

Army Regulation 40–5

Medical Services

Army Public Health Program

**Headquarters
Department of the Army
Washington, DC
12 May 2020**

UNCLASSIFIED

SUMMARY of CHANGE

AR 40–5

Army Public Health Program

This major revision, dated 12 May 2020—

- o Changes the title from “Preventive Medicine” to “Army Public Health Program” (cover).
- o Identifies the 10 Essential Public Health Services developed by the Department of Health and Human Services as the fundamental framework for the Army Public Health Program (paras 1–6*b* and 3–1*b*).
- o Introduces the Performance Triad as the Army-approved content for the areas of Sleep, Physical Activity, and Nutrition and a key initiative within the Army Health Promotion Program (paras 1–7*a*, 2–14*g*, 2–14*h*(13)(*a*), 2–23*a*(7), and 3–13*c*(1)).
- o Introduces the concepts of Public Health Enterprise and enterprise governance (paras 1–7*b*, 1–7*c*, and 3–2).
- o Emphasizes requirements and responsibilities for conducting public health surveillance and inspections at privatized facilities (paras 1–7*s* and 3–19).
- o Clarifies supportive role for occupational health in civilian employment decision making (paras 1–7*v*, 1–7*w*, 2–28, 2–29, and 3–6*c*).
- o Prohibits invasive body art operations such as tattooing and piercings, other than piercing the earlobe, on Army installations (para 1–7*y*).
- o Establishes requirements for using approved systems of records to archive public health information (paras 1–7*x* and 3–20).
- o Establishes the Deputy Chief of Staff for Public Health as The Surgeon General’s principal advisor on public health issues and the public health authority for the Army (para 2–12*b*).
- o Eliminates the U.S. Army Center for Health Promotion and Preventive Medicine and establishes the U.S. Army Public Health Center as the U.S. Army Medical Command organization that provides technical and support capabilities to support Army readiness (paras 2–12*b*(8) and 2–17*cc*).
- o Introduces requirements for quality management and the process for obtaining accreditation (paras 2–12*b*(9), 2–17*s*, 2–19*m*, 2–20*g*, 2–21*g*, and 3–18*a*).
- o Eliminates references to Regional Medical Commands, U.S. Army Medical Centers, and U.S. Army Medical Activities and aligns public health responsibilities under “regional health authorities,” “installation medical authorities,” and “installation public health authorities” (paras 2–19, 2–20, and 2–21).
- o Incorporates Army Directive 2018–07–11, Prioritizing Efforts—Readiness and Lethality (Update 11) (para 2–27*e*).
- o Changes the designation of preventive medicine functional areas to public health program elements and updates the characterization for each element (paras 3–5 through 3–17).
- o Adds the following public health program elements: occupational and environmental medicine, veterinary services, and public health emergency management (paras 3–8, 3–9, and 3–17).

- o Renames field preventive medicine as operational public health, health risk communication as public health communication, and Soldier, Family, community health, and health promotion as community-based prevention and health promotion (paras 3–10, 3–13, and 3–16).
- o Redefines “preventive medicine” as a distinct medical specialty within the field of public health (glossary).
- o Updates existing and adds new definitions to the terms section (glossary).

Medical Services
Army Public Health Program

By Order of the Secretary of the Army:

JAMES C. MCCONVILLE
General, United States Army
Chief of Staff

Official:


KATHLEEN S. MILLER
Administrative Assistant
to the Secretary of the Army

History. This publication is a major revision.

Summary. This regulation establishes practical measures for the preservation and promotion of health, the prevention of disease and nonbattle injuries, and improvement of personal readiness. This regulation implements Executive Order 12196; DOD 6055.05–M; DODD 4715.1E, DODD 6000.12E, DODD 6200.04, DODD 6205.02E, DODD 6400.04E, and DODD 6490.02E; Department of Defense Instruction (DODI) 1010.10, DODI 1322.24, DODI 1400.25, DODI 4150.07, DODI 6050.05, DODI 6055.01, DODI 6055.05, DODI 6055.07, DODI 6055.08, DODI 6055.11, DODI 6055.12, DODI 6055.15, DODI 6060.02, DODI 6200.03, DODI 6205.4, and DODI 6490.03.

Applicability. This regulation applies to the Regular Army, the Army National Guard/Army National Guard of the United States, and the U.S. Army Reserve, unless otherwise stated. It applies to U.S. Military Academy cadets, U.S. Army Reserve Officer Training Corps cadets when engaged in directed training ac-

tivities, foreign national military personnel assigned to Army components, Department of the Army Civilian personnel, and nonappropriated fund personnel. Further, this regulation applies to all elements of the Army across the range of military operations from military engagement, security cooperation, and deterrence through large-scale combat operations, to include activities during mobilization. Except for those public health services defined in DODI 6055.01 for supporting DOD contractor personnel during outside continental United States force deployments or specifically provided for in contracts between the Government and a contractor, this regulation does not generally apply to Army contractor personnel and contractor operations.

Proponent and exception authority. The proponent of this regulation is The Surgeon General. The proponent has the authority to approve exceptions or waivers to this regulation that are consistent with controlling law and regulations. The proponent may delegate this approval authority, in writing, to a division chief within the proponent agency or its direct reporting unit or field-operating agency, in the grade of colonel or the civilian equivalent. Activities may request a waiver to this regulation by providing justification that includes a full analysis of the expected benefits and must include formal review by the activity's senior legal officer. All waiver requests will be endorsed by the commander or senior leader of the requesting activity and forwarded through their higher headquarters to the policy proponent. Refer to AR 25–30 for specific guidance.

Army internal control process. This regulation contains internal control provisions in accordance with AR 11–2

and identifies key management controls that must be evaluated (see appendix B).

Supplementation. Supplementation of this regulation and establishment of command and local forms are prohibited without prior approval from The Surgeon General (DASG–HS), 7700 Arlington Boulevard, Falls Church, VA 22042–5143.

Suggested improvements. Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications and Blank Forms) directly to The Surgeon General (DASG–HS), 7700 Arlington Boulevard, Falls Church, VA 22042–5143.

Committee management. AR 15–1 requires the proponent to justify establishing/continuing committee(s), coordinate draft publications, and coordinate changes in committee status with the U.S. Army Resources and Programs Agency, Department of the Army Committee Management Office (AARP–ZA), 9301 Chapek Road, Building 1458, Fort Belvoir, VA 22060–5527. Further, if it is determined that an established “group” identified within this regulation, later takes on the characteristics of a committee, as found in the AR 15–1, then the proponent will follow all AR 15–1 requirements for establishing and continuing the group as a committee.

Distribution. This regulation is available in electronic media only and is intended for the Regular Army, the Army National Guard/Army National Guard of the United States, and the U.S. Army Reserve.

Contents (Listed by paragraph and page number)

Chapter 1
Introduction, page 1

*This regulation supersedes AR 40-5, dated 25 May 2007.

Contents—Continued

Purpose • 1–1, *page 1*
References and forms • 1–2, *page 1*
Explanation of abbreviations and terms • 1–3, *page 1*
Responsibilities • 1–4, *page 1*
Records management (recordkeeping) requirements • 1–5, *page 1*
Scope of Army public health • 1–6, *page 1*
Public health policy • 1–7, *page 1*

Chapter 2

Responsibilities, *page 3*

Assistant Secretary of the Army (Acquisition, Logistics and Technology)/Army Acquisition Executive • 2–1, *page 3*
Assistant Secretary of the Army (Installations, Energy, and Environment) • 2–2, *page 4*
Assistant Secretary of the Army (Manpower and Reserve Affairs) • 2–3, *page 4*
Chief, National Guard Bureau • 2–4, *page 4*
Director of the Army Staff • 2–5, *page 5*
Deputy Chief of Staff, G–1 • 2–6, *page 5*
Deputy Chief of Staff, G–2 • 2–7, *page 6*
Deputy Chief of Staff, G–3/5/7 • 2–8, *page 6*
Deputy Chief of Staff, G–4 • 2–9, *page 6*
Chief, Army Reserve/Commanding General, U.S. Army Reserve Command • 2–10, *page 6*
Chief of Engineers/Commanding General, U.S. Army Corps of Engineers • 2–11, *page 6*
The Surgeon General • 2–12, *page 6*
Commanding General, U.S. Army Forces Command • 2–13, *page 8*
Commanding General, U.S. Army Training and Doctrine Command • 2–14, *page 8*
Commanding General, U.S. Army Materiel Command • 2–15, *page 10*
Commander, U.S. Army Installation Management Command • 2–16, *page 10*
Commander, U.S. Army Medical Command • 2–17, *page 10*
Commanders, Army commands, Army service component commands, and direct reporting units • 2–18, *page 12*
Regional health authorities • 2–19, *page 13*
Installation medical authorities • 2–20, *page 14*
Installation public health authorities • 2–21, *page 14*
Healthcare providers • 2–22, *page 15*
Commanders at all levels • 2–23, *page 16*
Senior commanders • 2–24, *page 16*
Unit and command surgeons • 2–25, *page 17*
Unit and command veterinarians • 2–26, *page 17*
Unit commanders and leaders • 2–27, *page 18*
Managers and supervisors at all levels • 2–28, *page 18*
Civilian personnel or human resources managers • 2–29, *page 19*
Installation Federal Employee Compensation Act or Injury Compensation Program administrator • 2–30, *page 20*
Longshore and Harbor Workers' Compensation Act, Headquarters, Department of the Army, G–9 coordinator • 2–31, *page 20*
Military personnel officers • 2–32, *page 20*
Army personnel • 2–33, *page 20*

Chapter 3

Program Administration, *page 21*

Section I

Public Health Enterprise and Program Goal, page 21
Background • 3–1, *page 21*
Public health enterprise • 3–2, *page 21*
Program goal • 3–3, *page 22*

Section II

Public Health Program Elements, page 23

Contents—Continued

Introduction • 3–4, *page 23*
Health surveillance and epidemiology • 3–5, *page 23*
Occupational health • 3–6, *page 23*
Environmental health • 3–7, *page 24*
Occupational and environmental medicine • 3–8, *page 24*
Veterinary services • 3–9, *page 25*
Operational public health • 3–10, *page 25*
Health risk assessment • 3–11, *page 25*
Clinical public health • 3–12, *page 26*
Community-based prevention and health promotion • 3–13, *page 26*
Public health toxicology • 3–14, *page 26*
Public health laboratory services • 3–15, *page 27*
Public health communication • 3–16, *page 27*
Public health emergency management • 3–17, *page 28*

Section III

Prescribed Procedures, page 28
Quality management • 3–18, *page 28*
Public health requirements for privatized facilities • 3–19, *page 29*
Public health information systems • 3–20, *page 29*

Appendixes

- A. References, *page 30*
- B. Internal Control Evaluation, *page 39*

Glossary

Chapter 1

Introduction

1-1. Purpose

This regulation defines and sets policies for the Army Public Health (PH) Program. It defines the Army PH Enterprise concept and assigns responsibilities for optimizing readiness and health throughout the Army and across the range of military operations, including Joint and combined operations.

1-2. References and forms

See appendix A.

1-3. Explanation of abbreviations and terms

See the glossary.

1-4. Responsibilities

Responsibilities are listed in chapter 2.

1-5. Records management (recordkeeping) requirements

The records management requirement for all record numbers, associated forms, and reports required by this regulation are addressed in the Army Records Retention Schedule-Army (RRS-A). Detailed information for all related record numbers, forms, and reports are located in ARIMS/RRS-A at <https://www.arims.army.mil>. If any record numbers, forms, and reports are not current, addressed, and/or published correctly in ARIMS/RRS-A, see DA Pam 25-403 for guidance. Medical records are maintained according to AR 40-66.

1-6. Scope of Army public health

a. PH is the preservation, maintenance, and restoration of health in Army populations through the anticipation, prediction, identification, surveillance, evaluation, prevention, and control of disease and nonbattle injuries (DNBI). It is one of the functional areas of the Military Health System for which The Surgeon General (TSG) is the Army functional proponent. PH is a major enabler for Army readiness and a major component of force health protection in its application throughout all Army activities.

b. The scope of Army PH, inclusive of veterinary and dental PH, includes those functions and services that contribute to the identification, assessment, prevention, or mitigation of DNBI; promoting, improving, sustaining, and restoring health; and supporting readiness in Army populations. It includes relevant and appropriate capabilities and functions of the 10 Essential PH Services established through the Department of Health and Human Services (see para 3-1*b*).

c. Army PH is comprised of the services, activities, and products through which the Army optimizes the health of its population. Population health management is the intentional and proactive use of a variety of individual, organizational, and population-based interventions to reduce the burden of DNBI on operational forces, to identify and improve the health status of all beneficiaries, and to help manage the healthcare demand of defined populations.

1-7. Public health policy

The goal of the PH Program is to enhance and sustain optimal levels of readiness and health in all Army populations through effective application of PH services and practices to prevent and minimize the impacts of diseases and injuries and promote healthy behaviors. The Army PH Program—

a. Utilizes the Army Health Promotion Program to implement services in support of the National Prevention Strategy (available at <https://www.surgeongeneral.gov/priorities/prevention/strategy/index.html>). A key initiative within the Army Health Promotion Program is the implementation of the Performance Triad as the Army-approved content for the areas of sleep, physical activity, and nutrition. The Performance Triad is designed to function as a key foundation for Soldier readiness and the health of all Army populations.

b. Utilizes an enterprise governance process for the planning, resourcing, delivery, monitoring, oversight, execution, and standardization of Army institutional PH Program services.

c. Applies the PH Enterprise governance process to the planning and delivery of Army institutional PH services executed on Joint bases and consistent with an established Joint Service Memorandum of Agreement (MOA) or Memorandum of Understanding (MOU).

d. Ensures that the PH components of the Army Safety and Occupational Health Program (ASOHP) are synchronized with the Army Safety and Occupational Health Management System (ASOHMS).

e. Develops a culture where Army leaders at all levels are able to make informed risk decisions about health threats and considers, in all risk decisions, the overall risk to personnel arising from short-term and long-term exposures across all Army activities (see AR 11–35).

f. Operates a system of comprehensive, continuous, and consistent military medical, behavioral, dental (see AR 40–35), occupational and environmental health (OEH) (see DODI 6490.03 and DODI 6055.05), and veterinary PH surveillance (see DODD 6400.04E) using Joint technologies, practices, and procedures across the military services to—

(1) Assess and enable the maintenance, protection, and restoration of the physical, mental, and dental health of Army personnel throughout their military service.

(2) Capture data about individual health status; instances of DNBI; medical interventions such as immunizations, treatments, and chemoprophylaxis; and potential and actual exposures to health hazards. Department of the Army (DA) Civilian health information will be limited to information relevant to the position held.

(3) Provide PH assessments supporting risk management decision making.

(4) Identify health threats and assess risks.

(5) Assist in establishing military PH goals and targets.

(6) Report the health status of Army units and the impact on readiness.

(7) Implement early intervention and control strategies.

(8) Manage and maintain all PH data for future analyses.

g. Sustains the readiness of the force by protecting Army personnel from potential and actual harmful exposures to chemical, biological, radiological, nuclear, and high-yield explosive (CBRNE) warfare agents; endemic communicable diseases; food-, water-, and vector-borne diseases; zoonotic diseases; ionizing and nonionizing radiation; combat and operational stressors; heat, cold, altitude, and other environmental extremes; environmental and occupational hazards; toxic industrial chemicals (TICs) and toxic industrial materials (TIMs); psychological threats; and other physical, biological, chemical, and radiological agents during all Army activities.

h. Adheres to federal, state, and host nation laws, regulations, and guidance governing OEH during peacetime in nondeployed situations and during training exercises, except for uniquely military equipment, systems, and operations as authorized in Executive Order 12196 and for all other PH functions during peacetime in nondeployed situations and during training exercises. The statement of work will also include requirements for contractors to adhere to DOD and Army PH regulations and guidance, whichever are more stringent.

i. Strives to adhere to peacetime United States or host nation health standards for OEH exposures, whichever are more stringent, across the full range of military operations.

(1) When the mission or the overall health of deployed personnel warrant risk decisions that may modify the application of peacetime health standards, such decisions will be made by the brigade commander or above, as far as practical, or as specified in operational plans and orders (see para 1–7*i*(2)).

(2) These decisions must be based on a complete consideration of operational as well as health risks and available contingency guidance and criteria so that the total risk to our Soldiers, DA Civilians, and military working animals is minimized. This decision-making will be deliberate, documented, and archived.

j. Uses the risk management process to minimize the total health threat and risk to personnel across the full range of military operations. Army PH policies are intended to allow commanders to execute decisive action while minimizing the total health risk to Soldiers, DA Civilians, and military working animals, according to applicable DOD/Army policies, implementing instructions, and regulations (see AR 11–35, DA Pam 385–30, and ATP 5–19).

k. Supports Global Health Engagement missions and activities in accordance with applicable legal authorities and appropriation statutes (see DODI 2000.30).

l. Provides support as the DOD Lead Service for Veterinary PH in accordance with DODD 6400.04E to:

(1) Implement and evaluate food protection measures (food safety and food defense) to ensure food ingredients and food products are safe, wholesome, meet quality standards, and are free from unintentional and intentional contamination and adulteration as described in AR 40–656/NAVSUPINST 4335.10A/MCO 10110.48, AR 40–657/NAVSUP 4355.4H/MCO P10110.31H, and AR 40–660/DLAR 4155.26/NAVSUPINST 10110.8C/AFR 161–42/MCO 1011038.C.

(2) Provide veterinary PH guidance, consultation, and clinical support regarding zoonotic diseases that may threaten DOD populations and endemic animal diseases that may threaten U.S. agricultural systems.

(3) Provide consultation for animal welfare on DOD installations.

(4) Provide veterinary consultation and support for DOD Human-Animal Bond Programs, DOD animal-assisted activity/therapy programs, and service/assistance animals owned by authorized beneficiaries.

(5) Provide comprehensive veterinary medical care for DOD-owned animals, animals owned by authorized DOD beneficiaries, and non-DOD government-owned animals in accordance with interagency agreements. This care will include measures to prevent, control, and treat animal diseases and conditions that present a PH, safety, or animal health threat to a DOD installation or the surrounding community, and to maintain veterinary clinical skills proficiency and deployment readiness as described in AR 40–905/SECNAVINST 6401.1B/AFI 48–131.

m. Provides dental PH services for the promotion of oral health, and prevention and control of oral diseases and conditions that may present health threats to Army populations (see AR 40–35).

n. Identifies, prepares for, responds to, and recovers from All-Hazards/PH emergencies caused by biological incidents, either intentionally introduced or naturally occurring; the appearance of an infectious agent or biological toxin; zoonotic disease; natural disaster; chemical attack or accidental release; radiological or nuclear attack or accident; and/or high-yield explosive detonation.

o. Ensures all new or modified materiel and their corresponding use scenarios are subjected to a health hazard assessment per the policies and procedures found in AR 40–10 and DA Pam 40–11. This includes a process for evaluating Soldier exposure to potential sources of occupational hazards during field training and deployment environments. The process for evaluating Soldier exposure is called the Soldier occupational health assessment.

p. Operates an integrated pest management (IPM) program, ensuring that only those pesticides that are both U.S. Environmental Protection Agency- and state-registered and listed in the installation pest management plan are used (see DODI 4150.07). Only those pesticides listed in the DOD Contingency Pesticide List can be used during contingency operations in accordance with DODI 4150.07 and DA Pam 40–11.

q. Ensures all PH laboratories are accredited or abide by accepted quality assurance and quality control procedures.

r. Ensures that all new chemicals and materials being added to the Army supply system have a toxicity assessment and toxicity clearance performed.

s. Ensures contract terms for privatized facilities that service DOD beneficiaries contain provisions allowing installation PH personnel scheduled and unscheduled access to conduct inspections and surveillance to assess conditions that may impact PH and safety (see AR 210–22, DODD 4715.1E, and DODD 6200.04).

t. Uses science-based PH communication and health risk assessment as key components of all Army PH program elements.

u. Educates Army personnel and informs employers of co-located contractor personnel of health threats, risks, and appropriate unit and individual preventive countermeasures.

v. Provides replacement, job transfer, periodic, and termination occupational medical surveillance examinations for Army personnel and eligible contractor personnel potentially exposed to health hazards in the work environment as described in DOD 6055.05–M.

w. Provides occupational medical qualification determination examinations when requested by commanders, their designated representatives, or authorized human resources personnel in accordance with the applicable human resources policy and procedures.

x. Acquires, archives, and stores PH data using only approved DOD health information systems and procedures that will comply, when applicable, with the provisions of the Health Insurance Portability and Accountability Act and the Privacy Act (see DODI 6025.18 and DODI 1400.25, Vol. 1403). It ensures all PH data and information are entered, managed, analyzed, and reported in an appropriate system of records.

y. Ensures that body art and body modification operations (for example, tattooing and piercings), with the exception of the piercing of earlobes, are prohibited on Army installations.

z. Incorporates Army PH information management (IM) and information technology (IT) requirements into military health information systems.

