



DEPARTMENT OF THE NAVY

BUREAU OF MEDICINE AND SURGERY
2300 E STREET NW
WASHINGTON DC 20372-5300

IN REPLY REFER TO
BUMEDINST 6200.17
BUMED-M35
17 Oct 2006

BUMED INSTRUCTION 6200.17

From: Chief, Bureau of Medicine and Surgery
To: Ships and Stations Having Medical Department Personnel

Subj: PUBLIC HEALTH EMERGENCY OFFICERS (PHEO)

Ref: (a) DOD Directive 6200.3 of 12 May 2003
(b) OPNAVINST 3440.17
(c) CNICINST 3440.17
(d) OPNAVINST 5430.48D
(e) DOD Instruction 5200.08 of 10 Dec 2005
(f) Emergency Health Powers Working Group draft white paper: "Advancing
Emergency Health Powers On Military Installations"
(g) OPNAVINST 3100.6H

Encl: (1) Public Health Emergency Officer Duties and Responsibilities
(2) Public Health Emergency Officer Core Competencies and Recommended
Training
(3) Sample Memorandum of Agreement between (Operational, Regional, or
Installation Command) and (Navy Medicine Organization Providing the PHEO)

1. Purpose

a. To provide Chief, Bureau of Medicine and Surgery (BUMED) policy for supplying Public Health Emergency Officers (PHEO) for requesting military commanders required by references (a) through (c) to designate a PHEO.

b. To define PHEO duties and responsibilities as required by references (a) through (c), and to provide guidance in their qualifications, training, and selection.

2. Background. Large-scale emergencies, whether of natural, technologic, or terrorist origin, often threaten the lives and health of a large number of people. Reference (a) defines them as public health emergencies (PHE). Recent events have highlighted the critical need for public health expertise in both preparing for and responding to PHEs. The purpose of the PHEO, as described in reference (a), is to provide the military commander with the public health expertise and support required to enable sound management decisions before, during, and after PHEs.

3. Applicability. Applies to all BUMED activities that have assigned personnel suitable to be designated as a PHEO by a military commander per reference (a), to all shore installations per reference (c), and to operational command surgeons under the authority of reference (d).

4. Policy. Commanders, commanding officers (COs), and officers in charge (OICs) of activities under BUMED authority shall nominate appropriate personnel to be designated a PHEO by requesting military commanders, following references (a) through (c) and (e). If no suitable personnel are assigned to the BUMED activity, it shall request assistance from its Navy Medicine regional command to identify appropriate personnel. These actions will be governed by the following guidance:

a. Requesting Military Commanders (RMC). Expect RMCs to be Navy or Marine Corps region or installation commanders in most cases. References (a) and (c) direct Navy regions and installations to designate PHEOs and reference (a) directs MTFs to provide installation PHEOs. Reference (a) also states that “every military commander required by DOD Directive 5200.8 [now superseded by reference (e)] to issue regulations for protecting and securing property and places under his or her command shall designate a PHEO...”. Per reference (e), designating commanders (DC) include “commanding officers of Naval ships or afloat units, commanders, or commanding officers of Naval shore activities or installations, bases, camps, stations, and supply activities, subject to the jurisdiction, administration, or in the custody of the Department of the Navy.” Thus, BUMED activities must be prepared to assist commanders other than Navy and Marine Corps region and installation commanders with PHEO selection, when requested.

b. Coordination. Per reference (c), PHEO designation is an element of the Navy Installation Emergency Management Program. Both Navy regions and Navy installations are directed to have Emergency Management Working Groups (EMWG). BUMED activities shall engage the applicable EMWG(s) to coordinate PHEO assignments that will best serve the particular local constellation of region/installations in the event of a PHE.

(1) For PHE-related matters, each PHEO reports only to the military commander who designated him or her. However, there must be extensive communication and coordination among PHEOs both laterally (among nearby commands) and vertically (installation to region) for there to be an accurate common operating picture of the PHE and its evolution.

(2) Certain public health or emergency health powers decisions may need to be made by the regional commander and mandated to the installations in the region. Therefore, the regional PHEO must stay in close contact with all installation and command PHEOs to be able to advise the regional commander effectively regarding region-wide issues.

(3) In areas where multiple installations exist in close proximity within a region, commanders may be better served by a single PHEO, rather than separate PHEOs as suggested by reference (a).

(4) In localities where multiple Services have installations, coordination among the Services for PHEO assignments will result in the greatest level of preparedness for PHE events.

