The New Mexico Modular Emergency Medical System (NM MEMS)

A Framework for Medical Surge Response Planning

October 2007

NEW MEXICO
DEPARTMENT OF
HEALTH

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Building a Healthy New Mexico!

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October 17, 2007

Dear New Mexico Health System Partner and Stakeholder:

A catastrophic incident with public health ramifications, such as a pandemic, **will** occur. It is no longer "if," but rather a matter of "when." Because of this reality, health emergency preparedness and medical or patient surge response planning through public-private partnerships is essential.

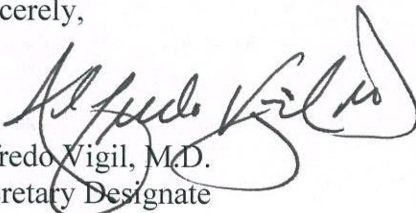
The New Mexico Modular Emergency Medical System (NM MEMS): A Framework for Medical Response to Overwhelming Patient Surge, October 2007 is the medical surge response planning model adopted by the New Mexico Department of Health and will be formalized as a response specific appendix to Annex 5: Health, Medical and Mortuary of the *New Mexico State All-Hazard Emergency Operations Plan*. This Framework is strongly recommended for use by local jurisdictions to plan for incidents in which an overwhelming surge of patients will exceed existing resource capacity of local health systems.

Numerous health system stakeholders dedicated their valuable time and expertise to develop and refine the NM MEMS model and their input is reflected in this document.

Now the implementation phase for NM MEMS begins. The NMDOH will select three New Mexico communities to participate in the NM MEMS Implementation project. These pilot communities will demonstrate the use of the NM MEMS framework for medical patient surge response plan development within their respective jurisdictions. A NM MEMS Implementation Manual will be available for pilot community use and refined based on their experience. The Manual will include: a toolkit developed to assist with the application of the NM MEMS functions and assumptions to the planning process; an updated *New Mexico Department of Health All Hazard Incident Management Glossary*; an assessment process to determine current local medical surge capacity and capabilities; and, basic education and teaching materials to inform local stakeholders about NM MEMS. All materials will be available on the NMDOH website in early 2008.

I am grateful to those health system stakeholders throughout our state that collaborated with the department to refine the NM MEMS framework. By working together in full partnership, we are building a stronger system that is able to meet present and future challenges, to the benefit of the people in New Mexico.

Sincerely,



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NEW MEXICO
MODULAR EMERGENCY MEDICAL SYSTEM
FRAMEWORK

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THE NEW MEXICO MODULAR EMERGENCY MEDICAL SYSTEM

Introduction:

Historical data suggest that the majority of incidents whether natural, accidental or human-made and intentional, do not produce overwhelming medical or patient surge, nor damage health care facilities beyond usefulness. Typically, the resulting patient numbers are accommodated within the existing health care infrastructure using routine or normal patient flow protocols and care standards. However, in catastrophic incidents such as pandemic influenza or a strategic act of terror, an overwhelming number of people may seek care in an environment of depleted or possibly nonexistent resources.

To accommodate situations that result in a surge of patients that exceeds the capacity of existing resources, the New Mexico Department of Health (NMDOH) and its partners have developed the New Mexico Modular Emergency Medical System (NM MEMS). NM MEMS is the medical or patient surge response construct for local, regional, statewide and interstate emergency planning recommended by NMDOH. Although adapted from the original Modular Emergency Medical System model developed by the US Department of Defense in the late 1990s to respond to a release of a non-communicable biological agent, NM MEMS utilizes an all-hazard approach for medical or patient surge planning. This ***NM MEMS Framework*** presents what the Department of Health and its system partners view to be the plan development model for medical response during an emergency or incident, one which creates overwhelming patient surge that existing and available resources and routine delivery systems are unable or inadequate to accommodate.

Background:

Utilization of the Modular Emergency Medical System as a medical surge response planning concept in New Mexico was first introduced and described in 2002 during initial NM DOH discussions regarding public and private sector health emergency preparedness planning. The New Mexico Modular Emergency Medical System (NM MEMS) medical surge response construct was further developed by staff and consultants from the New Mexico Department of Health, Bureau of Health Emergency Management over the last three years.

In February 2006, the New Mexico Department of Health, the New Mexico Department of Public Safety/Office of Emergency Management, the Governor's Office of Homeland Security, the New Mexico Emergency Managers Association (including Tribal Emergency Managers), and the Indian Health Service established the Unified Command to Prepare for Pandemic Influenza. The development of the *NM MEMS Consultation Draft* was a General Control Objective of the Unified Action Plan, which was endorsed by Governor Bill Richardson. Unified Command is a National Incident Management System (NIMS) compliant approach to planning and response.

