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HEADQUARTERS, US NORTHERN COMMAND
250 Vandenberg Street
Peterson AFB, CO 80914-3270
06 January 2017

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

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

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

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

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

g. Area of Concern.

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

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

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

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

h. Deterrent Options.

(1) Force Health Protection (FHP). Traditional deterrent options against 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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(4) Accidents/Misuse. The on-going evolution in life sciences presents an inherent risk of misuse (or accidental release) of agents that have similar characteristics as a naturally occurring PI&ID.

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

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

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

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

3. The Plant/Animal category is for non-human diseases of operational significance (e.g., may hinder mission assurance or result in a 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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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

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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989
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.

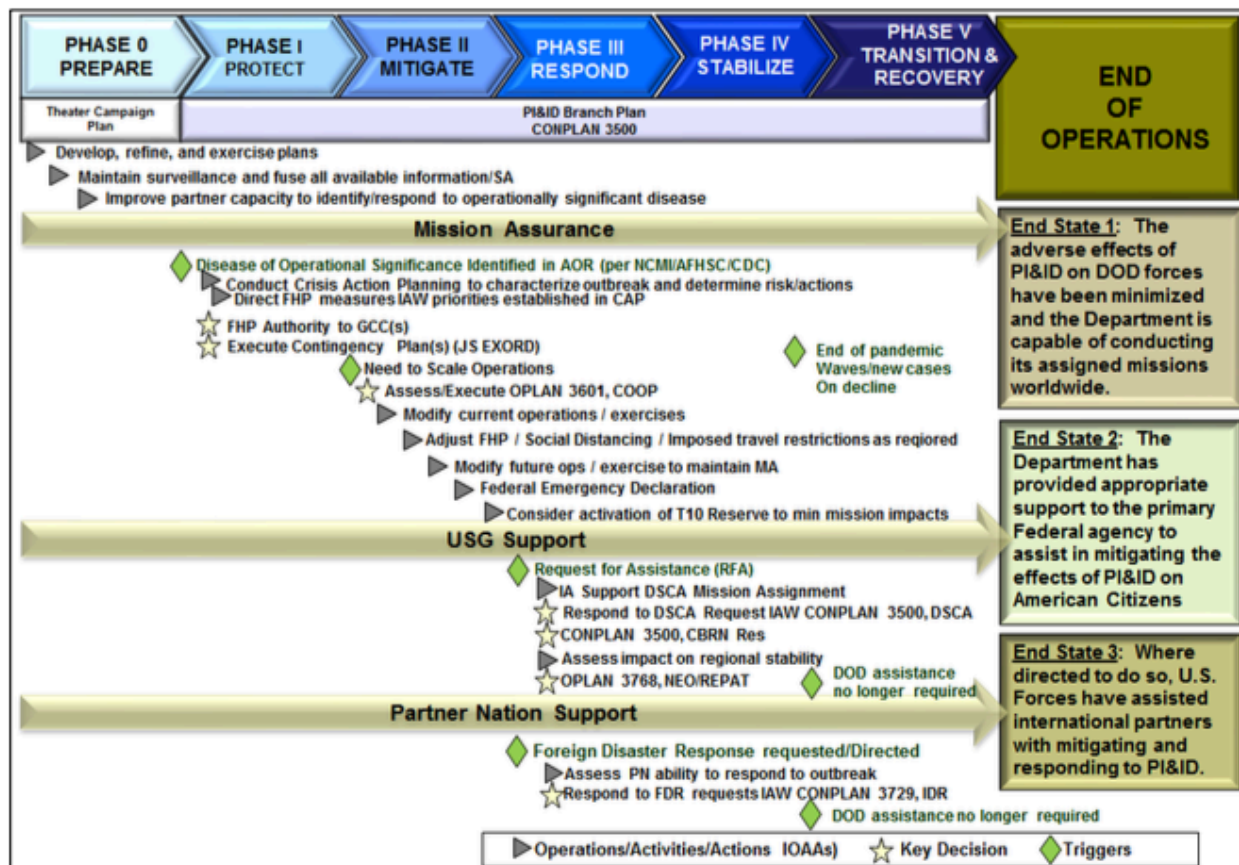
1000
1001 (1) Commander's Intent.