(5) Small installations may not require a PHEO, but where an installation PHEO will not be designated, a PHEO representative should be designated to maintain liaison with the nearest PHEO. The PHEO representative should be a member of the medical department with some background in public health and preventive medicine.

c. PHEO Qualifications

(1) Per reference (a), a PHEO “shall be a senior health professions military officer or Department of Defense (DOD) civilian employee affiliated with the command, or the commander of a higher level or associated command” and “should be the command surgeon, local equivalent, hospital commander, or other senior leader with experience and training in functions essential to effective PHE management.”

(2) PHEOs should have a Master of Public Health (MPH), 2 years experience in public health, preventive medicine, or environmental health, and significant operational experience (preferably a complete tour of duty). However, other officers with a strong public health background who can meet PHEO competencies with additional training can serve as PHEOs.

(3) PHEOs may be officers of any corps who meet PHEO qualifications.

d. PHEO Duties and Responsibilities

(1) Per reference (a), authorities and responsibilities of the PHEO are subject to the direction and authority of the commander making the designation. Enclosures (1) and enclosure (3) appendix A, based largely on reference (f), delineate a recommended set of responsibilities for the purpose of establishing continuity of duties across BUMED activities.

(2) The PHEO is an advisor to the DC, and the assignment of a PHEO does not alter the legal or regulatory responsibilities of the commander.

e. Training. BUMED activities shall provide appropriate training for their staff being designated as PHEOs to ensure core competencies are met. Refer to enclosure (2) for guidance and continuity.

f. Memoranda of Agreement (MOA). BUMED activities shall coordinate MOAs with commanders requesting PHEO support. Such MOAs shall address specific PHEO responsibilities, level of support (both pre-event and during-event), and location of support and funding of costs incurred (travel, etc.). Refer to enclosure (3) for an example MOA.

5. Responsibilities

a. BUMED, through the Navy Medicine Office of Homeland Security/Contingency Support (BUMED-M35), is responsible for overall policy regarding PHEO qualifications, training, responsibilities, and selection.

b. NAVMED Regional Commanders shall ensure oversight of PHEO support provided by their subordinate activities to requesting commanders.

c. Operational Command Surgeons should coordinate with supporting BUMED activities to nominate appropriate personnel to serve as PHEOs when public health expertise beyond that available within the command is needed.

d. Navy Medicine Support Command is responsible for PHEO program management through the Navy Environmental Health Center and PHEO training through Navy Medicine Manpower, Personnel, Training and Education Command.

e. PHEOs shall:

(1) Perform duties and assignments as guided by enclosure (1) and assigned by the designating operational commander.

(2) Maintain the necessary knowledge and skills as guided by enclosure (2), including a minimum of 20 hours of continuing medical education (CME)/continuing education unit (CEU) in public health or disaster management.

(3) Immediately notify the applicable Navy Medicine Regional Commander, the Surgeon General of the Navy, the Medical Officer of the Marine Corps, and the Assistant Secretary of Defense (Health Affairs), through the Deputy Assistant Secretary of Defense (Force Health Protection and Readiness), in case of declaration or imminent declaration of a PHE, or in case of other milestone events with far-reaching public health significance. Report by the most expeditious means available, but also by following all applicable guidance in reference (g).



D. C. ARTHUR

Distribution is electronic only via the Navy Medicine Web site at:
<http://navymedicine.med.navy.mil/default.cfm?seltab=directives>

PUBLIC HEALTH EMERGENCY OFFICER
DUTIES AND RESPONSIBILITIES

1. Public Health Emergency Officer (PHEO). The PHEO is the frontline responder on a military installation in a PHE, whether of natural, technologic, or terrorist cause. PHEOs are responsible for providing commanders with guidance and recommendations on preparing for, declaring, responding to, and recovering from a PHE. The advice provided by PHEOs must be consistent with current medical, scientific, and public health knowledge, and must consider the population at risk, command critical missions, and processes and procedures of military and national response plans (NRPs).

a. PHEO Core Duties and Responsibilities

- (1) Maintain awareness of threats to public health of all types.
- (2) Provide recommendations for the declaration of a PHE.
- (3) Provide public health expertise and consultation to the installation commander.
- (4) Ensure appropriate epidemiologic investigations of suspected cases of serious communicable disease are performed, in coordination with military, host nation, Federal, State, tribal, and local health officials as appropriate.
- (5) Provide recommendations regarding appropriate diagnosis, treatment, and prophylaxis of individuals infected with or potentially exposed to epidemic disease or biological agents.
- (6) Ensure declarations of PHEs and exercise of emergency health powers, as specified in reference (a), are integrated into emergency management plans.
- (7) Collaborate with installation logistics and acquisition personnel to determine local requirements for medical countermeasures and personal protective equipment (PPE) for medical and non-medical emergency management personnel, and other covered populations.
- (8) Provide appropriate risk communication to affected population groups.
- (9) Maintain close coordination with local, tribal, State, host nation, or national health departments for all actions undertaken following this guidance.

b. Within each of these broad categories of core responsibilities are a number of supporting tasks and responsibilities that the PHEO must be able to accomplish. The tables in appendix A to enclosure (3) are not exhaustive, but reflect a consensus baseline.

