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This manual implements Department of Defense Instruction (DoDI) 6200.03, *Public Health Emergency Management (PHEM) Within the DoD*, Department of Defense Directive (DoDD) 6490.02E, *Comprehensive Health Surveillance*, DoDD 6200.04, *Force Health Protection*, and Air Force Policy Directive (AFPD) 48-1, *Aerospace Medicine Enterprise*. It explains the procedures for surveillance, prevention, control, and reporting of diseases and conditions of public health or military significance. Unless otherwise directed, Air Force (AF) medical personnel follow the methods for controlling and preventing disease as described in the Centers for Disease Control and Prevention (CDC) publication, *Morbidity and Mortality Weekly Report* (MMWR), *Recommendations and Reports* and its supplements and the American Public Health Association publication, *Control of Communicable Diseases Manual*. Where applicable, the most recent guidelines from these publications are used as the standard. This manual applies to all Regular Air Force (RegAF) Airmen, Air National Guard (ANG), and Air Force Reserve (AFR). **Note:** ANG and AFR will be collectively referred to as Air Reserve Component (ARC) within an AF Medical Treatment Facility (MTF) or similar unit responsible for public health activities. Due to ARC capability limitations the following paragraphs do not apply to ARC: 1.8.4.7, 1.8.4.8, 1.8.4.9, 1.8.4.10, 1.8.4.13, 1.8.4.15, 1.8.4.16, and **Chapter 2**.

This manual requires the collection and or maintenance of information protected by the Privacy Act of 1974 authorized by *Title 10 United States Code*, Section 55, Automated Medical and Dental Care. The applicable System of Records Notice(s) is F044 AF SG R, *Reporting of Medical Conditions of Public Health and Military Significance* (June 16, 2003, 68 FR 35646) available at: **http://dpclo.defense.gov/Privacy/SORNs.aspx**. Forms affected by the Privacy Act must have an appropriate Privacy Act statement. Ensure all records created as a result of

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SUMMARY OF CHANGES

This re-write of AFI 48-105, *Surveillance, Prevention, and Control of Disease and Conditions of Public Health or Military Significance*, has been substantially revised and needs to be completely reviewed. Major changes include: reclassification of this document from AFI to AFMAN; reorganization of sections from attachments to chapters; updated tiering statements to better comply with AFI 33-360; updated roles and responsibilities; and updated Tuberculosis prevention and control guidance.

Chapter 1

ROLES AND RESPONSIBILITIES

1.1. United States Air Force Surgeon General (AF/SG) will:

1.1.1. Provide policy guidance on the surveillance, prevention, control, treatment and reporting of diseases and conditions of public health or military significance.

1.1.2. Ensure compliance with Department of Defense (DoD) directives and instructions and serves as the executive agent for the DoD Respiratory Pathogen Surveillance Program.

1.2. Air Force Medical Readiness Agency (AFMRA) will:

1.2.1. Establish and execute Air Force policies and guidance for the surveillance, prevention, control, treatment and reporting of diseases and conditions of public health or military significance.

1.2.2. Represent AF/SG for surveillance, prevention, and control of diseases and conditions of public health or military significance, or delegate representation for AF/SG involvement, including collaborative research, to other DoD or Federal agencies and organizations.

1.2.3. Review periodic reports of various disease surveillance, prevention, and control programs and make recommendations to AF/SG for improvement.

1.2.4. Utilize evidence-based information and population health data to assist Major Commands (MAJCOMs) and MTFs in optimizing population health through effective and efficient healthcare delivery and disease detection, prevention, treatment, and control.

1.3. Air Reserve Component (ARC) Surgeons General will:

1.3.1. Coordinate with AFMRA to provide their component's policies and guidance for surveillance, prevention, control, treatment, and reporting of diseases and conditions of public health or military significance.

1.3.2. Ensure ANG and AFR medical units report cases of *Armed Forces Reportable Medical Events* acquired while the member is on military status on federal installations to ANG Surgeon General, AFR Command Surgeon General, state/local health officials, and to the United States Air Force School of Aerospace Medicine Public Health and Preventive Medicine Department (USAFSAM/PH).

1.4. MAJCOM and Air Forces Forward Surgeons General will:

1.4.1. Provide specific Command policy and guidance to fixed and deployed MTFs for surveilling, preventing, controlling, treating, and reporting diseases and conditions of public health and military operational significance in accordance with DOD, DHA, and Air Force policy.

1.4.2. During disease outbreaks, public health emergencies, and pandemic events ensure that Air Force medical components transmit reports on exposures, diseases, injuries and fatalities involving deployed personnel. After deployments, will ensure that Air Force medical components forward copies of lessons learned and after-action reports to the Joint Lessons Learned Information System at **https://www.jllis.mil/apps/index.cfm** and the National

Center for Medical Intelligence (NCMI) under the "Send NCMI Information" link at **https://www.ncmi.detrick.army.mil/**.

1.4.3. Provide operational guidance and oversight to MTFs during disease outbreaks, public health emergencies, or biological incidents of operational significance.

1.5. USAFSAM/PH will:

1.5.1. Develop and conduct training on prevention, investigation, control, reporting requirements and applied epidemiology of diseases and conditions of public health or military significance.

1.5.2. Provide worldwide consultation services to DoD components in public health surveillance, epidemiology, preventive medicine, and outbreak response.

1.5.3. Conduct comprehensive health surveillance for the Air Force by managing, monitoring, and analyzing the available integrated surveillance data and other Air Force-specific data (e.g., Air Force Disease Reporting System internet (AFDRSi)) capturing disease, risk factors, and other significant health events. Report relevant and actionable findings and trends to appropriate DoD authorities.

1.5.4. Support the Defense Health Agency (DHA), Public Health Division in the standardization of laboratory data and information for surveillance, including identifying emerging pathogens and common sources of disease outbreaks.

1.5.5. Manage the laboratory component of the DoD respiratory pathogen surveillance program; coordinate with Service representatives, the DHA/Armed Forces Health Surveillance Branch (AFHSB)/Air Force Satellite Cell, and with DHA/AFHSB/DoD Global Emerging Infections Surveillance (DoD-GEIS) Program Office.

1.5.5.1. Identify sentinel bases for etiology-based influenza surveillance in collaboration with Army, Navy, DoD-GEIS, and CDC points of contact. Sentinel sites are available online at the USAFSAM website: **https://hpws.afrl.af.mil/epi-consult/influenza/dashboard/index.cfm**.

1.5.5.2. Provide viral collection materials to sentinel sites. Provide viral collection materials to non-sentinel sites upon request. Analyze and report positive influenza isolates to appropriate personnel at MTFs for notification and follow-up.

