PREVENTIVE MEDICINE AND POPULATION HEALTH

COMDTINST 6000.7
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United States Coast Guard

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COMMANDANT INSTRUCTION 6000.7

Subj: PREVENTIVE MEDICINE AND POPULATION HEALTH

Ref: (a) Public Health Emergency Management in the Department of Defense (DoD), DoD Instruction 6200.03
(b) Coast Guard Human Immunodeficiency Virus (HIV) Program, COMDTINST M6230.9 (series)
(c) U.S. Coast Guard Competency Management System Manual, COMDTINST M5300.2 (series)
(d) Immunizations and Chemoprophylaxis for the Prevention of Infectious Diseases, COMDTINST M6230.4 (series)
(e) Coast Guard Anthrax Vaccine Immunization Program (AVIP), COMDTINST 6230.3 (series)
(f) Coast Guard Occupational Medicine Manual, COMDTINST M6260.32
(g) Coast Guard Smallpox Vaccine Program (SVP), COMDTINST 6230.10 (series)
(h) Comprehensive Contraceptive Counseling and Access to the Full Range of Methods of Contraception, Defense Health Agency Procedural Instruction 6200.02

1. PURPOSE. This Instruction promulgates policy regarding the practice of Preventive Medicine and Population Health in the Coast Guard. Preventive Medicine is the medical discipline concerned with the prevention of injury and illness, including the prevention of progression of injuries and illnesses that have already occurred. Population Health is the medical discipline concerned with the collection and analysis of health and health care-related data with the intent to implement evidence-based interventions to reduce the burden of disease and injury in a population(s). This Instruction's focus is on the Coast Guard, i.e. Preventive Medicine and Population Health efforts toward Coast Guard military and civilian personnel, as well as dependents and retirees.

2. ACTION. All Coast Guard unit commanders, commanding officers, officers-in-charge, deputy/assistant commandants, and office chiefs of headquarters staff elements must comply with the provisions of this Instruction.

3. AUTHORIZED RELEASE. Internet release is authorized.

4. DIRECTIVES AFFECTED. This is a new Commandant Instruction; the contents were derived from the former Coast Guard Medical Manual.

5. DISCLAIMER. This guidance is not a substitute for applicable legal requirements, nor it itself a rule. It is intended to provide operational guidance of Coast Guard personnel and is not intended to nor does it impose legally binding requirements on any party outside the Coast Guard.

6. MAJOR CHANGES. Before the promulgation of this Instruction, the Coast Guard's Preventive Medicine policy was governed by Chapter 7 of COMDTINST M 6000.1F. This Instruction incorporates the previous policy with the following changes:

   a. expansion of the role of the Public Health Emergency Officer and alternates;

   b. institution of the requirement for a Coast Guard Surveillance Testing Program;

   c. expansion of the role of contact tracing particularly with regard to pandemic phases; institution of the Trainee Health Program;

   d. formalization of the Population Health Optimization Working Group; and

   e. institution of the requirement to analyze medical and health-related data to assess the health and injury/illness trends of Coast Guard personnel across the spectrum of health care encounters and fitness for duty determinations using epidemiologic methods and Health Information Technology, with the goal of maximizing the health and duty availability of Coast Guard personnel.

7. ENVIRONMENTAL ASPECT AND IMPACT CONSIDERATIONS. The Office of Environmental Management, Commandant (CG-47) reviewed this Commandant Instruction and the general policies contained within, and determined that this policy falls under the Department of Homeland Security (DHS) categorical exclusion A3. This Commandant Instruction will not result in any substantial change to existing environmental conditions or violation of any applicable federal, state, or local laws relating to the protection of the environment. It is the responsibility of the action proponent to evaluate all future specific actions resulting from this policy for compliance with the National Environmental Policy Act (NEPA), other applicable environmental requirements, and the U.S. Coast Guard Environmental Planning Policy, COMDTINST 5090.1 (series).

8. DISTRIBUTION. No paper distribution will be made of this Instruction. An electronic version will be located Coast Guard Directives System Library internally, and if applicable on the Internet at www.dcms.uscg.mil/directives .

9. RECORDS MANAGEMENT CONSIDERATIONS. Records created as a result of this Instruction, regardless of format or media, must be managed in accordance with the records retention schedules located on the Records Resource Center SharePoint Online site: https://uscg.sharepoint-mil.us/sites/cg61/CG611/SitePages/Home.aspx.

10. FORMS/REPORTS. The forms referenced in this Instruction are available on the Coast

Guard Standard Workstation or on the Internet: www.dcms.uscg.mil/Our-Organization/Assistant- Commandant-for-C4IT-CG- 6/The-Office-of-Information-Management-CG- 61/Forms- Management/ .

11. SECTION 508. This Instruction adheres to Accessibility Guidelines and Standards as promulgated by the U.S. Access Board. If changes are needed, please communicate with the Coast Guard Section 508 Program Management Office at: Section.508@uscg.mil .

12. REQUESTS FOR CHANGES. Units and individuals may recommend changes via the chain of command to: HQS-DG-lst-CG-112@uscg.mil .

/DANA L. THOMAS/
Rear Admiral, U.S. Coast Guard
Director, Health, Safety, and Work-Life

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PREVENTIVE MEDICINE AND POPULATION HEALTH

CHAPTER 1. GENERAL

CHAPTER 2. COMMUNICABLE DISEASE CONTROL

CHAPTER 3. IMMUNIZATIONS AND ALLERGY IMMUNOTHERAPY (AIT)

CHAPTER 4. MONITORING OF POPULATION HEALTH

CHAPTER 1. GENERAL

A. Scope. The scope of preventive medicine involves all activities that prevent or mitigate illness, disease, and injury, including immunizations, communicable disease control, epidemiologic monitoring of acute and chronic conditions, population health, and clinical preventive services, including screening and testing for asymptomatic or presymptomatic conditions.

B. Responsibilities.

1. Unit Medical Officer. The Unit Medical Officer (MO) is responsible to the Commanding Officer/Officer-In-Charge (CO/OIC) for implementing all directives issued by the Commandant, which relate to the health of members of the command. The unit MO shall:

   a. Evaluate the command's health care capabilities to fulfill Periodic Health Assessment (PHA) and Occupational Medical Surveillance and Evaluation Program (OMSEP) requirements.

   b. Develop and supervise an environmental health and safety program to prevent disease and injury and to maintain the Commandant's established sanitation standards.

   c. Monitor the incidence of disease, injury, and disability (including duty availability) in personnel and where indicated in adjacent communities, such as during declared or threatened public health emergencies (PHEs), pandemics, and epidemics.

   d. Use epidemiological methods to determine the cause(s) of disease, injury, and disability; monitor incidence levels; and track severity or an impact on unit medical readiness.

   e. Consult with Commandant (CG-1121) regarding known or suspected outbreaks of communicable disease and other unit or community public health or environmental health issues.