PUBLIC HEALTH EMERGENCY OFFICER
MAJOR AREAS OF RESPONSIBILITY

1. Maintaining Situational Awareness. Early detection is essential to ensure a prompt and effective response to a biologically caused public health emergency, including disease containment and the provision of prophylactic medicines, antidotes, or vaccines. Towards that end, DOD continues to integrate its surveillance, detection, and reporting systems. As part of this effort, DOD has partnered with the CDC and state and local health agencies to enhance detection and reporting of reportable illnesses as part of routine surveillance mechanisms. This continuous "situational awareness" is critical to ensuring the earliest possible warning to protect the military and beneficiary population. As such, PHEOs must possess a robust understanding of disease surveillance.

2. Recommend Declaration of a Public Health Emergency

a. In the event of a bioterrorism event or a potential pandemic disease outbreak, military commanders may need to restrict freedom of movement to mitigate the public health threat. In the absence of rapid and definitive diagnostic tests, vaccines, or cures; isolation, restriction of movement, and quarantining remain the best countermeasures against the spread of disease and illness. The initial response to the public health emergency involving an infectious agent will focus on containing the organism at its source, if feasible, to prevent a potential pandemic. Once spread beyond the initial focus occurs and the organism is introduced into a larger population of susceptible individuals, the focus of containment activities will shift to public health and individual measures to slow and prevent transmission.

b. Containment measures are those that attempt to limit or slow the transmission of disease and may affect individuals, groups, or entire communities. Quarantine refers to the restriction of disease carriers to an area where their contact with non-exposed, non-carriers is limited. Isolation, which is almost exclusively used in an institutional setting, is initiated for diseases that may be transmitted through casual contact or respiratory transmission. Another form of restriction of movement is the "Cordon Sanitaire," which is usually associated with confining people to a defined geographic area in which there is a disease outbreak.

c. The PHEO plays a key role in assessing potential public health emergencies and advising commanders. The PHEO must be ready to advise military installation commanders on actions to limit the spread of the outbreak and to mitigate the health and social impacts of a potential pandemic by sustaining infrastructure, military mission capability, and essential services. Military commanders' decisions regarding restriction of movement on a military installation of infected or potentially-infected DOD and non-DOD personnel will be determined by the nature of the outbreak and the laws,

regulations, and policies governing those specific situations, especially concerning non-military personnel. Commanders must obtain legal and medical advice from their appropriate staffs on individual situations. Current quarantine laws, regulations, and enforcement procedures vary widely from State-to-State. While a Centers for Disease Control (CDC) model State Emergency Health Powers Act has been developed, not all States have adopted or implemented this model. PHEOs should be familiar with the State laws, the Public Health Service Act (42 USC 264), Executive Orders 13295 and 13375, 42 USC 243, International Health Regulations, and the Federal Response Plans.

3. Expert Advice and Consultation to the Commanders

a. Installation commanders have the ultimate responsibility for declaring a public health emergency on a military installation. The commander relies on his or her staff to provide the expertise needed to make these decisions, and will turn to the installation PHEO, legal counsel, PAO, security forces commanders, and logistical officers, among others, to provide expert advice in a PHE.

b. The PHEO's central role in coordinating and advising the response to a PHE, however, cannot be overstated. Issues on which commanders may consult PHEOs include: planning for effective disease intervention strategies; the declaration of a PHE and implementation of emergency health powers; the release of public information on public health; the conduct of epidemiologic investigations and interpretation of their results; the designation of appropriate isolation/quarantine facilities and sustaining operations to support individuals and communities; adjudication of release or requests from quarantine; and coordination with local, State, national, and host nation public health officials.

4. Epidemiological Outbreak Investigation

a. Outbreak investigations, an important and challenging component of public health, can help identify the source of ongoing outbreaks and prevent additional cases. The most compelling reason to investigate a recognized outbreak of disease is that exposure to the source(s) of infection may be ongoing; thus, by identifying and eliminating the source of infection it may be possible to prevent additional cases. Conducting an outbreak investigation is a cooperative effort that demands a rapid, organized, complete, and reliable response.

b. If the outbreak is ongoing at the time of the investigation, it is urgent to find the source of the outbreak to prevent additional cases. If the outbreak involves hundreds or thousands of households, an unprecedented surge in response capacity, especially public health, hospital workers, and other staff, will be needed. Preparation for a large-scale investigation should be considered response planning.

c. When executed correctly, an outbreak investigation can provide valuable information such as the severity of the disease; the number and geographic distribution of persons ill and potentially exposed; how the infection is spreading; and the timetable of the illness outbreak. PHEOs must be trained and experienced in conducting outbreak investigations.