1.5.5.3. Generate regular reports during the influenza season and an annual report at the end of each influenza season. Provide these reports to sentinel sites, AFMRA, MAJCOMs, DoD-GEIS, Service, and Office of the Assistant Secretary of Defense for Health Affairs points of contact.

1.5.5.4. Coordinate findings in viral identification and typing with the CDC for consideration in national influenza vaccine selection.

1.5.6. Provide clinical reference lab and diagnostic services for DoD components, including performing requested Air Force accessions screening.

1.5.7. Manage the Air Force Medical Entomology Program.

1.5.7.1. Provide consultation and recommendations for vector surveillance, pest management and control, vector-borne and zoonotic disease investigation and response, and personal protection as outlined in AFI 48-102, *Medical Entomology Program*.

1.5.7.2. Offer identification and laboratory analysis services to support surveillance, prevention, control and management of medically important pests. Provide field support upon request.

1.5.8. Provide consultative support for tuberculosis (TB), including guidance on TB risk assessment and prevention of TB transmission.

1.5.9. Provide on-site epidemiological response support to Air Force activities upon request, and notify MAJCOM medical leadership when assistance is required or requested. To request on-site support, the MTF Commander or Director, Aerospace Medicine Commander, Chief of Medical Staff (SGH), or Chief of Aerospace Medicine (SGP) should send the request directly to the USAFSAM Commander, Public Health Department Chair, or Epidemiology Consult Service Division Chief.

1.5.10. Plan and program for appropriate resources to examine, analyze, and respond to, as necessary, diseases and conditions of public health or military significance.

1.5.11. Manage Food Operational Response and Technology Laboratory in accordance with AFI 48-116, *Food Safety Program*. Provide guidance to installations on foodborne/waterborne illness outbreak investigation and response, as well as in-house or contract laboratory analytical services to installations for pathogen detection in food samples implicated during an outbreak investigation.

1.6. Air Education and Training Command and Air Force Training Centers will:

1.6.1. Collect, analyze, and disseminate information on significant events and mortality from the training populations, and participate in DoD efforts to reduce morbidity and mortality in training populations.

1.6.2. Maintain information systems to track health events in the training populations and program for appropriate resources to examine, analyze, and respond to diseases and conditions that affect the health of those involved in training.

1.6.3. Perform population-based febrile respiratory illness surveillance at Air Force Basic Military Training. The Naval Health Research Center in San Diego, California, manages this population-based component of the DoD Respiratory Pathogen Surveillance Program.

1.7. Installation Responsibilities.

1.7.1. Installation Commanders will ensure all units/tenants comply with requirements for preventing and controlling diseases, injuries and other reportable medical events in accordance with DoDD 6200.04. **(T-0)**.

1.7.2. **Unit/Squadron Commander will:**

1.7.2.1. Ensure unit personnel report to the MTF, Reserve Medical Unit, and/or Guard Medical Unit for screening, immunizations and medical appointments, as required by DoDD 6200.04. **(T-0)**.

1.7.2.2. Ensure that unit personnel processing to and arriving from overseas locations (e.g., permanent change of station, deployment, temporary duty) or planning overseas travel (to include leisure travel) contact the MTF for a determination of which health assessments, screenings, immunizations, and medical exams are recommended or required. **(T-1)**. ARC medical units may not have staffing or the ability to address leisure travel review for its Service members or their families.

1.7.2.3. Ensure unit personnel complete appropriate routine screenings, immunizations, and medical exams as required by DoD and Air Force guidance in accordance with DoDD 6200.04. **(T-0)**.

1.7.2.4. Ensure that non-prescription public health countermeasures (e.g., sanitation measures, insect repellent, mosquito netting) are issued at home station to include training (as health threat driven), and for deployment. **(T-1)**. Ensure unit personnel obtain required prescription products (e.g., malaria prophylaxis) and direct personnel to comply with recommendations for use. **(T-1)**.

1.7.3. **Base Civil Engineer will** collaborate with Bioenvironmental Engineering and Public Health to ensure the base has a safe water supply, effective sanitation infrastructure (e.g., proper sewage and trash disposal), effective disease vector and reservoir control (e.g., insects, rodents), proper site selection, and any other environmental safeguards necessary to reduce illnesses or injuries on the base, taking into consideration operational priorities and resources. **(T-2)**.

1.7.4. **Medical Treatment Facility Commander or Director will:** (**Note**: This section applies to the Active Component only unless otherwise specified as also an Air Reserve Component [ARC] responsibility).

1.7.4.1. Provide for the surveillance and control of diseases, injuries, and conditions that adversely impact the health of the base population, and recommend and take actions to prevent or reduce their impact in accordance with DoDD 6490.02E (applies to ARC). **(T-0)**.

1.7.4.2. Ensure collection, surveillance, prevention, detection, treatment, and public health activities adhere to DoD, Air Force, CDC guidelines, and applicable federal, state/local, or host nation requirements. **(T-0)**. Ensure these activities are integrated with Infection Prevention and Control and Population Health functions as required by AFI 44-108, *Infection Prevention and Control Program* and AFI 44-173, *Population Health*, respectively (applies to ARC). **(T-1)**.

1.7.4.3. Appoint, in writing, physician(s) as clinical consultants for TB and HIV. **(T-2)**. Appoint additional physician(s) as clinical consultants for other communicable disease control measures based on real or potential health threats (applies to ARC). **(T-2)**.

1.7.4.4. Ensure Force Health Protection Prescription Products (FHPPP) (e.g., malaria prophylaxis or Pyridostigmine Bromide tablets), when dispensed to individual personnel, are appropriately prescribed by an appropriately credentialed and privileged healthcare provider. **(T-1)**. Ensure the MTF dispenses FHPPP to individuals with a legal prescription, appropriate education, and documentation in the DoD Electronic Health Record (applies to ARC). **(T-1)**.

1.7.4.5. Maintain TB screening and immunization functions and ensure complete documentation in the Aeromedical Services Information Management System (ASIMS), or currently approved tracking system (applies to ARC). **(T-1)**.

1.7.4.6. Ensure collection and surveillance of communicable, environmental, and other reportable medical events in accordance with *Armed Forces Reportable Medical Events Guidelines & Case Definitions* document as posted by the AFHSB (see **Attachment 1** for URL) and ensure reporting to USAFSAM/PH via AFDRSi, MAJCOM Public Health, and state/local or host nation officials, as appropriate (applies to ARC). **(T-0)**.

1.7.4.7. Ensure contracts for healthcare employees, volunteers, and students clearly specify appropriate prophylaxis and vaccination requirements, and delineate the support provided by the contractor/providing entity and the MTF. **(T-2)**.

1.7.4.8. Ensure that healthcare providers and clinical laboratory personnel notify Public Health of patients with reportable diseases or other unusual diseases/conditions. **(T-1)**.