Chapter 2 Responsibilities

2–1. Assistant Secretary of the Army (Acquisition, Logistics and Technology)/Army Acquisition Executive

The ASA (ALT)/AAE will plan, program, and budget for the integration of requirements identified by the Army PH Program with the Army’s acquisition programs. This includes:

a. The health hazard assessment of Army materiel throughout the full life cycle of these items (see AR 40–10, AR 70–1, AR 602–2, and AR 700–142) and the Soldier occupational health assessment (see AR 40–10 and AR 385–10).

b. The development of nonmedical materiel (such as instruments, equipment) in conjunction with TSG to rapidly identify and measure health threats in the environment for the purpose of assessing immediate and long-term health risks to Army personnel.

c. The establishment of procedures to assure that program managers and other authorized individuals request life cycle toxicology information by:

- (1) Requesting toxicity assessments for new chemicals and formulations to be used in new products; and
- (2) Requesting toxicity clearances for chemicals and chemical-based materiel added to the Army supply system or used in new systems and platforms.

d. The issuance and maintenance of U.S. Army Medical Command (MEDCOM)-approved interim standards for health threats and threshold effect levels for chemical, biological, radiological, and nuclear (CBRN) contaminants, electromagnetic environments, and directed energy levels for safe exposure (see AR 40–10 and AR 70–75).

e. In coordination with MEDCOM, the planning, programming, and budgeting for the issuance and maintenance of criteria and instrumentation requirements to support assessment of crew casualties during system tests and evaluations (see AR 40–10 and AR 70–75).

2–2. Assistant Secretary of the Army (Installations, Energy, and Environment)

The ASA (IE&E) will—

- a. Provide executive leadership at the Army Secretariat level to ensure timely—
 - (1) Integration of DOD directives and policies concerning Army OEH with Army policies, doctrine, and guidance.
 - (2) Compliance with Army OEH requirements.
- b. Establish goals, policies, priorities, and oversight for Army OEH.
- c. Provide Army OEH input to the Defense Planning and Programming Guidance, The Army Plan, Army Programming Guidance Memorandum, and through the Under Secretary of Defense for Personnel and Readiness in the Defense Health Program (DHP) Fiscal Guidance.
- d. Provide policy, goals, guidance, and management oversight of the ASOHP as the Army component of the DOD Safety and Occupational Health Program.
- e. Coordinate with TSG to ensure PH requirements are incorporated into contractual documents for privatized facilities on Army installations.
- f. Establish policy and advocate for DOD PH systems of records.
- g. Accomplish lead agent duties for DOD’s interaction with the Agency for Toxic Substances and Disease Registry (ATSDR). Mission authority for DOD’s interaction with ATSDR is delegated to the Commander, MEDCOM.

2–3. Assistant Secretary of the Army (Manpower and Reserve Affairs)

The ASA (M&RA) will—

- a. Provide executive leadership at the Army Secretariat level—
 - (1) To ensure timely integration of DOD directives and policies concerning health and fitness with Army policies, doctrine, and guidance.
 - (2) For the development and implementation of Army health and fitness policies.
 - (3) For the development of job series-specific policies that include medical or physical requirements for all Army personnel employed in a given job series.
 - (4) To ensure civilian medical and physical position requirements are defined prior to filling a position.
- b. Oversee the integration of Army health and fitness policy with Army activities, operations, policies, and doctrine.
- c. Provide Army PH input to the Defense Planning and Programming Guidance, The Army Plan, Army Programming Guidance Memorandum, and through the Under Secretary of Defense for Personnel and Readiness in the DHP Fiscal Guidance.
- d. Coordinate with TSG and the Director of Army Safety (DASAF) to evaluate injury, illness, claims, and cost data for the Federal Employee Compensation Act (FECA) and Longshore and Harbor Workers’ Compensation Act (LHWCA) in order to inform program and policy guidance (see paras 2–30 and 2–31).

2–4. Chief, National Guard Bureau

The CNGB, or the Director, Army National Guard if so delegated, will—

- a. Provide emphasis, resources, policy, and implementation guidance to each state and territory adjutant general for the execution of PH services at Army National Guard installations supporting training and mobilization activities.
- b. Provide command emphasis, policy, and guidance to each state and territory adjutant to ensure PH readiness for Army National Guard personnel.
- c. Appoint the Army National Guard/Army National Guard of the United States Surgeon to coordinate with TSG and the MEDCOM Deputy Chief of Staff for Public Health (DCS–PH) on PH issues.

d. Ensure that each state and territory surgeon appoints an Army PH program manager to serve as liaison with the MEDCOM, DCS–PH for coordinating PH service support.

e. Ensure that state adjutants general provide a safe and healthy work and living environment for all assigned and supported populations by:

(1) Resourcing, implementing, and enforcing PH aspects of installation infrastructure and services in coordination with installation medical and PH authorities, to include:

(*a*) Enabling PH personnel to provide the medical oversight and monitoring of installation infrastructure and services that may pose health threats. PH personnel provide the technical advice and assistance to senior commanders to minimize risks from such threats.

(*b*) Resourcing for PH support at state-owned installations, armories, and facilities, which is the responsibility of the state and territory adjutants general.

(2) Ensuring safe drinking water, food, worksites, and recreational activities.

(3) Coordinating with the supporting medical and PH authorities to ensure required PH services are provided at installations that do not have tenant PH assets. PH services for these tenant organizations and other supported military personnel will be established through local installation or other types of support agreements. (See DA Pam 40–11 for implementing guidance.)

f. Ensure that state adjutants general provide occupational health services that include, but are not limited to:

(1) Safety and Occupational Health Program according to AR 385–10 and 29 CFR 1960.

(2) Ergonomics Program with an ergonomics subcommittee and an ergonomics officer according to DA Pam 40–21.

(3) Respiratory Protection Program according to AR 11–34.

(4) Army Hearing Program according to DA Pam 40–501.

(5) Army Vision Conservation and Readiness Program according to DA Pam 40–506.

(6) Health Promotion Program according to AR 600–63 and DODI 1010.10.

(7) Army Industrial Hygiene Program according to DA Pam 40–503.

(8) Army Radiation Safety Program according to AR 385–10 and DA Pam 385–24.

g. Ensure that state adjutants general support and encourage participation in activities and functions that promote healthy behaviors, increase readiness, and improve performance through approved Army programs.

h. Ensure that state adjutants general provide facility support for Army wellness centers.

i. Ensure that state adjutants general appoint a Public Health Emergency Officer (PHEO), based on the nomination by the regional health authority, in consultation with the installation medical and PH authorities according to AR 525–27 and DODI 6200.03.

j. Ensure that state adjutants general control stray animals on fixed installations by incorporating a stray animal control plan into the garrison IPM Plan.

2–5. Director of the Army Staff

On behalf of DAS, the Commander, U.S. Army Combat Readiness Center/Director of Army Safety will—

a. Coordinate with TSG and the MEDCOM DCS–PH to ensure Army Medical Department (AMEDD) support for safety and injury prevention, and worksite safety and occupational health programs as outlined in AR 385–10 are synchronized and coordinated with Army safety personnel, where appropriate, to support a unified PH effort in reducing injuries and worksite illnesses across the Army.

b. Exchange accidental injury data with TSG for an accurate assessment of the Army health status.

c. In coordination with ASA (M&RA) and TSG, evaluate FECA and LHWCA injury, illness, claims, and cost data to inform program and policy guidance.

2–6. Deputy Chief of Staff, G–1

The DCS, G–1 will—

a. Provide executive leadership at the Army Staff level for the integration of health and fitness policies and doctrine with Army personnel policies and doctrine.

b. Provide executive leadership for the development of job series-specific policies that include medical or physical requirements for all Army personnel employed in a given job series.

c. Serve as the functional proponent for Army health promotion and wellness and coordinate with TSG for the development, execution, and evaluation of health promotion activities (see DODI 1010.10).

d. Ensure that Army personnel data in support of all Army, DOD, and Joint contingencies and exercises are periodically provided to the Defense Manpower Data Center. Data will include daily strength by unit and total deployed, grid location of each unit (company size and higher), and inclusive dates of individual Army personnel deployment.

These personnel data provide denominators for deployment medical surveillance analyses as well as location information for identifying potential exposures for OEH surveillance.

e. Ensure that Army personnel location data are regularly updated and made available to medical surveillance systems such that accurate denominators for garrison medical surveillance analyses can be established.

f. Ensure its information systems, which include medical data, are compatible with DOD medical information systems.

g. Ensure civilian medical and physical position requirements are defined prior to filling a position.

h. Provide DA Civilian manpower data to TSG to enable establishment of a reliable cohort of individuals requiring PH services.

i. Ensure goals and objectives of the Commanders Ready and Resilient Council (CR2C) (formerly named the Community Health Promotion Council) are met (see AR 600–63).

2–7. Deputy Chief of Staff, G–2

The DCS, G–2 will—

a. Advise the ASA (IE&E) and TSG on medical intelligence.

b. Provide functional policy and guidance on the collection and dissemination of medical intelligence.

2–8. Deputy Chief of Staff, G–3/5/7

The DCS, G–3/5/7 will—

a. Exercise Army general staff responsibility for the integration of PH into planning and training across the range of military operations.

b. Support Global Health Engagement missions and activities in accordance with proper statutory authorities and appropriation law.

c. Ensure all source information and data regarding Army personnel exposures or potential exposures to CBRN agents are identified, summarized, and submitted via official operational channels to TSG/MEDCOM G–3/5/7 and DCS–PH.

2–9. Deputy Chief of Staff, G–4

The DCS, G–4 will ensure the—

a. Integration of PH policy into:

(1) The transportation, storage, handling, and disposal of hazardous material or hazardous waste.

(2) Deployment-related housing, food and bottled water procurement and storage, food preparation, water purification, mortuary affairs, laundry, and shower operations.

b. Provision of support to field sanitation activities.

2–10. Chief, Army Reserve/Commanding General, U.S. Army Reserve Command

The CAR/CG, USARC will—

a. Provide command emphasis, resources, policy implementation, guidance, and oversight for the execution of PH services at U.S. Army Reserve (USAR) installations supporting training and mobilization activities.

b. Provide command emphasis, policy, and guidance to ensure PH readiness for USAR personnel.

c. Appoint an Army PH program manager to serve as liaison with the MEDCOM DCS–PH for coordinating PH service support.

2–11. Chief of Engineers/Commanding General, U.S. Army Corps of Engineers

The COE/USACE, in addition to the responsibilities in paragraph 2–18, will—

a. Coordinate with TSG and the MEDCOM DCS–PH on the health aspects of environmental issues including environmental compliance, environmental baseline surveys, OEH site assessments, pollution prevention, hazardous waste minimization, feral animal risk mitigation (FARM), risk assessment, and risk communication program requirements.

b. Ensure coordination of environmental program data with TSG for an accurate assessment of the impact of environmental conditions on the Army health status.

c. Ensure that health risk assessments are submitted to TSG for review and approval.

2–12. The Surgeon General

a. TSG will provide oversight of PH activities as outlined in this regulation and will—

(1) Provide leadership, proponentcy, policy, prioritization, and coordination for the Army PH Program.

- (2) Plan, program, budget, and oversee the execution of resources in support of PH activities.
- (3) Determine and direct the use of appropriate preventive measures, pharmaceuticals, and biologics for DNBI control.
- (4) Ensure that prevention is integrated with the practice of Army medicine at all levels and in all settings.
- (5) Determine if Army medical and nonmedical materiel present a health hazard to personnel according to AR 40–10, AR 40–60, and AR 70–1, and provide medical policies, health standards and guidance, and recommendations to protect personnel from the hazard presented.
- (6) Develop functional policy and guidance for the medical aspects of Army OEH risk management policies (see AR 11–35).
- (7) Develop guidance that allows commanders to identify, assess, and mitigate the health risks resulting from exposures to natural or manmade occupational and environmental hazards.
- (8) Develop programs to conduct long-term surveillance in Army populations identified to be at a potential increased risk of adverse health outcomes due to exposures, as appropriate.
- (9) Develop procedures to ensure Army personnel exposed (confirmed and potential exposures) to hazards during any Army operation are appropriately screened and managed with exposure assessment data entered into the appropriate system of records as outlined in DA Pam 40–11 (see AR 11–33, DODI 6490.02E, and DODD 6490.03).
- (10) Develop policy for medical care to prevent morbidity from occupational injuries and illnesses.
- (11) Ensure compliance with public law, adherence to Army regulations, and effective integration of safety and occupational health strategy, policy, priorities, requirements, program resources, and associated enterprise management information systems through participation in the Army’s Safety and Occupational Health Senior Executive Council.
- (12) Develop policy and guidance for the medical aspects of the ASOHP, ensuring that medical aspects support the ASOHMS.
- (13) Develop health protection policy as part of the Army Protection Program outlined in AR 525–2.
- (14) Develop policy and guidance for execution of Army Health Promotion Program responsibilities as outlined in AR 600–63.
- (15) Develop PH emergency management policy and guidance in support of the Army Emergency Management Program as outlined in AR 525–27 and consistent with and in support of DODI 6055.17 and DODI 6200.03.
- (16) Ensure AMEDD support for safety and injury prevention, and worksite safety and occupational health programs as outlined in AR 385–10 and DA Pam 40–503 are synchronized and coordinated with Army safety personnel, where appropriate, to support a unified PH effort in reducing injuries and worksite illnesses across the Army.
- (17) Coordinate with the U.S. Department of Veterans Affairs regarding exposed or potentially exposed populations, as appropriate.
- (18) Adhere to applicable Defense Health Agency (DHA) guidance to ensure that the Army provides equitable veterinary service support throughout the DOD as directed in DODD 6400.04E, including support for PH aspects of operational and tactical missions for all DOD components.
- (19) In coordination with ASA (M&RA) and DASAF, evaluate FECA and LHWCA injury, illness, claims, and cost data to inform program and policy guidance.
 - b.* The DCS–PH functions as the PH authority for the Army and will serve as TSG’s principal advisor on PH issues. On behalf of TSG, the DCS–PH will—
 - (1) Establish PH policies, standards, regulations, and directives to protect and promote health, improve Army PH Program effectiveness, assess and communicate health risks, and enhance the environment of Army populations.
 - (2) Provide strategic direction, guidance, and prioritization for PH activities considering AMEDD strategies and validated health threat assessments.
 - (3) Provide consultation, tools, and assistance to support TSG’s responsibilities outlined in AR 600–63.
 - (4) Assist in implementing Army population-based health activities that link medical outcomes, medical utilization, and epidemiology with individual, Family, and community health initiatives.
 - (5) Use the PH Enterprise governance process to ensure the standardized delivery of institutional PH services.
 - (6) Provide staff support and consultative services for PH, as requested, to the Army Staff, Army commands (ACOMs), Army service component commands (ASCCs), and direct reporting units (DRUs).
 - (7) Develop and maintain MOUs/MOAs or inter-service support agreements to enable full PH support external to MEDCOM.
 - (8) Provide technical and support capabilities through the U.S. Army Public Health Center (APHC) to enhance Army readiness by identifying and assessing current and emerging health threats, developing and communicating PH solutions, and monitoring the readiness, quality, and effectiveness of the Army’s PH Enterprise (see para 2–17cc for APHC responsibilities).

- (9) Establish a formal quality management process for Army PH.
- (10) Execute TSG's responsibilities, as specified in AR 200-1, functioning as the Army executive point of contact for all OEH aspects of the Army's Environmental Program and as TSG's reviewing authority for all environmental documents submitted by DA activities.
- (11) Serve as the Office of The Surgeon General (OTSG)/MEDCOM staff lead to coordinate between the combined staffs of OTSG and MEDCOM and the DHA Immunization Healthcare Branch on all military vaccine-related programs and efforts.
- (12) Serve as OTSG/MEDCOM staff lead to coordinate with DHA on all DOD Suicide Event Report-related surveillance and reporting activities and efforts.
- (13) Promote the adoption and execution of evidence-based PH communication tools, processes, and principles.
- (14) Provide advocacy, strategic direction, guidance, and prioritization for the Army PH Program.
- (15) Execute TSG's responsibilities in implementing the PH components of Army OEH risk management.
- (16) Execute TSG's responsibilities for The Army Chemical Agent Safety Program and Biological Defense Safety Program according to AR 385-10.
- (17) Issue and maintain military-unique OEH and CBRN exposure standards, criteria, and guidelines.
- (18) Execute TSG's responsibilities for the Army Ergonomics Program (see DA Pam 40-11 and DA Pam 40-21).
- (19) Coordinate with the DASAF to ensure Army compliance with Occupational Safety and Health Act (Public Law 91-596, as amended) health standards.
- (20) Provide PH representation and liaison as appropriate.
- (21) Coordinate with the U.S. Army Medical Department Center and School (AMEDDC&S), Health Readiness Center of Excellence (HRCoE) and U.S. Army Medical Research and Materiel Command (MRMC) concerning doctrine, organization, training, materiel, leadership and education, personnel, facilities, and policy (DOTMLPF-P) solutions to Army PH issues.
- (22) Coordinate with the U.S. Army Training and Doctrine Command (TRADOC) concerning the prevention and control of injuries and communicable diseases and promote health and wellness in recruit and other training populations.
- (23) Coordinate with the MEDCOM DCS, G-3/5/7 on clinical PH policies.
- (24) Identify requirements and coordinate internally and externally to MEDCOM to develop, procure, or modify IM/IT tools to support the Army PH Enterprise.
- (25) Develop, monitor, evaluate, and report PH activity process and outcome metrics.
- (26) Execute TSG's responsibilities in support of safety and injury prevention, and worksite safety occupational health programs and services specified in AR 385-10.
- (27) Coordinate with the U.S. Army Materiel Command (AMC) Logistic Civil Augmentation Program concerning service support contracts.
- (28) Execute TSG's responsibilities for the PH aspects of emergency management, as specified in AR 525-27, functioning as the ex-officio Army PHEO.
- (29) Coordinate with the AMEDD professional consultants regarding PH aspects within their specialties.

2-13. Commanding General, U.S. Army Forces Command

The CG, FORSCOM, in addition to the responsibilities in paragraph 2-18, will—

- a.* Coordinate with AMEDDC&S, HRCoE to identify the required force structure and capabilities to implement the PH aspects of combat health support according to Army and Joint doctrine.
- b.* Coordinate with OTSG in planning, programming, and budgeting for required capabilities to implement the PH aspects of combat health support according to Army and Joint doctrine.
- c.* When organic capabilities are overwhelmed or insufficient, coordinate with MEDCOM, TRADOC, and the Army DCS, G-3/5/7 to provide augmented in-theater medical analytical capability for theater-level rapid nuclear, radiological, biological, chemical, environmental, infectious disease, and psychological risk identification and assessment to support operational health risk management.

2-14. Commanding General, U.S. Army Training and Doctrine Command

The CG, TRADOC, in addition to the responsibilities in paragraph 2-18, will—

- a.* Develop, in coordination with MEDCOM, doctrine, tactics, techniques, and procedures; implementation plans; operational requirements; and appropriate training and education for leaders and others to use in assessing, communicating, managing, and countering health threats during all Army activities.
- b.* Incorporate health risk assessment training into TRADOC leadership schools, as appropriate.