5. Diagnosis, Treatment, and Prophylaxis of Individuals Infected or Potentially Exposed

a. Guidance on the clinical management of persons with quarantinable diseases should be developed in advance of any potential outbreak. Intervention in suspected or confirmed disease clusters must address administration of vaccines and/or drug prophylaxis to all probable exposed persons.

b. Initial clinical management may include the use of anti-viral agents, where available, as well as supportive care with emphasis on the rapid identification and treatment of secondary complications. Provision of care may be provided in an inpatient or outpatient setting. The decision to hospitalize an individual is based on the physician's clinical assessment, available resources, and the suitability of the alternate environment for ongoing care.

c. All installations should establish community containment plans and checklists that include triggers or thresholds for implementation of containment measures. The plans should include the identification of appropriate outpatient, treatment, isolation, and quarantine facilities and communications networks. All installations should exercise the plans with traditional (e.g., public health and health care workers, volunteers) and non-traditional (e.g., transportation workers) community partners. Target chemoprophylaxis requires intensive disease surveillance to ensure coverage of the entire affected area, effective communication with the affected community, and rapid distribution and administration.

6. Planning and Conducting Exercises for Emergency Health Powers

a. During a PHE, commanders are faced with significant and unique health, logistical, ethical, legal, social, mission, and psychological challenges in dealing with emergency health powers and disease control and containment measures. Isolation, restriction of movement, and quarantine require operationally, socially, clinically, and logistically complex strategies to manage sick or potentially exposed people. Movement restriction, which requires people to stay home from work or remain isolated at work for extended periods, places considerable stress on operational units, communities, households and families, and individuals.

b. Planning and conducting exercises for the challenges of effective implementation of emergency health powers will yield a dividend for the DOD. The PHEO provides installation commanders with the expertise necessary to construct, review, and test operational plans for this type of contingency. A comprehensive exercise program should address the trans-jurisdictional issues of the military and local civilian community, mutually-agreed upon protocols and testing of these plans through tabletop and actual exercises to identify areas for improvement. Further, the PHEO participates in the development of self-assessment tools for preparedness, including performance standards, tabletop simulations, and field and other exercises.

7. Logistics and Acquisition of Medical Countermeasures and PPE

a. PHEs place great stress on MTFs and impact the health care delivery provided to those seeking care and, if quarantine or restriction of movement is implemented, preventive treatment and care for those affected. To manage the overwhelming demand without compromising the function of the MTF, optimal methods for delivering medical supplies, medical countermeasures, and PPE should be established. The PHEO plays an integral role in this process.

b. In conjunction with logistics, command, and resources management, the PHEO will establish limited stockpiles of PPE to ensure that potentially infected personnel seeking care at the health care facility do not spread the virus to other patients or to health care providers treating patients during a pandemic. Planning factors must be determined and used to establish stockpiles. For example, in planning for pandemic influenza, the DOD applied the CDC's estimate that 35 percent of the population within their treatment area will contract influenza, approximately half of which will seek medical care.

c. PPE, including respirators and masks, protective gowns, gloves, and eye protection as appropriate, must be considered in the planning phases for a PHE. Additional items to consider stockpiling are antibiotics to treat secondary infections, antivirals to assist in treating patients, and prophylaxes for health care workers and populations that may be in quarantine.

d. If PHEOs are unable to establish a stockpile of required PPE because the cost is prohibitive, every effort must be made to ensure reliable and dependable delivery of medical material. The medical logistics support staff must work in concert with the PHE planning process to coordinate with vendors to ensure that routine supply and re-supply amounts will not suffer during a pandemic. As such, PHEOs must ensure their logistical support elements have processes in place to cover surge requirements for an extended period of time.

8. Risk Communication

a. Leaders can have a measurable effect on the well-being of their members through clear, rapid, and sincere communication. A well-prepared leader has communication plans and resources in place to minimize the number of decisions about communication that must be made in the event of an emergency. PHEOs must assist with planning communications, developing key messages, and providing answers to the installation community's questions.

b. This communication is initiated before a crisis occurs and continues throughout the event. Installation preparedness for implementing individual- and installation-wide control measures can be enhanced by improving public understanding of disease outbreaks and the benefits of community-wide disease control practices. Installation communication efforts should include explaining how individual actions (e.g., compliance) and community efforts (e.g., snow days) can help reduce disease transmission. Education campaigns may describe the criteria, justification, process, role, methodology, and durations of quarantines and the social, medical, and psychological ways in which persons will be supported during the quarantine period. Key messages prepared for use during exercises should be adapted for use in actual PHEs.

c. Installation-level education campaigns involving community partners can instill a sense of trust and confidence in the installation's ability to respond to a PHE. These campaigns should be undertaken before a pandemic to ensure preparedness and the adequate communication of roles and responsibilities to all levels of government, segments of society, and individuals.