2. Preventive Medicine Technicians (PMT's). PMT's are individuals who have been trained to conduct contact tracing and other communicable disease control activities. If assigned or available to a unit, PMTs are responsible for contact tracing and other communicable disease control activities. . Advice on duties that utilize the specific training of PMTs can be obtained from Commandant (CG-1121).

3. Senior Medical Officers, PSC-PSD-med and CGRC. Under the policy leadership of COMDT (CG-11) and technical direction of HSWL SC, the Senior Medical Officers (or their designees) assigned to the Medical Branch, Personnel Services Division, Personnel Service Center and Coast Guard Recruiting Command shall support COMDT (CG-11) in developing requirements for Health Information Technology (HIT) systems that allow for the tracking and epidemiologic analysis of all accession and retention waivers, Medical Evaluation Boards, and Physical Evaluation Boards. These officers, or their designees, shall report such data to the Population Health Optimization Work Group (PHOWG) on at least an annual basis.

4. The Chief of Preventive Medicine and Population Health (CPM). Commandant (CG-1121) shall provide policy recommendations and other consultation as needed to Commandant (CG-11), the Health, Safety, and Work-Life Service Center (HSWL SC), Regional Practices (RPs), and individual health care providers.

   a. The CPM must develop evidence-informed policies for the prevention and control of diseases of public health importance and will maintain liaison with federal/military and State/Local/Tribal/Territorial (SLTT) public health authorities to coordinate appropriate response to public health threats.

   b. The CPM will also serve as the primary designated Public Health Emergency Officer (PHEO) for the Coast Guard.

      (1) All headquarters and HSWL SC medical personnel who qualify for training as PHEOs, as defined by Ref (b), shall attend the Public Health Emergency Management (PHEM) course, offered by the Defense Medical Readiness Training Institute, and will be designated as alternate or regional PHEOs by Commandant (CG-11).

      (2) During a declared PHE, the CPM may assign alternate PHEOs , in consultation with their normal supervisor.

      (3) When notifying Commandant (CG-11) of an outbreak, pandemic, epidemic, and/or PHE, the CPM has Direct Liaison Authority (DIRLAUTH) with Commandant (CG-11), but shall copy his/her chain of command. This DIRLAUTH shall continue for the duration of than outbreak, pandemic, epidemic, and/or PHE

      (4) The CPM shall serve as the Senior Medical Advisor to any Crisis Action Team (CAT) that is activated in response to a PHE and may, at the discretion of the Deputy Commandant of Mission Support (DCMS), serve as the DCMS CAT Director.

   c. The CPM will coordinate internally with the Senior Disaster Epidemiologist, Chief of Force Health Protection, Chief of Occupational Medicine, and the

Chief Medical Informatics Officer regarding population health, epidemiologic, and data collection/analysis matters.

d. The CPM may, as directed/delegated by Commandant (CG-11), implement Commandant (CG-11)'s Technical Authority with regard to any Coast Guard unit consultation related to known or suspected outbreaks of communicable disease. Units shall not promulgate public health guidance except under the supervision of Commandant (CG-11).

e. The CPM shall generally serve as the Chair of the Population Health Optimization Working Group (PHOWG), unless otherwise directed by COMDT (CG-11). In all cases, the CPM must be a voting member and must be the primary epidemiologic consultant to the PHOWG.

CHAPTER 2 COMMUNICABLE DISEASE CONTROL

A. General. The Disease Reporting System-Internet (DRSi) representative is responsible for complying with Federal, SLTT, and military communicable disease reporting requirements. The DRSi representative is recommended to be an officer but may be E-4 through E-7. In order to have an effective communicable disease control program, DRSi representatives must:

1. Recognize communicable diseases according to the current Armed Forces Reportable Medical Events Guidelines and Case Definitions, issued periodically by the Armed Forces Health Surveillance Division of the Defense Health Agency. These documents can be found at: https://www.med.navy.mil/Portals/62/Documents/NMFA/NMCPHC/root/Documents/program-and-policy-support/Armed-Forces-Reportable-Medical-Events- DOD-VERSION.pdf

2. Each clinic and sickbay shall have at least one designated staff member and one alternate responsible for submitting medical event reports (MERs).

3. Notify COs/OICs about Reportable Medical Events (RMEs) and recommend appropriate preventive and control measures.

4. Submit required federal/military/SLTT reports. In rare cases, OPSEC requirements may prevent immediate notification of non-military authorities.

B. Disease Outbreak.

1. Definition. An outbreak (or epidemic) is an increase in the incidence of a communicable disease over and above what is historically or seasonally expected in a given population. For the purposes of military health, there need not be a large number of cases or a high severity of illness to consider an increase in incidence to be an outbreak as long as unit medical readiness is threatened or impacted. Similarly, it is not always advisable to wait until cases are confirmed or probable (using the case definitions cited in Figure 1 below) to begin taking disease control measures. For some diseases such as Category A Bioterrorism Agents/Diseases (https://emergency.cdc.gov/agent/agentlist-category.asp Preparedness & Response), a single case is considered to be an outbreak. For all known or suspected outbreaks, consult the CPM at Commandant (CG-1121).

2. The designated DRSi representative shall:

   a. Recognize outbreaks and establish a case definition, in consultation with CPM at Commandant (CG-1121).

   b. Investigate the source of the agent and how it is spread.

   c. Recommend to the CO/OIC appropriate initial prevention and control measures.

d. Complete an MER using the DRSi or current MER reporting system. The Armed Forces Reportable Medical Events Guidelines and Case Definitions documents provide detailed definitions of military RMEs.

e. Follow communicable disease policy guidance disseminated by Commandant (CG- 11) in the event of a bioterrorist threat or a natural or man-made communicable disease threat.

C. Medical Event Reporting.

1. Circumstances requiring reports.

a. Any outbreak;

b. Any person diagnosed with any disease listed in the Armed Forces Reportable Medical Events Guidelines and Case Definitions at https://www.med.navy.mil/Portals/62/Documents/NMFA/NMCPHC/root/Documents/program-and-policy-support/Armed-Forces-Reportable-Medical- Events-DOD-VERSION.pdf These documents describe at what diagnostic stage (possible, suspected, probable, confirmed, etc.) reporting shall be initiated.

c. Any epizootic (e.g. animal epidemic) potentially transmissible from animals to humans (e.g. avian influenza viruses, swine influenza/variant influenza viruses);

d. Any vector borne disease potentially transmissible from insects (e.g. ticks, mosquitos) to humans.

e. Any Coast Guard asset (vessel or aircraft) that is quarantined at a foreign port;

f. Any medical condition deemed worthy of reporting by DRSi representative; or

g. Any RME as mandated by a cognizant SLTT health department.