In summer 2007, a NMDOH BHEM Planning Committee representing state and local emergency management, emergency responders, public health and private sector health care system stakeholders participated in the creation of the *NM MEMS Consultation Draft* during a series of facilitated sessions where discussion of the model, core functions and assumptions led to this final version or Framework for broad stakeholder consideration and use. (See list of Contributors). The NM MEMS Framework development process provided an important opportunity for key stakeholders to gain a collective understanding of the

response environment during a catastrophic incident and the application of the NM MEMS functions.

NMDOH worked with partners to develop NM MEMS to foster the understanding of and need for medical surge response planning by all local health and emergency management systems. The New Mexico Modular Emergency Medical System will be formalized as a response specific appendix to Annex 5: Health, Medical and Mortuary of the *New Mexico State All-Hazard Emergency Operations Plan.* As such, the NM MEMS Framework will inform local jurisdiction planning and the *Department of Health Emergency Operations Plan*, which guides the development and implementation of preparedness strategies and resource application. NM MEMS is managed according to the principles of the National Incident Management System (NIMS) and is implemented locally through multi-agency coordination (MAC) of operations.

To assist local communities in developing a medical or patient surge response plan using NM MEMS, NMDOH is producing an Implementation Manual to accompany this NM MEMS Framework. The *New Mexico Department of Health All Hazard Incident Management Glossary* will be updated to define NM MEMS terms and will be part of the Implementation Manual. Tools to assist local medical surge response planning have been identified during the stakeholder NM MEMS development process and are being collected from other states and will also be included in the Implementation Manual.

Description:
The NM MEMS model is built around two core functions: Alternate Outpatient Care Areas (AOCAs) and Alternate Inpatient Care Areas (AICAs). These temporary patient care areas located within or adjacent to existing patient care facilities serve as the operational backbone of the response model. Other key functions and response assumptions must be considered during overwhelming patient surge to support the complex and connected activities necessary for an effective response and are also a significant part of NM MEMS. Those additional functions are also described within the NM MEMS Framework. Many of the functions and assumptions described in the Framework will apply ***only*** during the implementation of NM MEMS response plans and are to be considered ***only*** under described conditions. Further, not all NM MEMS functions or assumptions will apply to every situation. NM MEMS is modular and scalable, and addresses the mobilization of key resources to respond to an incident depending upon patient numbers, acuity type(s) and required medical services.

Since the utilization of NM MEMS functions imply that both the quantity and the quality of resources are inadequate to meet patient care needs resulting from the incident, it is likely that “normal” health care delivery will need to be modified. This modification is addressed in the function titled *“Delivery of Care Under Overwhelming Patient Surge Conditions.”* These conditions will compel the state regulatory bodies, health care system administrators and the individual health care professional to consider adjustment of scopes of care and practice in order to ensure the delivery of a reasonable level of care.

There are two major premises of NM MEMS utilization in response planning. They are:

- The “best” place (economy of personnel and availability of specialty resources and infrastructure) for sick or injured patients to be treated is within the existing health care infrastructure. As such, NM MEMS functions and concepts will rely heavily

upon an existing healthcare infrastructure-based response that utilizes existing resources and space to create "alternate" areas of care. While these new alternate areas will challenge the overall healthcare infrastructure operation, this approach ensures that patients are best positioned to receive reasonable care under the prevailing circumstances with available resources and personnel.

- For a community to adequately plan for a response to an incident of overwhelming medical or patient surge, there must be an accurate and realistic initial assessment of the community's resources that are routinely and predictably available; as well as, a measurement of the capability to "surge" within the existing patient care infrastructure. To develop a response plan to overwhelming medical or patient surge and identify the threshold(s) for activation, a pre-determination of existing capacities and capabilities must occur. This determination or assessment will require the coordination, collaboration and understanding of the NM MEMS Framework and its purpose by all local responders and planners.

Local Planning and Local Response:

All response begins at the local level. Effective local incident planning or emergency preparedness activities must consider overwhelming patient surge conditions. Experience with medical response to incidents has shown that all local healthcare system partners must be able to adapt to an overwhelming number of patients in a relatively short time. Experience also indicates that the majority of patients resulting from an incident are not critically injured or ill. Most are without immediate life-threatening injuries or illness, yet are still in need of medical screening and care. This large number of minimally to moderately injured or ill patients represents the greatest impact of the surge that must be accommodated and managed by existing resources.