1.7.4.9. Ensure reportable medical events diagnosed at clinical visits are correctly coded, using the International Classification of Diseases (ICDs), and entered into current information systems. **(T-1)**. **Note**: ICD codes for reportable events are listed in the *Armed Forces Medical Events Guidelines and Case Definitions* document (see **Attachment 1** for Universal Resource Locator (URL)).

1.7.4.10. Ensure adequate resources and training are provided for surveillance, prevention and control of diseases and conditions of public health or military significance. **(T-1)**. **Note**: Public Health personnel should have the appropriate mobile capability (e.g., laptop, tablet) to perform real-time epidemiologic data collection during emergency events such as disease outbreaks or disaster investigations in-garrison and in the deployed environment.

1.7.4.11. Ensure providers are aware of current clinical management guidelines when treating patients (applies to ARC). **(T-1)**.

1.7.4.12. Ensure compliance with the requirements of the DoD Respiratory Pathogen Surveillance Program (applies to ARC). **(T-0)**.

1.7.4.13. Ensure MTF implements an effective Childhood Blood Lead Screening program that follows current CDC guidelines in accordance with applicable state/local regulations (see **Chapter 2** for Childhood Blood Lead Screening). **(T-0)**.

1.7.4.14. Ensure MTF implements an effective TB control program that follows current CDC guidelines (see **Chapter 3** for Tuberculosis Detection and Control Program) (applies to ARC). **(T-1)**.

1.7.4.15. Ensure MTF complies with Rabies Prevention Program requirements in accordance with applicable state/local regulations and AFI 48-131, *Veterinary Health Services* (see **Chapter 4** for Rabies Prevention Program). **(T-0)**. The Rabies Prevention Program must follow current CDC guidelines. **(T-2)**.

1.7.4.16. Ensure MTF offers travel medicine services to military personnel and MTF-enrolled TRICARE beneficiaries in accordance with the Travel Medicine User Guide, located at

https://kx.health.mil/kj/kx7/PublicHealth/Pages/content.aspx#/FH/TravelMedicine. (T-1).

1.7.5. **Chief of Medical Staff (SGH) and Chief of Aerospace Medicine (SGP) will:**

1.7.5.1. Assist Public Health in developing MTF instructions and procedures to implement the surveillance and control of diseases, injuries, and conditions that adversely impact the health of the base population. **(T-2)**.

1.7.5.2. Provide clinical guidance to the MTF medical professional staff for the prevention, control, surveillance, treatment, and reporting of diseases and conditions of public health or military significance. **(T-2)**.

1.7.5.3. At training installations, oversee trainee population health. **(T-2)**. Collaborate with unit commanders at wing and installation forums for preventing and controlling diseases and injuries in the trainee population. **(T-2)**.

1.7.5.4. The SGH will ensure that all credentialed medical staff are briefed annually on reportable medical events and animal bite treatment and reporting requirements. **(T-2)**.

1.7.6. **Public Health (Active Component Only) will:**

1.7.6.1. Conduct community or location-specific public health surveillance, which includes chemical, biological, radiological, and nuclear terrorism and syndromic surveillance as directed by DoDI 6200.03 and DoDD 6490.02E. **(T-0)**. Provide information to the MTF Commander or Director and medical staff as necessary. **(T-1)**.

1.7.6.2. Conduct and manage epidemiological surveillance and contact interviews, and serve as a non-clinical consultant on disease prevention, education and control programs. **(T-1)**. In the event of a suspected or declared public health emergency, these activities (including reporting) shall be conducted in coordination with the Public Health Emergency Officer (PHEO) and state and/or local health departments, as appropriate. **(T-1)**. **Note:** In the event of outbreaks in training populations Public Health should coordinate with a preventive medicine physician, if available.

1.7.6.3. Inform the MTF Commander or Director, providers, the PHEO, MAJCOM Public Health, USAFSAM/PH, and, if deployed, the Joint Task Force/Theater Surgeon of the incidence, prevalence, modes of transmission, and recommended control measures for diseases/conditions of Public Health or military significance, as necessary. **(T-2)**.

1.7.6.4. Review MTF surveillance data and conduct investigations as appropriate. **(T-1)**.

1.7.6.4.1. Ensure appropriate syndromic surveillance is being conducted to assess threats to public health through the use of the Electronic Surveillance System for the Early Notification of Community-based Epidemics (ESSENCE) or other established surveillance systems as required by DoDD 6490.02E. **(T-0)**. Each MTF will have at least two active ESSENCE account holders. **(T-1)**.

1.7.6.4.2. Conduct special surveillance not specified by this directive, as appropriate. **(T-2)**. Conditions not identified as reportable in the *Armed Forces Reportable Medical Events Guidelines and Case Definitions* document (See **Attachment 1** for URL) may require special surveillance activities when the local risk is significant. **(T-2)**. **Note**: When initiating special surveillance activities, institutional review board

review is usually not needed (see DoDI 3216.02_AFI40-402, *Protection of Human Subjects and Adherence to the Ethical Standards in Air Force Supported Research*), but ethical principles (e.g., equal protections and due process) still apply to participant selection and interaction. If ethical questions cannot be resolved within the MTF, ethical consultation is available in accordance with DoDI 6025.27, *Medical Ethics in the Military Health System*.

1.7.6.4.3. Provide health surveillance, disease and injury prevention (including immunization recommendations and screening) for recruits and training populations based on the unique population risk characteristics (e.g., age, challenging physical activities, and close living quarters) in accordance with national recommendations, DoD, and Air Force policies. **(T-1)**.

1.7.6.4.4. Perform active and passive surveillance to detect, track, and trend the incidence of reportable diseases/conditions of public health significance at a frequency determined by the Aerospace Medicine Council. **(T-2)**.

1.7.6.5. Evaluate risk of vector-borne and zoonotic disease in the local geographical area and, if indicated, develop a vector surveillance plan in accordance with AFI 48-102. **(T-2)**.

1.7.6.6. Collaborate with the local military installations as well as state/local or host nation public health officials. **(T-2)**. Maintain awareness of local epidemiological activities, including local surveillance, prevention, and control capabilities. **(T-2)**.

1.7.6.7. Complete disease-specific case investigation forms as mandated by federal/state/local or host nation health officials. **(T-0)**.

1.7.6.7.1. Transmit all Air Force reportable medical events to USAFSAM/PH via the AFDRSi website (referred to as Medical Event Reports in AFDRSi). **(T-1)**. **Note**: the web link for AFDRSi can be found on the Air Force Public Health Knowledge Exchange (KX) page at **https://kx.health.mil/kj/kx7/PublicHealth/Pages/content.aspx#/.**

1.7.6.7.1.1. Armed Forces medical events guidelines and case definitions for reportable and urgently reportable medical events are available at the following AFHSB website: **https://health.mil/Military-Health-Topics/Combat-Support/Armed-Forces-Health-Surveillance-Branch/Reports-and-Publications.**

1.7.6.7.1.2. Report urgently reportable medical events within 24 hours as required by DoDI 6200.03. **(T-0)**. Report all other reportable medical events as soon as possible, but no later than 14 calendar days or once confirmatory lab results are available. **(T-1)**.