9. Coordination with Local and State Health Departments CONUS and with Host-nation and Allied Forces OCONUS

a. State, local, and tribal public health departments play an extremely important role in all hazards, emergency preparedness, and response. PHEOs must have working relationships with public health officials and access to response plans for their State, local, or tribal area. The PHEO must support installation commanders and installation response planners by ensuring the establishment of formal or informal collaborative agreements and relationships between local civilian and military commanders for the management of a declared community-wide PHE. In areas with multiple jurisdictions, whether civilian, military, Federal, or tribal, planning for quarantine must be based on collaborative command and control, best articulated in a Memoranda of Agreement (MOA) or Memorandum of Understanding (MOU).

b. Early collaboration of non-medical officials should be obtained in exercise planning periods. Health officers initiate quarantine measures, but non-medical personnel largely implement them. Success of an exercise requires active collaboration by a wide variety of local public officials and non-medical military officers. Communities planning to exercise quarantine in collaboration with local military commanders should enlist the cooperation of local military force protection as well as medical officers early in their planning.

PUBLIC HEALTH EMERGENCY OFFICER
CORE COMPETENCIES AND RECOMMENDED TRAINING

1. Public Health Emergency Officer Core Competencies. The following knowledge and skills are the minimum necessary for a PHEO to perform his or her duties and responsibilities:

- a. Knowledge of disease and other health threats with the potential for creating a PHE.
- b. Knowledge of Federal, State, tribal, local, and host nation statutes, regulations, and policy applicable to public health aspects of emergency management preparedness, response, and recovery.
- c. Knowledge and skills in disease outbreak and other public health threat investigation, analysis, and reporting.
- d. Knowledge of prevention, countermeasures, diagnosis, containment, and treatment of diseases or conditions that may pose a public health threat.
- e. Skills in public health risk communication.
- f. Knowledge and skills in emergency management, including:
 - (1) Health threat and hazard analysis.
 - (2) Emergency operations planning.
 - (3) Design, development, execution, and evaluation of emergency management exercises.
 - (4) Emergency management continuous quality improvement processes.
 - (5) Emergency management response, including National Incident Management System and the Incident Command System.
 - (6) Federal, State, local, and host nation emergency management plans and procedures.
 - (7) Knowledge of area of responsibility (AOR) installations' jurisdiction status (exclusive Federal, concurrent, proprietary, other) and resulting effect on primacy of Federal, State, or other laws with respect to quarantine, reporting, and other aspects of PHEs.

2. Supporting Educational Recommendations. The PHEO should have a Master of Public Health, a minimum of 2 years experience in public health, preventive medicine, environmental health, and significant operational experience, preferably a complete tour. The PHEO will also require extensive knowledge in the principles of emergency management. Specific training or experience in the following areas is recommended:

- a. Epidemiology related to bioterrorist agents and pandemic diseases.
- b. Public health law related to quarantine and disease reporting requirements at the international, national, State, and host nation levels.
- c. The NRP and Emergency Support Functions #6 and #8 (ESF-6, 8).
- d. DOD CONUS response coordination with Joint Regional Medical Planners (JRMPS) and the Joint Regional Medical Planning Offices (JRMPOs).
- e. Service and DOD disease surveillance systems and programs.
- f. Disease containment strategies for individuals and populations.
- g. Risk communication.
- h. International, Federal, and State quarantine law and the legal basis for quarantine authority.
- i. Health Insurance Portability and Accountability Act (HIPAA) regulations.
- j. Status of Forces Agreements (SOFAs), MOUs, MOAs, and other relevant agreements related to disease containment.
- k. Specific health threats to the DOD installation based on geographic location and Force Health Protection concerns.
- l. Infectious diseases, chemical, biological, radiation, nuclear and explosive (CBRNE) agents.
- m. Installation, region, Service, and COCOM response plans.
- n. DOD, Federal, and State public health tools for rapid epidemiological investigation and control of suspected or confirmed acts of biological or chemical terrorism, coupled with a designated stockpile of terrorism-related medical supplies via a national pharmaceutical stockpile.

o. Coordination of an epidemiological investigation with military or civilian law enforcement organizations in response to a suspected terrorist event

p. "Train-the-trainer" education to prepare to train other personnel, including installation commanders, judge advocates general (JAGs) and PAOs on PHEs.