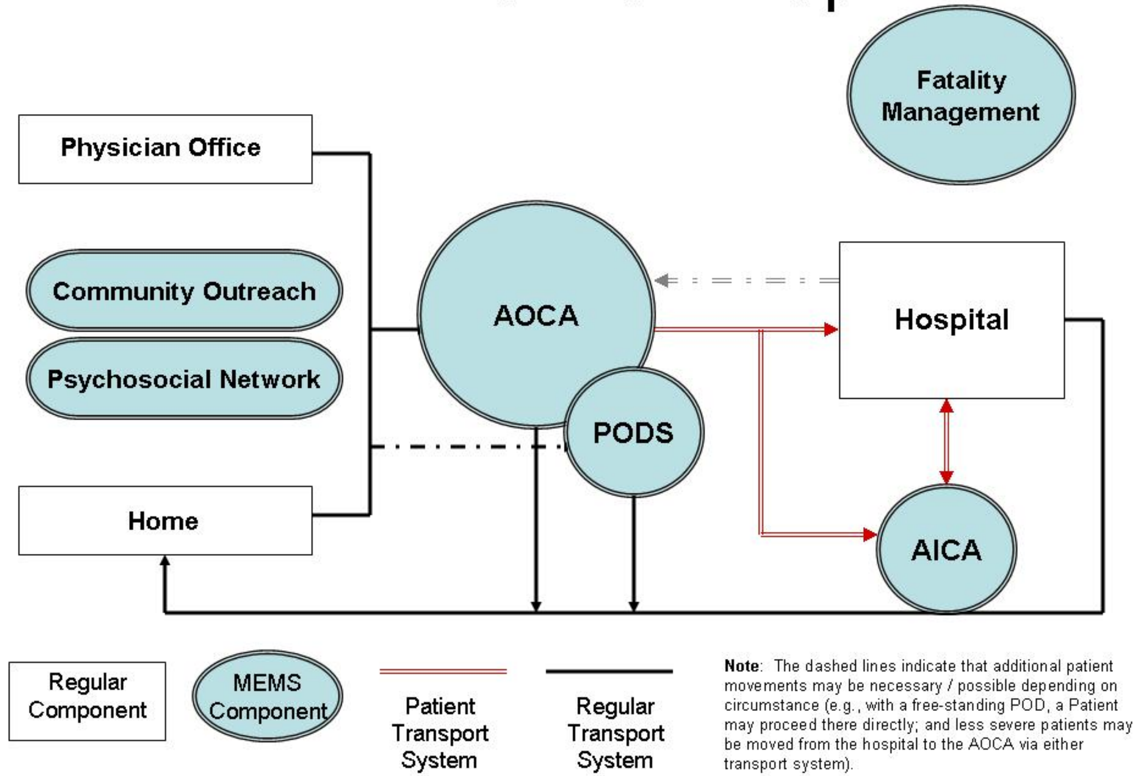
The NM MEMS Framework will guide local response planning and will be implemented at the local level, which is dependent upon accurate resource assessment, coordination, and management among all response partners. Hospitals, primary care clinics, other health care institutions and emergency planners, using the NM MEMS Framework to develop medical surge capacity within an emergency operations plan, must identify and coordinate with all health system response partners to plan and exercise prior to an incident in order to maximize the use of available personnel and health resources and assure plan's effectiveness.

Each local emergency operations plan must identify and describe the thresholds at which NM MEMS functions will be activated. Tools to guide appropriate NM MEMS function utilization in response plan development will be provided within the Implementation Manual. The decision to implement any medical surge response plan will be jurisdiction-determined and based upon the assessment of available capacity, resource management and incident demands.

NM MEMS planning assumptions include:

a. The best place (economy of personnel and availability of specialty resources and infrastructure) for sick or injured patients to be treated is within the existing health care infrastructure.

b. An assessment of existing local capacities and capabilities must occur first in order to develop a response plan for overwhelming medical and patient surge and to identify the thresholds for activation.
c. The vast majority of incidents **will not** produce overwhelming patient surge, deplete routinely available resources or damage the healthcare infrastructure.
d. Overwhelming medical surge or infrastructure incapacity may lead to the activation of alternative patient flow and patient care techniques.
e. NM MEMS planning must consider an environment of diminishing or depleted resources with little to no immediate re-supply of essential personnel, medical supplies, pharmaceuticals and/or services.
f. During a response to overwhelming patient surge, the need for resources will outweigh their availability.
g. Guidance for identifying thresholds for NM MEMS functions implementation will be provided by the State and executed in local jurisdictions based upon the assessment of available health system capacity and resource management, and will be based on incident demands.
h. NM MEMS planning will be locally determined and coordinated, transparent and community-based.
i. The provision of medical services during overwhelming patient surge will be coordinated and supported through a Multi-Agency Coordination (MAC) System.
j. NM MEMS functions and assumptions are related to and dependent upon the implementation of a NM MEMS medical surge response plan only.
k. NM MEMS represents the "what" or the goal for overwhelming medical surge planning and a coordinated local planning process determines the "how" by developing an effective response plan.
l. All medical surge response plans will be National Incident Management System (NIMS) compliant.
m. Response to all medical or patient surge incidents, whether minor, moderate, or overwhelming in scope, will be practiced, evaluated and improved through community and statewide exercises and drills.
n. Medical surge plan efficacy will be measured through exercises and drills.