2. Reporting Process. DRSi representative must use the DRSi for all MERs.

a. The DRSi can be accessed https://data.nmcphc.med.navy.mil/ndrsi/

b. For any critical conditions listed in Figure 1 below, health services personnel must directly contact the CPM (by phone, email, text message, or instant message) at Commandant (CG-1121) within 24 hours. Do not wait until laboratory confirmation to initiate contact with the CPM; even suspected cases of these diseases must be reported within 24 hours. The CPM at Commandant (CG-1121) must review the information in DRSi and must contact the RP/clinic/sickbay for all critical conditions.

c. For all other conditions listed in the Armed Forces Reportable Medical Events Guidelines and Case Definitions, DRSi reporting shall be initiated, by the DRSi representative, within seven duty days of confirmed or probable diagnosis; direct contact with the CPM is not required.

d. The CPM must review all MERs on a weekly basis for medical trends and outbreaks.

Figure 1

Medical Event Reporting Chart within 24 Hours

PHONE COMMANDANT (CG-1121) WITHIN 24 HOURS & COMPLETE A MEDICAL EVENT REPORT IN DRSI[1]

Animal Bites	**Diphtheria**	**Influenza Associated Hospitalization**	
Anthrax	***E. coli* O157:H7**	**Malaria**	**Smallpox**
Botulism	**Encephalitis**	**Measles**	**Syphilis**
Brucellosis	**Foodborne Outbreak**	**Meningococcal Disease**	**Tuberculosis**
Carbon Monoxide Poisoning	***Haemophilus influenzae type B (invasive disease)***	**Pertussis**	**Tularemia**
Chemical Agent Exposure	**Hantavirus Infection**	**Plague**	**Yellow Fever**
Cholera	**Heat Illness**	**Poliomyelitis**	**Any Disease Cluster or Outbreak**
Cold Weather Injuries[2]	**Hemorrhagic Fever**	**Q Fever**	
	Hemolytic Uremic Syndrome (HUS)	**Rabies**	

Potential agent of Bioterrorism

1 - HIV, AIDS, Suicide and Occupational Illness / Injury are reported through other mechanisms
2 - Frostbite, Immersion Foot, Hypothermia, or other cold injury resulting in a limited duty status.

D. Sexually Transmitted Infection (STI) Program.

1. Background. STIs, including syphilis, gonorrhea, chlamydia, and the human immunodeficiency virus (HIV), are important and preventable causes of morbidity, mortality, and associated lost productivity and increased health care costs.

2. Duties of the Coast Guard Clinic or Sick Bay. The unit clinic or sick bay must provide a coordinated, comprehensive STI control program including:

   a. Education and prevention counseling of those at risk.

   b. Detection of asymptomatically infected individuals.

   c. Effective diagnosis and treatment of infected individuals.

   d. Partner Services (PS).

   e. Immunization of persons at risk for vaccine-preventable STIs.

   f. Proper annotation and maintenance of health records.

   g. Protection of confidentiality.

3. Senior Medical Officer (SMO). The SMO (the senior physician in a clinic) oversees the medical management of the local STI control program; recommends STI control activities to COs/OICs; establishes and maintains liaison with SLTT health authorities; and ensures confidentiality of the patient and his/her sexual partner(s).

4. Medical Officer (MO). The MO who initially evaluates the patient shall perform an appropriate diagnostic evaluation based on current CDC guidelines. The MO must fill out Syphilis Record, Standard Form 602 (or electronic equivalent), on all patients diagnosed with syphilis and file it in the patient's medical record. All military patients presenting for evaluation of a possible STI must be tested for serological evidence of syphilis and HIV infection and must be tested for other STIs as well. Additionally, all active duty and reserve members must be tested for HIV every 24 months. Reservists are required to have a current HIV test within 2 years of the date called to active duty if the orders are for 30 days or more. Refer to Ref (c) for more details on the Coast Guard's HIV program.

5. MOs must treat STIs according to the most current recommendations of the CDC.

6. Health Services Technician (HS) or Preventive Medicine Technician (PMT). An HS or PMT assigned to administer the local STI control program must be paygrade E-5 or higher. They must perform the following actions:

a. Perform Partner Services (PS): PS, part of contact tracing for STI, is a set of activities intended to alert people exposed to STIs and facilitate appropriate counseling, testing, and treatment. Individuals with HS or comparable training must lead the PS. PMTs may be involved in both PS and contact tracing.

b. Information about named partners who are not active duty Coast Guard members shall be passed by PMT or HS (as previously described in this section) to the cognizant SLTT public health function for partner notification. Valuable PS and STI resources are available on the internet from the Navy and Marine Corps Public Health Center's Sexual Health and Responsibility Program (SHARP) at: https://www.med.navy.mil/Navy-Marine-Corps-Public- Health-Center/Population-Health/Health-Promotion-and- Wellness/Reproductive-and-Sexual-Health/Sexual-Health-and-Responsibility- Program-SHARP/. Additional resources on PS are available from CDC at STD Program Partner Services | STDs | CDC .

c. Annotate and sign the Chronological Record of Care, Standard Form 600 (or electronic equivalent), in each patient's medical record to indicate that the MO/HS/PMT interviewed the patient, discussed symptoms, complications, treatment, and the importance of partner notification(s).

7. Consider Test of Cure (TOC) if regimen adherence is suspect, if symptoms continue, or if reinfection is suspected. TOC is no longer routinely indicated for cases of gonorrhea and chlamydia where a CDC-recommended or CDC-alternative treatment regimen is completed. See https://www.cdc.gov/std/treatment-guidelines/default.htm for comprehensive STI treatment recommendations.

a. Active duty personnel must report to regular sick call for TOC. Place a suspense notice to check with the attending MO to ensure the patient receives TOC.

b. Exception: any person with pharyngeal gonorrhea who is treated with an alternative regimen must return 14 days after treatment for a TOC using either culture or Nucleic Acid Amplification Test (NAAT). If the NAAT is positive, effort must be made to perform a confirmatory culture before retreatment. All positive cultures for TOC must undergo antimicrobial susceptibility testing.

c. Cross-reference all positive STI cases from the clinic laboratory log to ensure all STI patients have been contacted and interviewed. This shall be performed on the first duty day of each week.

d. Ensure security and confidentiality of all STI forms, reports, and logs.

e. Complete timely reporting. HIV/AIDS reporting must be consistent with Ref (c).

f. Syphilis, gonorrhea, chlamydia, and acute cases of hepatitis are reportable events in every state and the Coast Guard. The requirements for reporting other STIs differ by State. The National Coalition of STI Directors website: http://www.ncsddc.org/who-we-are has links to State- specific STI reporting requirements.