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

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(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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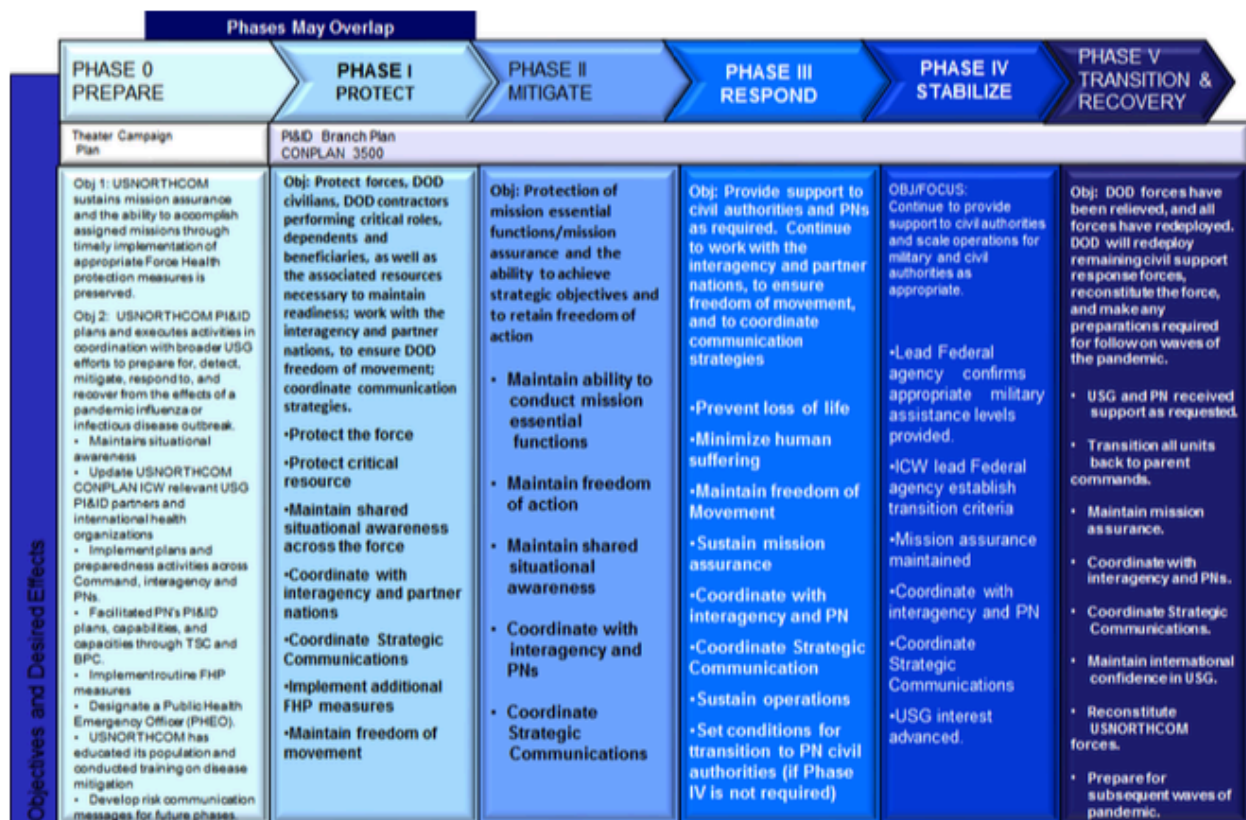
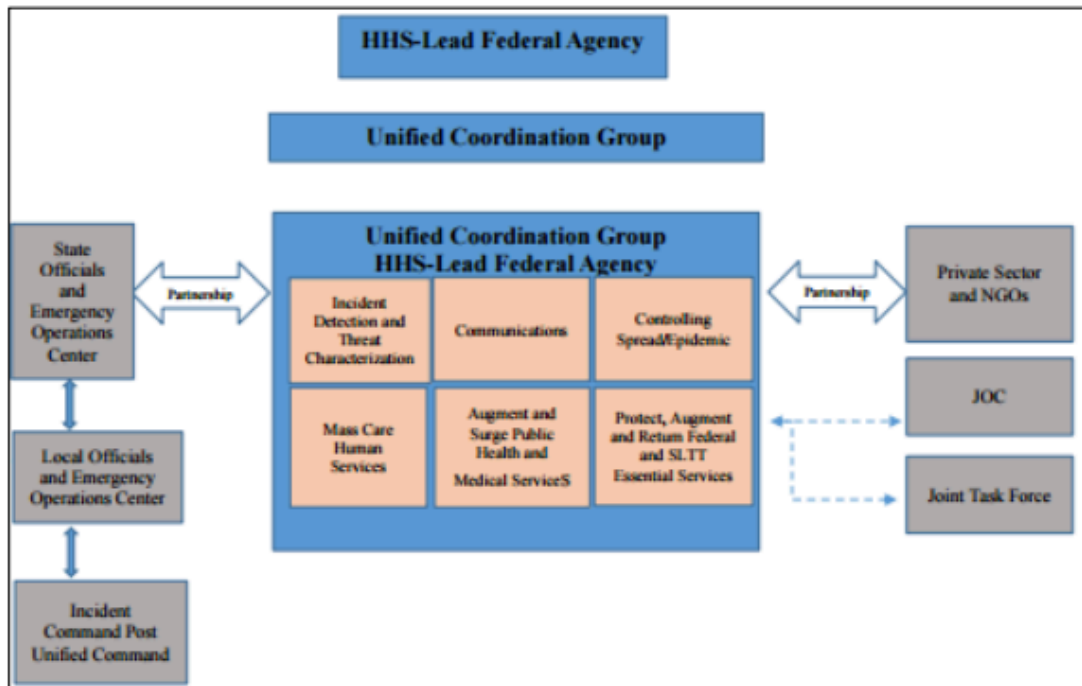