MEMS Flow Map
Fatality Management
Physician Office
Community Outreach
Psychosocial Network
AOCA
PODS
Hospital
AICA
Home
Regular Component
MEMS Component
Patient Transport System
Regular Transport System
Note: The dashed lines indicate that additional patient movements may be necessary / possible depending on circumstance (e.g., with a free-standing POD, a Patient may proceed there directly; and less severe patients may be moved from the hospital to the AOCA via either transport system).

ALTERNATE OUTPATIENT CARE AREAS (AOCA)

Summary: The temporary ambulatory care areas set up within existing facilities or in temporary structures outside of existing facilities.

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Description: The AOCAs may be located in, or adjacent to, the hospital(s), if there is a hospital, or may be set up in other locations such as a primary care clinic or other appropriate structure within the community. Local planners will determine the best location for the AOCA. The mission of the AOCA is to:

- Direct patients affected by the incident, especially those who are non-critical patients, away from hospital emergency departments.
- Render basic medical screening and provision of medical care.
- Provide limited treatment and stabilization.
- Provide distribution of prophylaxis, medication, self-help information, psychosocial support and instruction.

Planning Assumptions:

a. Staffing of an AOCA will be structured to process the expected number of patients, with personnel assigned based on redefined roles to maximize resources.
b. Patients arrive at the AOCA primarily by their own means.
c. Patients requiring in-patient care are transported to either a hospital or an Alternate Inpatient Care Area (AICA).
d. It is expected that the majority of patients will be discharged home or back into the community.
e. Patients determined to be pre-terminal are accommodated, monitored and provided palliative care.
f. Deceased patients are pronounced dead and transferred to the AOCA's temporary morgue.

ALTERNATE INPATIENT CARE AREAS (AICA)

Summary: The temporary inpatient care areas established during overwhelming patient surge.

Description: In general, the AICA will be located in a hospital(s) but may also be set up in areas external to the hospital, ideally in close proximity to a hospital. AICAs are temporary and designed to be limited to patients of the same acuity level with the same illness, housed or "cohorted" together in a common healthcare environment. The AICA provides illness-specific and supportive care utilizing the existing support services of the associated hospital (e.g. laboratory, radiology, pharmacy and food service). The AICA is designed to treat patients who need inpatient treatment, but do not require advanced care, such as mechanical ventilation or those who are likely to die from their illness. Restricting the type of patients treated at an AICA serves two purposes. First, it allows a streamlined approach to patient care, as most patients will require similar treatment following pre-established critical pathways or clinical practice guidelines. Second, in situations where isolation is desirable but impractical, this plan groups patients with similar infections/exposures and limits exposure to non-infected persons, a practice recommended by the Association for Professionals in Infection Control and Epidemiology, Inc. (APIC) and the Centers for Disease Control and Prevention (CDC).

Planning Assumptions:

a. The best place (economy of personnel and infrastructure needs) for sick or injured patients to be treated is within the existing health care infrastructure.
b. During overwhelming medical surge, the goal of response will be to optimize the use of available resources to provide a reasonable level of healthcare to those affected by the incident.
c. The AICA facilities, as well as medical personnel and supplies, will be most efficient if directed to patients of the catastrophic incident only.
d. The type of incident and availability of resources will determine the staffing of the AICA. The number of patients expected to survive will dictate the allocation of medical staff.
e. The AICA will function more efficiently and require fewer dedicated specialized resources if located within, adjacent to or in close proximity to a supporting hospital(s).

DELIVERY OF CARE DURING OVERWHELMING PATIENT SURGE CONDITIONS

Summary: Providing care during a catastrophic incident accompanied by a surge of patients may exceed available resources and require adjustments in normal resource management and triage.

Description: In the event of a widespread public health emergency or other catastrophic incident, there could be a surge of patients that would overwhelm the health care system, specifically, the normal response capabilities of emergency medical services (EMS), hospitals, primary care clinics, and other health care providers. Response to a patient surge resulting from a mass casualty incident that would become a public health emergency (i.e. infectious disease pandemic, act of biological terrorism or a natural disaster) will require the health care system to manage large numbers of victims with very limited health care resources, including personnel, equipment, hospital beds, and pharmaceuticals.

Under conditions of overwhelming patient surge, a goal of response will be to optimize the use of available resources in relation to demands in order to provide a reasonable level of healthcare to those affected by the incident. Legally and ethically, an acceptable "standard of care" requires that a health care provider (or health care system) exercise the education, training, skills and diligence that is reasonably expected of a health care provider (or health care system) practicing under the same or similar circumstances. This standard essentially means that a prudent health care provider should provide a reasonable diagnostic and treatment process for the care of a certain type of patient, with a certain type of illness, under certain clinical circumstances, which include available resources. Exemptions regarding scopes of practice during emergencies may exist in State statutes for professional licensing boards.