E. STI Treatment. MOs must treat STIs according to the most current recommendations of the CDC.

F. STI Pre-Exposure Prophylaxis. Pharmaceutical Pre-Exposure prophylaxis for STI prevention is prohibited except in the case of HIV. HIV Pre-exposure prophylaxis (PrEP), if initiated for persons meeting high-risk criteria, must follow Defense Health Agency guidelines available at: https://www.health.mil/-/media/Files/MHS/Policy-Files/DHAPI-602529--Guidance- for-the-Provision-of-HIV-PrEP-Signed-122020.ashx

G. STI Immunizations. MOs must review the immunization status of all patients presenting with a possible STI. All military personnel must receive Hepatitis A and Hepatitis B vaccines (unless vaccine series is complete). Other beneficiaries who seek evaluation for a possible STI must receive Hepatitis A and Hepatitis B vaccines if indicated (based on current CDC guidelines). Human papillomavirus (HPV) vaccination may be recommended based on age consistent with CDC recommendations available at https://www.cdc.gov/mmwr/volumes/68/wr/mm6832a3.htm.

H. STI Reporting.

1. DoD/ Coast Guard health care beneficiaries (TRICARE). Exposure information of DoD/ Coast Guard health care beneficiary partners must be reported via the DRSi as well as to any cognizant SLTT health authority using an agency-specific form and process or using CDC Form 73.2936S – Field Record. Forms are available from the CDC at https://www.cdc.gov/std/Program/forms/InterviewRecordInstructions03-07-08.pdf

   (Local protocol will dictate which specific STIs need to be reported to the State, but all conditions in the Armed Forces Reportable Medical Events Guidelines and Case Definitions must be reported via the DRSi)

2. Non-DoD/ Coast Guard health care beneficiaries (NON-TRICARE). Exposure information of non-DoD/Coast Guard health care beneficiary partners must be reported to the cognizant SLTT public health authority. Health services personnel must follow local guidance for local reporting of partners. This may entail locally designated forms and procedures. For partners located outside the local area, partner identification information may be sent to the State public health authority (who will forward the report to the cognizant State or local health authority) using a State-specific form and process or using CDC Form 73.2936S – Field Record (see

paragraph (1) above). Health services personnel shall not expect confirmation of receipt or a disposition report. If a disposition report is desired, the health services personnel must state this on the Field Record, and provide a statement of justification and return address/phone number.

I. Contact Tracing.

1. Background: Contact tracing is used to contain and mitigate diseases of pandemic potential, such as COVID-19, as well as other communicable diseases with the potential for epidemic spread, such as measles. Following the identification of an individual who has a positive diagnostic test for diseases of pandemic potential or other communicable diseases, contact tracing identifies, monitors, and supports close contacts who may have been exposed or infected. Close contacts are notified of their potential exposure, quarantined, tested, monitored for symptoms, and informed about available support resources. The intent of contact tracing is to limit impacts to personnel and operations by limiting the spread of disease during a pandemic or communicable disease outbreak.

2. Definitions.

   a. Contact Tracer (CT): an individual assigned to conduct case and close contact interviews.

   b. Contact Tracing Administrator (CTA): contact tracing team leader. CTAs may be military members E7 or above, or contractors. In smaller units (i.e. units with an OIC), a CTA may be an E5 or above.

   c. Contact Tracing Mentor (CTM): MO assigned to provide oversight and assistance to a contact tracing team.

3. Scope. The Coast Guard contact tracing program is limited to cases and contacts directly connected with the Coast Guard. Only cases from the following groups may be traced by Coast Guard contact tracers:

   a. Active Duty Military and Civilian employees, including NAF employees.

   b. Reserve Military members who are working in Coast Guard workspaces on Active Duty orders, or drilling.

   c. Any individual residing in Coast Guard housing.

   d. Auxiliarists or contractors working in Coast Guard workspaces.

4. Operation of contact tracing during pandemic phases.

a. Interpandemic/interevent period: Units shall identify PMTs or other staff who will serve as Contract Tracers, CTA, and CTM. Identified staff shall obtain appropriate training and access to CGECTA, the Coast Guard's repository for all contact tracing information. Units shall annually exercise the contact tracing program, to test and validate plans, policies, procedures and capabilities.

b. Threatened or early pandemic/event period: units and HSWL SC shall consult with COMDT (CG- 1121) about identification of outbreaks (as per Chapter 2B) and need to institute widespread contact tracing. Identification of additional personnel needed to serve as surge staffing in defined contact tracing roles shall occur in coordination with HSWL SC.

c. Intrapandemic/intraevent period: Units shall conduct ongoing identification and training of surge staff to conduct contact tracing, as well as periodic consultation with COMDT (CG-1121) regarding program management and direction, and communication with HSWL SC regarding staffing and training needs. Unit responsible personnel (CTA and CT) shall maintain and update contact tracing records in CGECTA.

5. Roles and Responsibilities.

a. Office of Health Services, COMDT (CG-1121): Manages the Coast Guard contact tracing program and ensures that the requirement for access to contact tracing-related HIT systems such as the Coast Guard Electronic Contact Tracing Application (CGECTA) is maintained.

b. HSWL SC: identify and assign CTMs, oversee contact tracing teams, monitor ContactTracing@uscg.mil inbox, and assign new cases to the appropriate contact tracing team.

c. COs/OICs: During the interpandemic/interevent period, ensure at least one non-medical service member maintains the CTA competency code and maintains access to CGECTA. During a pandemic or other communicable disease PHE, the recommended CT Team composition per unit sizes are: Units >500 people - a minimum of 10 CTs and two CTAs; Units <100 people - a minimum of 2 CTs. Appoint a second team of CTAs responsible for oversight of multiple contact tracing teams supporting smaller units. Units with contact tracing teams shall inform HSWL SC when establishing or expanding a contact tracing team and ensure compliance with this Instruction and any related Technical Directives from HSWL SC.

d. COs of Cutters: identify and assign a CTA, a CT, or both who will facilitate information sharing about watch sections and schedules to enable rapid contact tracing while in port, and conduct contact tracing of infections while underway. During the interpandemic/interevent period, the CTA/CT may be the medical staff assigned to the cutter, if any.

e. CTAs: Maintain a roster of unit CT Team/s within the assigned area of responsibility (AOR). Connect with CTs frequently to ensure capture of all cases in the electronic data collection system. Notify CTs of any changes in program policy or procedures. Notifies HSWL SC of all issues affecting program implementation and effectiveness.

