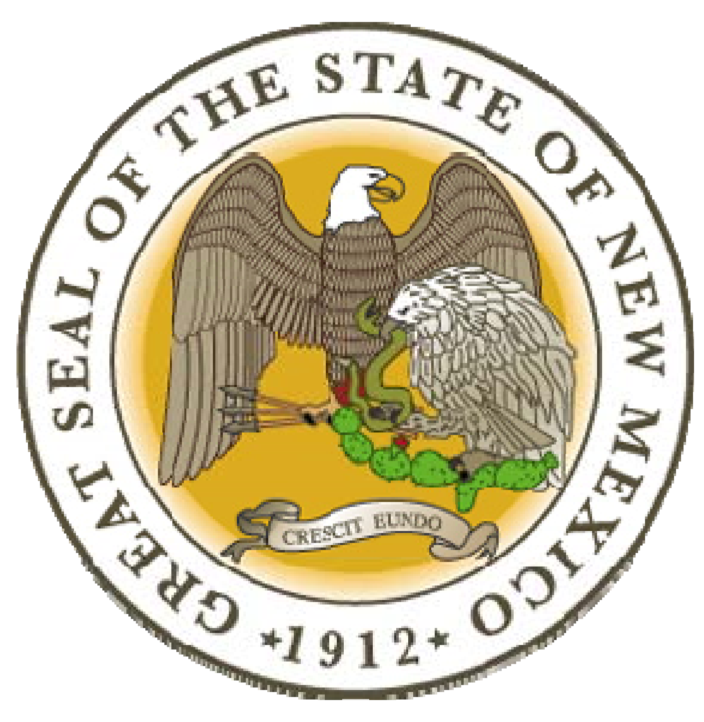

The New Mexico Pandemic Influenza Operational Plan (PIOP)

July 2008

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Governor of New Mexico	Honorable Bill Richardson
NMDOH Cabinet Secretary	Alfredo Vigil, MD
State Epidemiologist	C. Mack Sewell, MS, DrPH
BHEM Bureau Chief	Tres Schnell, MSW

Agency in Charge of PIOP Coordination and Construction:

New Mexico Department of Health (NMDOH)
Epidemiology and Response Division (ERD)
Bureau of Health Emergency Management (BHEM)
1301 Siler Road, Building F
Santa Fe, NM 87507

Pandemic Influenza Planning 'Strike Team':

- Victoria Armijo
- Anne Barraza
- Mike Finney
- George Marsden
- Suzette Porter
- Monica Roybal
- David Selvage
- Mack Sewell
- Chad Smelser
- Jackie Sparks
- Tom Török
- Don Torres

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INTRODUCTION

According to the World Health Organization, “an influenza pandemic occurs when a new influenza virus appears against which the human population has no immunity, resulting in several simultaneous epidemics worldwide with enormous numbers of deaths and illness.”

Influenza is a highly contagious respiratory virus that is responsible for annual outbreaks in the United States and other countries. Each year, approximately 200,000 people are hospitalized and 36,000 die in the U.S. from influenza infection or a secondary complication. During an influenza pandemic, the level of morbidity and mortality from influenza-related complications can increase dramatically worldwide.

During the last century, three influenza pandemics caused excess mortality, morbidity and societal burden throughout the world. The most severe of these, the "Spanish" influenza pandemic of 1918, killed over 500,000 people in the United States and had a worldwide mortality of 20 to 40 million. The 1918 pandemic was notorious for its predilection for healthy young adults. After 1918, two global outbreaks of influenza A occurred. In 1957, Asian influenza caused approximately 68,000 deaths in the United States. During the Hong Kong pandemic in 1968-69, mortality in the United States was estimated at 34,000 deaths, with 51 million Americans affected by influenza and a total economic burden of $3.9 billion.

New strains of influenza viruses are inevitable and can emerge unpredictably, and spread rapidly and pervasively through susceptible populations, sometimes causing pandemics. This is due in large part to two features of the influenza virus: its ability to exchange genetic information between strains and its ability to occasionally "jump" species barriers between mammalian and avian hosts. Experts agree that future pandemics of influenza are likely, if not inevitable. The sudden and unpredictable emergence of pandemic influenza can cause severe health and social consequences.