These "standards of care" will be applied in each functional area of medical response and will be in effect for as long as it is reasonably necessary to accommodate the health care system's response during overwhelming patient surge. When a catastrophic incident occurs causing an overwhelming number of patients to seek care, a public health emergency may be declared through the New Mexico Public Health Emergency Response Act* (PHERA). The New Mexico PHERA allows the Governor and state executive agencies to exercise extraordinary powers in response to a public health emergency, such as the rationing of health care supplies and the utilization of health facilities.

During overwhelming patient surge conditions and or limited and insufficient resources, the following types of decisions are typical of those that will be required:

- Identification of essential clinical services, including elements of critical care delivery and prophylactic treatment that will continue during medical surge;
- Determine use of pharmaceuticals and equipment that have been stockpiled.
- Criteria determining the prioritization of patients to receive the limited and available medical resources (i.e. how to choose between two medically equal individuals when there is only enough resources for one);
- Criteria for care of patients who qualify for essential clinical services but who are not exposed or infected with the particular agent responsible for patient surge;

- Criteria for patients who are terminally ill or mortally injured and may require palliative care;
- Procedures to ensure that planning for resources needed to provide palliative care receives equal importance as efforts to provide medical care; and,
- Policies and procedures for documentation of financial expenditures and other costs resulting from response to patient surge are developed.

Discussions should be held about the environment influencing the need for these "hard" decisions prior to the incident by every institution, its response partners, individual providers and community leaders. Elected officials at all levels of government should be included in order to maximize available personnel and other resources and to assist the community in recovery after the incident.

Planning Assumptions:

a. *Delivery of Care During Overwhelming Patient Surge* is distinguished from typical emergency department overcrowding and the crises that arise in handling daily patient flow or surge.
b. The term "overwhelming medical or patient surge" has been used to distinguish the sudden, insidious, unexpected and overwhelming increases in demand for medical services that would occur during a major public health incident.
c. The concept of "standard of care" allows for the practice of different standards of medical care in unusual circumstances (i.e. in the face of exigent circumstances such as would occur during "overwhelming medical or patient surge").
d. When the demands for health care services exceed existing health care resources (i.e., lack of availability of hospital, ICU or specialty care beds, need for alternate care sites; inadequate medical equipment, medicine and supplies; lack of sufficiently trained or qualified medical personnel to provide medical care, etc.), the "standards of care" will be met if such resources are utilized in a *reasonable* manner in an effort to achieve the greatest benefit (i.e. the best chance of survival and recovery within the limits of available resources).
e. It is necessary to develop evidence-based "standards of care" that will be applicable to the health care system's response to "overwhelming medical or patient surge" and to recognize that practicing within such "standards of care" will be appropriate under the circumstances in an effort to optimize patient outcomes and to save the most lives possible.
f. Communities must have discussions pre-incident regarding "standard of care" and the realities of limited resources and community impact.

*Public Health Emergency Response Act (PHERA), Sections 12-10A-1, et seq., NMSA 1978, now part of the New Mexico Emergency Powers Code created by the 2006 New Mexico Legislature (Laws 2005, Chapter 22)

INCIDENT MANAGEMENT (IM)

Summary: The incident management section frames the incident as local response, and multi-agency coordination and support.

Description:
The functions of NM MEMS can be operated either as components of an ICS structure, or in support of an ICS structure. If NM MEMS functions operate as components of an ICS structure, they will be managed by the healthcare providers that sponsor them, but they will be under the command and control of the ICS structure within which they are operating. If NM MEMS functions operate in support of an ICS structure, then they will coordinate their operation in support of the ICS structure through their participation in the Multi-Agency Coordination System.

New Mexico Emergency Operations System: All response provided in emergencies will be consistent with the existing emergency management infrastructure of the State of New Mexico and as articulated in the *State of New Mexico All Hazard Emergency Operations Plan.* The New Mexico Emergency Operations System provides the structure for organizing, coordinating and mobilizing resources utilizing the concepts and principles of the National Incident Management System (NIMS), including the Incident Command System (ICS) and Multi-Agency Coordination (MAC). This command structure is based on ICS principles, including unified command (UC). Under this structure, the Incident Commander oversees all aspects of the multi-agency incident response. The ICS separates responsibilities into four well-defined sections: 1) Planning, 2) Operations, 3) Logistics, and 4) Administration and Finance.

Planning Assumptions:

a. An incident with overwhelming patient surge will surpass any local institution or jurisdictional capacity.
b. NIMS is the overriding principle in organizing the response, support, and coordination at the local, state, interstate, and national levels.
c. At both the local and state level, there will be multi-agency coordination of operations.
d. NM MEMS operations will be NIMS-compliant.

PUBLIC INFORMATION (PI)

Summary: NM MEMS-related public information will be provided through the Public Information System established in response to the incident that caused the activation of NM MEMS.