6. Staffing and Training.

a. HSWLSCTD 2020-12 provides guidance on contact tracing staffing and training requirements.

b. Contact tracing is a public health function but does not need to be conducted by medical personnel. Contact tracing may be conducted by trained staff who possess sufficient communications, administrative, organizational, and data management skills.

c. Contact tracing is a collateral duty. Sources for contact tracing staffing include but are not limited to PMTs, other medical personnel, Reservists, Coast Guard civilians, and active duty personnel.

d. Staffing needs may fluctuate as the size of outbreaks increases and decreases. When demand for contact tracing increases, additional personnel may need to be identified and additional teams established, in coordination with HSWL SC. Individuals who have the CTA/CT competency (listed in Direct Access) already completed, as described below, shall be prioritized for surge staffing.

e. Upon designation as CTA or CT, a member must complete CTA/CT training to receive competency code and designation letter. The CTA/CT competency code is assigned upon completion of training and command designation, per Reference (d).

f. Training verification instructions are provided in the Coast Guard Contact Tracing Guide.

g. All personnel who are active members of a Coast Guard Contact Tracing Team, with a current contact tracing competency code within Direct Access shall have access the current Coast Guard CT HIT system. To add new contact tracers email ContactTracing@uscg.mil. When a member is no longer preforming the contact tracing mission for a particular unit that member shall notify the Contact Tracing Program at email ContactTracing@uscg.mil at which time they must be removed from the Coast Guard CT HIT system, unless they are assigned as a CT for their new unit.

h. Upon receipt of a positive test result, a member or their designee (i.e. supervisor, contact tracer, etc.) shall use the CGECTA application to trigger a contact tracing investigation at: https://dhs.servicenowservices.com/uscg_contacttracing

i. Once a case notification has been made, the CT shall complete the contact tracing interview and enter the case in the Coast Guard CT HIT system, currently CGECTA, at https://dhs.servicenowservices.com/.

7. Resources and References.

a. CGECTA: https://dhs.servicenowservices.com/uscg_contacttracing

b. Text Illness Monitoring System (TIM): https://tim2-cdc.omniengage.net/MicroStudy/ui/login.jsf

c. ContactTracing@uscg.mil: questions about contact tracer access to CGECTA or communication with contact tracing program leadership.

d. U.S. Coast Guard Contact Tracing Guide.

e. Contact Tracing Technical Directive HSWLSCTD 2020-12.

J. Public Health Surveillance Testing Program (STP) for Diseases of Epidemic or Pandemic Potential.

1. Background: Vaccination is the definitive tool to prevent and mitigate the spread of highly contagious infectious diseases. Vaccination also reduces morbidity and mortality. The more members vaccinated, the greater the risk reduction obtained by members in a unit, across the Coast Guard. However, as with influenza, circulating variants change and vaccination rates may never reach sufficient levels to ensure population-wide disease elimination. The Coast Guard, with high- density residential settings such as training dormitories and vessels, and with a need to continue its statutory missions in the face of communicable disease threats, shall remain on guard against undetected outbreaks with other strategies, including the STP.

2. Purpose. The Coast Guard is required to maintain a capability to conduct active and passive disease surveillance. In the Coast Guard, this function is known as the Surveillance Testing Program (STP). The Coast Guard's overarching purpose for the STP is to identify and isolate infected service members, provide needed health care, and mitigate/interrupt transmission of highly communicable diseases that can reduce mission capability. Surveillance testing provides senior Coast Guard leadership a strategic view of current infections and transmission of disease within the Coast Guard workforce and adjacent communities. This view aids operational risk management decision- making while providing mission support to Coast Guard operations.

3. Objectives

a. Maintain personnel readiness via early identification of pre- and asymptomatic disease, reducing infection transmission especially in congregate settings such as TRACENs and the Coast Guard Academy (CGA).

b. Ensure infected personnel are expeditiously isolated to prevent an outbreak, and receive appropriate health care.

c. Maintain Coast Guard operations and mission execution in an environment with known infectious diseases of epidemic potential.

d. Build and expand Coast Guard bio surveillance capabilities to prevent the spread of other emerging infectious diseases (e.g. novel strains of influenza) in order to mitigate the impact on operations.

4. STP Methods.

a. Wastewater Testing (WWT) is an inexpensive and non-invasive alternative to screening large numbers of individuals for asymptomatic infections; a single test can indicate an infected individual in a population providing justification for subsequent targeted screening. It can also inform decision makers as to when all infected individuals have been removed from a population. Onsite confirmatory PCR testing (diagnostic) allows units to quickly follow up and isolate infected individuals, preventing future outbreaks and protecting the Coast Guard. During the COVID-19 pandemic, WWT was been used within the Coast Guard at TRACENs and aboard Cutters. WWT also has the potential to detect other pathogens with epidemic potential, such as influenza A and B. WWT works best when combined with pooled/micropooled testing strategies, as described in Para 2.J.d (2) below.

b. Pooled testing or micro-pooling of samples is another form of PCR testing/screening. For groups with low expected prevalence of infection, pooled sampling increases sampling capabilities by testing up to five (5) individuals at once. A negative pooled test means that no further confirmatory individual PCR tests are needed for persons in that pool. A positive pool requires diagnostic PCR testing of every person in the pool. Additional protocols can be developed for testing co-infections with other pathogens, e.g. Influenza A and B. In the case of COVID-19, implementing pooled surveillance decreased the per test cost by >85%, from $120 to $16 per test.

5. Duties.

a. COMDT (CG-1121) shall provide organizational leadership and technical direction for the STP.

b. Operational Commanders must always consult with their medical advisor or COMDT (CG-1121) for any questions related to testing or the interpretation of results.

c. Medical Personnel must notify their district Senior Medical Executive or Regional Practice Director if and when individual level positive results are identified in follow-up to pooled testing.

d. Surveillance laboratories shall have the following Areas of Responsibility workload may be redistributed, however, as demand changes over time:

(1) USCG Academy Lab: USCGA and units located in District Nine.

(2) TRACEN Cape May Lab: Units located in Districts One, Five, Seven, and Eight.

(3) TRACEN Petaluma Lab: Units located in Districts Eleven, Thirteen, Fourteen, and Seventeen.

(4) TRACEN Yorktown: LANTAREA Cutters.

CHAPTER 3. IMMUNIZATIONS AND ALLERGY IMMUNOTHERAPY (AIT).