Figure 1.a., PI&ID Response Objectives & Effects by Phase

(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).

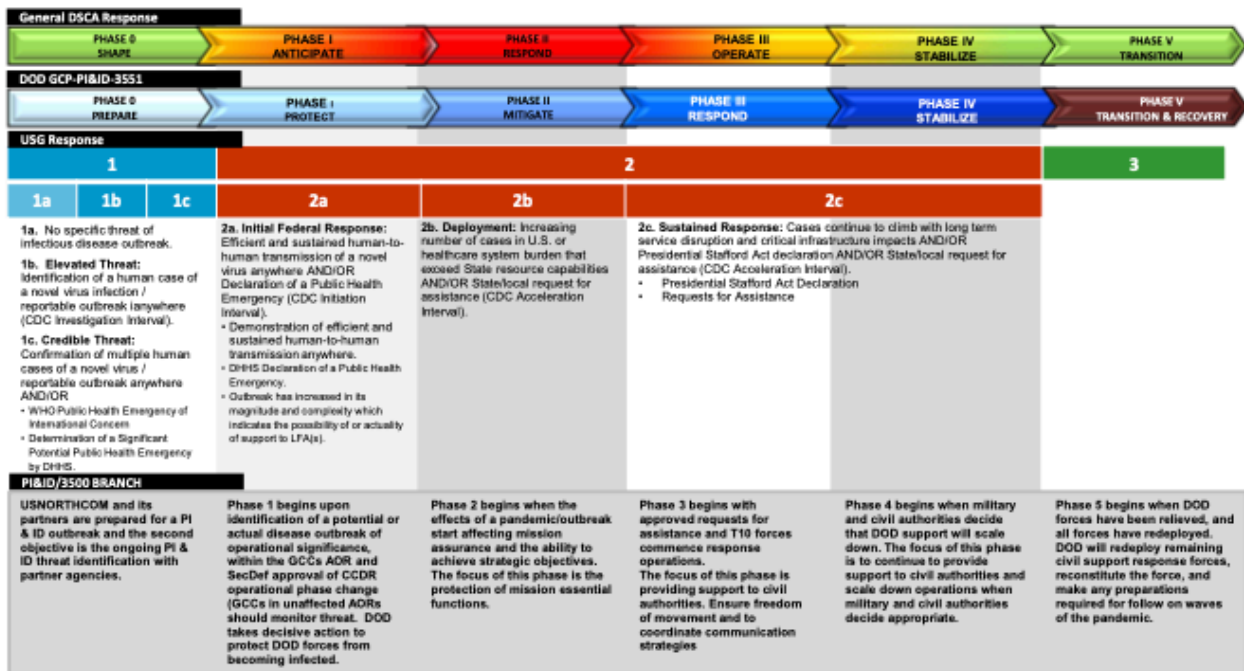
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Note: This figure represents a local level and may occur in those jurisdictions significantly affected by a large-scale biological incident. The UCG develops appropriate national-level response actions to such incidents while overseeing implementation 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.