Description: NM MEMS public information preparedness and response functions, tasks, and activities will be carried out through the State's implementation of the NIMS Public Information System that is part of the existing emergency response infrastructure. During an incident, a Joint Information Center (JIC) will be set up to provide one uniform message to the public. Via the JIC, the Public Information Officer (PIO) and other information officers will develop and distribute to local partners key messages that need to be relayed to the public through the media. Depending on the emergency, the PIO will be able to use messages prepared ahead of time to expedite communication to the public. The JIC, as well as communications through the JIC, will comply with the State's command and control plan.

Communicating with the public prior to and during an incident is usually tasked to a Public Information Officer (PIO). The goal of public information is twofold:

- in a pre-incident stage, to inform and educate the public on how to prepare for a health emergency and where to find information about seeking appropriate care and to remaining safe during an incident; and,
- in a response stage, to provide credible information to the public as soon as possible to reduce the risk of mortality and morbidity.

Planning Assumptions:

a. NM MEMS public information preparedness and response functions, tasks, and activities will be carried out through the State's implementation of the NIMS Public Information System that is part of the existing emergency response infrastructure.
b. In a crisis, the New Mexico Department of Health will be accessible to the public, the media and all constituents.
c. Communications will be transparent, open, honest, immediate, and based on the best scientific and incident assessment information available.
d. A team approach will be utilized, so that physicians, epidemiologists, first responders and others can report their own areas of investigation and response.
e. Public information officers will give information to the public about how they should respond to the emergency.
f. Messages will focus on reducing the public's fear and uncertainty.
g. It is important to provide credible information to the public through the media.

POINT OF DISPENSING SITES (POD)

Summary: Point of Dispensing (POD) sites are designed to provide mass prophylaxis, as well as patient information and individual support services.

Description: POD sites do not provide direct patient care. The number of POD sites and locations needed to conduct mass prophylaxis activities are scalable based on the incident/event and are located in pre-identified facilities throughout the State of New Mexico.

A key to decreasing the impact of an infectious disease is to provide a vaccine, if available, or treatment with antibiotics or other appropriate medications as soon as possible to those exposed to a pathogenic agent. PODs will be implemented at pre-designated sites to provide mass prophylaxis. Guidance on prioritization of groups to receive medications will be developed at the State level and disseminated to communities for implementation into their planning process. This information should be communicated to the public prior to any incident, to increase the likelihood that people understand the reasoning behind such decisions. Proper planning and early incorporation of those decisions into the community's emergency operations plan (EOP) will minimize delays and confusion. These plans should also be coordinated with State plans for the receipt of these pharmaceuticals.
No New Mexico communities have enough pharmaceutical supplies readily available to them for mass prophylaxis programs. For this reason, the Centers for Disease Control and Prevention (CDC) has developed caches of medications and medical supplies specifically for use during a chemical or biological terrorist attack, infectious disease outbreak or disaster. The Strategic National Stockpile (SNS) is a national repository of antibiotics, chemical antidotes, antitoxins, life-support medications, IV and airway maintenance supplies and medical/surgical items. The SNS is designed to rapidly supplement and re-supply local and state public health and medical agencies in a national emergency. These supply shipments, called Twelve-hour Push Packs or Vendor Managed Inventory are positioned in strategically located and secure warehouses and ready for immediate release to a designated area within 12 hours of the federal decision to deploy SNS assets. New Mexico's SNS program is administered by the Bureau of Health Emergency Management. Even if the SNS is not deployed, the POD concept can be used to provide medication, patient information and individual support services as needed.

Planning Assumptions:

a. New Mexico Department of Health personnel at local and regional levels are responsible for the oversight and management of POD sites. PODS that are implemented by tribes on tribal lands will be managed by tribal personnel.
b. In order to conduct a mass prophylaxis effort, a decision must be made regarding the breakdown and distribution approach to be used for the target population. Depending on the type of incident and how much information is available to the regional officials, prophylactic treatment may be appropriate for all of the population in the affected area, or for only a subset of it. Further, the dosage of medication distributed (e.g. a 3 day supply or more) will also affect the number of persons treated. These decisions are the domain of public health officials.
c. Security at each POD site will be necessary, particularly if there is any measure of public panic.

d. In areas of multi-ethnicity, language interpretation services will be required. This includes persons who can interpret verbal, as well as written information. At the POD site locations, this will be particularly important for screening (exposure, consent and allergy screening) and self-care instruction.
e. Interpretation of information for visually and hearing impaired individuals and other services to accommodate persons with physical and cognitive disabilities should be provided.
f. Mass prophylaxis programs should complement treatment provided by the AOCAs.
g. Community Outreach augments a mass prophylaxis program beyond what the AOCA can provide and reach affected individuals who are unable to visit an AOCA.
h. In multi-jurisdictional communities (e.g. county and tribe), cooperative and collaborative planning is essential in executing effective community outreach and mass prophylaxis programs. Many people in New Mexico live in one jurisdiction and work in another. For this reason, mutual advance planning and exercises are strongly encouraged.