A. General.

1. Ref (d) lists general policy, procedures, and responsibilities for immunizations and chemoprophylaxis. Temperatures and vital signs are not required during immunization-only encounters.

B. Unit Responsibilities.

1. Immunizing all individuals. Active duty and reserve unit Commanding Officers are responsible for immunizing all individuals under their purview and maintaining appropriate records of these immunizations in accordance with Reference (d) and subject to the exemptions stated therein. Immunization reconciliation is part of Individual Medical Readiness (IMR), and shall be conducted by HS staff annually as part of the Periodic Health Assessment. If local conditions warrant and pertinent justification supports, the RP may grant authority to deviate from specified immunization procedures on request; consultation by the immunizing HS staff with the district Senior Medical Executive (SME) and/or the CPM at COMDT (CG- 1121) may be required.

2. Unit Commanding Officers. Unit Commanding Officers shall arrange local immunizations for their unit's members. If this is not possible, the Unit CO shall request assistance from the Coast Guard clinic overseeing units in the geographic area. The Reserve Health Readiness Program (RHRP) is an option for obtaining medical readiness-related immunizations for SELRES and TRICARE Prime Remote personnel.

C. Equipment and Certification Requirement.

1. Immunization sites. All immunization sites must have the capability to administer emergency medical care if anaphylaxis or other allergic reactions occur. A designated Coast Guard MO or Pharmacy Officer must certify in writing that the registered nurse or HS selected to administer immunizations is qualified.

D. Immunization Site Responsibilities.

1. In the event an MO cannot be present, a registered nurse or HS3 or above can be certified to administer immunizations to AD and SELRES when the designated Coast Guard MO who oversees their independent activity has trained and certified in writing such registered nurses and HSs to conduct immunizations in an MO's absence.

2. Vaccine Information Statement (VIS). Every health care provider who administers vaccines must provide a VIS if available from the CDC.

3. Vaccines that are Investigational New Drugs (INDs) or available under Emergency Use Authorization (EUA). require documentation of informed consent prior to

administration. The person being vaccinated shall receive any and all documentation intended to fulfill the intent of a VIS if an approved VIS is not yet available.

4. Per the National Childhood Vaccine Injury Act (NCVIA) of 1986, health care providers are required to obtain the signature of the vaccine recipient, parent, or legal guardian acknowledging receipt of the VIS.

    a. In the rare event of an immediate anaphylactic reaction following vaccination, an emergency equipped vehicle must be readily available to transport patients to a nearby (within 10 minutes) health care facility staffed with an Advanced Cardiac Life Support (ACLS) or Advanced Life Support (ALS) - certified provider or an EMS with ACLS/ALS capability must be within a 10-minute response time of the site.

5. Review and document immunizations. All immunizations must be entered in the current medical readiness database (e.g. MRRS) and documented in the Electronic Health Record. Medical Officer co-signature for routine immunizations (as specified in Ref d) of Active Duty and SELRES is not required.

    a. Clinic personnel and IDHS must be cognizant of the use of the approved/proper medical and administrative exemption codes in the medical readiness database. These codes can be found in Appendix C to Ref (d).

    b. Commandant (CG-1121) shall review all medical permanent codes on an annual basis; clinics are required to provide updated medical information to support or end a permanent medical exemption, as indicated. Medical temporary codes and administrative temporary codes must be reviewed and verified by the HSA every 365 days and 90 days, respectively.

    c. The Senior Health Services Officer (SHSO) must ensure all health care personnel receive appropriate training regarding the following: use of exemption codes, verifying accuracy of exemption codes of members in their clinic's medical AOR, and following up on temporary and permanent medical exemptions.

6. Immunization Training. Additional immunization training opportunities are offered by the Immunization Health care Branch (IHB) of the Defense Health Agency. See https://health.mil/Military-Health-Topics/Health-Readiness/Immunization-Healthcare for details.

7. Emergency immunizations. In some clinical situations (e.g., tetanus toxoid for wound prophylaxis, gamma globulin for hepatitis A exposure, post-exposure prophylaxis for rabies exposure), the medical indication may be to immunize even though certain requirements above cannot be met (e.g. access to ACLS/ALS equipment or staff trained in ACLS/ALS)). Such incidents commonly occur at sea and remote units or during time-sensitive situations (SAR, etc.). If the medical benefits outweigh the chance of a serious allergic reaction, the immunizing HS staff must take every available precaution possible, and administer the vaccine or immune globulin. Obtain radio, telephone, or message

advice from the DMOA or Flight Surgeon on call through the closest Coast Guard command center.

8. Adverse reaction.

   a. In an emergency, EMS must be activated and BLS/ACLS/ALS care must be initiated.

   b. If an adverse reaction to a vaccine is suspected by anyone, including the person being vaccinated, the facility shall notify the Vaccine Adverse Event Reporting System (VAERS) using form VAERS-1. The likelihood of a causal relationship between the observed signs or symptoms and the vaccine is *NOT* a requirement for reporting to VAERS. This reporting system is for anyone who suspects a vaccine adverse reaction. The VAERS form can be found at https://vaers.hhs.gov/index.html. Instructions for reporting to VAERS are available at VAERS - Report an Adverse Event (hhs.gov).

E. Immunization on Reporting for Active Duty for Training.

1. When a reservist reports for active duty training, the receiving unit shall review the individual's immunization information in the medical readiness database, administer any delinquent immunizations whenever possible, and enter the information in the medical readiness database and reprint out the Adult Preventative and Chronic Care Flowsheet, DD Form 2766.

2. The individual's Reserve unit shall give the member a re-immunization schedule for the following year if one is needed for that period.

F. Specific Vaccination Information.

1. Coast Guard policy. Coast Guard policy concerning immunizations follows the recommendations of the CDC's Advisory Council on Immunization Practices (ACIP), in concert with DHA-IHB, unless there is a military-relevant reason to do otherwise. Any immunizing agent licensed (or authorized under Emergency Use Authorization) by the FDA or DHHS may be used, but only FDA-approved vaccines may be made mandatory without a specific Presidential Executive Order.

2. Detailed information. Detailed information on adult vaccines can be found in Ref (d). Accessions include recruits, cadets, band members, and Direct Commissioned Officer participants. Unless specified below, follow the policies of the Instruction.

3. Anthrax. Administer anthrax vaccine in accordance with Ref (e).

4. Human Papillomavirus (HPV). In accordance with CDC/ACIP guidelines, health care providers must recommend HPV vaccination, including for all service members through age 26 years. HPV vaccination can be given to service members ages 27

through 45 years who might benefit from vaccination based on shared clinical decision-making. HPV vaccination is not mandatory.