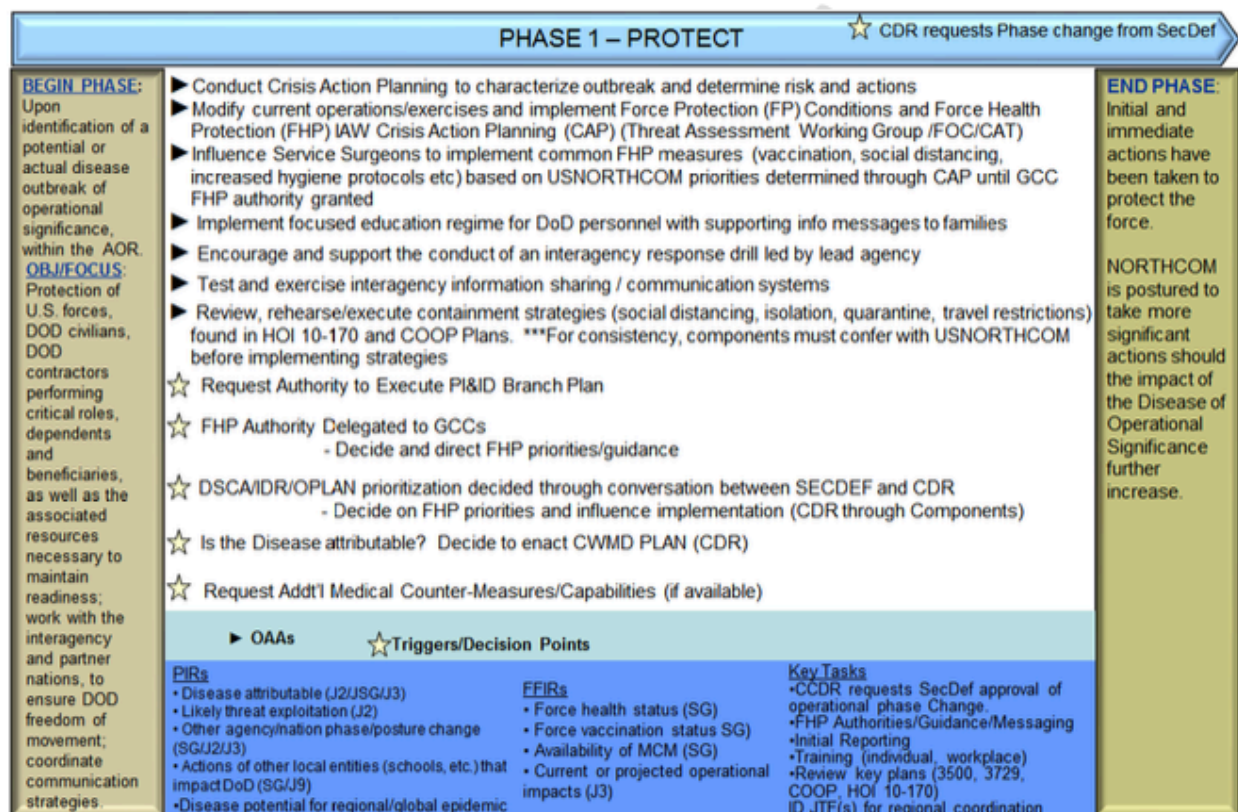


Figure 2, PI&ID Response Phase 1 - Protect

(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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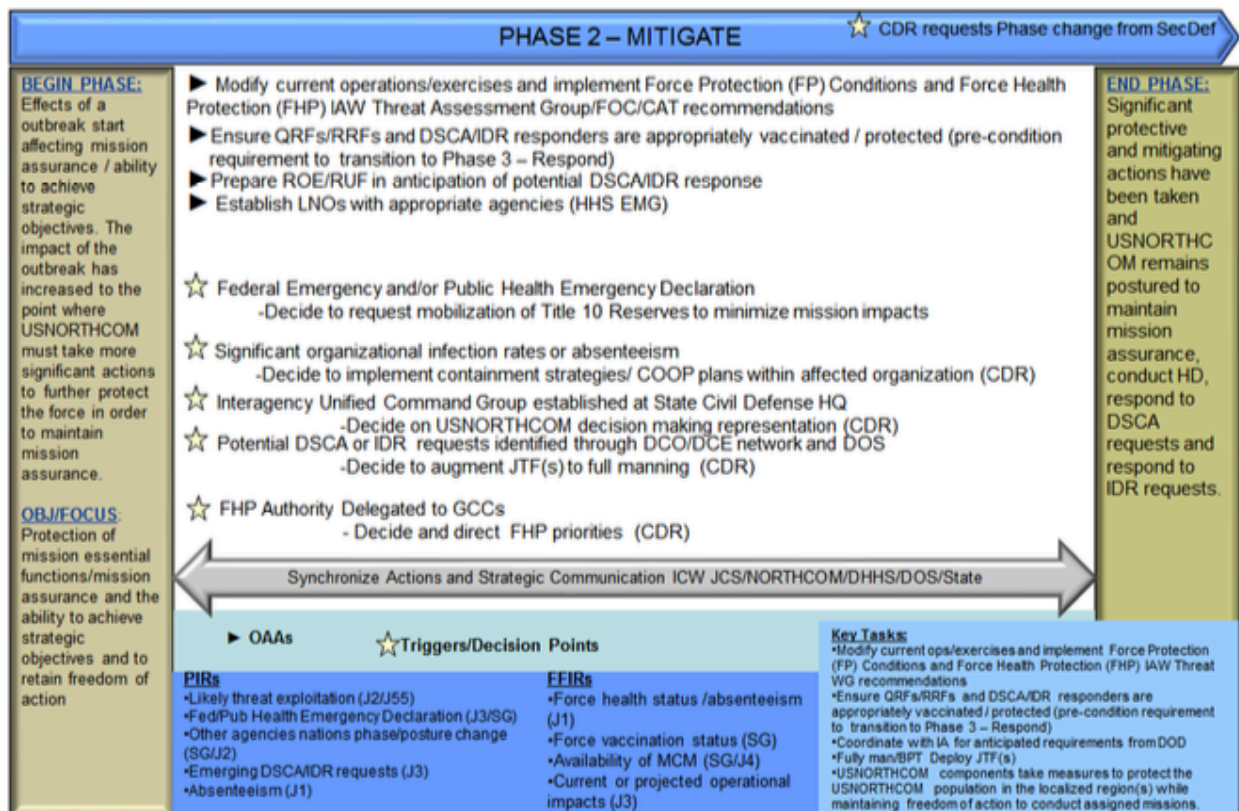