1.7.6.7.2. Report disease information as required by their state, local, and/or host nation Public Health officials. **(T-0)**.

1.7.6.8. Review test results provided by the laboratory and other electronic data sources to ensure timely identification and investigation of reportable and communicable infections, including disease/conditions of public health or military significance not identified in the *Armed Forces Medical Events Guidelines and Case Definitions*

document (See **Attachment 1** for URL) (e.g., Childhood Blood Lead as outlined in **Chapter 2**). **(T-1)**.

1.7.6.9. Disseminate information derived from public health surveillance in a timely manner to healthcare providers and appropriate MTF committees (e.g., Aerospace Medicine Council, Population Health Working Group, Professional Staff, Occupational Health Working Group, and Infection Control) regarding incidence or prevalence of diseases and conditions that are affecting, or potentially affecting the installation's personnel. **(T-2)**.

1.7.6.10. At sentinel respiratory pathogen surveillance sites, provide the Primary Care Manager (PCM) team with program instructions and updates, including the case definition for influenza-like illness other current circulating respiratory illnesses. **(T-2)**. Coordinate with the PCM teams and MTF laboratory to ensure questionnaires and respiratory samples for influenza or other current circulating respiratory illnesses are sent to USAFSAM using the prescribed mechanism **(T-2)**.

1.7.6.11. Interview individuals with communicable infections that require contact tracing following current CDC guidelines (see **Chapter 3** for specifics on Tuberculosis Detection and Control). **(T-1)**.

1.7.6.12. Refer contacts of patients with reportable diseases or diseases/conditions of public health or military significance, if eligible, for medical care and counseling within the MTF; refer non-TRICARE beneficiaries to the health department in their area of residence. **(T-1)**. ARC Public Health will submit information to local and state health authorities as required. **(T-1)**.

1.7.6.13. Perform disease outbreak investigations and work with the SGP and PHEO to advise the MTF Commander or Director on the management and control of disease outbreaks. **(T-2)**.

1.7.6.14. Coordinate travel medicine services for military personnel and MTF-enrolled TRICARE beneficiaries in accordance with the Travel Medicine User Guide, located at **https://kx.health.mil/kj/kx7/PublicHealth/Pages/content.aspx#/FH/TravelMedicine.** Infectious disease physicians, preventive medicine physicians, or travel medicine clinics may replace or augment Public Health in providing this service. **(T-1)**.

1.7.6.15. To request on-site support from USAFSAM/PH, recommend the MTF Commander or Director, Aerospace Medicine Commander, SGH, or SGP send the request directly to the USAFSAM Commander, Public Health Department Chair, or Epidemiology Consult Service Division Chief. Notify MAJCOM medical leadership when this assistance is required or requested. Additional responsibilities are outlined in **Chapter 2**, **Chapter 3**, and **Chapter 4**.

1.7.7. **Clinical Laboratory (Active Component Only) will:**

1.7.7.1. Notify providers and Public Health of reportable diseases/conditions meeting laboratory criteria for diagnosis as listed in the *Armed Forces Reportable Medical Events Guidelines and Case Definitions* document (see **Attachment 1** for URL) as required by DoDD 6200.04. **(T-0)**. Notify Public Health of any unusual pattern of laboratory testing results or significant increase in incidence of a disease. **(T-1)**.

1.7.7.2. Participate in the CDC Laboratory Response Network for Bioterrorism and Chemical Terrorism. **(T-1)**. Report identification of potential offensive biological and chemical agents as directed by CDC-DoD notification protocols in accordance with DoDI 6200.03. **(T-0)**. Facilitate process for forwarding clinical, environmental, and food specimens (e.g., unusual pathogens, antibiotic-resistant strains, chemical and radiological exposures), where appropriate or required, to DoD or civilian reference labs. **(T-1)**.

1.7.7.3. During epidemiological and outbreak investigations, coordinate with Public Health on appropriate sample collection protocols, test availability, and result reporting. **(T-2)**.

1.7.7.4. For respiratory pathogen surveillance, sentinel MTFs will send respiratory specimens to USAFSAM as directed by DHA. **(T-0)**.

1.7.8. **MTF Information Management Officer will** maintain systems to support reporting and surveillance activities, including training population, and immunization tracking databases. **(T-2)**.

1.7.9. **MTF Medical and Dental Providers will:**

1.7.9.1. Counsel individuals on communicable diseases, risk factor reduction, and early recognition of symptoms. **(T-1)**.

1.7.9.2. Refer patients to Public Health with reportable diseases/conditions listed in the *Armed Forces Reportable Medical Events Guidelines and Case Definitions* (see **Attachment 1** for URL), Air Force-specific reportable medical events (listed on the USAFSAM/PH website, see **Attachment 1** for URL), diseases that require contact tracing, or those required by state/local, or host nation directives. **(T-0)**. Diseases/conditions that have public health impact or military significance are also reported to Public Health. **(T-1)**.

1.7.9.3. Use case definitions and ICD Codes for reportable events outlined in the *Armed Forces Reportable Medical Events Guidelines and Case Definitions* document (see **Attachment 1** for URL). **(T-1)**. If a case definition is not available in the Armed Forces Guidelines, use CDC guidelines and case definitions. **(T-1)**.

1.7.9.4. Report to Public Health, within 24 hours, diseases or conditions determined to be urgently reportable (list of urgently reportable medical events available at USAFSAM website, see **Attachment 1** for URL), any unusual disease activity, disease clusters or indications of a possible outbreak as required by DoDI 6200.03. **(T-0)**. Ensure appropriate reporting through chain of command, Infection Preventionist, SGH, and PHEO as required by local policy. **(T-3)**. All non-urgent reportable diseases/conditions must be reported as soon as possible, but no later than 7 calendar days after identification. **(T-1)**.

1.7.9.5. At sentinel respiratory pathogen surveillance sites, identify patients meeting the case definition for influenza or other current circulating respiratory illnesses, collect respiratory specimens, and ensure completion of the questionnaire. **(T-1)**.

1.7.9.6. Prescribe pre- and post-exposure prophylaxis, including vaccines, as directed by DoD, AF, or Combatant Command policies following CDC or the Advisory Committee on Immunization Practices (ACIP) recommendations. **(T-0)**.