COMMUNICATIONS INTEROPERABILITY (CI)

Summary: NM MEMS communication and information management related needs will be addressed through the NIMS communication and information management system established by the State of New Mexico.

Description: Emergency personnel such as firefighters, police and EMS agencies are the first to arrive at the scene of an emergency and are supported by a variety of public safety agencies, including 911 call center staff and other local, state, and federal authorities. Timely communications, often occurring with wireless radios, are vital to response effectiveness, first responders and public safety. Communications interoperability, also referred to as compatibility or connectivity, refers to the capability of different electronic communications systems to readily connect with each other in order to enable timely communications.

All health care system entities must include communication interoperability into the emergency operations plans to ensure redundant two-way communication capability. For example, hospitals must be able to ensure communication during an incident that would allow for communication between and among hospitals and with the local emergency operations center and patient transportation personnel. Regularly scheduled tests of the interoperable communications system must be conducted at the state and local level in order to ensure effective communications capability during a state of emergency.

Improving interoperability of communications will improve overall response to an incident that is challenged by overwhelming patient surge.

Planning Assumptions:

a. Primary communication systems, such as land-lines and cell phones will become overloaded very quickly and alternate means of communications are essential for continued operation.
b. Back up or redundancy in communication plans should include Very High Frequency (VHF) and Ultra High Frequency (UHF) in both the government band and the Amateur Radio band.
c. Trained communication operators are a vital component for the continued operation of communications from any location.
d. There should be numerous personnel trained and equipped as communicators at every response location. These individuals should be trained and able to communicate by any means necessary.

PATIENT TRANSPORTATION SYSTEM (PTS)

Summary: NM MEMS Patient Transportation System (PTS) will be integrated into the jurisdiction incident command structure and is specifically tasked to move patients in and out of all care areas.

Description: Emergency planners will integrate the PTS into the community's mass evacuation and emergency transportation plans in order to avoid duplicate or overlapping requests for transportation resources. The system design must also be able to address all safety and security concerns pertinent to the event.

Planning Assumptions:

a. NM MEMS patient transport will be coordinated through the existing patient and general transport systems operating at the state, tribal, and local levels.
b. Transportation resources will be adjusted according to the distance between modules, terrain to be covered, weather, the nature of the event, and other variables specific to the location and systems involved.
c. The emergency planning workgroups, in coordination with the affected medical community will identify, list, and obtain mutual aid agreements with local transportation resources available.
d. During the event any requests for transport resources will be directed through the appropriate channels of the incident command system.
e. Planning for patient transport vehicles, other than ambulances, will be necessary during overwhelming medical or patient surge.

COMMUNITY OUTREACH NETWORK (CON)

Summary: Community outreach will be provided through the coordinated operation of a variety of public health, healthcare and social service organizations in the community affected by the incident. Coordinated systematic community outreach will help ensure that persons with disabilities, the elderly, and other vulnerable populations, especially the home bound, have access to services from the health care delivery system and are provided basic life sustainment measures.

Description: The community outreach effort may require workers to distribute information, collect information about the perceived target population, distribute prophylaxis, provide emotional support or determine transportation requirements to move patients, especially those who could not access the AOCA, throughout the community. Outreach could include such basic life sustainment services as: the dissemination of public information and education about self care and the incident; ensuring that food and other provisions are available, especially during orders of quarantine, social distancing or medical self-isolation measures; and, the provision of triage and prophylaxis.

A secondary purpose of Community Outreach (CO) may be to provide some form of patient care beyond mass prophylaxis, such as patient assessment and triage. Information about AOCAs, AICAs and PODS, and appropriate access to health care will need to be communicated to the community at large. The connection between Public Information (PI) and Community Outreach (CO) is integral for effective utilization of available health care resources. In planning, the CO component must be structured in a flexible manner so that it can either be an intense effort lasting for a few days, or a more extended one lasting several weeks.

Planning Assumptions:

a. There are many ways for a locality to conduct a community outreach effort. Some options are not appropriate for every situation or for every jurisdiction. Each will need to determine which method, or combination of methods, would be the most appropriate for their community.
b. Planners should consider the exact tasks to assign to the outreach effort. Tasks will be determined by the nature of the incident, for example, whether or not a communicable agent is involved.
c. The geographic, cultural, and social make-up of the community will greatly effect how the outreach program will operate and how many resources will be required. For instance, it will require fewer resources to canvass a single apartment building than several individual houses or ranches in rural or frontier areas.
d. Informational materials and messages used during outreach must be multi-lingual, culturally appropriate and adapted for the hearing or visually impaired.
e. State agencies have an integral role in supporting community outreach. The NM Human Services Department is responsible for ensuring the continuity of services to provide food stamps, medical assistance, general assistance, Temporary Assistance for Needy Families (TANF), and to oversee the Medicaid program.
f. Community-based organizations (e.g. faith-based, health councils) may be included to plan and exercise community outreach when first responder personnel are unavailable or to ensure that all resources are utilized for community outreach purposes.