The Next Influenza Pandemic: What to Expect

A pandemic has the potential to result in large numbers of deaths (estimated between 20,000-25,000 deaths in New Mexico), overwhelming the New Mexico’s mortuary resources, including morgue capacity, medical investigative and forensic personnel, and services available for disposition of bodies. A pandemic is highly likely to produce large numbers of sick people that require care at the same time.

The initial pandemic phase will last 8 – 17 weeks and will likely be followed by a series of pandemic influenza waves each also lasting several weeks to months, continuing for up to two years after the initial outbreak.

A pandemic will seriously impact and overwhelm every healthcare, social and economic structure on a global scale simultaneously. Resources and assistance from all federal, state, and local governments will be severely limited or not available.

A severe pandemic will have major consequences for the local, national, and global economy. Due to the large numbers of affected individuals and social disruption, production of goods and services will suffer. In New Mexico, it is estimated that the Gross Domestic Product (GDP) could drop 5.42% ($3.7 billion loss)

Widespread illness in New Mexico’s communities will also increase the likelihood of sudden and significant workforce shortages in critical community infrastructure services, such as: military personnel, law enforcement, firefighters, utility workers, transportation workers, human services

and those agencies that provide essential infrastructure services to the public. Employee absenteeism rates will range from 25-50% for several weeks or months.

Despite medical and health care intervention during a pandemic influenza outbreak, people will die due to limitations in medical resources and available healthcare workforce.

The purpose of planning for pandemic influenza is to:

- reduce mortality
- reduce morbidity
- minimize social and economic disruption

The threat of pandemic is not as much a question of *if*, but rather a question of *when*.

New Mexico Impact Models*

Based on the HHS Pandemic Influenza Plan, the clinical disease attack rate will be 30% in the overall population. Of those affected, 50% will seek outpatient medical care. The number of hospitalizations and deaths will depend on the virulence of the pandemic virus.

The following table illustrates the impact of pandemic influenza on New Mexico. Given these projections, New Mexico's pandemic response plan is vitally important to protecting the Health of New Mexicans. This plan is designed so that the New Mexico Department of Health (NMDOH) and all other state agencies providing essential services will be ready to respond when a pandemic strikes.

Moderate (1957/68-like virus)		**Severe (1918-like virus)***	
Illness: (30% of population)	600,000	Illness: population)	600,000 (30% of
Outpatient medical care: (50% of those ill)	300,000	Outpatient medical care: ill)	300,000 (50% of those
Hospitalization:	8,500	Hospitalization:	10,000 – 50,000
ICU care:	1,980	ICU care:	2,680
Mechanical ventilation:	990	Mechanical ventilation:	1,340
Deaths:	1,670	Deaths:	20,000

* **NOTE:** The estimates were derived from *FluSurge* (Centers for Disease Control and Prevention: http://www.cdc.gov/flu/flusurge.htm) and projections from the recent federal influenza pandemic plan. Mortality in New Mexico for a 1918 – like influenza strain is more realistically projected at 20,000-25,000 deaths.

New Mexico's Unique Pandemic Influenza Planning Conditions

New Mexico is known for its cultural and geographic diversity. However, many of the conditions within the state that make it unique also create additional challenges for pandemic influenza planning. These conditions include the following:

1. New Mexico is the 5th largest state geographically but has a population of only 2 million people.
2. 50% of New Mexico's population resides in rural or frontier areas where services are scarce and the distances from homes to medical care, hospitals and even shopping exceed 50 miles.
3. Residents depend on vehicles in order to access services. Poor residents will continue to be disproportionately affected by the ongoing increases in gas prices. This situation further limits the ability of many residents to access services, particularly in rural and frontier areas.

4. Access to health care is a serious problem. According the United Health Foundation, New Mexico ranks 49th in the nation for access to health insurance coverage (see http://www.unitedhealthfoundation.org/ahr2007/states/NewMexico.html).
5. Poverty is an acute problem. New Mexico ranks 43rd in the nation for per capita income (see http://www.infoplease.com/ipa/A0104652.html).
6. Food insecurity, especially among children, is a serious issue. According to the latest food insecurity and hunger rankings, New Mexico ranks 3rd in the nation in food insecurity (see http://www.centeronhunger.org/whatsnew.html). This problem disproportionately affects children across New Mexico, many of whom depend on subsidized school lunch and WIC programs for adequate daily nutrition.
7. All of New Mexico's 33 counties are partial or full Health Professional Shortage Areas (HPSAs) according to the Bureau of Primary Health Care (BPHC) at the Health Resources Services Administration (HRSA) (see hsc.unm.edu/som/outreach/documents/1.HealthProfessionsShortageAreas.pdf)
8. As a border state, New Mexico experiences a relatively high level of legal and illegal immigration across the international border with Mexico. People travel back and forth across the border on a daily basis for purposes of employment, being with family, medical care and other services.
9. Trade with Mexico accounts for as much as 60% of imports into the United States for certain sectors, especially the agriculture sector. Much of this trade comes through New Mexico.
10. New Mexico is home to 26 tribes and pueblos, each with their own sovereign governments and varying health care systems. The majority of Native American residents of the tribes and pueblos reside in rural or frontier areas of the state in conditions of extreme poverty.