3. Specific Curricula Supporting PHEO Core Competency Development:

a. Medical Management of Chemical and Biological Casualties Course (MMCBC) (Course #6H-F26, School Codes 877/879). The course is designed for Medical Corps and Nurse Corps officers; Physician Assistants; Medical Service Corps officers in specialties 67B, C, or E; and other selected medical professionals. Classroom instruction, laboratory, and field exercises prepare graduates to effectively manage casualties of chemical and biological agent exposure. Course Length: 5 days.

b. Medical Effects of Ionizing Radiation Course. This course, sponsored by the Armed Forces Radiobiology Research Institute (AFRRI), focuses on the effects of ionizing radiation, and the diagnosis and medical management of those effects. Course Length: 1 day.

c. Homeland Security Medical Executive Course (HLSMEC). Sponsored by the Defense Medical Readiness Training Institute (DMRTI), trains senior medical officers (O4-O6) for command and senior staff positions in support of the NRP, and to the challenges and complexities of a CBRNE event or natural disaster in the United States and its territories. HLSMEC is held at least once a year in San Antonio or may be exported to a funding unit or organization. Course Length: 5 days.

d. Tri-service CBRNE Training Program. The current Tri-Service CBRNE Training Program is a modular, web-based distance-learning product called the Emergency Medical Preparedness and Response Course (EMPRC) available at the navy Knowledge On-Line Web site at: <https://wwwa.nko.navy.mil>.

e. IS-100 Introduction to Incident Command System. Sponsored through the Department of Homeland Security, Federal Emergency Management Agency, Emergency Management Institute. Available at: www.training.fema.gov/EMIWEB/IS100.asp.

f. IS-700 National Incident Management Systems, An Introduction. Sponsored through the Department of Homeland Security, Federal Emergency Management Agency, Emergency Management Institute. Available at: www.training.fema.gov/EMIWEB/IS700.asp.

BUMEDINST 6200.17
17 Oct 2006

g. IS-800 NRP, An Introduction. Sponsored through the Department of Homeland Security, Federal Emergency Management Agency, Emergency Management Institute. Available at: www.training.fema.gov/EMIWEB/IS800.asp.

h. IS-120 An Introduction to Exercises. Sponsored by the Department of Homeland Security. This course introduces individuals to the basics of exercise program management, design, development, conduct, evaluation, and improvement planning. Available at: <http://209.176.175.84/hseep2/IS120/login.asp>.

SAMPLE

MEMORANDUM OF AGREEMENT
BETWEEN (OPERATIONAL, REGIONAL, OR INSTALLATION COMMAND)
AND (NAVY MEDICINE ORGANIZATION PROVIDING THE
PUBLIC HEALTH EMERGENCY OFFICER)

1. Background. In the event of large-scale emergencies, whether of natural, technologic, or terrorist origin, often threaten the lives and health of large numbers of people. Recent events have highlighted the critical need for public health expertise in both preparing for and responding to public health emergencies (PHEs).
2. Purpose. This agreement is between the (operational, regional, or installation command) and (Navy Medicine organization providing the PHEO) to provide the military commander with the public health expertise and support required to enable sound management decisions before, during, and after PHEs.
3. It is agreed that:
 - a. (Insert name and rank) is designated the PHEO for (insert military organization) effective (insert date).
 - b. PHEO responsibilities begin well in advance of declaration of a PHE. The PHEO will contribute approximately (.1-.5) full time equivalent (FTE) to pre-event activities, including planning and exercises.
 - c. During a PHE, the PHEO will support the designating commander on a full-time basis and will report to him or her directly. Upon declaration of a PHE, temporary additional duty (TAD) orders will be written by the nominating medical commander stating such declaration.
 - d. PHEO duties may include those enumerated in enclosure (1) of BUMEDINST 6200.17, but are performed at the express direction of the designating commander. Specific additional functions **assigned** to the PHEO or functions specifically **not assigned** to the PHEO must be identified in writing by the designating commander.
4. The PHEO's place of duty shall be:
 - a. _____ during pre-event periods.
 - b. _____ during public health emergencies.
5. Expenses such as transportation and per diem will be paid by _____.

6. Duties and responsibilities **not to be performed** should be lined out on pages 1, 2, and 3 of Appendix A.

7. Additional duties not listed in Appendix A, **but to be performed** are:

- a. _____.
- b. _____.
- c. _____.
- d. _____.
- e. _____.
- f. _____.
- g. _____.
- h. _____.
- i. _____.
- j. _____.
- k. _____.