PSYCHOSOCIAL NETWORK (PN)

Summary: This function is a network of psychosocial services, including traditional behavioral health services, crisis response, and psychological first aid, to support individuals, families, communities and emergency responders (including health care workers) during a widespread public health emergency (i.e. an infectious disease pandemic) or other catastrophic event (i.e. a natural disaster), where systems delivering such services will be inadequate or unavailable.

Description: During a public health incident, collaboration among various agencies, communities and individuals to provide ongoing services will be required on an ongoing basis for an extended period of time. The concept of "delivery of care during overwhelming medical surge" applies to psychosocial services, similar to other health care services. Thus, while a response to individuals in need of psychosocial services during an incident will be a priority, the resources required for delivery of such services to individuals will be exceeded by the demand. While the State's existing behavioral health assets will be utilized as available, due to the increase in demand for services and the shortages of personnel that will likely occur during the incident, it will be necessary for emergency volunteer groups, faith-based organizations, community service organization, and the general public to assume new roles and responsibilities relating to the emotional well-being of family, neighbors and fellow community members, particularly at-risk individuals.

Planning Assumptions:

a. Psychological support is considered to be an extension of the personal health care responsibility of every individual that must be shared by all affected by the incident.
b. The need for psychosocial support may be required for several months to a year following an incident and will largely depend upon individuals, communities, family members, and co-workers to support each other.
c. The success of NM MEMS and the State's response will rely, in part, on the public's awareness of the incident, as well as their level of individual emotional and physical preparedness.
d. As part of ongoing emergency preparedness planning, it is the responsibility of lead agencies of the State to provide to all public and private sectors community (both pre-incident and on an ongoing basis) available information regarding potential incidents, as well as instruction related to emergency awareness and preparedness (i.e. personal and family coping strategies and the basic principles of psychological first aid).
e. The NM Human Services Department (HSD) is the State Mental Health Authority. They have the responsibility to negotiate with the federal government when the state is eligible for FEMA's crisis counseling funding. HSD is also the lead agency for the Behavioral Health Collaborative which oversees mental health and substance abuse services throughout the state. Local Collaboratives identify needs, help develop a range of resources and ensure the responsiveness and relevance of behavioral health services.
f. The full range of psychosocial needs will be addressed ranging from psychological first-aid from neighbors to the needs of those with behavioral health disorders.
g. The training of health care workers, especially in behavioral health, will comprehensively address the concepts of disaster mental health, including the

unique emotional aspects and effects of a prolonged public health emergency, as well as the appropriate clinical interventions designed to address both acute and long-term traumatic stress disorders related to a prolonged and/or catastrophic incident with high levels of mortality.

h. Consideration must be given to the disruption in treatment for behavioral health disorders among patients presenting during medical or patient surge, particularly the need to ensure availability of psychotropic medication and treatment for displaced community members (e.g., shelter residents, AOCA, and CO).

FATALITY MANAGEMENT (FM)

Summary: Fatalities occurring during any incident, including those requiring implementation of NM MEMS, will be addressed through the application of existing state, tribal, and local mortuary plans.

Description: A plan that addresses management of mass fatalities will be included in the State of New Mexico All- Hazard Emergency Operations Plan in Annex 5, "Public Health, Medical, and Mortuary." This Plan should address all identifiable issues concerning sensitivity and respect for cultural and religious issues relating to management and burial of the dead. Protocols for Native Americans, especially those who have died outside of their tribal lands, already exist between tribes, hospitals, funeral homes, and the Office of the Medical Investigator (OMI). As such, local jurisdictions should incorporate state mass fatality plan policies and protocols into their emergency operations planning.

Planning Assumptions:

a. Most New Mexico hospitals are not prepared to store bodies, and some do not currently have any mortuary facilities and are not equipped with supplies, such as body bags.
b. Under the use of the Incident Command System (ICS) in New Mexico, it is assumed that "All Response Is Local."
c. Should OMI resources become overwhelmed in an incident involving mass fatalities, OMI would request additional support (i.e. FEMA Disaster Mortality [DMORT] teams and NMDOH NMserves volunteer registry) through the Incident Unified Command.

RESOURCE MANAGEMENT (RM)

Summary: NM MEMS capabilities and capacities planned by healthcare providers and coordinated by local Emergency Managers through Emergency Operations Plans (EOP) will depend upon a reliable system of acquisition, inventory, maintenance and replacement of resources. These resources will be categorized as to kind and type, and recorded in the NIMS Resource Management System maintained by the State of New Mexico.

Description: To be determined.

Assumptions: To be determined.

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