- c. Incorporate PH communication training into TRADOC leadership schools, as appropriate, to help standardize an Army culture that supports evidence-based communication practice.
- d. Develop and implement, through the U.S. Army Chemical, Biological, Radiological, and Nuclear School and in close cooperation with MEDCOM, the doctrinal, training, organizational, and materiel solutions to the risks presented by CBRN agents and toxic industrial hazards.
- e. Coordinate with MEDCOM and OTSG regarding PH issues in the training base.
- f. Incorporate deployment and garrison risk mitigation of health threats into cadre training.
- g. Ensure that Performance Triad concepts are incorporated into existing health promotion curricula in Army schools (see AR 600–63).
- h. Through the Commander, AMEDDC&S, HRCoE—
 - (1) Provide doctrine, training, leader development, organization, and Soldier system solutions for validated Army and Reserve Component PH requirements.
 - (2) Coordinate with MEDCOM and MRMC in the development of materiel solutions to PH requirements.
 - (3) Coordinate with MEDCOM and Reserve Component organizations for participation in and technical support of the PH components of the training mission and functions of the Directorate of Training and Academic Affairs (DoTAA).
 - (4) Coordinate with MEDCOM and the Reserve Components to—
 - (a) Participate in the development and delivery of PH curriculum in all applicable courses sponsored by the DoTAA.
 - (b) Participate in force integration activities, such as:
 - 1. Capabilities development and integration.
 - 2. Force structure and analysis.
 - 3. Theater medical information management.
 - 4. Technology insertion.
 - 5. War fighting experimentation.
 - 6. AMEDD systems integration.
 - 7. Operational test and evaluation.
 - 8. Strategic planning and force management.
 - (c) Plan for the provision of PH sustainment training for units and individuals.
 - (d) Develop doctrine and conduct training in appropriate courses that supports Global Health Engagement skill development for Army medicine.
 - (5) Coordinate with the MEDCOM DCS–PH concerning AMEDD PH personnel proponency issues.
 - (6) Coordinate to incorporate PH concepts and practices into officer and enlisted training manuals and Soldier common task training manuals, as applicable.
 - (7) Represent and advocate in coordination with MRMC, PH-related Army science and technology objectives.
 - (8) Provide PH doctrine and training on reportable medical events, the use of the Disease Reporting System internet (DRSi), pesticide use reporting and recordkeeping, and the North Atlantic Treaty Organization DNBI reporting procedures.
 - (9) Develop and conduct comprehensive PH foundational and advanced training courses.
 - (10) Incorporate appropriate PH training in command surgeon preparation courses such as brigade/division surgeons’ courses, AMEDD Basic Officer Leader Course, U.S. Army School of Aviation Medicine’s Army Flight Surgeons’ Primary Course to include deployment surveillance requirements and procedures, OEH-related diseases and injuries, CBRN exposure recognition, travel medicine, operational PH, and PH communication.
 - (11) Train healthcare providers on PH concepts and practices and the basics of OEH threats, their potential for health effects, requirements for treatment and/or medical surveillance, and PH communication.
 - (12) Establish, maintain, and disseminate lessons learned from previous and ongoing deployment PH-related issues.
 - (13) Update training support packages with key PH guidance to include:
 - (a) Promotion of individual/unit health and wellness (Performance Triad, tobacco-free living).
 - (b) Prevention of communicable diseases.
 - (c) Reduction of injuries.
 - (d) Behavioral health and suicide prevention.
 - (e) Prevention of illness and injury due to exposure to feral animals (that is, FARM).
 - (14) Maintain liaison and coordination with the DCS–PH as part of the PH Enterprise governance process regarding training and capabilities development and integration.
 - (15) Incorporate training on applicable PH systems of records into the AMEDDC&S curriculum.

2–15. Commanding General, U.S. Army Materiel Command

The CG, AMC, in addition to the responsibilities in paragraph 2–18, will—

- a.* Support the AAE in developing the nonmedical materiel (such as instruments, equipment) in conjunction with TSG to rapidly identify and assess the short-term and long-term health risks presented by OEH threats.
- b.* Support the AAE, program executive officers, and program managers in analyzing all emerging Army systems for environmental effects, including noise and toxic and hazardous wastes and releases associated with normal system testing, production, use, maintenance, and disposal.
- c.* Through the Commander, MPMC—
 - (1) Provide biomedical materiel and information solutions for military PH capabilities to enhance, sustain, and protect health, fitness, and performance.
 - (2) Provide capabilities to support:
 - a.* DOD and Joint surveillance and laboratory diagnosis of emerging and reemerging infectious, zoonotic, and vector-borne diseases of military significance.
 - b.* Surveillance for early notification of disease outbreaks of military importance.
 - c.* DCS–PH in the development of data for the derivation of CBRN exposure standards, criteria, and guidelines.
 - 3.* Maintain liaison and coordination with the DCS–PH as part of the PH Enterprise governance process regarding PH research and development and fielding of PH solutions, capabilities, and information products.

2–16. Commander, U.S. Army Installation Management Command

The Commander, IMCOM, in addition to the responsibilities in paragraph 2–18, will—

- a.* Coordinate with MEDCOM on the PH-related aspects of installation management including installation master planning, facilities design and construction, renovation, environmental compliance, health risk assessment, IPM plans, emergency management, and PH communication requirements.
- b.* Coordinate with PH personnel regarding the Installation Toxics Management Program according to the USACE PWTB 200–1–144 and Legionella control in building water systems according to USACE EM 200–1–13.
- c.* Coordinate with MEDCOM on the training, monitoring, and evaluation of installation CR2C initiatives, actions, and subprocesses.
- d.* Ensure installations implement an IPM program and report control activities to the installation PH authority (see DA Pam 40–11 and DODI 4150.07).
- e.* Coordinate with ASA (IE&E) to ensure lease agreements for privatized facilities that operate on Army installations and provide services to DOD personnel include allowances for unannounced PH inspections and surveillance activities.

2–17. Commander, U.S. Army Medical Command

The Commander, MEDCOM, in addition to the responsibilities defined in paragraph 2–18, will—

- a.* Identify the roles and responsibilities within the current MEDCOM construct to include regional health authorities, specified in paragraph 2–19, for the execution of PH services.
- b.* Provide clinical and nonclinical PH services at Army installations and Joint installations where the Army is designated as the lead agent for PH.
- c.* Adhere to applicable DHA guidance to ensure that MEDCOM provides support to veterinary service missions throughout the DOD as directed in DODD 6400.04E.
- d.* Develop and execute installation, regional, and worldwide PH services to support the entire range of military operations.
- e.* Plan, program, budget, and execute resources in support of PH activities.
- f.* Coordinate with the DA staff and appropriate medical organizations to provide PH augmentation support when directed or requested.
- g.* Provide command guidance and oversight including program evaluation of the priorities, services, and direction for PH with the assistance of the MEDCOM DCS–PH.
- h.* Ensure PH resources are executed in accordance with program priorities, goals, and objectives.
- i.* Provide command guidance to AMEDDC&S, HRCoE and MPMC for PH issues and needs for DOTMLPF–P solutions.
- j.* Develop doctrine, implementation plans, procedures, capabilities, and training for medical and OEH surveillance to assess and effectively communicate health risks and exposures.
- k.* Ensure that OEH risk management and PH communication training is incorporated into the AMEDDC&S, HRCoE curriculum.
- l.* Include Army PH requirements in Army medicine strategic and mid-term planning activities.

- m.* Ensure Army PH nurses are identified for each installation to serve as the health consultant for IMCOM child and youth services programs (see AR 608–10).
- n.* Establish Radiological Advisory Medical Teams and response capabilities at appropriate locations as required by AR 40–13.
- o.* Appoint a MEDCOM Radiation Safety Staff Officer to act as the senior radiation safety officer for MEDCOM (see DA Pam 385–24).
- p.* Ensure PH concerns are addressed in All-Hazards planning as part of the MEDCOM Emergency Management Program.
- q.* Issue and maintain interim standards for health hazards and threshold effect levels for CBRN contaminants, electromagnetic environments, and directed energy levels for safe exposure (see AR 40–10 and AR 70–75).
- r.* Issue and maintain criteria and instrumentation requirements to support assessment of crew casualties during system tests and evaluations (see AR 70–75).
- s.* Establish and provide oversight for a quality management system for the Army PH Program.
- t.* Develop and resource appropriate IM/IT strategies, processes, tools, and solutions to ensure the availability of IM and IT support to implement Army PH policies and services.
- u.* Ensure appropriate personnel within MEDCOM receive training on depleted uranium (DU) and that the management of Army personnel exposed to DU is as directed in DA Pam 40–11.
- v.* Develop the procedures and guidance for MEDCOM subordinate commands to obtain intelligence products regarding health, industrial, and environmental threats.
- w.* Submit production requirements for valid medical intelligence product requests to the National Center for Medical Intelligence, Defense Intelligence Agency.
- x.* Provide periodic evaluation of installation safety and occupational health programs along with a plan to ensure appropriate follow-up and resolution of corrective actions. A copy of the evaluation along with the plan for resolution will be provided to the senior commander.
- y.* Ensure synchronization and coordination with staff elements of the DCS, G–1, as appropriate, to support a unified PH effort in promoting health and wellness across the Army.
- z.* Support a unified PH effort in reducing injuries and worksite illnesses across the Army as outlined in AR 385–10 by synchronizing and coordinating with Army Safety personnel.
- aa.* Provide global PH Enterprise strategic and operational PH services in accordance with applicable legal authorities and appropriation statutes.
- bb.* Exercise mission execution authority for DOD’s interaction with ATSDR through the APHC.
- cc.* Through the Director, APHC provides technical and support capabilities to enhance Army readiness by:
 - (1) Establishing and maintaining capabilities to support all PH program elements characterized in paragraphs 3–5 through 3–17 and DA Pam 40–11.
 - (2) Assisting the DCS–PH Directorates in developing PH policy and guidance.
 - (3) Identifying, assessing, and providing recommendations for solutions to legacy, current, and emerging PH issues to include but not limited to:
 - (a)* Monitoring health outcomes and health hazards at the population level.
 - (b)* Collaborating with regional health authorities to provide strategic and operational services and expertise spanning the PH Enterprise to the Army and DOD.
 - (c)* Performing Armywide scientific and technical studies, surveys, evaluations, consultative services, and assistance visits in coordination and collaboration with regional health authorities.
 - (d)* Maintaining a knowledge management system for all PH-related technical reports and other deliverables.
 - (e)* Developing, training, staffing, equipping, and operating PH Response Teams to support the full range of military operations as defined and described in ATP 4–02.42.
 - (4) Developing, testing, and implementing scientific and technical PH solutions.
 - (5) Facilitating the development, procurement, and sustainment of standardized PH equipment and supplies, not available through the U.S. Army Medical Materiel Agency, across the PH Enterprise in coordination with TRADOC.
 - (6) Developing and disseminating PH information and evidence-based best practices.
 - (a)* Participating in DOD, Army, AMEDD, and national/international scientific and technical studies, working groups, committees, integrated process teams and advisory groups to advocate and advance AMEDD goals and objectives at the direction of the DCS–PH.
 - (b)* Conducting training with stakeholders for PH topics and practices that are not available as a course of instruction through AMEDDC&S, HRCoE.
 - (c)* In coordination with AMEDDC&S, HRCoE, developing curriculum and conducting training.

(7) Assuring effectiveness and quality of the PH Enterprise through the establishment, review, and analysis of PH Enterprise metrics.

(a) Monitoring, evaluating, and reporting on the reach, effectiveness, adoption, implementation, and maintenance (sustainment) of PH services and capabilities.

(b) In coordination and collaboration with the DCS–PH, assessing the outcome of organizational inspection programs to identify trends and improvement opportunities.

(8) Administering the Global Veterinary Medical Practice (GVMP) by:

(a) Overseeing the Business Practice Operations for Veterinary Treatment Facilities across the DOD in support of GVMP policies, goals, and objectives.

(b) Providing management, administration, and oversight of the GVMP.

(9) Providing PH laboratory support for the Army PH Program by:

(a) Performing animal care tasks associated with the welfare (medical care, health assessments, and feed/water) and housing of government-owned animals used for PH studies conducted at APHC laboratory facilities.

(b) Performing laboratory tasks associated with: sampling kit preparation, management, and shipping; sample processing and management; review of APHC- and contract-generated laboratory data and technical documents; primary and secondary data reviews; laboratory management; quality control analysis; and laboratory method development.

(c) Providing reference laboratory support for OEH surveillance.

(d) Providing DOD certification training to personnel who sign shipping papers for the transport of medical specimens to include infectious substances, select agents, and regulated medical waste (see DTR 4500.9–R, Part II).

(e) Providing consultative, field, and laboratory services to monitor, evaluate, and support the AMEDD’s role in the Army Pest Management Program; operate the DOD Pesticide Hotline; archiving all DOD contingency and Army Garrison pesticide application records; and maintaining laboratories for the surveillance, identification, and analyses of vector-borne diseases and insecticide resistance.

(f) Performing analysis of urine specimens collected for DU bioassays and metal fragments removed from Army personnel.

(10) Serving as the DOD liaison to execute activities as outlined in the Memorandum of Understanding Between U.S. Department of Health and Human Services Agency for Toxic Substances and Disease Registry and the U.S. Department of Defense for Public Health Assessments, Toxicological Profiles, and Related Activities at DOD Facilities, dated 22 September 2015.

(11) Appointing a medical emergency manager (MEM) to act as the senior PH emergency management consultant for APHC.

(12) Planning, programing, budgeting, and executing resources in support of APHC activities.

(13) Establishing and maintaining a Human Research Protection Program (HRPP) on behalf of the Army PH authority (DCS–PH) to ensure the protection of humans, their private data, and biological specimens when performing PH practice and research activities.

(a) Serving as the Institutional Official of the HRPP.

(b) Establishing a Public Health Review Board (PHRB) to distinguish PH practice from human subject research regulated under Title 32, Code of Federal Regulations, Part 219 (32 CFR 219).

(c) Appointing a Human Protections Administrator. The Human Protections Administrator will manage the HRPP and the functions of the PHRB and serve as a consultant to the Army and DOD institutional review boards (IRBs) regarding authorized PH activities.

(14) Establishing, maintaining, and supporting an Institutional Animal Care and Use Committee (IACUC) to ensure that all research, testing, development, and evaluation efforts, to include toxicology studies using animal subjects adhere to requirements set forth in AR 40–33/SECNAVINST 3900.38C/AFMAN 40–401(I)/DARPAINST 18/USUHSINST 3203.

(15) Providing Enterprise support for PH accreditation.

(16) Providing Enterprise training, evaluation, technical consultation, and monitoring of existing standardized Army wellness centers and establishment of new Army wellness centers.

(17) In collaboration with the Directorate of Medical Education, OTSG, monitoring, consulting, training, and facilitating the programming of graduate medical education for military physicians specializing in General Public Health and Preventive Medicine (area of concentration (AOC) 60C) and Occupational and Environmental Medicine (AOC 60D).

2–18. Commanders, Army commands, Army service component commands, and direct reporting units

Commanders of ACOMs, ASCCs, and DRUs will—

- a. Provide command emphasis, resources, facilities support, policy implementation, guidance, and oversight to subordinate commands and activities to execute PH activities within their commands.
- b. Request PH technical assistance through MEDCOM.
- c. Coordinate with higher headquarters or MEDCOM on issues associated with PH emergency planning and response.
- d. Coordinate with MEDCOM on the training, monitoring, and evaluation of installation CR2C initiatives, actions, and subprocesses.

2-19. Regional health authorities

Responsibilities for Army regional health authorities will apply to Army organizations designated by the Commander, MEDCOM as having a responsibility to administer or oversee all PH activities in their defined region. Army regional health authorities will—

- a. Establish and maintain capabilities to support all area of responsibility (AOR) PH program elements characterized in paragraphs 3-5 through 3-17 and DA Pam 40-11.
- b. Identify, assess, and provide recommendations for solutions to current and emerging regional PH issues to include but not limited to:
 - (1) Informing the DCS-PH through the appropriate chain of command of emerging PH issues that may have an impact beyond the region's scope or AOR.
 - (2) Performing scientific and technical studies, surveys, and evaluations within the AOR in coordination and collaboration with command surgeons and installation medical and PH authorities.
 - (3) Developing, training, staffing, equipping, and operating PH Response Teams to support the full range of military operations as defined and described in ATP 4-02.42.
 - (4) Consulting with MEDCOM regarding current monitoring activities, PH information, and evidence-based PH solutions.
- c. Provide regional PH Enterprise oversight, to include operational guidance, technical assistance, mentorship, coordination, and consultative support as specified in DA Pam 40-11.
- d. Implement PH Enterprise governance throughout the region by:
 - (1) Planning, coordinating, overseeing, implementing, reporting, and evaluating activities, plans, and policies; and delivering PH services according to the enterprise governance process and DA Pam 40-11.
 - (2) Collaborating with MEDCOM and APHC to develop and review PH Enterprise roles, responsibilities, business rules, practices, plans and policies, and governance relationships.
- e. Plan, program, budget, and execute resources in support of regional PH activities.
- f. Coordinate support for USAR and Army National Guard/Army National Guard of the United States units requiring PH services according to established MOAs/MOUs, this regulation, and the guidance provided in DA Pam 40-11.
- g. Perform consultative services and assistance visits to installation PH Programs and operational units upon request.
- h. Review and consolidate Army-specific PH environmental program requirements within the region for transmission to MEDCOM.
- i. Ensure installation PH authorities identify the PH services needed at Army installations within their designated health services area and execute PH services in accordance with this regulation and DA Pam 40-11.
- j. Ensure installation PH authorities are conducting zoonotic and vector-borne disease surveillance efforts and coordinate with local, state, or federal PH authorities on the results and trends associated with ongoing surveillance.
- k. Provide veterinary service support, coordination, and collaboration when requested for food and water risk assessment activities.
- l. Identify an audiologist to serve as the Army Hearing Program Manager for the region and provide audiology program oversight.
- m. Implement a quality management system and conduct formal evaluations of each installation PH Program within the region.
- n. Ensure all PH information is entered, managed, reported, and maintained in an appropriate system of records.
- o. Ensure appropriate disposition and oversight of all human-use activities are reviewed by an appropriate IRB or PHRB in accordance with 32 CFR 219 and DODI 3216.02.
- p. Appoint a Regional PHEO and command MEM to act as the senior PH emergency management consultant as outlined in AR 525-27 and DA Pam 40-11.
- q. Army regional health authorities in the European and Pacific AORs will establish and maintain a PH Response Team in order to respond to emerging or ongoing PH emergencies or incidents within their AOR.

- r. Appoint a Regional Radiation Safety Staff Officer to act as the senior radiation safety officer for the region as outlined in DA Pam 385–24.
- s. Provide appropriate regional PH representation on the Enterprise Laboratory Information Management System Configuration Control Board.
- t. Appoint a qualified person to serve as the Regional Vision Conservation and Readiness Program Manager (see DA Pam 40–506).

2–20. Installation medical authorities

The installation medical authority is the commander or director of the medical treatment facility (MTF) who executes DHA or DOD public health policies and procedures. If DHA or DOD public health policies and procedures are not prescribed, the installation medical authority will—

- a. Establish, in coordination with the installation PH authority, effective installation PH services and capabilities.
- b. Ensure that reportable medical events, including outbreaks as defined by the Armed Forces Reportable Medical Events Guidelines and Case Definitions (available at <https://www.med.navy.mil/sites/nmcphc/documents/program-and-policy-support/armedforcesguidelines14mar12.pdf>), are reported through the DRSi as designated by DA Pam 40–11 and are reported to the local civilian (state, territory, host nation) health authorities as required by PH law. This includes reports from subordinate clinics and clinics at satellite locations.
- c. Comply with all federal, state, local, DOD, and Army medical and administrative reporting requirements including applicable Occupational Safety and Health Administration requirements for work-related injuries and illnesses.
- d. Coordinate with the installation PH authority to nominate a PHEO, in consultation with the respective regional health authority.
 - (1) Establish an MOA or MOU with the serviced installation for necessary capabilities for PH emergency management response.
 - (2) Ensure PHEOs and MEMs are members and active participants in the Installation Emergency Management Workgroup.
- e. Designate a credentialed occupational medicine physician to provide required support to each occupational health clinic supported by the command, including those supported installations where no physician is assigned.
- f. Appoint an audiologist to serve as the installation Hearing Program Manager in accordance with DA Pam 40–501.
- g. Coordinate with the installation PH authority to develop and implement a quality management system for PH services.
- h. Plan, execute, and resource Soldier, Family, community health, and health promotion activities tailored to their AOR and its beneficiary population.
- i. Coordinate with the installation PH authority as described in DA Pam 40–11 to ensure:
 - (1) Army wellness centers provide integrated and standardized primary prevention programs and services that promote and sustain lifestyles to improve overall readiness and well-being.
 - (2) Support is provided for medical readiness activities to prepare Soldiers for the full range of operational deployments within the continental United States (CONUS) and outside CONUS.
 - (3) Support is provided for communicable and chronic disease prevention, surveillance, and control.
 - (4) Support is provided for consultation in the case management process to provide oversight for patients in specified PH diagnoses.
 - (5) Support is provided for injury prevention, surveillance, and control, in particular coordination with the CR2C as outlined in AR 600–63.
 - (6) Support is provided to other clinical PH program elements and services as described in DA Pam 40–11.