8. Resources. Execution of this support agreement is contingent upon local funding availability. Therefore, approval of this support agreement does not constitute approval of additional resources. Any funding or billet requirements that cannot be accommodated within your existing budget must be separately addressed through normal budget processes or other special programs.

9. Health Insurance Portability and Accountability Act (HIPAA). Both parties understand and will adhere to DOD 6025.18R, DOD Health Information Privacy Regulation of 24 January 2003, Section C3.4.

10. Effective Period. This agreement is effective upon date of signature for a period of _____.

11. Modification, Change, or Amendment. Any modifications, changes, or amendments to this agreement must be in writing, and are contingent upon BUMED-M8 approval. Subsequent to BUMED approval, the modification, change, or amendment must be signed by all parties.

12. Concurrence. It is agreed that this written statement embodies the entire agreement of parties regarding this affiliation, and no other agreements exist between parties except as expressed in this document. All parties to this agreement concur with the level of support and resource commitments that are documented herein.

Commanding Officer
Naval Region/Installation _____

Commanding Officer
Naval MTF _____

Date

Date

APPENDIX A
DUTIES AND RESPONSIBILITIES OF THE PHEO

1. SITUATIONAL AWARENESS OF PUBLIC HEALTH THREATS

- Ensure relevant surveillance and information systems are monitored.
- Establish installation-level rapid notification of suspected or confirmed cases of quarantinable diseases to the PHEO.
- Establish processes for sharing information on suspected or confirmed cases with local, tribal, state, federal or host nation public health authorities.
- Ensure PHEO accessibility 24/7:
 - Develop a phone triage protocol to process reports.
 - Enlist a cadre of responders available within 30 minutes of receiving report/call.
 - Ensure that MHS and LRN procedures and protocols are in compliance.
- Ensure all reportable suspected and confirmed cases are reported following current policy.
- Ensure that active and passive systems monitor inpatient and outpatient data sources to detect cases and clusters of public health significance in all covered populations.
- Maintain contact with Service and DOD sources of expert epidemiologic support
- Oversee hospital surveillance of quarantinable diseases, including:
 - Quarantine of groups of exposed people.
 - Containment measures that apply to specific sites.

2. DECLARATION OF A PHE

- Ensure decision algorithms for declaration of a PHE are developed, trained, and executed.
- Ensure that PHE declaration results in appropriate notification and procedures.
- Advise appropriate strategy for containment (individual and community-based):
 - Short term, voluntary home curfew.
 - Suspension or restriction of group assembly.
 - Cancellation of public events.
 - Closure of public places.
 - Restriction of travel or shelter-in-place.
 - "Cordon Sanitaire."
- Ensure a process to handle quarantine exemptions.
- Establish procedures for medical evaluation and isolation of those who exhibit signs of illness.
- Develop protocols for monitoring and enforcing quarantine procedures.
- Address psychological health support needs.
- Ensure protection of persons, including medical examination, testing, vaccination, and treatment.
- Establish guidelines for termination of a PHE.

3. PROVIDE EXPERTISE AND CONSULTATION TO THE COMMANDER

- Advise installation and other commanders on medical/public health aspects of a public disease emergency and disease containment strategies.
- Educate commanders on specific quarantinable and other diseases of concern.
- Advise on public health and disease outbreak emergency response policies, plans, procedures, and guidelines in support of command and control capabilities to properly respond to disasters, public health emergencies, and disease outbreaks.
- Advise MTF commanders on preparedness, prevention, response, exercise, and training activities.
- Institute emergency response programs for public health and disease outbreaks on military installations to include active and Reserve component installations, Reserve Centers, armories, as appropriate, in CONUS.
- Recommend a public health emergency be declared (and appropriately implement vaccination, quarantine, and social distancing when necessary).
- Maintain essential services and mission capability.
- Advise on public health measure for mass care functions.

4. EPIDEMIOLOGIC OUTBREAK INVESTIGATION

- Identify contacts and conduct contact tracing.
- Remain current on all aspects of procedures for quarantinable and other diseases of interest.
- Establish a coordination process and procedure for outbreak investigations with military, State, and local health officials, security, and investigative agencies as appropriate.
- Conduct and support epidemiological investigations, and coordinate investigations with civilian authorities.
- Establish containment measures for individuals, including:
 - Patient isolation.
 - Management of contacts.
- Participate in PHE exercises and drills and incorporate lessons learned into plans.
- Plan for provision of care in non-hospital settings.
- Ensure that public health surveillance for infectious diseases and injuries—including events that might indicate terrorist activity—is timely and complete, and reporting of suspected terrorist events is integrated with the evolving, comprehensive networks of the national public health surveillance system.

