard Bureau
NHRC	Naval Health Research Center
NMCC	National Military Command Center
OCONUS	Outside Continental United States
PHEO	Public Health Emergency Officer
Sec Def	Secretary of Defense
Service SGs	Service Surgeons General
TMDS	Theater Medical Data Store
USAFSAM	U.S. Air Force School of Aerospace Medicine
WHO	World Health Organization

Service Public Health Centers: USAFSAM, Navy and Marine Corps Public Health Center, and the U.S. Army Center for Health Promotion & Preventive Medicine