Figure 3, PI&ID Response Phase 2 - Mitigate

(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.

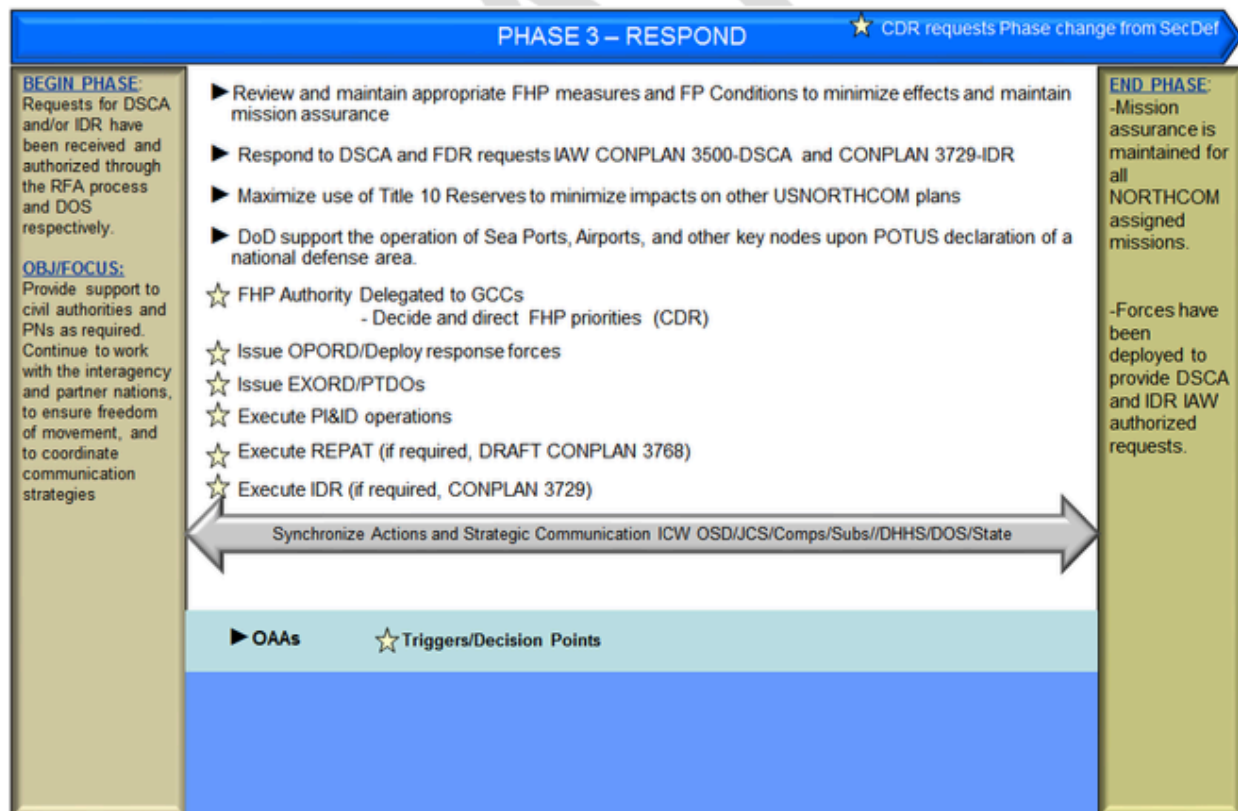


Figure 4, PI&ID Response Phase 3 - Respond

(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.
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