5. GUIDANCE ON DIAGNOSIS, TREATMENT, AND PROPHYLAXIS OF THOSE INFECTED OR POTENTIALLY EXPOSED

- Maintain currency on Service, MHS, and other policy guidance (DHHS, FDA) regarding disease diagnosis, treatment, and prophylaxis.
- Develop strategies for “just-in-time” (JIT) training of non-clinical staff and others who involved in diagnosis, treatment, and medical care for exposed and potentially exposed.
- Ensure appropriate infection control practices to prevent disease spread.
- Identify and isolate all potential patients.
- Consider implementation shielding, cancellation of public events, and snow days.
- Improvise prioritization of services in the event of reduced staffing.
- Establish parameters and capabilities to execute a “community triage” program.
- Ensure the needs of special populations are addressed through thorough provisions of appropriate information and assistance, to include children, disabled, and institutionalized.
- Reference JCAHO altered standards of care that may need to be addressed, such staff ratio in a declared PHE.
- Ensure development of mass vaccination and mass chemoprophylaxis distribution plans or annexes.

6. SUPPORT DEVELOPMENT OF PLANS AND EXERCISE FOR EMERGENCY HEALTH POWERS

- Ensure medical facilities have procedures to detect, prevent spread, and manage impact of quarantinable diseases that build on existing operational and National preparedness plans.
- Coordinate with local public health, community, health care facilities at the local, State, regional, and country/Federal level as response partners for a public health emergency
- Identify potential isolation and quarantine facilities.
- Plans for “clinics” and “hotlines.”
- Ensure MTFs have pandemic staffing contingency plans.
- Ensure installations participate in planning, training, and exercise activities with other agencies.
- Encourage COCOM components to participate in similar operations with the host nation as requested.
- Develop operational objectives for PHE response.
- Prepare for on-site assistance from DOD and others, including: technical and emergency response personnel.
 - Centers for Disease Control and Prevention.
 - Strategic national stockpile personnel.
 - National Disaster Medical System teams.
 - Emergency medical response teams.
 - Other specialized response teams.
- Plan for emergency credentialing.

7. LOGISTICS/ACQUISITION OF MEDICAL COUNTERMEASURES AND PERSONAL PROTECTIVE EQUIPMENT

- Conduct a capacity assessment defining the resources, including the identification of health care and quarantine surge capacity resource shortfalls, requirements for specific diseases, and installation population.
- Establish plans and systems for providing mass distribution of medications and other appropriate supplies to care for potentially large numbers of patients and maintain quarantined population.
- Ensure appropriate surge-capacity capability to sustain health care delivery and health medical support in quarantine situations.
- Distribute vaccines and anti-viral medications following appropriate plans and guidance.
- Identify principal materiel requirements for pandemics, include vaccines, anti-viral/antibacterial drugs, ventilators, and PPE.
- Coordinate purchases of drugs and vaccine through the Defense Supply Center Philadelphia (DSCP).
- Maintain procedures for the receipt, storage, and distribution of assets received from Federal stockpiles.

8. CONDUCT RISK COMMUNICATION

- Pre-draft messages for PHE situation scenarios which should include such information as disease progression, movement restriction rationale, availability, and location of support services.
- Pre-plan venues, methods, locations, times, and communicators of information related to the PHE.
- Ensure public information and education on disease of concern is communicated clearly, early, and repeatedly.
- Notify and communicate with the population during the PHE.
- Identify language-specific materials for educating patients, family, and the community.
- Establish “community triage” communications capabilities, including hotlines.
- In coordination with the appropriate PAO, release the:
 - Declaration of a PHE and its termination.
 - Steps individuals should take to protect themselves.
 - Actions taken to control or mitigate the emergency.

9. COORDINATION WITH LOCAL/STATE, HOST-NATION AND ALLIED FORCE HEALTH AND OTHER OFFICIALS

- Establish working relationships with PHE management agencies, emergency medical services, medical, health, behavioral care providers, fire, law enforcements, other Federal, State, local response organizations, local emergency planning committees, humanitarian and volunteer organizations, academic institutions, and other pertinent agencies and organizations.
- Maintain familiarity with state and host nations in disease reporting, quarantine, and other disease containment strategies and how they apply to installation population and activities.
- Coordinate planning and execution of medical and public health aspects of disease containment strategies with local officials.
- Ensure individuals subject to ROM are provided written notice of the reason for ROM as soon as feasible, as well as the plan of examination, testing, and/or treatment.
- Develop a system so that all non-military personnel subject to ROM who contest the reason have an opportunity to present information supporting exemption or release to the commander within 8 hours of receipt.
- Participate in local, Statewide, and regional PHE plans, exercises, and drills.
- Partner with law enforcement regarding enforcement, quarantine process, and procedures.
- Provide education to first responders and others in the use of PPE.