1.7.9.7. Screen, treat, and follow-up with personnel with actual or potential communicable infections as directed by DoD, AF, CDC, and any applicable guidelines or policies, taking into account the local epidemiology and high-risk groups (such as basic military trainees), as necessary. **(T-1)**. The PCM team tracks required follow-up appointments, laboratory tests, and completion of all treatment protocols. **(T-1)**. **Note**: This paragraph also applies to tracking of patients who receive non-Food and Drug Administration approved blood products.

1.7.9.8. Additional responsibilities are listed in **Chapter 2**, **Chapter 3**, and **Chapter 4**.

1.7.10. **Air Reserve Component Medical Units will:** Report cases of *Armed Forces Reportable Medical Events* (see **Attachment 1** for URL) detected while the member is on active military status on federal installations to Air National Guard Surgeon General or Headquarters Air Force Reserve Command Surgeon General; and to USAFSAM/PH; and their respective local Public Health authorities. **(T-0)**.

Chapter 2

CHILDHOOD BLOOD LEAD SCREENING

2.1. Overview. The objective of this program is to identify children living on and off base who are at risk for environmental lead exposure in accordance with state/local regulations and following CDC guidelines.

2.2. MTF Commander or Director will: MTF Commander or Director will ensure MTFs implement an effective Childhood Blood Lead Screening program in accordance with state/local regulations for screening, investigation, treatment, and follow-up. **(T-0)**.

2.3. Chief of Medical Staff (SGH) will: Chief of Medical Staff (SGH) will coordinate with Public Health to ensure the development of a local risk assessment questionnaire for targeted lead screening. **(T-1)**. **Note**: This questionnaire supplements the CDC's standard lead exposure screening questions and reflects the community-specific lead exposure risk, including high-risk parental occupations.

2.4. MTF Medical Providers will:

2.4.1. Ensure parents receive educational materials about prevention and risk of childhood lead exposure. **(T-2)**.

2.4.2. Conduct universal childhood blood lead testing when required by state/local regulations. **(T-0)**. Otherwise, medical providers will conduct targeted or risk-based screening following current CDC guidelines. **(T-1)**.

2.4.3. Conduct targeted screening through risk assessment questionnaire beginning at 9-12 months of age and periodically between ages 24 months to 6 years, as directed by state/local guidance. **(T-0)**. Ensures results of questionnaires are recorded in the electronic health record. **(T-1)**.

2.4.3.1. Consider blood lead testing for children under the age of 6 with one or more lead-exposure risk factors for blood lead levels. Use CDC guidelines for instructions on blood lead sampling technique, treatment and follow-up of elevated blood lead levels (BLLs). **(T-1)**.

2.4.3.2. Refer all children with venous BLLs above current CDC reference value to Public Health. **(T-1)**.

2.5. Public Health will:

2.5.1. Initiate a lead toxicity investigation for any confirmed pediatric venous BLLs above the current CDC reference value. **(T-1)**. Coordinate with Bioenvironmental Engineering or local Public Health department for lead sampling of the facility based on epidemiological data following current CDC and Occupational Safety and Health Administration guidelines. **(T-1)**. **Note:** Ensure Bioenvironmental Engineering will review the local lease agreement prior to initiating any sampling in Privatized Housing Areas to determine if the base or state has jurisdiction. **(T-0)**.

2.5.1.1. Reports an elevated venous blood test (i.e., above the current CDC reference value) once per child 6 years and under (follow-up test results on the same case are not counted again) to USAFSAM/PH using AFDRSi. **(T-1)**.

2.5.1.2. Provide findings from lead toxicity investigation to the patient's medical provider. **(T-1)**.

2.5.1.3. Track and follow-up on elevated blood lead results for children 6 years of age and under. **(T-3)**.

2.5.2. Report all BLLs to state/host nation as required. **(T-0)**.

2.6. USAFSAM/PH will:

2.6.1. Provide surveillance and report significant findings or unusual trends on blood lead results to AFHSB. **(T-2)**. Submit an annual calendar year summary of the Childhood Blood Lead Screening Program. **(T-2)**.

Chapter 3

TUBERCULOSIS (TB) DETECTION AND CONTROL PROGRAM

3.1. Overview. The objective of this program is to align the Air Force TB program with the national program to eliminate TB. The Air Force Medical Service follows current CDC guidelines for TB prevention and control. The following guidance is intended to cover areas where CDC guidance is vague or does not exist.

3.1.1. The Air Force TB screening program will be a targeted program based on environmental and operational mission requirements.

3.1.2. The TB testing program for Air Force personnel will be limited to individuals with high-risk TB exposure histories or those with clinical indications for testing.

3.1.3. TB screening for recruits and new accessions will be based on current clinical recommendations and guidance from trainee health medical leadership. **Note:** Dependents can be screened and/or tested based on clinical recommendation.

3.2. MTF Commanders or Directors will:

3.2.1. Ensure MTFs and ARC Medical Units implement an effective TB control program following current CDC guidelines. **(T-1)**.

3.2.2. Ensure a written plan for prevention of transmission and treatment of TB for the MTF and ARC Medical Unit is completed and reviewed annually. **(T-1)**. The plan will include a multi-disciplinary healthcare team (e.g., SGH, Infection Control, Public Health, and Bioenvironmental Engineering) evaluation and a written TB risk assessment following CDC guidelines. **(T-1)**. The plan will also include appropriate respiratory protection for potentially exposed healthcare workers, effective engineering controls, education (including risk factors, signs, and symptoms), counseling and evaluation of healthcare workers, and identification and treatment of individuals with active disease or latent tuberculosis infection (LTBI). **(T-1)**.

3.3. Public Health will:

3.3.1. Coordinate with the Infection Prevention and Control Function and Bioenvironmental Engineering to ensure compliance with relevant Occupational Safety and Health Administration guidelines for the control of occupational exposure to TB. **(T-3)**.

3.3.2. Implement MTF TB exposure control plan for prevention of transmission and treatment of TB if necessary. **(T-1)**. Reviews plan annually recommending risk-based procedures for screening, control, and protection against TB following current CDC guidelines. **(T-1)**. Coordinates the review with Infection Control Committee and Bioenvironmental Engineering. **(T-1)**.

3.3.3. Conduct risk assessment of individuals, including re-deployers and beneficiaries returning from high-risk TB endemic locations and countries to determine the frequency of TB testing. **(T-1)**. Follow local city, county, and/or state recommendations if their guidance requires more frequent testing or inclusion of other individuals. **(T-0)**.

3.3.4. Perform the initial LTBI patient interview following current CDC guidelines and refers patient to PCM. **(T-1)**.

3.3.5. Perform contact tracing following current CDC guidelines and ensures the proper screening, and treatment as indicated, for individuals who may have become infected from persons with active TB disease. **(T-1)**.