2–21. Installation public health authorities

The installation PH authority is the senior PH professional as designated or recognized by TSG or DHA as the commander, director, or chief of an installation’s PH Program. The installation PH authority provides coordinated, efficient, and thorough delivery of PH services on the installation. Installation PH authorities follow DHA or DOD public health policies and procedures. If DHA or DOD public health policies and procedures are not prescribed, installation PH authorities will—

- a. Establish and provide effective installation PH services, in coordination with the installation medical authority and in accordance with DA Pam 40–11.
- b. Develop and implement local guidance for installation PH services described in this regulation and DA Pam 40–11.
- c. Implement PH Enterprise governance.

- d.* Coordinate and resource PH services for the installation support mission and at those installations that do not have assigned PH personnel, to include veterinary services at DOD installations within the AOR.
- e.* Establish contact with satellite installations that do not have tenant PH assets and establish an MOU or MOA to identify the PH service activities that will be performed at those sites.
- f.* Plan, program, prioritize, budget, and execute resources in support of installation PH activities.
- g.* Implement a quality management system, develop a quality management plan, and evaluate PH services as specified in paragraph 3–18 and DA Pam 40–11.
- h.* Ensure Army PH nurses are identified for each installation to serve as the health consultant for IMCOM child and youth services programs (see AR 608–10).
- i.* Serve on the installation CR2C as one of the three chairs for the commander’s CR2C Board of Directors and direct resources in support of CR2C initiatives.
- j.* Establish and maintain liaison with appropriate federal, state, and local PH authorities.
- k.* Serve as the PH representative on appropriate medical and installation boards, councils, and committees.
- l.* Coordinate with the installation medical authority to ensure that reportable medical events, including outbreaks, as defined by the Armed Forces Reportable Medical Events Guidelines and Case Definitions, are reported through the DRSi as specified in DA Pam 40–11 and are reported to the local civilian (state, territory, host nation) health authorities as required by PH law. This includes case reports from subordinate clinics and clinics at satellite locations.
- m.* Participate on Armed Forces disciplinary control boards and coordinate with representatives of civil agencies concerned with health and welfare as prescribed in AR 190–24/OPNAVINST 1620.2A/AFI 31–213/MCO 1620.2D/COMDTINST 1620.1E.
- n.* Coordinate with the installation medical authority to nominate, in consultation with the respective regional health authority, a PHEO to function as the principal advisor to the installation senior mission commander for PH-related activities during a suspected or declared PH emergency (see AR 525–27).
- o.* In coordination with the installation medical authority, notify unit and installation commanders of potentially serious health threats.
- p.* Provide PH information and other health-related input for the Installation Status Report according to AR 210–14 and implementing instructions as published by the DA Assistant Chief of Staff for Installation Management (or equivalent report on non-Army led Joint bases).
- q.* Work with safety personnel to ensure commanders and the senior commander receive comprehensive ASOHP support.
- r.* Advise the senior commander on the health aspects of the installation Environmental Program.
- s.* Coordinate with field units within the AOR to provide any required or requested supplemental PH support.
- t.* In coordination with the installation medical authority, provide PH expertise to support the medical augmentation team for installations having a nuclear, chemical, or biological surety mission.
- u.* Coordinate with the installation medical authority to designate a physician credentialed to provide medical oversight of each occupational health clinic within the command, including those supported installations where no physician is assigned.
- v.* Conduct zoonotic disease surveillance and control, coordinating with appropriate installation technical experts (such as veterinary services and installation pest management) and local, state, or federal PH authorities on results and trends.
- w.* Work with the installation pest management coordinator on prevention and control of medically important vectors.
- x.* Ensure all PH information, including administrative management data, is entered, managed, reported, and maintained in an appropriate system of records.
- y.* Provide training opportunities for operational PH personnel and units to maintain and improve their skills.
- z.* Ensure the protection of humans, their private data, and biological specimens when performing PH practice and research activities, to include PH surveys, guided by the ethical principles of respect for persons, beneficence, and justice as established by federal laws and regulations.
- aa.* Ensure appropriate disposition and oversight of all human-use activities are reviewed by an appropriate IRB or PHRB in accordance with DODI 3216.02.

2–22. Healthcare providers

Healthcare providers follow DHA or DOD public health policies and procedures. If DHA or DOD public health policies and procedures are not prescribed, healthcare providers will—

- a.* Promote the health and well-being of their patients by integrating appropriate and current prevention strategies in their delivery of primary care services (see para 3–12a).

- b.* Initiate PH patient referrals when required for the continuation of PH specialty care.
- c.* Support and participate in the advocacy of approved Army health promotion, PH, and population health improvement activities.
- d.* Support comprehensive health surveillance, PH monitoring activities, and PH evaluations through accurate and timely entry of diagnoses and external cause codes into medical records systems.
- e.* Inform the supporting installation PH Program of the following:
 - (1) All incidents of DNBI on the Armed Forces Reportable Medical Events Guidelines and Case Definitions and any other incidents that must be reported to local civilian PH authorities, using the guidance provided in DA Pam 40–11 and in accordance with local and state disease reporting guidelines.
 - (2) Disease or injury hazards that may require PH assessment and intervention.
 - (3) All cases of suspected or confirmed exposures to chemical warfare agents or weaponized TIMs.

2–23. Commanders at all levels

Commanders at all levels are responsible and accountable for the health of their command. They will—

- a.* Ensure that the health of all personnel and military working animals in their command is promoted, sustained, and protected in all military activities through aggressive implementation of PH services. Command PH Program responsibilities include:
 - (1) Training.
 - (2) Hazard control and hazard communication.
 - (3) Proper use of personal protective measures and protective clothing and equipment.
 - (4) Immunization and chemoprophylaxis.
 - (5) PH communication.
 - (6) Worksite, occupational health, and environmental health surveillance.
 - (7) Supporting and encouraging participation in activities and functions that promote healthy behaviors, increase readiness, and improve performance, such as the Performance Triad.
 - (8) FARM.
- b.* Program and budget for resources, and provide training to comply with individual and unit responsibilities for improving and maintaining health and fitness.
- c.* Implement occupational health, including ensuring that Soldiers and DA Civilian employees under their command who are enrolled in an occupational health medical surveillance program comply with the medical surveillance requirements including preplacement, periodic, and out-processing or termination medical evaluations (see DA Pam 40–11 and ATP 4–02.8).
- d.* Ensure the protection of humans, their private data, and biological specimens when performing PH practice and research activities, to include PH surveys, are guided by the ethical principles of respect for persons, beneficence, and justice as established by federal laws and regulations.
- e.* Ensure Soldiers who were exposed to known or suspected occupational or environmental threats, to include CBRN materiel and feral or wild animals, report their exposure to medical personnel.
- f.* Ensure military working animals who were exposed to known or suspected occupational or environmental threats, to include CBRN materiel and feral or wild animals, are evaluated by veterinary medical personnel.
- g.* Provide leadership and personal example in improving and sustaining individual and unit health and fitness.
- h.* Ensure that contingency and operational plans include the appropriate elements of PH as characterized in paragraph 2–23*a.*
- i.* Prevent or minimize health risks using Army risk management principles (see AR 11–35, ATP 5–19, and DA Pam 385–30).
- j.* Adhere to federal, state, and host nation statutory and regulatory laws, directives, licenses, and guidance governing PH functions in garrison and during training exercises.
- k.* Coordinate with the local contracting office to ensure contracts are written that provide for adherence to occupational health laws and regulations.
- l.* Ensure that assigned PH personnel receive, enter, manage, report, and maintain all PH information in the appropriate systems of records.

2–24. Senior commanders

Senior commanders will—

- a.* Provide a safe and healthy work and living environment for all assigned and supported populations by:
 - (1) Resourcing, implementing, and enforcing PH aspects of installation infrastructure and services in coordination with installation medical and PH authorities, to include:

(a) Enabling PH personnel to provide the medical oversight and monitoring of installation infrastructure and services that may pose health threats. PH personnel provide the technical advice and assistance to senior commanders to minimize risks from such threats.

(b) Resourcing for PH support at state-owned installations, armories, and facilities, which is the responsibility of the state and territory adjutants general.

(2) Ensuring safe drinking water, food, worksites, and recreational activities.

(3) Coordinating with the supporting medical and PH authorities to ensure required PH services are provided at installations that do not have tenant PH assets. PH services for these tenant organizations and other supported military personnel will be established through local installation or other types of support agreements. (See DA Pam 40–11 for implementing guidance.)

b. Provide occupational health services that include, but are not limited to:

(1) Safety and Occupational Health Program according to AR 385–10 and 29 CFR 1960.

(2) Ergonomics Program with an ergonomics subcommittee and an ergonomics officer according to DA Pam 40–21.

(3) Respiratory Protection Program according to AR 11–34.

(4) Army Hearing Program according to DA Pam 40–501.

(5) Army Vision Conservation and Readiness Program according to DA Pam 40–506.

(6) Health Promotion Program according to AR 600–63 and DODI 1010.10.

(7) Army Industrial Hygiene Program according to DA Pam 40–503.

(8) Army Radiation Safety Program according to AR 385–10 and DA Pam 385–24.

c. Support and encourage participation in activities and functions that promote healthy behaviors, increase readiness, and improve performance through approved Army programs.

d. Provide facility support for Army wellness centers.

e. Appoint a PHEO, based on the nomination by the regional health authority, in consultation with the installation medical and PH authorities according to AR 525–27 and DODI 6200.03.

f. Ensure control of stray animals on fixed installations by incorporating a stray animal control plan into the garrison IPM Plan.

2–25. Unit and command surgeons

Unit and command surgeons, as the senior AMEDD officers present for duty will—

a. Advise the command on all PH matters pertaining to the command.

b. Provide staff and technical oversight of all PH assets of the command.

c. Provide implementing guidance for operational PH services and capabilities.

d. Serve as the command's medical intelligence officer.

e. Ensure that medical events in the Armed Forces Reportable Medical Events Guidelines and Case Definitions are reported through the DRSi as specified in DA Pam 40–11 and are reported to the local civilian (state, territory, host nation) health authorities as required by PH law. This includes events occurring in deployed settings.

f. Coordinate with the installation PH authority for PH support when in a garrison environment.

g. Coordinate health risk communication needs and actions with MEDCOM and the installation public affairs office to ensure situational awareness and to align with strategic communication actions when in a garrison environment.

h. Support and encourage participation in activities and functions that promote healthy behaviors, increase readiness, and improve performance through approved Army programs.

2–26. Unit and command veterinarians

Unit and command veterinarians, as the senior Veterinary Corps officer present within a headquarters (in the operational setting) will—

a. Provide input to the unit or command surgeon on animal health and welfare, food protection, and veterinary PH as they pertain to the command and in accordance with AR 40–33/SECNAVINST 3900.38C/AFMAN 40–401(I)/DARPAINST 18/USUHSINST 3203, AR 40–657/NAVSUP 4355.4H/MCO P10110.31H, AR 40–905/SECNAVINST 6401.1B/AFI 48–131, and DODD 6400.04E.

b. Provide staff and technical oversight of all veterinary service functions within the command.

c. Provide implementing guidance for military working animal emergency care and veterinary care eligibility determination for contract working dogs, other non-DOD government-owned animals, host nation and allied working animals, and animals injured as a result of U.S. military operations as outlined in ATP 4–02.8.

d. Provide implementing guidance on the evacuation of privately owned pets of personnel in the event of a non-combatant evacuation event.

2–27. Unit commanders and leaders

In addition to the responsibilities defined in paragraph 2–23, unit commanders and leaders will—

a. Inform, motivate, train, and equip subordinates and work closely with Army PH personnel to prevent or mitigate exposures to local or mission-specific health threats to reduce the risk of DNBI. Broad categories of disease and injuries include:

- (1) Heat injuries caused by heat stress and insufficient water consumption.
- (2) Cold injuries caused by combinations of low temperatures, wind, and wetness.
- (3) Diseases and injuries caused by arthropods, other pests, feral/wild animals, and hazardous plants.
- (4) Diarrheal diseases caused by consuming contaminated food or water, practicing poor personal hygiene, or failing to maintain unit sanitation measures.
- (5) Diseases, trauma, or injuries caused by poor health or fitness or injuries caused by training or sports.
- (6) Occupational and environmental diseases and injuries caused by or attributed to physical, chemical, biological, radiological, and other environmental exposure hazards.
- (7) Disease and injuries resulting from exposure to high altitudes.
- (8) Communicable diseases and sexually transmitted diseases.
- (9) Noise-induced hearing injury.
- (10) Stress disorders resulting from psychological threats.
- (11) Eye injury and vision loss.

b. Ensure compliance with PH guidance and the use of countermeasures.

c. Promote combat and operational stress control programs and procedures.

d. Participate as members of the CR2C and Personal Readiness forums according to the guidance provided in AR 600–63.

e. When required during deployment activities, ensure the establishment, manning, training, and equipping of unit field sanitation teams at the company level, or obtain field sanitation team support from another unit, according to Army doctrine published in ATP 4–02.8, ATP 4–02.55, and ATP 4–25.12.

f. Institute unit-level FARM procedures when in operational environments as outlined in Armed Forces Pest Management Board (AFPMB) TG No. 3.

g. Execute the unit leader responsibilities defined in ATP 4–02.8. Reserve Component unit commanders and leaders may request guidance and support from the regional health authority.

h. Contribute to comprehensive health surveillance through maintenance of administrative data systems containing health-related outcomes of interest (for example, physical fitness, profiles, discharges).

i. Provide after-action reports after deployments and training exercises that include PH issues to AMEDDC&S as part of the Center for Army Lessons Learned Program (see AR 11–33).

j. Record and report all pesticide applications, except arthropod skin and clothing repellent applications, according to the guidance in DA Pam 40–11.

k. Ensure compliance with pre- and post-deployment surveillance procedures.

2–28. Managers and supervisors at all levels

a. Army managers and supervisors at all levels will—

(1) Ensure that the health of all personnel under their supervision is sustained and protected in all Army activities through aggressive implementation of PH activities, to include:

(a) Training.

(b) Hazard control.

(c) Immunizations and chemoprophylaxis.

(d) Communication of hazards and health risks.

(e) Worksite OEH surveillance.

(f) Subordinate participation in required occupational health exams.

(2) Program and budget resources to provide training, correct workplace deficiencies, and control hazards.

(3) Implement health surveillance requirements, ensuring that personnel enrolled in an occupational health medical surveillance program comply with surveillance requirements including medical qualification exams, preplacement, periodic, and out-processing or termination medical evaluations (see DA Pam 40–11 and DOD 6055.05–M).

(4) Advise and support the installation safety and occupational health advisory council on injury compensation matters.

(5) Provide leadership and personal example in improving and sustaining individual and unit health and fitness.

(6) Minimize health risks using Army risk management principles (see DA Pam 385–30).

(7) Adhere to federal, state, and host nation statutory and regulatory laws, directives, licenses, and guidance governing OEH in garrison and during training exercises.

(8) With respect to DA Civilian employees—

(a) Ensure that potential health hazards for an employee are documented and communicated to the employee and the occupational health clinic.

(b) When requesting medical qualification determination services, provide the occupational health clinic with a copy of the position description and an individualized form appropriate to the employee's employment category (for example, Optional Form (OF) 178 (Certificate of Medical Examination) for a Title 5 appropriated fund employee and DA Form 3437 (Department of the Army Nonappropriated Funds Certificate of Medical Examination) for a nonappropriated fund employee). The individualized form should clearly indicate what medical qualification determination service is being requested, state the physical and environmental factors of the position, and list the minimum medical requirements for the position. All medical qualification determination examinations are requested in accordance with the human resource policy for the relevant employee group (for example, 5 CFR 339 for Title 5 appropriated fund employees and AR 215–3 for nonappropriated fund employees).

(c) Ensure that any requirements to undergo a medical examination; receive laboratory testing and immunization; and use protective clothing and equipment, including respiratory equipment, safety eye and foot wear, and hearing protection, are written in job descriptions and job announcements as conditions of employment.

(d) Make available to healthcare providers who treat DA Civilian employees with occupational injuries and illnesses the job requirements and environmental conditions, as well as the necessary Department of Labor (DOL) forms as instructed by the installation FECA or Injury Compensation Program administrator or the LHWCA, Headquarters, Department of the Army (HQDA) G–9 coordinator (see paras 2–30 and 2–31).

(e) For appropriated fund employees with medical standards or physical requirements in their position description for the position held, and in accordance with applicable personnel guidance (see para 2–29b), request an occupational health medical qualification determination for employees continuing work or returning to work following an injury or illness (see 5 CFR 339 and DODI 1400.25, Vol. 810). Nonappropriated fund employees are not evaluated by installation occupational health; coordination for return to work is through the Civilian Personnel Advisory Center-Nonappropriated Fund (see AR 215–1).

(f) Refer all employees to the occupational health clinic before they return to duty from any absence due to any illness or injury that could impair their job performance according to Equal Employment Opportunity Commission (EEOC) guidelines (see EEOC Notice Number 915.002).

(g) Refer food handlers and patient care personnel to the occupational health clinic before they return to duty from any absence due to illness in accordance with guidance from local servicing civilian personnel support offices or human resources managers (see para 2–29).

b. Reserve Component managers and supervisors may request guidance and support from the regional health authority.

2–29. Civilian personnel or human resources managers

Local servicing civilian personnel support offices or human resources managers will take the following actions, subject to EEOC guidelines and U.S. Office of Personnel Management regulations, to assist medical personnel in implementing the ASOHP:

a. Ensure that medical qualification determination services requests—

(1) Are made throughout employment of an individual, to include preplacement, periodic, and termination, for those employees with medical or physical requirements, in accordance with applicable laws and regulations for the relevant employee position.

(2) Whether originated by human resources personnel or by managers or supervisors, provide the occupational health clinic with a copy of the position description, and an individualized form appropriate to the employee's employment category (for example, OF 178 for a Title 5 appropriated fund employee and DA Form 3437 for a nonappropriated fund employee). The individualized form should clearly indicate what medical qualification determination service is being requested, state the physical and environmental factors of the position, and list the minimum medical requirements for the position. All medical qualification determination examinations are requested in accordance with human resource policy for the relevant employee group (for example, 5 CFR 339 for Title 5 appropriated fund employees and AR 215–3 for nonappropriated fund employees).

(3) Are planned and coordinated with the servicing occupational health clinic, the employee, and, when appropriate, with the supervisor.

b. Provide guidance to managers and supervisors at all levels on how and when to refer employees for occupational health clinical evaluations following injury or illness, whether or not the employee has had an absence (see paras 2–28a(8)(e) and 2–28a(8)(f)).

c. Ensure that all new personnel whose jobs have medical standards or physical requirements in-process through the supporting occupational health services. New personnel whose jobs do not have medical standards or physical requirements may voluntarily in-process through the supporting occupational health services.

d. During out-processing or termination of employment:

(1) Assist management in ensuring that departing personnel enrolled in an occupational health medical surveillance program complete an out-processing or termination of exposure medical evaluation.

(2) Include the occupational health clinic on all personnel out-processing checklists for those personnel whose jobs have medical standards or physical requirements or are part of an occupational health medical surveillance program.