5. Influenza. Administer the seasonal influenza vaccine annually, in accordance with and subject to the exemptions in reference (d), to all AD and SELRES Coast Guard personnel (including accessions) and Coast Guard civilian personnel as delineated in Ref (d).

6. Smallpox. Administer the smallpox vaccine in accordance with Ref (d) and (g). Smallpox vaccinations shall no longer be given at Coast Guard accession points. For smallpox VAERS events, Coast Guard health care personnel shall continue to use the VAERS and must also report smallpox vaccine (ACAM 2000) cardiac-related adverse events to the Naval Health Research Center (NHRC) at 619-553-9255. Upon receipt of the report, NHRC personnel will contact eligible cases and request their consent to participate in the Smallpox Vaccine Myopericarditis Registry.

G. Coast Guard -Specific Immunization Policies. The Coast Guard follows the Immunization policies set forth in Ref (d), with the following exceptions and additional policies.

1. Permanent Medical Exemptions.

   a. The decision to grant a permanent medical exemption is made by COMDT (CG-1121); all requests for a permanent medical exemption, whether from a patient or a Coast Guard health care provider, shall be sent to COMDT (CG-1121) for a decision.

   b. Coast Guard MOs shall route an official memo documenting the request for a permanent medical exemption along with a recommendation for or against granting the exemption.

      (1) Coast Guard MOs shall route the request through their supervising Senior Medical Executive (SME) or Regional Practice Director (RPD).

      (2) Coast Guard MOs who are SMEs or RPDs, or Deputy HSWL SC (om), shall route the request through HSWL SC (om).

      (3) If the Coast Guard MO is HSWL SC (om), the memo is routed directly to COMDT (CG- 1121).

   c. COMDT (CG-1121) shall document its decision in an official memo and return it to the treating MO through the same routing as it was received.

   d. COMDT (CG-1121) shall track permanent medical exemptions and provide data to COMDT (CG-11) as directed.

e. Permanent medical exemptions require review every 12 months. Prior to the expiration of each 12 month period, the Coast Guard MO responsible for the patient with a permanent medical exemption shall obtain any needed consultation and route an official memo directly to COMDT (CG-1121) with a recommendation that the exemption be continued or terminated.

2. Temporary Medical Exemption Second Opinions and Appeals. Occasionally, a Coast Guard member may feel that he or she should be granted a temporary medical exemption from a mandatory vaccine due to a medical condition, even when the treating Coast Guard Medical Officer (MO) does not agree. In this case, the Coast Guard member may request a second opinion from another provider. This provider may be another Coast Guard provider, a DoD provider, or a civilian provider inside or outside of the Military Health System, but it is recommended that the second opinion provider be a specialist in diagnosing and treating the condition(s) of concern. If the treating Coast Guard MO already consulted another such provider prior to deciding whether or not to grant a temporary medical exemption, that counts as the second opinion. If the second opinion provider disagrees with the treating Coast Guard MO and the Coast Guard MO still does not grant a temporary medical exemption, or if the second opinion provider agrees with the treating MO but the patient still does not agree that a temporary medical exemption is not warranted, the patient may appeal the decision to HSWL SC (om). The patient must notify the treating MO of his/her intent to appeal within 10 duty days of receiving notification that the treating MO had denies the temporary medical exemption request, taking into account the second opinion. To appeal, the treating MO shall provide a written memo to HSWL SC (om) presenting the appeal and including documentation of the second opinion provider's recommendation. HSWL SC (om) shall evaluate the appeal using a procedure documented in a HSWL SC Technical Directive. The decision of HSWL SC (om) is final and shall be provided to the patient's treating Coast Guard MO in writing. HSWL SC (om) shall track temporary medical exemption appeals and provide relevant data to COMDT (CG-11) as directed. The military member's supporting Coast Guard clinic or sickbay must continue to code a military member as Medically Exempted (Temporary) in MRRS while they appeal a temporary medical exemption decision.

3. Permanent Medical Exemption Second Opinions and Appeals. In the same way, a Coast Guard member may feel that he or she should be granted a permanent medical exemption from a mandatory vaccine due to a medical condition, even when the treating Coast Guard MO does not agree and plans to recommend against the permanent medical exemption to COMDT (CG-1121). In this case, the Coast Guard member may request a second opinion from another provider. This provider may be another Coast Guard provider, a DoD provider, or a civilian provider inside or outside of the Military Health System, but it is recommended that the second opinion provider be a specialist in diagnosing and treating the condition(s) of concern. If the treating Coast Guard MO already consulted another such provider prior to deciding whether or not to recommend a permanent medical exemption, that counts as the second opinion. The second opinion must be received by the treating MO prior to submission to COMDT (CG-1121). Documentation of the second opinion must be sent to COMDT (CG-1121) along with the Coast Guard MO's recommendation to grant to deny the

request. If COMDT (CG-1121) denies the permanent medical exemption request, military members may appeal COMDT (CG- 1121)'s decision. The intent to appeal must be communicated to COMDT (CG-1121) by official memo within 10 duty days of a military member's receipt of COMDT (CG- 1121)'s determination. COMDT (CG- 11) is the appeal authority or permanent medical exemption appeals and COMDT (CG-11)'s decision on the matter is final. COMDT (CG-1121) must route permanent medical exemption appeals to COMDT (CG-11) upon receipt. In doing so, COMDT (CG-1121) must present its views, the views of the member and any second opinion provider/specialist, and must include any second opinion provider/ specialist's clinical notes as an enclosure. COMDT (CG-11) shall document its decision in a written memo. COMDT (CG-1121) shall track permanent medical exemption decisions and report to COMDT (CG-11), as directed. The military member's supporting Coast Guard clinic or sickbay must continue to code a military member as Medically Exempted (Temporary) in MRRS while they appeal a permanent medical exemption decision.

4. Military members are not authorized to participate in medical research that would require them not to receive a mandatory vaccination, and Coast Guard Medical Officers shall not grant medical exemptions for this purpose. Exception: Members who have already received a valid administrative or medical exemption for a specific vaccine may seek permission to participate in studies related to that vaccine from their CO/OIC. In such a case, the member's participation in the research shall not last longer than the term of the underlying (administrative or medical) exemption.

5. Coast Guard MOs may grant pregnant or breastfeeding women a temporary medical exemption to a vaccination even if the MOs and/or prenatal/pediatric providers recommend vaccination. In such cases, a Coast Guard MO shall counsel the patient that the Coast Guard MO recommends the patient be vaccinated. The patient shall then acknowledge in writing that their exemption from vaccination is Against Medical Advice (AMA). Pregnancy medical exemptions shall be no longer than the time necessary to reach the end of maternity leave. Breastfeeding medical exemptions shall not be granted for longer than one year. A breastfeeding medical exemption may follow a pregnancy medical exemption without break.