3.3.6. Monitor local TB risk and provide prevention and educational messages for the installation population. **(T-3)**.

3.3.7. Reports active TB cases within 24 hours (or next duty day) to USAFSAM/PH via AFDRSi. **(T-1)**.

3.4. Primary Care Management (PCM) team will:

3.4.1. Evaluate all individuals with non-negative TB tests. Non-negative tests include:

3.4.1.1. Tuberculin skin test (TST) indurations greater than or equal to 5mm.

3.4.1.2. Indeterminate or positive blood assays for *M. tuberculosis* Interferon-Gamma Release Assay (IGRA).

3.4.2. Record positive reactions, initial and follow-up care on AF Form 2453, *Tuberculosis Detection and Control Data.* Places AF Form 2453 in the patient's medical record upon completion of medical treatment. **(T-1)**. PCM will document all patient interventions, including attempts to contact member, in the electronic health record. **(T-1)**.

3.4.3. Ensure all patients with LTBI or active TB are referred to Public Health for contact tracing, education, and reporting. **(T-3)**.

3.4.3.1. ARC providers in collaboration with ARC Public Health equivalent will refer patients for initial LTBI patient interview and contact investigation following current CDC guidelines to respective RegAF servicing MTF/state/local Public Health departments/private practice physicians. **(T-2)**.

3.4.3.2. ARC Public Health equivalent will obtain medical documentation on the status of patients requiring X-Ray clearance and LTBI treatment determination from start to completion, deferment, and exemption. **(T-2)**.

3.4.4. Evaluate patients for active disease. Provides clinical management and follow-up of patients with LTBI or active TB following CDC guidelines. **(T-1)**.

3.4.5. Ensure recent converters who do not have active TB but who are on flying status, have flying status handled in accordance with current AFMRA LTBI prophylaxis policy. **(T-1)**. If the services of the flyer are of a critical nature, (e.g., in a combat zone or for alert force manning and unable to be in Duty Not Involving/Including Flying status for three days) and active TB has been ruled out; LTBI treatment can be delayed for up to 18 months with the approval of the base SGP. **(T-1)**. SGP will document approval in the electronic medical record. **(T-1)**. During this time the flight surgeon will continue to monitor the flyer closely until his/her services are no longer critical and treatment can be initiated. **(T-1)**.

3.5. Immunization Technician or Personnel Administering Tuberculosis Testing will:

3.5.1. Follow current CDC guidance on testing procedures and interpretation of tests. **(T-1)**. If TST induration is greater than or equal to 5mm, refer patient to Public Health. **(T-2)**.

3.5.2. Trained Immunization Clinic personnel and other clinicians with appropriate training can place, read, and record Purified Protein Derivative skin tests. **(T-3)**.

3.6. Tuberculosis Testing Programs.

3.6.1. The Air Force TB testing program is a targeted program. Air Force personnel (including deployers and other forward-based personnel) are only to be tested when they have high-risk exposures, high-risk occupations (e.g., healthcare workers), or are employees with clinical indications for testing as per local Aerospace Medicine Council recommendation.

3.6.2. Persons with LTBI who are at risk for developing active TB disease fall into two categories: those who have been recently infected, and those with clinical conditions that increase the risk of progression from LTBI to TB disease.

3.6.3. Recent infection should be suspected in close contacts of a person with active TB, persons who have immigrated from or visited areas of the world with high rates of TB, residents or employees of congregate settings (homeless shelters, correctional facilities, and nursing homes), healthcare workers caring for patients who are at increased risk of TB and children exposed to adults who are at increased risk for TB.

3.6.4. Clinical conditions that increase the risk of progression from LTBI to TB disease include HIV infection, persons who are receiving immunosuppressive therapy such as tumor necrosis factor–alpha (TNF-α) antagonists, systemic corticosteroids equivalent to ≥15 mg of prednisone per day for one month or longer, or immune suppressive drug therapy following organ transplantation, diabetes mellitus, chronic renal failure or hemodialysis, gastrectomy, jejunal bypass, history of cancer of the head, neck, or lung, silicosis, low body weight (10% below ideal), and younger than 5 years of age.

3.7. Testing Methods for Tuberculosis.

3.7.1. The Mantoux tuberculin skin test (TST) uses Intermediate-strength Purified Protein Derivative that is an intradermal injection. Most people who have been infected with TB will have a T-cell mediated delayed-type hypersensitivity reaction at the injection site, peaking at 48-72 hours after the injection. The TST is the preferred test in children younger than 2 years of age.

3.7.1.1. The TST may be administered either on the same day as live virus vaccines or must be performed four to six weeks after the administration of live virus vaccine. The TST must be delayed at least four weeks *after* smallpox vaccine administration, unless operational or clinical circumstances require administration of TST on the same day.

3.7.1.2. Measure TST reactions in millimeters of induration (not erythema) and record the results in ASIMS and the electronic health record. Do not delete results of previous TB tests in the Air Force automated immunization tracking system.

3.7.1.3. Refer all individuals with TST indurations greater than or equal to 5 mm to Public Health. If active TB is suspected, alert the Infection Preventionist, the PCM team, and Public Health to ensure that appropriate precautionary infection control measures are applied.

3.7.2. IGRAs – Detect the presence of *M. tuberculosis* infection by measuring the immune response to TB proteins in a blood sample. IGRAs can be used in all circumstances in which

the TST is used, including contact investigations, evaluation of recent immigrants who have had Bacille Calmette-Guerin vaccination, and TB screening of healthcare workers and others undergoing serial evaluation for *M. tuberculosis* infection. An IGRA is the preferred test in persons who may be unlikely to return for TST reading and persons who have received Bacille Calmette-Guerin vaccination.

3.8. Indications for TB Screening Tests.

3.8.1. Screen RegAF and ARC members during initial processing at officer or enlisted accession centers or at their first duty station. **(T-1)**.

3.8.2. Perform annual testing for all individuals stationed in a high-prevalence overseas area and who have direct and prolonged contact with high-risk populations or have high-risk exposure. **(T-1)**. Perform another TB test at 3 months (no later than 6 months) after returning to CONUS or a low TB prevalence OCONUS location. **(T-1)**.

3.8.3. Combatant Command may direct additional TB testing. When the Combatant Command defers to Service policy for TB testing, then the following applies:

3.8.3.1. Individuals who deployed to high-prevalence areas for 30 consecutive days or greater and who had direct and prolonged contact with the local population or had high-risk or known exposure to an active TB case should receive a TB test at 3 months (no later than 6 months) post-deployment. **(T-1)**.

3.8.3.2. Testing more frequently than every 12 months is not necessary for personnel who deploy regularly to high prevalence areas unless they have other risk factors for TB. **(T-1)**.

3.8.4. Perform baseline two-step TST or one IGRA for healthcare workers (including civilians, contractors, and volunteers) upon employment/volunteer service if there is no verifiable history of being tested within the previous 12 months. **(T-1)**. A documented, initial TB test done on accession (baseline test) for Air Force personnel is considered the first step of the two-step TST. **(T-1)**. The second step should be completed within 1-3 weeks at either the first duty assignment or subsequent training program. **(T-1)**.