(3) Offer voluntary out-processing through the supporting occupational health clinic to those personnel whose jobs do not have medical standards or physical requirements or are not part of an occupational health medical surveillance program.

e. Coordinate with the supporting occupational health clinic to provide an annual updated list of all local DA Civilian personnel encumbering positions with medical standards or physical requirements or who are part of an occupational health medical surveillance program. The list should include all DA Civilian personnel within the occupational health clinics' local AOR, with employee name, job series code, and supervisor name. The list will be used for planning and implementing the occupational health program.

2–30. Installation Federal Employee Compensation Act or Injury Compensation Program administrator

The installation Injury Compensation Program administrator, assisted by local or organizational personnel who are assigned injury compensation duties, provides consultative assistance to managers and supervisors for their related responsibilities covering appropriated fund employees.

2–31. Longshore and Harbor Workers' Compensation Act, Headquarters, Department of the Army, G–9 coordinator

The LHWCA, HQDA G–9 coordinator, assisted by local or organizational personnel, as needed, provides consultative assistance to managers and supervisors for their related responsibilities covering nonappropriated fund employees.

2–32. Military personnel officers

a. Military personnel officers for both tables of distribution and allowances (TDA) and tables of organization and equipment (TOE) units will—

(1) Ensure all Soldier in-processing and out-processing checklists include the occupational health clinic where such services are provided.

(2) Assist commanders in ensuring that Soldiers enrolled in an occupational health medical surveillance program comply with surveillance requirements including a preplacement and an out-processing or termination of exposure medical evaluation.

(3) Provide a list of all Soldiers, including their military occupational specialty codes, to the occupational health clinic where such services are provided for use in occupational health medical surveillance databases.

(4) Support the application of medical information management tools to document unit and individual Soldier medical readiness.

b. Military personnel officers at initial entry training installations will provide weekly installation troop strength data to the supporting medical commander.

c. USAR unit personnel officers will contact the Army regional health authority's Reserve Component point of contact for guidance and assistance by coordinating through the appropriate chain of command.

2–33. Army personnel

All Army personnel will—

a. Apply personal protective measures and use protective clothing and equipment when required.

b. Share the responsibility for ensuring a safe and healthy work environment by following administrative and engineering hazard controls.

c. Report unsafe conditions, hazardous exposures, animal bites and scratches, and occupational injury or illness to their supervisors.

- d.* Report to the supporting occupational health clinic for occupational medical surveillance or work-related injuries and illnesses as prescribed in this regulation.
- e.* Maintain the standards of health and fitness required for performance of duties.
- f.* Adhere to PH restrictions and health protection requirements implemented by commanders during a PH emergency.
- g.* Follow up with a healthcare provider for personal health issues identified during medical qualification determination or occupational medical surveillance examinations.

Chapter 3

Program Administration

Section I

Public Health Enterprise and Program Goal

3–1. Background

a. The core functions of PH are assessment, policy development, and assurance. Key aspects of these functions are effective communication, education, and collaboration with all affected populations.

(1) Assessment includes the regular and systematic collection and analysis of community health data, including health status of the beneficiary population, disease surveillance, OEH and veterinary food protection surveillance, investigation of outbreaks, and characterization of risk factors and causes of disease, injuries, and behavioral health conditions.

(2) Policy development includes advocacy, prioritization of needs, and development of plans and procedures for PH services and capabilities.

(3) The assurance function includes the process of determining that capabilities and services necessary to achieve agreed upon goals are provided; it entails implementing policies, program elements, and services; providing and managing resources; and evaluating and monitoring processes and outcomes.

b. The 10 Essential PH Services provide the fundamental framework for the National PH Performance Standards and serve as the foundation for PH accreditation. The 10 Essential PH Services are:

- (1) Monitor health status to identify and solve community health problems.
- (2) Diagnose and investigate health problems and health hazards in the community.
- (3) Inform, educate, and empower people about health issues.
- (4) Mobilize community partnerships and actions to identify and solve health problems.
- (5) Develop policies and plans that support individual and community health efforts.
- (6) Enforce laws and regulations that protect health and ensure safety.
- (7) Link people to needed personal health services and assure the provision of health care when otherwise unavailable.
- (8) Assure competent public and personal healthcare workforce.
- (9) Evaluate effectiveness, accessibility, and quality of personal and population-based health services.
- (10) Research for new insights and innovative solutions to health problems.

3–2. Public health enterprise

a. The Army PH Enterprise is a unified PH team that applies enterprise-approach relationships between institutional and operational PH assets across the Army. It includes interdependent resources (people, organizations, and technology) that must coordinate their functions, share information, and report data in support of a common PH mission.

(1) Enterprise relationships are inclusive of command and technical staffs, both vertical and horizontal, and enable the implementation of a cohesive, standardized approach to PH planning, resourcing, execution, and asset distribution.

(2) Institutional PH is comprised of those TDA medical and PH organizations that provide PH services to the installation and surrounding military communities.

(3) Operational PH represents the PH services executed by TOE units and individuals assigned to TOE units to provide PH services in the operational setting.

b. The PH Enterprise enables consistent PH services by promptly delivering technical guidance and assistance, encouraging professional development, implementing continuous quality improvement, and highlighting best practices across the enterprise.

c. Using an enterprise approach for PH enhances and sustains force readiness; protects and improves the health, fitness, and well-being of the Army population; and executes effective veterinary services across the DOD.

d. The PH Enterprise includes a defined set of business rules for governance of institutional PH activities and resourcing as outlined in DA Pam 40–11.

e. The PH Enterprise provides:

(1) Emphasis on readiness through a PH-centric approach with an overall strategy of prevention-based Army medicine.

(2) A cohesive, standardized approach to Army PH, emphasizing prevention and healthy lifestyles.

(3) A single accountable agent for PH services with shared responsibilities across the Army.

(4) Responsiveness, timeliness, efficiencies, consistency, and effectiveness of appropriate PH support locally, regionally, and across the Army.

(5) Integration and synchronization in the delivery of PH services throughout the MEDCOM as well as the Army through the use of a PH service line management process.

(6) Accountability, responsibility, monitoring, and oversight of Enterprise planning, programming, budgeting, execution, and evaluation for all PH services and products; and for ensuring the execution of veterinary services across the DOD.

(7) Synchronization, integration, and standardization of health and wellness programs and services at installations, including on-post programs such as suicide prevention, alcohol and substance abuse prevention, and fitness, for which TSG does not have HQDA functional proponentcy.

(8) Flexibility and interoperability throughout the MEDCOM to more efficiently plan, resource, and cross-level PH assets in training exercises and in response to PH emergency missions.

(9) Integrated PH planning, resourcing, training, and assessment for timely response to PH threats such as accidental or intentional contamination of food and water supplies, zoonotic diseases, and emerging and re-emerging communicable diseases.

(10) Integrated PH performance improvement and innovation to attain efficient and effective Army PH services.

3–3. Program goal

a. The overall goal of the Army PH Program is to enhance and sustain Army readiness by preventing or mitigating disease, illness, and injury; promoting healthy lifestyles and environments; and improving, sustaining, and restoring health in all Army populations.

b. The goal is attained by:

(1) Providing a comprehensive, holistic Army PH Enterprise that communicates a vision and a strategy for Army PH and focuses on readiness, prevention, healthy lifestyles, and the protection or restoration of health.

(2) Enabling a PH Enterprise that is able to identify, assess, and implement measures to prevent DNBI and eliminate or mitigate exposures to hazards that reduce readiness.

(3) Delivering an integrated Army PH Enterprise that spans the full spectrum, from individual Soldier health to the health of all Army populations, across the full range of Army missions, operations, and activities at all Army locations.

(4) Ensuring Army units and all personnel are trained, equipped, and capable of supporting PH and force health protection requirements to prevent, minimize, and mitigate diseases, illnesses, and injuries during all military activities.

(5) Establishing and maintaining collaborations and delivering Army PH services that enable and contribute to an effective and timely comprehensive health surveillance system.

(6) Ensuring and enabling data-driven prevention planning and PH decision making through routine summaries and reporting of medical and other relevant surveillance data.

(7) Ensuring PH assets at all levels are actively engaged in the mitigation of, preparing for, responding to, and recovering from PH and All-Hazards emergencies.

(8) Advocating for new equipment, materiel, chemicals, and materials developed, acquired, or supplied by the Army to have minimal health hazards.

(9) Ensuring scientific, technical, technological, and intelligence capabilities are adequate to perform the PH mission.

Section II

Public Health Program Elements

3–4. Introduction

a. The Army PH Program is composed of program elements, which are the primary functional areas used to organize or group similar activities. Those activities are individual or collective tasks, which are performed to produce or deliver a product or service to a customer.

b. Detailed implementing guidance and instructions for each of the Army PH Program elements described in paragraphs 3–5 through 3–17 are provided in DA Pam 40–11.

3–5. Health surveillance and epidemiology

a. Health surveillance activities are critical to the success of all PH services. Health surveillance is essential to the planning, implementation, and evaluation of PH practice and must be closely integrated with the timely dissemination of information to those who can act upon it.

b. Health surveillance includes the capabilities and activities necessary to collect, analyze, and interpret health-related data effectively on the—

- (1) Health status of Army personnel and military working animals throughout their time in service;
- (2) Health status of Army populations, communities, and installations;
- (3) Health hazards, risks, and exposures to Army personnel and military working animals; and
- (4) Disease, injury, behavioral, or social health conditions related to military service.

c. Epidemiology provides the foundation for PH activities and must be closely integrated with health surveillance capabilities.

d. Epidemiology consists of those capabilities and activities necessary to effectively identify populations at risk of disease, injury, behavioral, or social health conditions and the associated risk and protective factors. Epidemiology activities include:

- (1) Describing the frequency and distribution of disease, injury, and other health-related events within populations of interest.
- (2) Identifying the causes of diseases and injuries, including those of occupational and environmental origin.
- (3) Identifying and characterizing behavioral health and social health outcomes.
- (4) Identifying and recommending appropriate control measures to mitigate health risks and improve health outcomes.
- (5) Conducting timely epidemiologic investigations to identify causes and sources of a disease outbreak or cluster, or other negative health condition. The goals of such an investigation are to mitigate risks, decrease or eliminate adverse health outcomes, control disease transmission, and provide information that can help prevent future outbreaks.
- (6) Evaluating effectiveness and efficiency of disease, injury, and behavioral health services to determine whether health outcomes improve after implementation of an intervention (for example, training, policy, engineering control, or procedure).

3–6. Occupational health

The execution of Army occupational health services is primarily through Army medical assets funded through the DHP and delivered in accordance with DODI 6055.05, DOD 6055.05–M, and applicable laws, regulations, and issuances from DOD, DOL, and the U.S. Office of Personnel Management.

a. Occupational health is the science and practice of preventing human injury and illness and promoting well-being by identifying and evaluating occupational sources of health hazards and preventing or limiting those exposures. Occupational health hazards include risks from chemical, biological, radiological, physical, and psychological threats. These risks are evaluated using scientifically and technically defensible risk assessment methodologies.

b. The goal of occupational health is to optimize workforce protection and readiness, to include Soldiers and DA Civilian employees, in all environments and protect the health of populations exposed to occupational hazards.

c. Occupational health supports human resources personnel and line management, when requested, in making employment decisions, including hiring, retention, accommodation, and removal by providing medical advisory services.

d. Occupational health services consist of those capabilities necessary to anticipate, identify, assess, communicate, mitigate, and control occupational illness and injury from exposures encountered at the worksite. Occupational health services will be—

- (1) Implemented to include performance of safety and occupational data analyses to highlight high-risk behaviors and conditions and facilitate risk-reduction measures.

- (2) Delivered in accordance with laws and regulations applicable to the status of the employee being evaluated.
- e.* Occupational health consists of interdependent clinical and nonclinical functions. Nonclinical occupational health services and capabilities will be established for the following areas:
 - (1) Occupational illness and injury prevention and mitigation.
 - (2) Workplace risk assessment and hazard characterization.
 - (3) Occupational investigations, data analysis, and reporting.
 - (4) Hearing conservation services (see DA Pam 40–501).
 - (5) Vision conservation (see DA Pam 40–506).
 - (6) Industrial hygiene (see DA Pam 40–503).
 - (7) Ergonomics (see DA Pam 40–21).
 - (8) Radiation safety (see DA Pam 385–24).
 - (9) Health hazard assessment of Army materiel and Soldier occupational health assessment (see AR 40–10).
- f.* See paragraphs 3–8*a*(1) and 3–12 for the clinical aspects of occupational health.

3–7. Environmental health

a. Environmental health is the science and practice of preventing human injury and illness and promoting well-being by identifying and evaluating environmental sources of health hazards and limiting exposures. Environmental health addresses hazards found in air, water, soil, food, and other environmental media or settings that may adversely affect human health and the environment. It deals with risks from chemical, biological, radiological, noise, vector-borne, and climatic hazards.

b. The goal of Army environmental health is to optimize Soldier protection and readiness in all environments and protect the health of personnel, military families, and other relevant populations exposed to environmental hazards. Army environmental health services and capabilities anticipate, identify, and assess current and emerging environmental health hazards, develop and communicate environmental health solutions, and assure the quality and effectiveness of the environmental health activities.

c. Environmental health services and capabilities are established to ensure compliance with published standards to protect PH in the following areas:

- (1) Entomological sciences.
 - (2) Water resources protection.
 - (3) Drinking and recreational waters (see TB MED 575, TB MED 576, and TB MED 577/NAVME P-5010–10/AFMAN 48–138_IP).
 - (4) Air quality.
 - (5) Environmental noise.
 - (6) Waste management (see TB MED 593).
 - (7) Health risk assessment of environmental hazards.
 - (8) Climatic injury (see TB MED 507/AFPAM 48–152(I) and TB MED 508).
 - (9) Facility sanitation and hygiene (see TB MED 531).
- d.* See paragraphs 3–5, 3–8*c*, and 3–12*a* for the clinical aspects of environmental health.

3–8. Occupational and environmental medicine

a. Army occupational and environmental medicine consists of services provided by OEH professionals, primarily physicians and mid-level practitioners and nurses with specialized training. It provides consultative support, when requested, for the health surveillance and epidemiology services identified in paragraphs 3–5*b* and 3–5*d*.

(1) Occupational medicine develops, maintains support for, performs quality audits in, and provides training for select occupational health services identified in paragraph 3–6*e*. Occupational medicine includes:

- (*a*) Occupational medical determination and surveillance examinations.
 - (*b*) Work-related immunizations.
 - (*c*) Conducting PH investigations on the association between exposures and health outcomes.
 - (*d*) Support to the Army Aviation Medicine Program.
- (2) Environmental medicine provides consultative support, when requested, for select environmental health services identified in paragraph 3–7*c*.

b. Environmental medicine consists of those capabilities and activities necessary to respond to actual environmental exposures to Army personnel. These exposures may be—

- (1) Intentional (for example, use of weaponized TICs);
- (2) Unintentional (for example, Servicemembers discovering and handling decaying chemical warfare agents);
- (3) Accidental (for example, radiation exposure from a nuclear power plant mishap);

- (4) An intentional incident of environmental terrorism (for example, Iraqi oil well fires); or
- (5) Unknown exposures causing health concerns for a group of Soldiers.
- c. Environmental medicine services include (as appropriate per case)—
 - (1) Assessing the likelihood of health impact to individuals after exposure occurs,
 - (2) Developing and implementing evaluation process(es),
 - (3) Establishing a registry of affected Army personnel,
 - (4) Documenting the exposure(s) in Servicemember-specific records,
 - (5) Developing relevant informational products,
 - (6) Identifying the need for ongoing follow-up,
 - (7) Coordinating and/or communicating with the other Services and agencies such as the Veterans Administration,
 and
 - (8) Conducting epidemiologic studies to resolve concerns regarding exposures.

3–9. Veterinary services

a. The veterinary services specified in DODD 6400.04E and DODI 3216.01 are developed, implemented, and provided in accordance with the DOD issuances and governing regulations.

b. Veterinary services encompass:

(1) *Veterinary public health.* Veterinary PH focuses on the animal-human-environmental health interface in support of the Centers for Disease Control and Prevention’s One Health activities. Services include the practice of preventive veterinary medical care; animal welfare; human-animal bond advocacy; food protection; zoonotic and endemic animal disease surveillance, epidemiology, control, and prevention; health education and extension; shared management of domestic and wild animal populations; and assistance in preparing for and responding to PH emergencies.

(2) *Animal health.* Animal health includes the comprehensive medical and surgical care that leads to the health and welfare of military working animals and other animals entitled to veterinary care by the Army (for example, Servicemember pets and unit mascots) (see AR 40–905/SECNAVINST 6401.1B/AFI 48–131).

(3) *Food protection.* Army veterinary service food protection includes food safety and food defense. It encompasses activities associated with food sources, distribution, warehousing, and bulk storage (see AR 40–656/NAVSUPINST 4335.10A/MCO 10110.48, AR 40–657/NAVSUP 4355.4H/MCO P10110.31H, AR 40–660/DLAR 4155.26/NAVSUPINST 10110.8C/AFR 161–42/MCO 1011038.C, AR 525–13, DODI 2000.12, and TB MED 530/NAVMED P–5010–1/AFMAN 48–147_IP).

3–10. Operational public health

a. Operational PH is the application of Army PH Program concepts and practices during military operations and field training activities. The objective of operational PH is to provide commanders with healthy and ready forces and to sustain health readiness during any military operation. When emphasized by commanders and unit leaders, operational PH can effectively reduce and prevent DNBI and maximize the fighting strength of the force.

b. The following established garrison-based PH activities will be reflected and appropriately modified during combat, contingency, and other support operations and field training exercises:

- (1) Health surveillance.
- (2) OEH surveillance and risk management.
- (3) Disease vectors and pest management, to include FARM.
- (4) Water management.
- (5) Food protection.
- (6) Waste management.
- (7) Heat, cold, and altitude.
- (8) Operational hearing services.
- (9) Health promotion.

3–11. Health risk assessment

a. Health risk assessment is a process that is used to estimate risks by synthesizing available information to identify health hazards; the probability or likelihood of exposure; the magnitude and timing of exposure; the specific kinds of injury, illness, or other effects caused by exposure; the severity of effects; and the probability or likelihood that exposure will result in predicted effects.

b. Health risk assessment is a core capability that enables risk management in order to optimize Soldier protection in all environments and protect the health and wellness of Soldiers, Family members, DA Civilians, and other populations. How well health risks are understood and articulated to commanders, affected parties, and stakeholders impacts the quality, timeliness, and cost effectiveness of preventive measures, intervention programs, research and development, and other risk management actions.

c. Health risk assessment services, capabilities, and knowledge assets will be developed and integrated across the Army PH program elements.

3–12. Clinical public health

a. Healthcare providers deliver preventive medicine services by employing primary, secondary, and tertiary prevention interventions to promote protective factors and mitigate risk factors for disease and disability. Examples of these services include:

- (1) Screening for early detection of disease;
- (2) Coordination with the installation PH authority for the timely notification of reportable medical events;
- (3) Examinations and diagnostic tests;
- (4) Education and counseling to prevent or mitigate the effects of a disease, injury, or unhealthy behavior;
- (5) Immunizations and chemoprophylaxis to prevent disease acquisition and transmission;
- (6) Referrals to community-based prevention and health promotion services; and
- (7) Medical interventions to reduce chronic disease risk.

b. Clinical personnel provide consultation to other healthcare providers and decision makers, to include installation leadership and civilian PH officials, on medical, behavioral, and environmental conditions of PH significance and serve on applicable garrison committees.

c. Clinical PH services are most effective when integrated with the other PH functions and linked to community-based programs and care is effectively coordinated with a multidisciplinary team of professionals within primary care and specialty clinics.