6. Health care providers shall neither grant a medical exemption nor provide medical counseling or advice related to an administrative exemption regarding a vaccine for which they themselves have an exemption of any kind. HSWL SC (om) must make exemption decisions in such cases.

H. Allergy Immunotherapy (AIT).

1. AIT involves gradually increasing patient exposures to quantities of specific allergens, in order to raise the patient's tolerance to the allergens and minimize symptoms of allergic disease.

2. AIT shall not be performed by IDHS in sickbays. AIT shall be restricted to clinics or sickbays only when MOs (with current ACLS/ALS certification) are present in the clinic.

3. AIT shall only be performed by trained providers including HS, IDHS, nurses and Medical Officers who have completed one of three approved training courses:

   a. United States Air Force's Introduction to Allergy/Allergy Extender Course.

   b. United States Army's Walter Reed National Military Medical Center's Immunology and Allergy Specialty Course (HS, IDHS, and nurses only).

   c. United States Navy's Remote Site Allergen Immunotherapy Administration Course: Immunotherapy Safety for the Primary Care Provider. For the Navy's remote course, the MO shall provide face to face training to the HS/IDHS. This course is available on the Coast Guard intranet website at the following URL: https://www.dcms.uscg.mil/Portals/10/CG1/cg112/CG1121/docs/pdf/AIT_for_the_provider.pdf?ver=2017-03-24-115634- 057

   2. All personnel involved in the administration of allergen immunotherapy shall participate in annual refresher training. The three courses listed above can be used to satisfy the annual refresher training requirement.

   3. All HSs, nurses and MOs must have completed the training and be designated in writing to administer AIT by the SHSO (or SME/RPD/HSWL SC (om)), as appropriate). MOs shall provide a self-attestation statement that they have undergone initial training to include the course attended and the date/s to the Professional Review Committee. MOs shall also provide a self- attestation statement that they have undergone refresher training to include the course attended and the date/s to the Professional Review Committee. HSAs must certify that HSs, IDHSs, and nurses have successfully completed initial and recurrent training. HSs, nurses and MOs are only authorized to give AIT to AD and SELRES members and only at maintenance doses. Clinical personnel shall not initiate immunotherapy or give escalating doses.

CHAPTER 4. MONITORING OF POPULATION HEALTH

A. General. Preventive health care for populations depends on an understanding of the type of health conditions seen within that population. Monitoring of the burden of acute and chronic diseases and injuries, distributed by person, place, and time, allows targeted health interventions to be designed and implemented. Both geographic trends in the occurrence of disease and demographic factors such as age, gender, and race/ethnicity, which can influence disease incidence and prevalence, must be analyzed. Use of existing data systems such as electronic health records allows ongoing and efficient population health surveillance of trends in the health of the Coast Guard and its beneficiaries.

B. Population Health Indicators. The CPM at COMDT (CG-1121), in consultation with HSWL SC and appropriate resources such as the US Preventive Services Task Force (USPSTF) recommendations, shall identify a set of key health indicators for the Coast Guard population which may include disease screenings, identification of disease or injury risk factors, immunization, and prevention counseling. Examples of indicators include annual influenza immunization rate, colon cancer screening rate for persons 45 and over, tobacco cessation counseling rate identification of individuals with risk factors for cardiovascular disease, and, as per Ref (h), access to comprehensive contraceptive counseling and contraceptive methods during Periodic Health Assessments (PHA) and at accession points.

C. Population Health Targets. The CPM at COMDT (CG-1121), in consultation with HSWL SC, USPSTF, Healthy People 2030, and other resources, shall identify targets that correspond to the selected health indicators. Targets shall be quantitative, specific, measurable with available data in a timely manner, and relevant to the Coast Guard workforce and mission.

D. Use of Electronic Health Record (EHR) to Monitor Health Indicators and Targets
In consultation with the Chief Medical Informatics Officer and DHA staff as needed, the CPM must develop plans to:

1. Measure baseline rates for population health targets, using data when available from MHS Genesis following its full implementation within Coast Guard,

2. Measure target rates periodically but no less frequently than annually, and

3. Communicate findings on population health targets to HSWL SC and the Coast Guard MO community on a regular basis, and provide opportunities for feedback from providers.

E. Population Health Optimization Working Group (PHOWG)

1. The purpose of the PHOWG is to optimize the health, especially the duty

availability, of Coast Guard military personnel.

2. The PHOWG may provide guidance on population health indicators and targets and their measurement in MHS Genesis, as described above.

3. The PHOWG shall report and advise to COMDT (CG-11) on issues requiring leadership awareness and/or development of new Coast Guard policy and guidance.

4. Unless directed otherwise by COMDT (CG-11), the CPM chairs this group, which includes at minimum representatives from all COMDT (CG-11) Offices, HSWL SC, the Medical Branch of the Personnel Services Division of the Personnel Service Center, and Coast Guard Recruiting Command.

5. The CPM shall:

   a. Convene the PHOWG approximately quarterly but no less frequently than twice yearly.

   b. Assure appropriate PHOWG record keeping including taking of minutes

   c. Either conduct or assign a periodic review of the Charter of this Working Group.

F. Trainee Health Program (THP)

1. One of the populations at highest risk of injury, communicable disease, and environmentally and occupationally related health conditions in the Coast Guard is the trainee population, due to its selection from across the United States (and in some cases international locations), the physical, mental, and emotional stress placed on this population, and the congregate living situations in which this population is typically quartered. For the purposes of the THP, the Coast Guard trainee population includes, but is not limited to, recruits and officer candidates undergoing Initial Entry Training (IET), CGA cadets, and personnel undergoing long-term formal training, such as Coast Guard “A” and “C” schools.

2. The THP shall be managed by the Chief of Force Health Protection, (CFHP), COMDT (CG-1121). The CFHP shall:

   a. Work closely with the CPM, the Disaster Epidemiologist, and the Chief of Occupational Medicine, within COMDT (CG-112), and liaise as needed with DoD THP leads.

   b. Maintain a collaborative relationship with the RPDs of the CGA and TRACEN Cape May, as well as the senior MOs assigned to other Coast Guard TRACENs.

c. Serve as the primary PHEO for trainee populations, in collaboration with the CPM.

d. Monitor injury and illness trends in trainee populations, participate in outbreak investigations and immunization and preventive health interventions, report findings to the PHOWG, and recommend measures to mitigate injury and illness.