3.8.5. In the absence of known exposure or evidence of ongoing TB transmission, health care personnel without LTBI should not undergo routine serial TB screening or testing at any interval after baseline (e.g., annually). **(T-1)**. Health care facilities may consider using serial TB screening of certain groups who might be at increased occupational risk for TB exposure, following current CDC guidance. **(T-2)**.

3.8.6. Perform baseline and subsequent TB testing for TRICARE beneficiaries following current CDC guidelines. **(T-1)**.

3.8.6.1. Baseline TB testing is indicated for individuals who are PCSing to a high TB prevalence country and who have no verification of having been previously tested. **(T-1)**. Testing should be completed prior to departure and 3 months after returning from the high TB prevalence country. **(T-1)**.

3.8.6.2. Baseline TB testing is indicated prior to overseas travel if individuals anticipate prolonged contact with populations in settings at high-risk for transmission of infectious TB (e.g., hospital, prison, homeless shelters). **(T-1)**. Testing should be repeated 3 months after returning from the high-risk setting. **(T-1)**.

3.8.7. Healthcare personnel with LTBI and no prior treatment will be offered, and strongly encouraged to complete, treatment with a recommended regimen, unless a contraindication exists. **(T-2)**. Healthcare personnel who do not complete LTBI treatment will be monitored with annual symptom evaluation to detect early evidence of TB disease and to reevaluate the risks and benefits of LTBI treatment. **(T-2)**.

Chapter 4

RABIES PREVENTION PROGRAM

4.1. Overview. The purpose of this chapter is to provide policies and procedures for rabies prevention and control across Air Force installations. It is intended primarily for use by Public Health, MTF medical providers, and others with related responsibilities or interests. AFI 48-131, *Veterinary Health Services* is the guiding document that provides specifics regarding rabies prevention and control in animals.

4.2. Reporting.

4.2.1. Military and TRICARE beneficiaries who are exposed to rabies or potentially exposed to rabies shall promptly report their animal exposure and seek medical treatment from a healthcare provider as soon as possible, preferably within 24 hours. **(T-1)**. Potential exposure events from an animal capable of spreading rabies include a bite or salivary contact with an open wound or mucous membrane. **Note:** Potential exposure to rabies virus includes any penetration of skin by the teeth of a potentially rabid animal; or contamination of scratches, open wounds, abrasions, breaks in skin integrity, or mucous membranes with saliva or other potentially infectious material (such as nervous tissue) from a potentially rabid animal. Inadvertent, seemingly inconsequential, or otherwise unrecognized bat contact will also be considered a potential rabies exposure event.

4.2.2. MTF medical providers shall initiate and complete all relevant portions of the DD Form 2341, *Report of Animal Bite – Potential Rabies Exposure*, for each patient with possible exposure to rabies and include the DD 2341 in the electronic health record documentation (to include patients evaluated/treated at off-base medical facilities). **(T-1)**. (Ref: AFI 48-131, *Veterinary Health Services*).

4.2.3. Individuals in deployed settings should be encouraged to report any possible rabies exposures on their Post-Deployment Health Assessment (DD Form 2796) as "animal bite" or in free-text sections of the forms. **(T-3)**.

4.3. Public Health will:

4.3.1. Monitor and communicate rabies risk in the local area to MTF providers. **(T-2)**. **Note:** Public Health should routinely review MTF surveillance data (e.g., emergency room reports) and conduct investigations as appropriate.

4.3.2. Track animal bite cases, track completion of post-exposure prophylaxis, report initiation of post-exposure prophylaxis meeting the case definition in the DoD *Armed Forces Reportable Medical Events Guidelines and Case Definitions* in AFDRSi and as required by state/local Public Health officials, and report to the Aerospace Medicine Council, as necessary. **(T-2)**.

4.3.3. The Public Health Officer (PHO) (or SGP/senior flight surgeon when PHO is unavailable) will review all animal bite case reports in order to verify appropriateness of case-specific risk assessment. **(T-2)**. As needed, the PHO, SGP/senior flight surgeon (or SGH), and the treating physician will meet to discuss cases when appropriateness of risk assessment/post-exposure prophylaxis treatment decision is in question. **(T-2)**.

4.4. Immunizations Clinic will:

4.4.1. Ensure administration of post-exposure prophylaxis is documented in the patient immunization record. **(T-2)**.

4.4.2. Notify individuals of required post-exposure prophylaxis and immunization schedule. **(T-2)**.

4.5. MTF Medical Providers will:

4.5.1. Initiate and complete DD Form 2341, *Report of Animal Bite—Potential Rabies Exposure*, for each patient with possible exposure to rabies and ensure the DD Form 2341 is included in the electronic health record documentation. **(T-2)**.

4.5.2. Ensure patients are assessed (to include immune status and currency of tetanus vaccine in accordance with ACIP recommendations), treated (to include tracking patients for completion of rabies prophylaxis when necessary), and educated following current CDC guidelines. **(T-1)**. PCM team will document all patient interventions, including attempts to contact member, in the electronic health record. **(T-0)**. **Note:** The need for post-exposure prophylaxis is to be based on a case-specific risk assessment by the treating MTF provider. The treating MTF provider should contact the PHO for assistance in determining rabies risk from an animal bite/exposure.

4.5.3. Ensure measures are in place to the completion of the protocol without deviations when rabies prophylaxis is initiated. **(T-1)**. **Note**: for most current treatment requirements and rabies risk assessment reference **https://www.cdc.gov/rabies/resources/index.html**. Such measures include, but are not limited to, chain of command notification (military personnel), notification of local/state child protective services or equivalent agency (dependent minors), and documentation of provider counseling.

4.5.4. Consult with Public Health for local rabies prevalence and most current rabies prophylaxis recommendations/guidelines. **(T-3)**.

4.6. Rabies Advisory Board (RAB) will:

4.6.1. Provide case-by-case medical consultation regarding rabies risk, prophylaxis, and prevention measures, in consultation with a US military veterinarian. **(T-2)**. The RAB shall be chaired by an appropriately credentialed and privileged medical corps officer and should be convened as needed to review high-risk cases. **(T-2)**.

4.6.2. Consist of an Air Force PHO and at least two MTF medical providers trained in rabies risk assessment or in preventive medicine (e.g., SGP, treating provider). **(T-2)**.

4.7. Aerospace Medicine Council will:

4.7.1. Review all reported animal bite/exposure cases, post-exposure prophylaxis administration, regional prophylaxis supply, documentation, supporting surveillance efforts, and other zoonotic diseases at least annually, or at frequency informed by local risk. **(T-3)**.