3–13. Community-based prevention and health promotion

a. Community-based prevention and health promotion capabilities aim to improve health readiness across the force in support of the National Prevention Strategy, DOD, DA, MEDCOM, and other PH partners. Army community-based prevention and health promotion targets a continuum of home, school, garrison, and deployed environments for Soldiers, Family members, retirees, and DA Civilian employees.

b. Health promotion engages and empowers individuals and communities to engage in healthy behaviors through any combination of health, education, economic, political, spiritual, or organizational activity designed to bring about positive attitudinal, behavioral, social, or environmental change. The delivery of health promotion is designed to change knowledge, skills, attitudes, behaviors, and the social and physical environments in order to proactively sustain and improve the health of the force as prescribed in AR 600–63 and DODI 1010.10. These activities are part of the spectrum of prevention, which results in influencing policy, changing organizational practices, fostering coalitions and networks, educating providers and the public, and strengthening individuals, families, and units. An integrated, multidisciplinary approach coordinates solutions that are driven by data and rigorous analysis, and deliberate prioritization. This approach leverages partnerships to achieve meaningful improvements in health and the environment for the individual and the community.

c. Primary prevention and health promotion includes:

- (1) Health promotion initiatives focused on the Performance Triad; child, family, and women’s health; and tobacco use.
- (2) Community-based prevention initiatives.
- (3) Development of health promotion services.

3–14. Public health toxicology

a. PH toxicology capabilities and services support the MEDCOM and the acquisition and research and development programs through the development of toxicity data and interpretations of that data. These services also support OEH risk management within the Army.

b. Army PH toxicology interacts with other DOD agencies, the U.S. Environmental Protection Agency, the Food and Drug Administration, the National Toxicology Program, and others as necessary.

c. Toxicology services and capabilities will be developed, implemented, and provided for the following specific areas:

- (1) Toxicological determination capabilities via in vivo, in vitro, and/or in silico methods.

- (2) Toxicological assessments of all new and potentially hazardous materials in research, development, and testing.
- (3) Toxicity clearances for Army chemicals, formulations, and materiel entering the Army supply chain.
- (4) Toxicologically-based assessments of health risks.
- (5) Derivation of toxicity-based exposure standards, criteria, and guidelines for military environmental and/or occupational health applications.
- (6) Toxicologic pathology studies in support of toxicity evaluation.
- (7) Toxicology investigative and consultative services in support of Army PH program elements and other military and government agencies.

3–15. Public health laboratory services

a. The mission of Army PH laboratories is to provide routine and responsive analytical services in support of Army personnel health readiness. Requirements in paragraphs 3–15*a* through 3–15*d* apply to fixed facility PH laboratories. The applicability of this regulation to deployable field laboratories is addressed in paragraph 3–15*e*. PH laboratory programs, capabilities, and services support the PH laboratory analysis needs associated with the other Army PH program elements. Army PH laboratories analyze a range of food, environmental, entomological, and industrial hygiene samples for a variety of chemical and radiological contaminants as well as infectious diseases. These laboratories provide services that are often unavailable or cost-prohibitive at clinical and other laboratories. PH laboratories collaborate closely with national and local laboratories in the U.S. and in foreign countries.

b. Army PH laboratories will participate in appropriate laboratory networks such as the Food Emergency Response Network and the Defense Laboratory Network as described in DODI 6440.03.

c. Clinical laboratories at installation MTFs also perform a variety of laboratory tests that support the Army PH Program.

d. Army PH laboratories will provide the following analytical capabilities:

- (1) Specialized clinical testing such as the analysis of DU in urine, embedded metal fragment analysis, and cholinesterase monitoring as described in TB MED 590.
- (2) Microbiology.
- (3) Radiochemistry and laboratory support for health physics.
- (4) Food chemistry to support veterinary food protection surveillance as described in DODD 6400.04E.
- (5) Analysis of vector-borne viral, bacterial, and rickettsial diseases of military PH significance to include the DOD Human Tick Test Kit Program and the DOD Lyme Disease Program.
- (6) Environmental laboratory analysis of air, water, and soil samples in support of applicable host nation, federal, state, and local environmental regulations.
- (7) Industrial hygiene laboratory analysis.
- (8) Analysis of military-unique compounds such as novel explosives.
- (9) Veterinary diagnostic analysis.
- (10) Custom method development and research support for toxicology and other Army PH program elements.

e. Deployable field laboratories operated by a Medical Detachment (Preventive Medicine or Veterinary Service Support) or the Area Medical Laboratory also provide a range of PH laboratory services tailored to meet operational needs. These laboratories will implement quality control and quality assurance practices to enhance the accuracy of laboratory results. Analytical capabilities from fixed facility laboratories may need to be pushed forward to field laboratories, when requested, in order to provide the necessary support.

3–16. Public health communication

a. PH communication enables the overall Army PH Program and supports the essential PH services to inform, educate, and empower people about health issues by using a science-based communication process to inform and shape decisions that enhance health. It incorporates the disciplines of research, theory, and practice and includes fields such as health communication, social and health marketing, and risk communication.

b. PH communication utilizes a wide range of methods to plan, design, execute, and evaluate programs based on the PH issue or problem. Methods may include public affairs, advertising, social media, individual and group instruction, stakeholder identification and partnership development, cultural recognition, community outreach, perception evaluation, message development, health and media literacy, media relations, and interventions. Interventions may include the development of website and mobile applications and the development and distribution of health information products.

c. Effective PH communication can increase knowledge, build trust and credibility, and affect positive behavior change among individuals, groups, organizations, communities, and society as a whole.

d. PH communication services and capabilities will be used within all Army PH program elements.

3–17. Public health emergency management

a. PH emergencies can appear and progress rapidly, leading to widespread health, social, and economic consequences. Military commanders must be prepared to make timely decisions to protect lives, property, and infrastructure and enable DOD installations and/or military commands to sustain mission-critical operations and essential services. Military commanders should expect a level of uncertainty during the decision-making process, especially during early stages of a PH emergency.

b. The PHEO is the central point of contact and clearinghouse for PH-related information during a suspected or declared PH emergency. The PHEO is appointed on an additional duty basis by the senior commander to function as the primary advisor/subject matter expert for PH emergencies; provide important synchronization between unit commanders, medical, veterinary, and PH capabilities; and ensure seamless coordination between the installation and the local civilian PH community.

c. PH emergency management is viewed by the Army as an integrating capability accomplished through the unified efforts of the PHEO, MEM, senior commander, installation emergency manager, and assigned PH personnel to identify, confirm, and control a PH emergency.

d. A PH emergency is defined in DODI 6200.03 as an occurrence or imminent threat of an illness or health condition that poses a high probability of—

- (1) A significant number of deaths in the affected population considering the severity and probability of the event;
- (2) A significant number of serious or long-term disabilities in the affected population considering the severity and probability of the event;
- (3) Widespread exposure to an infectious or toxic agent, including those of zoonotic origin, that poses a significant risk of substantial future harm to a large number of people in the affected population;
- (4) Healthcare needs that exceed available resources; and/or
- (5) Severe degradation of mission capabilities or normal operations.

e. A PH emergency may be caused by—

- (1) Biological incident, naturally occurring or intentionally introduced, such as the appearance of a novel, previously controlled, or eradicated infectious agent, biological toxin, or zoonotic disease;
- (2) Natural disaster;
- (3) Chemical attack or accidental release;
- (4) Radiological or nuclear attack or accident; and/or
- (5) High-yield explosive detonation.

Section III

Prescribed Procedures

3–18. Quality management

a. Quality management is an essential process for all PH entities to provide consistent, accurate, and reliable products and services. All aspects of the Army PH Enterprise will operate under a quality management system. The quality management system will fulfill the following objectives according to the detailed instructions described in DA Pam 40–11:

- (1) Conduct program evaluation to monitor performance of products and services and implement continuous process improvement measures.
- (2) Standardize policies and procedures for providing products and services across the Army PH Enterprise.
- (3) Adhere to internationally or nationally recognized assurance, accreditation, certification, or other regulatory standards where available.

b. All levels of the PH Enterprise will resource and engage in program evaluation activities to demonstrate effectiveness and improve performance.

c. Setting performance standards and measuring performance has been shown to be a catalyst for process and quality improvement.

(1) Army PH accreditation is a strategy to continuously improve the quality of PH services across the Enterprise and serves as a formal declaration that an installation's PH Program has met nationally recognized performance standards.

(2) The installation PH Program is analogous to civilian PH departments for their supported communities. PH accreditation of the installation PH Program will drive improvements in the delivery of local services by using performance standards.

d. Credentialing is the process by which an organization ensures competency of its professional staff based on education/training history and ongoing professional development. Credentialing requires establishment of a standardized process and systems of records for reviewing and archiving relevant educational or professional accomplishments (for example, degrees, certificates, and licenses) that are required for the individual to work within the scope of their position. Periodic renewal may be required for specific licenses and certifications.

e. The Army is committed to protecting the rights and welfare of humans and animals involved in PH practice or research activities involving human or animal subjects, whether the organization is conducting or supporting the activity.

(1) PH practice and research activities involving human subjects, their data, or biological specimens are guided by the ethical principles of respect for persons, beneficence, and justice as established by The Belmont Report (available at <https://www.hhs.gov/ohrp/regulations-and-policy/belmont-report/index.html>).

(2) PH practice, while not intended to contribute to generalizable knowledge, often involves interacting with individuals or obtaining information about them and thus shares similar legal and ethical concerns in regards to protecting human subjects and their information. PH practices such as evaluations of intervention outcomes or epidemiological surveillance may include activities that could appear to be research since similar scientific methodologies are employed.

(3) A Determination Official and PHRB are required to assist in distinguishing PH practice activities from research involving human subjects, ensuring appropriate disposition and oversight of all human-use PH activities, and promoting proper handling of protected health information (PHI) and personally identifiable information (PII) in both PH practice and research.

(4) An IACUC review is required for each PH practice or research activity involving animals. Institutions or commands without a local IACUC should consult with the APHC IACUC chairperson to determine if animal activities require IACUC oversight.

3–19. Public health requirements for privatized facilities

a. The authority and responsibility for DOD entities to conduct PH surveillance and inspections at privatized facilities is established through DOD directives and Army regulations.

(1) Private organizations are required to comply with state or local laws and applicable statutes and regulations (see AR 210–22). Activities within the private organization must be licensed, certified, or registered to operate if required by law. AR 210–22 further stipulates that the senior commander may terminate a private organization if it does not adhere to Army policy and procedures.

(2) Non-DOD tenants on military installations that provide services to military personnel, their dependents, and DOD Civilians must comply with all applicable laws and DOD policies relating to environment, safety, and occupational health (see DODD 4715.1E).

(3) These tenants should expect routine PH surveillance and inspections which are conducted in garrison settings to mitigate industrial, occupational, and environmental hazards and document significant exposures, including those associated with noise, climate, chemicals, radiation, infectious agents, air, food, water, waste, and pests (see DODD 6200.04). Such requirements should be included in the relevant lease agreement.

b. Privatized facilities such as guest lodging and family housing may operate facilities such as food service, playgrounds, swimming pools, and childcare, which require regular, unannounced health and safety inspections. Other private entities include laundry and dry cleaning services operated on CONUS installations.

c. Privatized facilities are operated under a lease agreement with DOD, which addresses jurisdiction for regulatory compliance.

(1) The majority of lease agreements indicate the military Service component has exclusive federal jurisdiction. As such, the installation PH authority retains responsibility for providing PH services at the privatized facility.

(2) For lease agreements that specify concurrent federal jurisdiction, regulatory compliance is shared between the installation PH authority and the local health department.

3–20. Public health information systems

PH surveillance and inspection data must be entered in the approved DOD or DA systems of records as specified in DA Pam 40–11.

Appendix A

References

Section I

Required Publications

DOD publications are available at the Office of the Secretary of Defense website (<https://www.esd.whs.mil/dd/>). CFR material is available at the Electronic Code of Federal Regulations website (<https://www.ecfr.gov/>).

AFPMB TG No. 3

Feral Animal Risk Mitigation in Operational Areas (Cited in para 2–27*f*.) (Available at https://www.acq.osd.mil/eie/afpmb/technical_guidance.html.)

AR 11–34

The Army Respiratory Protection Program (Cited in para 2–4*f*(3).)

AR 11–35

Occupational and Environmental Health Risk Management (Cited in para 1–7*e*.)

AR 40–10

Health Hazard Assessment Program in Support of the Army Acquisition Process (Cited in para 1–7*o*.)

AR 40–13

Radiological Advisory Medical Teams (Cited in para 2–17*n*.)

AR 40–33

The Care and Use of Laboratory Animals in DOD Programs (Cited in para 2–17*cc*(14).)

AR 40–60

Army Medical Materiel Acquisition Policy (Cited in para 2–12*a*(5).)

AR 40–66

Medical Record Administration and Healthcare Documentation (Cited in para 1–5.)

AR 40–656

Veterinary Surveillance Inspection of Subsistence (Cited in para 1–7*l*(1).)

AR 40–657

Veterinary/Medical Food Safety, Quality Assurance, and Laboratory Service (Cited in para 1–7*l*(1).)

AR 40–660

DOD Hazardous Food and Nonprescription Drug Recall System (Cited in para 1–7*l*(1).)

AR 40–905

Veterinary Health Services (Cited in para 1–7*l*(5).)

AR 70–1

Army Acquisition Policy (Cited in para 2–1*a*.)

AR 70–75

Survivability of Army Personnel and Materiel (Cited in para 2–1*d*.)

AR 190–24

Armed Forces Disciplinary Control Boards and Off-Installation Liaison and Operations (Cited in para 2–21*m*.)

AR 200–1

Environmental Protection and Enhancement (Cited in para 2–12*b*(10).)

AR 210–14

Installation Status Report Program (Cited in para 2–21*p*.)

AR 210–22

Private Organizations on Department of the Army Installations (Cited in para 1–7*s*.)

AR 215–3

Nonappropriated Fund Instrumentalities Personnel Policy (Cited in para 2–28*a*(8)(*b*).)

AR 385–10
The Army Safety Program (Cited in para 2–1a.)

AR 525–2
The Army Protection Program (Cited in para 2–12a(13).)

AR 525–27
Army Emergency Management Program (Cited in para 2–4i.)

AR 600–63
Army Health Promotion (Cited in para 2–4f(6).)

AR 608–10
Child Development Services (Cited in para 2–17m.)

ATP 4–02.8
Force Health Protection (Cited in para 2–23c.)

ATP 4–02.42
Army Health System Support to Stability and Defense Support of Civil Authorities Tasks (Cited in para 2–17cc(3)(e).)

ATP 4–02.55
Army Health System Support Planning (Cited in para 2–27e.)

ATP 4–25.12
Unit Field Sanitation Teams (Cited in para 2–27e.)

ATP 5–19
Risk Management (Cited in para 1–7j.)

DA Pam 25–403
Guide to Recordkeeping in the Army (Cited in para 1–5.)

DA Pam 40–11
Army Public Health Program (Cited in para 1–7o.)

DA Pam 40–21
Ergonomics Program (Cited in para 2–4f(2).)

DA Pam 40–501
Army Hearing Program (Cited in para 2–4f(4).)

DA Pam 40–503
The Army Industrial Hygiene Program (Cited in para 2–4f(7).)

DA Pam 40–506
The Army Vision Conservation and Readiness Program (Cited in para 2–4f(5).)

DA Pam 385–24
The Army Radiation Safety Program (Cited in para 2–4f(8).)

DA Pam 385–30
Risk Management (Cited in para 1–7j.)

DODD 4715.1E
Environment, Safety, and Occupational Health (ESOH) (Cited on title page.)

DODD 6200.04
Force Health Protection (FHP) (Cited on title page.)

DODD 6400.04E
DOD Veterinary Public and Animal Health Services (Cited on title page.)

DODI 1010.10
Health Promotion and Disease Prevention (Cited on title page.)

DODI 1400.25
DOD Civilian Personnel Management System (Cited on title page.)

DODI 2000.30

Global Health Engagement (GHE) Activities (Cited in para 1–7*k*.)

DODI 3216.01

Use of Animals in DOD Programs (Cited in para 3–9*a*.)

DODI 3216.02

Protection of Human Subjects and Adherence to Ethical Standards in DOD-Supported Research (Cited in para 2–19*o*.)

DODI 4150.07

DOD Pest Management Program (Cited on title page.)

DODI 6025.18

Privacy of Individually Identifiable Health Information in DOD Health Care Programs (Cited in para 1–7*x*.)

DODI 6200.03

Public Health Emergency Management Within the Department of Defense (Cited on title page.)

DTR 4500.9–R, Part II

Defense Transportation Regulation, Cargo Movement (Cited in para 2–17*cc*(9)(*d*)). (Available at <https://www.ustrans-com.mil/dtr/dtrp2.cfm>.)

EM 200–1–13

Environmental Quality: Minimizing the Risk of Legionellosis Associated with Building Water Systems on Army Installations (Cited in para 2–16*b*.) (Available at <https://www.publications.usace.army.mil/>.)

Executive Order 12196

Occupational Safety and Health Programs for Federal Employees (Cited on title page.) (Available at <https://www.archives.gov/federal-register/codification/executive-order/12196.html>.)

Public Law 91–596

Occupational Safety and Health Act of 1970, as amended (Cited in para 2–12*b*(19)). (Available at https://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=oshact&p_id=2743.)

PWTB 200–1–144

Toxics Management (Cited in para 2–16*b*.) (Available at <https://www.wbdg.org/ffc/army-coe/public-works-technical-bulletins-pwtb/pwtb-200–1–144>.)

5 CFR 339

Medical Qualification Determinations (Cited in para 2–28*a*(8)(*b*)).

29 CFR 1960

Basic Program Elements for Federal Employee Occupational Safety and Health Programs and Related Matters (Cited in para 2–4*f*(1)).

32 CFR 219

Protection of Human Subjects (Cited in para 2–17*cc*(13)(*b*)).

Section II**Related Publications**

A related publication is a source of additional information. The user does not have to read it to understand this publication. DOD publications are available at the Office of the Secretary of Defense website (<https://www.esd.whs.mil/dd/>).

A Dictionary of Public Health

Last, J.M. 2007. A Dictionary of Public Health. New York, New York: Oxford University Press.

AFPMB TG No. 37

Integrated Management of Stray Animals on Military Installations (Available at https://www.acq.osd.mil/eie/afpmb/technical_guidance.html.)

American Nurses Association, Scope and Standards of Practice: Public Health Nursing

2nd Edition 2013. (Available at <https://www.nursingworld.org>.)

American Veterinary Medical Foundation (AVMF)

One Health-What is One Health? (Available at <https://www.avma.org/kb/resources/reference/pages/one-health94.aspx>.)

AR 5–22

The Army Force Modernization Proponent System

AR 11–2

Managers' Internal Control Program

AR 11–33

Army Lessons Learned Program

AR 15–1

Department of the Army Federal Advisory Committee Management Program

AR 25–30

Army Publishing Program

AR 40–1

Composition, Mission, and Functions of the Army Medical Department

AR 40–3

Medical, Dental, and Veterinary Care

AR 40–25

Nutrition Standards and Education

AR 40–35

Preventive Dentistry and Dental Readiness

AR 40–68

Clinical Quality Management

AR 215–1

Military Morale, Welfare, and Recreation Programs and Nonappropriated Fund Instrumentalities

AR 350–10

Management of Army Individual Training Requirements and Resources

AR 381–11

Intelligence Support to Capability Development

AR 525–13

Antiterrorism

AR 600–9

The Army Body Composition Program

AR 600–85

The Army Substance Abuse Program

AR 600–110

Identification, Surveillance, and Administration of Personnel Infected with Human Immunodeficiency Virus

AR 602–2

Human Systems Integration in the System Acquisition Process

AR 608–18

The Army Family Advocacy Program

AR 608–75

Exceptional Family Member Program

AR 690–300

Employment

AR 700–48

Management of Equipment Contaminated with Depleted Uranium or Radioactive Commodities

AR 700–135

Soldier Support in the Field

AR 700–136

Tactical Land-Based Water Resources Management

AR 700–142

Type Classification, Materiel Release, Fielding, and Transfer

AR 702–11

Army Quality Program

ATP 3–34.5

Environmental Considerations

ATSDR, U.S. Public Health Service and U.S. Department of Defense

The Development of Toxicological Profiles for Hazardous Substances and PH Assessments and Related Activities at DOD Facilities, 22 November 2004 (Available at <https://www.atsdr.cdc.gov/toxprofiledocs/index.html>.)

Centers for Disease Control and Prevention, Core Functions of Public Health and How they Relate to the 10 Essential Services

(Available at https://www.cdc.gov/nceh/ehs/ephli/core_ess.htm.)

Centers for Disease Control and Prevention, One Health

(Available at <https://www.cdc.gov/onehealth/>.)

Communication at the Core of Effective Public Health

Bernhardt, J.M. 2004. *American Journal of Public Health*. 94(12):2051–2053. (Available at <https://www.ncbi.nlm.nih.gov/pmc/articles/pmc1448586/>.)

DA Pam 40–513

Occupational and Environmental Health Guidelines for the Evaluation and Control of Asbestos Exposure

DA Pam 385–40

Army Accident Investigations and Reporting

DFAS–IN Manual 37–100

The Army Management Structure (Available at <https://www.asafm.army.mil/>.)

DOD/DHA

Military Health System Review, Final Report to the Secretary of Defense, 29 August 2014 (Available at <https://www.health.mil/>.)

DOD Dictionary of Military and Associated Terms

(Available at <https://www.jcs.mil/>.)

DOD 5400.11–R

Department of Defense Privacy Program

DOD 6055.05–M

Occupational Medical Examinations and Surveillance Manual

DODD 5134.08

Assistant Secretary of Defense for Nuclear, Chemical, and Biological Defense Programs (ASD(NCB))

DODD 6000.12E

Health Services Support

DODD 6205.02E

Policy and Program for Immunizations to Protect the Health of Service Members and Military Beneficiaries

DODD 6490.02E

Comprehensive Health Surveillance

DODI 1100.21
Voluntary Services in the Department of Defense

DODI 1322.24
Medical Readiness Training

DODI 1336.05
Automated Extract of Active Duty Military Personnel Records

DODI 2000.12
DOD Antiterrorism (AT) Program

DODI 4105.72
Procurement of Sustainable Goods and Services

DODI 4715.07
Defense Environmental Restoration Program (DERP)

DODI 6050.05
DOD Hazard Communication (HAZCOM) Program

DODI 6055.01
DOD Safety and Occupational Health (SOH) Program

DODI 6055.05
Occupational and Environmental Health (OEH)

DODI 6055.07
Mishap Notification, Investigation, Reporting, and Record Keeping

DODI 6055.08
Occupational Ionizing Radiation Protection Program

DODI 6055.11
Protecting Personnel from Electromagnetic Fields

DODI 6055.12
Hearing Conservation Program (HCP)

DODI 6055.15
DOD Laser Protection Program

DODI 6055.17
DOD Emergency Management (EM) Program

DODI 6060.02
Child Development Programs (CDPs)

DODI 6060.4
Department of Defense (DOD) Youth Programs (YPs)

DODI 6205.4
Immunization of Other Than U.S. Forces (OTUSF) for Biological Warfare Defense

DODI 6440.02
Clinical Laboratory Improvement Program (CLIP)

DODI 6440.03
DOD Laboratory Network (DLN)

DODI 6490.03
Deployment Health

DODM 6440.02
Clinical Laboratory Improvement Program (CLIP) Procedures

EEOC Notice Number 915.002

Enforcement Guidance: Disability-Related Inquiries and Medical Examinations of Employees Under the Americans With Disabilities Act (ADA) (Available at <https://www.eeoc.gov/policy/docs/guidance-inquiries.html>.)

EM 385–1–1

Safety and Health Requirements (Available at <https://www.publications.usace.army.mil/usace-publications/engineer-manuals/>.)

Institute of Medicine Report, Noise and Military Service: Implications for Hearing Loss and Tinnitus

(Available at <https://www.nap.edu/>.)

Institute of Medicine Report, Potential Radiation Exposure in Military Operations: Protecting the Soldier Before, During and After (1999)

(Available at <https://www.nap.edu/>.)

Institute of Medicine Report, Protecting Those Who Serve: Strategies to Protect the Health of Deployed U.S. Forces. (2000)

National Academy of Sciences. (Available at <https://www.nap.edu/>.)

JP 1–0

Joint Personnel Support (Available at <https://www.jcs.mil/>.)

JP 4–02

Joint Health Services (Available at <https://www.jcs.mil/>.)

Memorandum from the Office of the Assistant Secretary, dated 23 March 1993

Management/Oversight of the Memorandum of Understanding (MOU) between the Department of Defense (DOD) and the Agency for Toxic Substances and Disease Registry (ATSDR) (Available at Assistant Secretary of the Army (Installations, Energy and Environment), 110 Army Pentagon (SAIE–ESO), Room 3D453, Washington DC 20310–0110.)

Memorandum from the Office of the Assistant Secretary (Installations, Logistics, and Environment), dated 20 March 1998

Subject: Agency for Toxic Substances and Disease Registry (ATSDR) Program Management Plan. (Available at Assistant Secretary of the Army (Installations, Energy and Environment), 110 Army Pentagon (SAIE–ESO), Room 3D453, Washington DC 20310–0110.)

Memorandum from the Office of the Assistant Secretary (Installations, Logistics, and Environment), dated 24 June 2016

Subject: Assignment of Mission Execution Functions Associated with Department of Defense Lead Agent Responsibilities for the Agency for Toxic Substances and Disease Registry. (Available at Assistant Secretary of the Army (Installations, Energy and Environment), 110 Army Pentagon (SAIE–ESO), Room 3D453, Washington DC 20310–0110.)

Memorandum of Understanding Between U.S. Department of Health and Human Services Agency for Toxic Substances and Disease Registry and the U.S. Department of Defense for Public Health Assessments, Toxicological Profiles, and Related Activities at DOD Facilities, dated 22 September 2015

(Available at U.S. Army Public Health Center, 8252 Blackhawk Road, Building E1675 (MCHB–PH–ATS), Aberdeen Proving Ground, Maryland 21010–5403.)

National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, Department of Health, Education and Welfare (DHEW)

(30 September 1978). The Belmont Report. Washington, DC: United States Government Printing Office. (Available at <https://www.hhs.gov/ohrp/regulations-and-policy/belmont-report/index.html>.)

Public Health and Preventive Medicine

Wallace, R.B. 2007. *Public Health and Preventive Medicine*. 15th edition. New York, New York: The McGraw-Hill Companies.

TB MED 507

Heat Stress Control and Heat Casualty Management

TB MED 508

Prevention and Management of Cold-Weather Injuries

TB MED 530

Tri-Service Food Code

TB MED 531

Field Sanitation Controls and Inspections

TB MED 575

Recreational Water Facilities

TB MED 576

Sanitary Control and Surveillance of Water Supplies at Fixed Installations

TB MED 577

Sanitary Control and Surveillance of Field Water Supplies

TB MED 590

Red Blood Cell-Cholinesterase Testing and Quality Assurance

TB MED 593

Guidelines for Field Waste Management

TM 3–11.42/MCWP 3–38.1/NTTP 3–11.36/AFTTP 3–2.83

Multi-Service Tactics, Techniques, and Procedures for Installation Emergency Management

TM 4–02.33/NAVMED P–5038

Control of Communicable Diseases Manual (Available at <https://secure.apha.org>.)

U.S. Department of Health and Human Services

Healthy People 2010. 2nd edition. Washington, DC, 2000 (Available at <https://www.cdc.gov>.)

Unified Facilities Guide Specifications (UFGS)

(Available at <https://www.wbdg.org/ffc/dod/unified-facilities-guide-specifications-ufgs>.)

5 CFR 293, Subpart E

Employee Medical File System Records (Available at <https://www.ecfr.gov/>.)

5 USC, Chapter 81

Compensation for Work Injuries

31 USC 1535

Agency agreements

31 USC 1536

Crediting payments from purchases between executive agencies

50 USC 1522

Conduct of chemical and biological defense program

Section III**Prescribed Forms**

This section contains no entries.

Section IV**Referenced Forms**

Unless otherwise indicated, DA Forms are available on the Army Publishing Directorate website (www.armypubs.army.mil) and optional forms are available on the General Services Administration website (<https://www.gsa.gov/reference/forms>).

DA Form 11–2

Internal Control Evaluation Certification

DA Form 2028

Recommended Changes to Publications and Blank Forms

DA Form 3437

Department of the Army Nonappropriated Funds Certificate of Medical Examination

OF 178

Certificate of Medical Examination

Appendix B

Internal Control Evaluation

B–1. Function

The function covered by this evaluation is PH.

B–2. Purpose

The purpose of this evaluation is to assist commanders in evaluating the key internal controls as outlined in this appendix (with medical personnel evaluating these key controls or resulting evaluation certified by some medical officer/official). This evaluation should be used at the following levels: HQDA, field-operating agency, ACOMs, ASCCs, DRUs, major subordinate commands, installations, and TOE units. It is not intended to cover all controls, but all controls applicable to an activity must be evaluated.

B–3. Instruction

Answers must be based on the actual testing of key internal controls (for example, document analysis, direct observation, sampling, simulation, other). Answers that indicate deficiencies must be explained and corrective action indicated in supporting documentation. These key internal controls must be formally evaluated at least once every 5 years. Certification that this evaluation has been conducted must be accomplished on DA Form 11–2 (Internal Control Evaluation Certification).

B–4. Test questions

- a.* Are practices and procedures in place and operating to determine adherence to health standards established in pertinent federal, state, local, and host government statutes and regulations and in Army regulations?
- b.* Were sufficient resources requested to accomplish all responsibilities designated in this regulation? Where actual resources received were insufficient, were those resources applied to the highest priority areas? Was the adverse impact of the unfunded requirements communicated to higher headquarters?
- c.* Is medical and OEH surveillance performed as required?
- d.* Are occupational health services provided as required to assist employment decision making by human resources and line management?
- e.* Is there an established two-way communication between clinical PH and local off-installation DHA medical facilities to assist with implementation of medical surveillance, health promotion, and coordination of readiness support?
- f.* Are Army personnel informed of all health threats and risks, and appropriate countermeasures?
- g.* Do Army PH laboratories maintain appropriate third party accreditation(s)?
- h.* For newly formed laboratories, are these laboratories actively taking steps to obtain appropriate third party accreditation(s)?
- i.* Are health hazards of new equipment and materiel assessed?
- j.* Are the same PH support services provided to all personnel (for example, military, DA Civilian, contractor) deployed for military operations?
- k.* Are there standard process outcome metrics applied to evaluate PH activities?
- l.* Are commanders, supervisors, and PH staff provided basic, specialized, and sustainment training that will enable them to properly execute their PH leadership and staff responsibilities?
- m.* Are DHP structure codes used for PH budget execution tracking and program analysis review?
- n.* Are PH issues addressed through the DOTMLPF–P process?
- o.* Are PH workloads documented?
- p.* Are PH concepts and practices incorporated into Army officer and enlisted training manuals and Soldier common task training manuals?
- q.* Are medical events reported through a military Medical Event Reporting System in compliance with state and local medical reporting requirements?
- r.* Have all identified PH personnel completed risk communication and media training?
- s.* Are respective public affairs representatives being engaged in planning discussions regarding identified PH risks?

B–5. Supersession

This evaluation replaces the evaluation previously published in AR 40–5, dated 25 May 2007.

B-6. Comments

Help make this a better tool for evaluating internal controls. Submit comments to The Surgeon General (DASG-PPM-NC), 7700 Arlington Boulevard, Falls Church, VA 22042-5143.

Glossary

Section I

Abbreviations

AAE

Army Acquisition Executive

ACOM

Army command

AFPMB

Armed Forces Pest Management Board

AMC

U.S. Army Materiel Command

AMEDD

Army Medical Department

AMEDDC&S

Army Medical Department Center and School

AOC

area of concentration

AOR

area of responsibility

APHC

U.S. Army Public Health Center

AR

Army regulation

ARIMS

Army Records Information Management System

ASA (ALT)

Assistant Secretary of the Army (Acquisition, Logistics and Technology)

ASA (IE&E)

Assistant Secretary of the Army (Installations, Energy, and Environment)

ASA (M&RA)

Assistant Secretary of the Army (Manpower and Reserve Affairs)

ASCC

Army service component command

ASOHMS

Army Safety and Occupational Health Management System

ASOHP

Army Safety and Occupational Health Program

ATP

Army techniques publication

ATSDR

Agency for Toxic Substances and Disease Registry

CAR

Chief, Army Reserve

CBRN

chemical, biological, radiological, and nuclear

CBRNE
chemical, biological, radiological, nuclear, and high-yield explosive

CFR
Code of Federal Regulations

CG
commanding general

CNGB
Chief, National Guard Bureau

COE
Chief of Engineers

CONUS
continental United States

CR2C
Commanders Ready and Resilient Council

DA
Department of the Army

DA Form
Department of the Army form

DA Pam
Department of the Army pamphlet

DAS
Director of the Army Staff

DASAF
Director of Army Safety

DCS
Deputy Chief of Staff

DCS–PH
Deputy Chief of Staff for Public Health

DHA
Defense Health Agency

DHP
Defense Health Program

DNBI
disease and nonbattle injuries

DOD
Department of Defense

DODD
Department of Defense directive

DODI
Department of Defense instruction

DODM
Department of Defense manual

DOL
Department of Labor

DoTAA
Directorate of Training and Academic Affairs

DOTMLPF-P

doctrine, organization, training, materiel, leadership and education, personnel, facilities, and policy

DRSi

Disease Reporting System internet

DRU

direct reporting unit

DTR

Defense Transportation Regulation

DU

depleted uranium

EEOC

Equal Employment Opportunity Commission

EM

engineer manual

FARM

feral animal risk mitigation

FECA

Federal Employee Compensation Act

FORSCOM

U.S. Army Forces Command

GVMP

Global Veterinary Medical Practice

HQDA

Headquarters, Department of the Army

HRCoE

Health Readiness Center of Excellence

HRPP

Human Research Protection Program

IACUC

Institutional Animal Care and Use Committee

IM

information management

IMCOM

U.S. Army Installation Management Command

IPM

integrated pest management

IRB

Institutional Review Board

IT

information technology

JP

Joint publication

LHWCA

Longshore and Harbor Workers' Compensation Act

MEDCOM

U.S. Army Medical Command

MEM
medical emergency manager

MOA
Memorandum of Agreement

MOU
Memorandum of Understanding

MRMC
U.S. Army Medical Research and Materiel Command

MTF
medical treatment facility

NDAA
National Defense Authorization Act

OEH
occupational and environmental health

OF
Optional Form

OTSG
Office of The Surgeon General

PH
public health

PHEO
Public Health Emergency Officer

PHI
protected health information

PHRB
Public Health Review Board

PII
personally identifiable information

PWTB
Public Works technical bulletin

TB MED
technical bulletin, medical

TDA
tables of distribution and allowances

TG
technical guide

TIC
toxic industrial chemical

TIM
toxic industrial material

TIR
toxic industrial radiological

TOE
tables of organization and equipment

TRADOC
U.S. Army Training and Doctrine Command

TSG

The Surgeon General

USACE

U.S. Army Corps of Engineers

USAR

U.S. Army Reserve

USARC

U.S. Army Reserve Command

Section II**Terms****Accountability**

The acknowledgment and assumption of responsibility for actions, products, decisions, and policies including the administration, governance, and implementation within the scope of the role or employment position and encompassing the obligation to report, explain, and be answerable for resulting consequences. There is only one accountable agent for any task/activity, and accountability can be assigned (to lower levels) or implied (at higher levels); however, it cannot be delegated.

Accountable agent

The individual designated by the commander to be the single point of accountability for the command's specific programs and services. The accountable agent is not intended to replace the authorities and prerogatives of commanders, but to assist commanders in providing leadership and unified, cohesive, coordinated, efficient, well-resourced programs and services. The accountable agent reports directly to the commander and informs, advises, and recommends actions for the functional integration and optimal delivery of specific programs and services.

All-hazards

A threat or an incident, natural or manmade, that warrants action to protect life, property, the environment, and the public's health or safety, and to minimize disruptions of government, social, or economic activities. It includes natural disasters, cyber incidents, industrial accidents, pandemics, acts of terrorism, sabotage, and destructive criminal activity targeting critical infrastructure.

Army installation

An aggregation of contiguous, or near contiguous, common mission-supporting real property holdings under the jurisdiction of or possession controlled by DA or by a state, commonwealth, territory, or the District of Columbia, and at which an Army unit or activity (Regular Army, USAR, or Army National Guard) is assigned. In addition to those used primarily by troops, the term applies to installation real properties such as depots, arsenals, ammunition plants (both contractor and government-operated), hospitals, terminals, and other special mission installations. An installation is a physical site uniquely identified by an Army location code.

Army personnel

As used in this publication, includes Regular Army; Army National Guard/Army National Guard of the United States and USAR personnel on active duty or inactive duty for training status; U.S. Military Academy cadets; U.S. Army Reserve Officer Training Corps cadets, when engaged in directed training activities; other DOD and foreign national military personnel assigned to Army components; and DA Civilian personnel and nonappropriated fund personnel employed by the Army worldwide. Except for those PH services defined in DODI 6055.01 for supporting DOD contractor personnel during force deployments or specifically provided for in contracts between the Government and a contractor, Army contractor personnel are not included in this definition. Servicemembers' dependents and co-residing family members living on Army installations are also included in this definition for purposes of environmental health and safety, and wellness activities. Volunteers are considered Army personnel only to the extent noted in DODI 1100.21 (for example, during training).

Army populations

Army populations include Army personnel and their beneficiaries, DA Civilians, retirees, military working animals, and family pets of Soldiers.

Biological agent

A microorganism that causes disease in personnel, plants, or animals or causes the deterioration of materiel.

Biologics

Medicinal preparations made from living organisms and their products, including serums, vaccines, antigens, and antitoxins.

Chemical warfare agent or chemical agent

A chemical substance which, because of its physiological, psychological, or pharmacological effects, is intended for use in military operations to kill, seriously injure, or incapacitate humans (or animals) through its toxicological effects. Chemical agents may be nerve agents, incapacitating agents, blister agents (vesicants), lung-damaging agents, blood agents, and vomiting agents.

Clinical public health

The integration of primary medical care, preventive medicine practice, and other PH activities aimed at fostering collaborative efforts in the monitoring of health, disease, and injuries in communities. Clinical PH includes the provision of other PH services in responding to community health-related problems needing immediate or long-term attention.

Combat and operational stress reactions

Describes the wide range of anticipated, maladaptive psychological and physical symptoms, generally transient, of any severity and nature which occur in individuals without any apparent mental disorder in response to combat and operational stress exposure, and which usually subside within hours or days.

Communicable disease

Illness due to a specific infectious agent or its toxic products that arises through transmission of that agent or its products from an infected person, animal, or inanimate reservoir to a susceptible host, either directly or indirectly, through an intermediate plant or animal host, vector, or the inanimate environment. Synonymous with infectious disease.

Comprehensive health surveillance

Health surveillance conducted throughout Servicemembers' military careers and DOD Civilian employees' employment, across all duty locations, and encompassing risk, intervention, and outcome data. Such surveillance is essential to the evaluation, planning, and implementation of PH practice and prevention and must be closely integrated with the timely dissemination of information to those who can act upon it (see DODD 6490.02E).

Contract working dog

Dogs that are owned by companies contracted by the DOD and required by the using DOD component for a specific purpose, mission, or combat capability. Contract working dogs are authorized military medical care and support when in an operational environment. Scope of care provided to these dogs is defined in each company's individual contract.

Department of Defense-owned animals

Animals that are owned by the DOD and authorized care by Army veterinary services. These include, but are not limited to: military working animals; authorized unit mascots; animals supported through appropriated and non-appropriated funds; stray animals on military installations in a DOD operated stray facility for the first 3 working days; animals used in biomedical research, education, training, and testing; and wild animals in confinement on military installations, such as deer. See also "military working animals."

Deployment

The rotation of forces into and out of an operational area.

Determination official

An official within an institution, sufficiently qualified through training and experience, to determine if activities meet the regulatory definition of research, include human subjects as defined in the DODI 3216.02, and qualify for an exemption from IRB review in accordance with section 101(b) of 32 CFR 219.

Direct reporting unit

An Army organization comprised of one or more units with institutional or operational functions, designated by the Secretary of the Army, providing broad general support to the Army in a normally single, unique discipline not otherwise available elsewhere in the Army. DRUs report directly to an HQDA principal and/or ACOM and operate under authorities established by the Secretary of the Army.