4.7.2. Annually invite representatives from the major agencies and organizations involved with rabies prevention and control across the military installation (e.g., Security Forces, US military veterinarian, local/state health officials) in order to review aspects of the Rabies Prevention Program. **(T-3)**.

4.7.3. Convene on a frequency determined by local MTF leadership in an appropriate epidemiological context informed by rabies risk to review and make recommendations on the Rabies Prevention Program. **(T-3)**.

DOROTHY A. HOGG, Lieutenant General, USAF,
NC Surgeon General

Attachment 1

GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION

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Prescribed Forms

AF Form 2453, *Tuberculosis Detection and Control Data*

DD Form 2341, *Report of Animal Bite—Potential Rabies Exposure*

Adopted Forms

AF Form 847, *Recommendation for Change of Publication*

DD Form 2341, *Report of Animal Bite – Potential Rabies Exposure*

DD Form 2796, *Post-Deployment Health Assessment*

Abbreviations and Acronyms

ACIP—Advisory Committee on Immunization Practices

AFDRSi—Air Force Disease Reporting System internet

AFHSB—Armed Forces Health Surveillance Branch

AFI—Air Force Instruction

AFMRA—Air Force Medical Readiness Agency

AFPD—Air Force Policy directive

AFR—Air Force Reserve

ANG—Air National Guard

ARC—Air Reserve Component

ASIMS—Aeromedical Services Information Management System

BLLs—blood lead levels

CDC—Centers for Disease Control and Prevention

CSTE—Council of State and Territorial Epidemiologists

DHA—Defense Health Agency

DoD—Department of Defense

DoDD—Department of Defense Directive

DoD-GEIS—DoD Global Emerging Infections Surveillance Program Office

DoDI—Department of Defense Instruction

ESSENCE—Electronic Surveillance System for Early Notification of Community-based Epidemics

FHPPP—Force Health Protection Prescription Products

HIV—Human Immunodeficiency Virus

ICDs—International Classification of Diseases

IGRA—Interferon-Gamma Release Assay

LTBI—Latent Tuberculosis Infection

MAJCOMs—Major Commands

MMWR—Morbidity and Mortality Weekly Report

MTF—Medical Treatment Facility

NCMI—National Center for Medical Intelligence

OPR—Office of Primary Responsibility

PCM—Primary Care Manager

PCS—Permanent Change of Station

PHEO—Public Health Emergency Officer

PHO—Public Health Officer

RAB—Rabies Advisory Board

RegAF—Regular Air Force

SG—Surgeon General

SGH—Chief of Medical Staff

SGP—Chief of Aerospace Medicine

TB—Tuberculosis

TST—Tuberculin Skin Test

URL—Universal Resource Locator

USAFSAM—United States Air Force School of Aerospace Medicine

USAFSAM/PH—United States Air Force School of Aerospace Medicine/Public Health and Preventive Medicine Department

Terms

Accessions—Service accessions include service members in recruit training, Officer Candidate School, service academy preparatory school, service academy, officer-indoctrination school, other officer accession programs, and officers that are directly commissioned.

Active surveillance—Requires direct action to collect disease information. For example, active surveillance includes: contacting physicians, hospitals, laboratories, or other health entities to actively search for disease cases.

Air Reserve Component (ARC)—Reserve forces that include the Air National Guard and the Air Force Reserve Command.

Diseases and conditions of public health or military significance—These are diseases or health conditions that impact the health or readiness of Air Force personnel, their dependents, or other eligible personnel and which have a potential for substantial mission degradation, widespread morbidity, or significant adverse sequelae or mortality.

High—risk TB prevalence country/area—A country or geographical area with a high prevalence of TB. See NCMI site **https://www.intelink.gov/ncmi/index.php** for country risk profile.

Disease outbreak—The occurrence of cases of disease in excess of what would normally be expected in a defined community, geographical area or season. An outbreak may occur in a restricted geographical area, or may extend over several countries. It may last for a few days or weeks, or for several years. A single case of a communicable disease long absent from a population, or caused by an agent (e.g., bacterium or virus) not previously recognized in that community or area, or the emergence of a previously unknown disease, may also constitute an outbreak and should be reported and investigated.

Knowledge Exchange (KX)—A web-based, collaborative platform used to disseminate policy, increase availability of programmatic resources, share best practices, standardize processes, and enhance collaboration among users through discussion boards.

Passive surveillance—The reliance on healthcare providers or laboratories to report cases of disease.

Population health—Refers to the health or health outcomes of a geographic population rather than the health or health outcomes of individuals.

Public health surveillance—The regular or repeated collection, analysis, and dissemination of uniform health information for monitoring the health of a population, and intervening in a timely manner when necessary.

Public Health Emergency Officer (PHEO)—A senior health professions military officer or DoD civilian employee, designated by the Installation Commander, with experience in preventive medicine/emergency response who is responsible for advising the Installation Commander in the exercising of emergency health powers (as outlined in DoDI 6200.03 and AFI 10-2519, *Public Health Emergencies and Incidents of Public Health Concern*) in the event of a suspected or confirmed public health emergency.

Potential exposure to rabies—Any penetration of skin by the teeth of a potentially rabid animal; or contamination of scratches, open wounds, abrasions, breaks in skin integrity, or mucous membranes with saliva or other potentially infectious material (such as nervous tissue) from a potentially rabid animal.

Reportable medical event—Diseases or conditions that may represent an inherent, significant threat to public health and military operations. These events have the potential to affect large numbers of people, to be widely transmitted within a population, to have severe or life-threatening clinical manifestations, and to disrupt military training and deployment. Reportable medical events were chosen by consensus and recommendations from each of the Services about notifiable diseases from the Centers for Disease Control and Prevention (CDC), the Council of State and Territorial Epidemiologists (CSTE), and events that military public health experts have identified as representing significant military threats that deserve additional emphasis for surveillance.

Screening—A method for early detection of disease or health problem before an individual would normally seek medical care. Screening is usually administered to individuals without current symptoms, but who may be at high-risk for certain adverse health outcomes.

Sentinel sites—Installations selected to enhance the Department of Defense's global influenza surveillance program by identifying patients meeting the case definition for influenza, collecting respiratory specimens, and ensuring completion of the influenza questionnaire.

Syndromic surveillance—The surveillance of disease syndromes (groups of signs and symptoms), rather than specific, clinical, or laboratory-defined diseases. Surveillance of syndromes recorded at the time of patient visit, instead of specific diagnoses reported after laboratory or other diagnostic procedures, can greatly lessen the time it takes to determine that an outbreak is occurring (ESSENCE is an example of a syndromic surveillance system). At a minimum, this syndromic surveillance includes respiratory (influenza-like illness), gastrointestinal, febrile illness (fever), and dermatologic conditions.