Disease and injury

Injury or degradation of functional capability sustained by personnel caused by DNBI or by enemy action.

Disease and nonbattle injuries

A subset of disease and injuries. All illnesses and injuries not resulting from enemy or terrorist action or caused by conflict. Also called DNBI.

Enterprise

An organization supporting a defined business scope and mission. An enterprise includes interdependent resources (people, organizations, and technology) that must coordinate their functions and share information in support of a common mission or set of related missions. See also “public health enterprise.”

Enterprise governance process

The system of management and controls exercised in the stewardship (accountability, transparency, and fairness) of the enterprise, including strategic direction, monitoring, and evaluating performance, managing risk, and shareholder reporting.

Environmental health

The science and practice of preventing human injury and illness and promoting well-being by identifying and evaluating environmental sources of health hazards and preventing or limiting those exposures.

Environmental medicine

A medical specialty aligned with occupational medicine under the umbrella of preventive medicine that focuses on assessing environmental exposures, including environmental contaminants, to individuals or populations and the adverse health outcomes that may result from those exposures.

Epidemiology

The most fundamental practice of PH, involves the study of the distribution and determinants of health-related states or events in specified populations and the application of this study to control health problems. Distribution refers to time, place, and person (demographics, behavioral characteristics). Determinants include causes, risks, or exposure types/volumes of activities, disease agents, or external OEH hazards. Health-related states or events are health outcomes (see “health outcome”). (See Public Health and Preventive Medicine.)

Ergonomics

The field of study that seeks to fit the job to the person, rather than the person to the job. This is achieved by the identification, assessment, and remediation of work-related musculoskeletal disorder risk factors and evaluation, design and modification of workplaces, environments, jobs, tasks, equipment, and processes in relationship to human capabilities and interactions in the workplace.

Feral animal risk mitigation

Policies, procedures, and practices collectively employed in an operational area to reduce the traumatic injury and disease risks posed by feral animals. Feral animals are free-roaming animals, usually a domestic species, with no apparent owner (see AFPMB TG No. 3).

Force health protection

Measures to promote, improve, or conserve the behavioral and physical well-being of Servicemembers to enable a healthy and fit force, prevent injury and illness, and protect the force from health hazards.

Garrison

Organization responsible for providing installation management services and operations. An Army garrison is a TDA organization that manages Army installations. Garrison command is the execution arm of the IMCOM. It delivers the majority of installation management services to both resident and nonresident organizations. The garrison’s mission is linked to the installation’s purpose. As the execution arm of IMCOM, the garrison’s mission is to provide installation management programs and services for mission activity commanders, Soldiers, DA Civilians, Family members, and retirees.

Global Health Engagement

Interaction between individuals or elements of DOD and those of a partner nation’s armed forces or civilian authorities, in coordination with other U.S. Government departments and agencies, to build trust and confidence, share information, coordinate mutual activities, maintain influence, and achieve interoperability in health-related activities that support U.S. national security policy and military strategy. Global Health Engagement activities establish, reconstitute, maintain, or improve the capabilities or capacities of the partner nation’s military or civilian health sector, or those of the DOD (see DODI 2000.30).

Government-owned animals

Includes both DOD-owned animals and animals owned, maintained, or managed by a federal agency or activity such as the U.S. Department of Homeland Security.

Health communication

The study or use of communication strategies to inform and influence individual and community decisions that enhance health. See also “public health communication.”

Health hazard

An existing or likely condition, inherent to the operation or use of materiel, that can cause death, injury, acute or chronic illness, disability, and reduced job performance by exposure to:

- a.* Acoustic energy.
- b.* Biological substances.
- c.* Chemical substances.
- d.* Oxygen deficiency.
- e.* Radiation energy.
- f.* Shock.
- g.* Temperature extremes and humidity.
- h.* Trauma.
- i.* Vibration.

Health hazard assessment

The application of biomedical knowledge and principles to document and quantitatively determine the health hazards of Army materiel, processes, or environments. This assessment identifies, evaluates, and recommends controls to reduce risks to the health and effectiveness of personnel who operate or maintain Army materiel. This assessment includes:

- a.* The evaluation of hazard severity, hazard probability, risk assessment, consequences, and operational constraints.
- b.* The identification of required precautions and protective devices.
- c.* Training requirements.
- d.* An estimate of medical cost avoidance.

Health marketing

Health marketing involves creating, communicating, and delivering health information and interventions using customer-centered and science-based strategies to protect and promote the health of diverse populations.

Health outcome

A direct measure or criteria representing a person’s physical and/or mental health status. Adverse health outcomes include diagnosed or reported medical conditions (disease, physical or mental, sign or symptom) and abnormal medical or laboratory results (for example, abnormal audiology exam). Clinically significant biological markers of disease or injury in an exposed population (such as cholinesterase, radiation, blood-lead levels) may also be identified as a health outcome for medical evaluations and medical surveillance of specifically exposed populations. (Adapted from Public Health and Preventive Medicine.)

Health risk assessment

Health risk assessment is both a process and a professional discipline.

- a.* The health risk assessment process is used to estimate risks by synthesizing available information to identify health hazards; the probability or likelihood of exposure; the magnitude and timing of exposure; the specific kinds of injury, illness, or other effects caused by exposure; the severity of effects; and the probability or likelihood that exposure will result in predicted effects.
- b.* As a PH discipline, health risk assessment is a multidisciplinary field of practice that is focused around the methods used to evaluate exposure to hazards, predict health risks and outcomes, and inform decision making to control or otherwise respond to unacceptable exposures to health hazards.

Health risk communication

See “risk communication” and “public health communication.”

Health surveillance

The overarching term that describes all aspects and types of surveillance related to human and animal health. Health surveillance is made up of sub-elements, including medical surveillance, which examine health outcomes (such as disease and injury) based on diagnoses recorded in healthcare IM/IT systems, and OEH surveillance, which focuses

on exposures (not outcomes), such as those described through analyses of air, water, and other media. Health surveillance is the regular or repeated collection, analysis, and interpretation of health-related data and the dissemination of information to monitor the health of a population and to identify potential health risks, thereby enabling timely interventions to prevent, treat, reduce, or control disease and injury. It includes OEH surveillance and medical surveillance (see DODD 6490.02E).

Health threat

A composite of ongoing or potential enemy actions; adverse environmental, occupational, and geographic and meteorological conditions; endemic diseases; and employment of CBRN weapons (to include weapons of mass destruction) that have the potential to affect the short- or long-term health (including psychological impact) of personnel (see JP 4-02).

Industrial hygiene

The science and art devoted to anticipation, recognition, evaluation, prevention, and control of those environmental factors or stresses, arising in or from the workplace or the community that may cause sickness, impaired health, and well-being, or significant discomfort among workers or among citizens of the community.

Initial entry training

Training presented to new enlistees with no prior military service. It is designed to produce disciplined, motivated, physically fit Soldiers ready to take their place for the Army in the field. This training includes basic combat training, one station unit training, and advanced individual training.

Installation medical authority

The commander or director of the MTF.

Installation public health authority

The installation PH authority is the senior PH professional as designated or recognized by TSG or DHA as the commander, director, or chief of an installation's PH Program. The installation PH authority is responsible for integrating, coordinating, and synchronizing delivery of the Army PH Program for the installation.

Note. Prior to the 2017 National Defense Authorization Act (NDAA), the MTF's Chief of the Preventive Medicine Department, under the medical commander, was responsible for installation preventive medicine services. Veterinary services were administered through the Public Health Command Activity. Changes to the organizational structure of the AMEDD (and MEDCOM) are pending at the time of this AR's publishing based on decisions from the 2017 NDAA, which may remove the function of PH from the MTF and combine the former functions of preventive medicine and veterinary services under a single organization/department.

Installation public health program

The organization or department, under the leadership of the installation PH authority, responsible for providing PH services and support activities for the installation to ensure Army readiness.

Institutional public health

TDA medical and PH organizations that provide PH services to the installation and surrounding military communities.

Ionizing radiation

Charged subatomic particles and ionized atoms with kinetic energies greater than 12.4 electron volts, electromagnetic radiation with photon energies greater than 12.4 electron volts, and all free neutrons and other uncharged subatomic particles (except neutrinos and antineutrinos).

Medical qualification determination

The clinical assessment of whether an individual DA Civilian employee meets the medical and physical qualifications for a position. This is a service delivered to human resources and line management after being requested on an OF 178 (or equivalent) for Title 5 appropriated fund employees, or on a DA 3437 for nonappropriated fund employees.

Medical surveillance

The ongoing, systematic collection, analysis, and interpretation of data derived from instances of medical care or medical evaluation, and the reporting of population-based information for characterizing and countering threats to a population's health, well-being, and performance (see DODD 6490.02E). See also "health surveillance."

Medical treatment facility

As used in this regulation, an MTF is a DA Civilian or uniformed services medical center, hospital, clinic, or other facility that is authorized to provide medical care.

Military working animals

Animals that are owned by DOD, have a specific military mission, and are considered active duty Servicemembers for the purposes of medical care and support. They include, but are not limited to, military working dogs, military working equids, and marine mammals.

Monitoring

Tracking program or function process execution and outputs.

Nonionizing radiation

Electromagnetic radiation with photon energies less than 12.4 electron volts.

Occupational and environmental health site assessment

Documents the OEH conditions found at a site (for example, base camp, bivouac site or outpost, or other permanent or semi-permanent basing location) beginning at or near the time it is first occupied. The assessment, done by Service environmental health personnel, includes site history; environmental health survey results for air, water, soil, and noise; entomological surveys; occupational and industrial hygiene surveys; and ionizing and nonionizing radiation hazard surveys, if indicated. Its purpose is to identify hazardous exposure agents with complete or potentially complete exposure pathways that may affect the health of deployed personnel (see DODI 6490.03).

Occupational and environmental health surveillance

The regular or repeated collection, analysis, archiving, interpretation, and dissemination of OEH-related data for monitoring the health of, or potential health hazard impact on, a population and individual personnel, and for intervening in a timely manner to prevent, treat, or control the occurrence of disease or injury when determined necessary (see DODD 6490.02E). See also “health surveillance.”

Occupational and environmental health threat

Any condition or situation that could result in an exposure to Army personnel and military working animals, which could lead to the development of an acute, delayed, or chronic health effect. Occupational and environmental health threats include but are not limited to:

- a.* Accidental or deliberate release of weaponized or nonweaponized TICs/TIMs, physical hazards (such as ionizing and nonionizing radiation, noise, heat, cold, and altitude) and the hazards/residue from the use of CBRNE material.
- b.* Food-, water-, vector-, and arthropod-borne threats, endemic diseases, zoonotic diseases, residues, or agents naturally occurring or resulting from previous activities of U.S. forces or other concerns, such as non-U.S. military forces, local national governments, or local national agricultural, industrial, or commercial activities.
- c.* The TICs/TIMs or hazardous physical agents (such as noise levels, blast overpressure, and ionizing and nonionizing radiation) currently being generated as a byproduct of the activities of U.S. forces or other concerns (including pre-deployment activities), such as non-U.S. military forces, local national governments, or local national agricultural, industrial, or commercial activities.
- d.* Combat and operational stress.
- e.* Nontraditional OEH threats/exposures, such as blast injury and embedded metal fragments; these threats may not be managed through traditional risk management activities, but Soldier exposures must be recorded, monitored, reported, and managed.

Occupational health

Promotes maintenance of the highest degree of physical and mental health and well-being of employees by monitoring employee health, and identifying and eliminating or mitigating workplace hazards. Occupational health supports human resources and line management when making employment decisions to hire, retain, terminate, or accommodate civilian employees. Occupational health involves the integrated application of many different disciplines including industrial hygiene, ergonomics, physical therapy, laboratory science, policy development and implementation, epidemiology, statistics, engineering, education, psychology, computer science, nursing, and medicine.

Occupational medicine

A medical specialty aligned with environmental medicine and aviation medicine under the umbrella of preventive medicine. Occupational medicine focuses on the prevention of work-related injuries and illnesses in employees and groups of employees, and provides medical advisory support to human resource personnel and line managers who make civilian employment decisions regarding hiring, retention, termination, and accommodation. Diagnosis and treatment may, but does not necessarily, occur as part of occupational medicine practice. Occupational medicine practitioners work closely with disciplines that monitor and analyze potential work-related hazards, to include industrial hygiene, laboratory science, ergonomics, and safety.

One Health

One Health is the integrative effort of multiple disciplines working locally, nationally, and globally to attain optimal health for people, animals, and the environment. One Health recognizes that the health of people is connected to the health of animals and the environment (see the Centers for Disease Control and Prevention website at <https://www.cdc.gov/onehealth/>). This is a government effort led by the Centers for Disease Control and Prevention.

Operational public health

The application of PH practices and conduct of PH-related activities within a geographic area where military operations are conducted by TOE units. Examples of military operations include training and exercises conducted in field environments or locations outside of a permanent U.S. military installation, humanitarian support, contingency operations, and combat or stability operations. (See the definitions for “operation” and “operational area” in the DOD Dictionary of Military and Associated Terms.)

Oversight

The process whereby the overseeing agency has the authority to “stop work” within an overseen agency to ensure that program or function process execution, outputs, and outcomes are within policies and standards.

Performance Triad

An evidence-based PH initiative with focus on the key foundations of wellness (sleep, physical activity, and nutrition). The Performance Triad utilizes coaching, mentoring, messaging, education, and collaborative partnerships across installations to improve and maintain the readiness, resilience, and health of the Total Army. For additional information, see <https://p3.amedd.army.mil>.

Personal readiness

An individual’s physical, psychological, social, spiritual, and family preparedness to achieve and sustain optimal performance in environments of uncertainty and persistent danger.

Pharmaceuticals

Pertaining to pharmacy or medicinal drugs.

Preventive medicine

A medical specialty within the field of PH that focuses on the health of individuals, communities, and defined populations with inherent goals of protecting, promoting, and maintaining health and well-being by preventing disease, injury, disability, and premature death. The purview of preventive medicine as a clinical practice encompasses primary, secondary, and tertiary prevention. Preventive medicine practitioners work closely with medical epidemiologists, statisticians, laboratory scientists, and other PH-related disciplines.

Principles of population medicine

A systematic approach to healthcare delivery for a beneficiary population. Such an approach includes self-care; community-based PH healthcare activities; and medical interventions to render primary, secondary, and tertiary comprehensive care, taking into consideration the determinants of health.

Program element

A component of a program. PH program elements are functional groupings of actions, processes, and services that are executed to achieve one or more program objectives.

Program evaluation

Systematic method for collecting, analyzing, and using information to answer questions about projects, policies, and programs particularly about their effectiveness and efficiency with a goal of improving performance.

Public health

The science and practice of promoting, protecting, improving, and, when necessary, restoring the health of individuals, specified groups, or the entire population (adapted from A Dictionary of Public Health). PH encompasses a wide range of capabilities, organizations, and professional disciplines operating in a systematic manner to effectively execute the 10 Essential PH Services.

Public health communication

Health communication is the scientific development, strategic dissemination, and critical evaluation of relevant, accurate, accessible, and understandable health information communicated to and from intended audiences to advance the health of the public (see American Journal of Public Health, Volume 94, 2004). PH communication may provide risk-based information or health education.

Public health emergency

According to DODI 6200.03, a PH emergency is an occurrence or imminent threat of an illness or health condition that may—

- a. Be caused by biological incident, manmade or naturally occurring; the appearance of a novel, previously controlled, or eradicated infectious agent or biological toxin; natural disaster; chemical attack or accidental release; radiological or nuclear attack or accident; high-yield explosive detonation, and/or zoonotic disease.
- b. Pose a high probability of a significant number of deaths in the affected population considering the severity and probability of the event; a significant number of serious or long-term disabilities in the affected population considering the severity and probability of the event; widespread exposure to an infectious or toxic agent, including those of zoonotic origin, that poses a significant risk of substantial future harm to a large number of people in the affected population; and/or healthcare needs that exceed available resources.
- c. Require notification to the World Health Organization as a potential PH Emergency of International Concern.

Public health enterprise

The set of command and technical staff relationships, both vertical and horizontal, throughout the U.S. Army, functioning as a unified Army PH team, implementing a cohesive, standardized approach to Army PH planning, resourcing, and asset distribution. See also “enterprise” and “enterprise governance process.”

Public health enterprise governance

The set of command and technical staff relationships, both vertical and horizontal; standardization of best practices; management controls; oversight and monitoring functions providing accountability; and quality improvement. See also “enterprise governance process” and “public health enterprise.”

Public health laboratory

PH laboratories analyze a range of food, environmental, entomological, and industrial hygiene samples for a variety of chemical and radiological contaminants as well as infectious diseases. These laboratories provide services that may be unavailable or are cost-prohibitive elsewhere. PH laboratories collaborate closely with national and local laboratories in the U.S. and in foreign countries to prevent and control health threats. (Adapted from the Association of Public Health Laboratories, available at <https://www.aphl.org/>; accessed 13 October 2017.)

Public Health Response Teams

Teams consisting of subject matter experts who are sufficiently trained and prepared to provide the appropriate level of response on order of TSG/MEDCOM, at the request of legitimate civil, federal, or defense authorities. These teams provide short-duration medical augmentation to regional domestic, federal, and DOD agencies responding to disaster, civil-military, humanitarian, and emergency incidents.

Public Health Review Board

The PHRB is an APHC chartered committee whose purpose is to assist, when requested, in distinguishing PH practice activities from research involving human subjects, ensuring appropriate disposition and oversight of all human-use activities, and promoting proper handling of PHI and PII in both PH practice and research.

Quality management

The use of systematic methods to monitor, assess, and improve the quality and efficiency of Enterprise processes and systems. These include, but are not limited to, quality assurance and quality control efforts.

Regional health authority

The authority designated as having responsibility to administer or oversee all medical activities (to include PH) at MTFs, installations, and facilities within their AOR. Examples prior to the 2017 NDAA include Regional Health Commands and Regional Public Health Commands.

Responsibility

The liability to be required to give account, as of one’s actions or the discharge of a duty or trust. The accountable agent defines responsibilities, which can be shared or delegated.

Risk communication

An interactive process to exchange information and opinion to facilitate informed decisions about real or perceived health threats. Risk communication is a subset of PH communication and is accomplished through building and maintaining relationships based on mutual trust and credibility.

Risk management

The process of identifying, assessing, and controlling risks arising from operational factors and making decisions that balance risk cost with mission benefits.

Senior commander

An officer designated on orders from HQDA as the senior commander of an installation. Normally the senior general officer at the installation. The senior commander's mission is the care of Soldiers, Families, and DA Civilians and to enable unit readiness. While the delegation of senior command authority is direct from HQDA, the senior commander will routinely resolve installation issues with IMCOM and, as needed, the associated ACOM, ASCC, or DRU.

Toxic industrial materials

A generic term for toxic, chemical, biological, or radioactive substances in solid, liquid, aerosolized, or gaseous form that may be used, or stored for use, for industrial, commercial, medical, military, or domestic purposes. Also called TIM. TIMs include:

a. Toxic industrial biological. Any biological material manufactured, used, transported, or stored by industrial, medical, or commercial processes that could pose an infectious or toxic threat. Also called TIB.

b. Toxic industrial chemical. A chemical developed or manufactured for use in industrial operations or research by industry, government, or academia that poses a hazard. Also called TIC.

c. Toxic industrial radiological. Any radiological material manufactured, used, transported, or stored by industrial, medical, or commercial processes. Also called TIR.

Veterinary food protection surveillance

The regular or repeated collection, analysis, archiving, interpretation, and dissemination of food protection data from veterinary food safety and food defense activities for monitoring the health of, or potential hazard impact on, the Joint force, their authorized beneficiaries, and DOD Civilians and to identify potential health risks enabling timely interventions to prevent, reduce, or control the occurrence of disease as part of comprehensive, Joint force health protection.

Weapons of mass destruction

In arms control usage, weapons that are capable of a high order of destruction and/or of being used in such a manner as to destroy large numbers of people. Can be nuclear, chemical, biological, or radiological weapons but excludes the means of transporting or propelling the weapon where such means is a separable and divisible part of the weapon.

UNCLASSIFIED

PIN 000500-000