New Mexico-Specific Pandemic Influenza Planning Assumptions

The following New Mexico-specific planning assumptions emanate directly from the unique set of conditions elaborated above:

1. Equitable distribution of New Mexico's pandemic medical countermeasures will be difficult. The vast distances between communities, the spiraling cost of gasoline, and the remoteness of certain communities, coupled with the anticipated decrease in human resources during an event, will challenge the state's ability to provide resources to all those who are in need.
2. Soaring gas prices adversely affect rural residents of the state. The expectation that people will be able to travel to services during a pandemic or any event, which is a basic assumption in New Mexico, is becoming less and less realistic as fuel costs rise and incomes stagnate.
3. New Mexico will need to find creative ways to reimburse providers who provide care during a pandemic. With almost 25% of the state's population being uninsured, and the percentage approaching 40% in rural and frontier areas, coupled with a lack of providers, the health care delivery system will be pushed to the breaking point. Providers and hospitals will need to be assured that they will be reimbursed for their services.
4. Despite New Mexico's plan to close schools as a community mitigation strategy, the fact remains that many children in the state depend on schools for food. In many rural or frontier areas of the state, the local elementary school is the only facility where meals are prepared and distributed on a daily basis. Safety-net strategies for ensuring nutritional security for these children have been developed and will be applied upon school closure.
5. The consequences of sharing an international border with Mexico during a pandemic are unknown. Pandemic influenza planning with Mexico is ongoing. However, effects of in- or out-migration on the demand for healthcare during a pandemic have not been determined.
6. Closing the U.S.--Mexico border is problematic given the dependence of the U.S. on Mexico for goods and services, especially agricultural products. The number of

individuals who live in one country and work in the other who need to cross the border is considerable. This circumstance will complicate pandemic response strategies.

7. New Mexico recognizes the sovereignty and independence of Native American tribes and pueblos. It is assumed that tribes and pueblos will have developed pandemic influenza plans that will incorporate New Mexico State and county support and services when the tribes deem it appropriate.

New Mexico's General Pandemic Influenza Planning Assumptions

The following planning assumptions apply equally to New Mexico and all other states in the nation:

1. Initially the pandemic will last 8 – 17 weeks nationally, and may be followed by a series of waves each lasting weeks to months for up to two years after the initial outbreak.
2. During all phases of a pandemic, there will be a significant amount of fear and anxiety experienced by all communities statewide.
3. In a severe pandemic 0.1% - 2.5% of workers who become ill may die. Urban services will be stressed, but will most likely remain functional.
4. In a severe pandemic, absenteeism attributable to illness, the need to care for ill family members and fear of infection may reach 40% during the peak weeks of a community outbreak.
5. An influenza pandemic has the potential to result in large numbers of sick individuals and deaths, potentially overwhelming the current medical and mortuary services in New Mexico.
6. Vaccine will not be available for at least six months after the beginning of a pandemic.
7. Certain public health measures (closing schools, quarantining household contacts of infected individuals,) are likely to increase rates of absenteeism.
8. 'Social distancing' strategies (e.g. postponing public gatherings) may be used to control the spread.
9. Isolation of ill people will be required.
10. Quarantine of people exposed to ill people may be implemented until it can be determined that they have not been infected.
11. Critical goods and services provided by contractors, consultants and vendors may be erratic or interrupted.
12. New Mexico may not be able to rely on mutual aid resources from state or federal agencies to support local response efforts as all Federal, state and local resources will be severely limited or not available at all.
13. Federal, state and local resources will be severely limited or not available during an influenza pandemic.
14. Communicating with the public and health care providers will be a critical component of the pandemic response.

New Mexico's 2008 Pandemic Influenza Operational Planning Strategy

In response to the scope and complexity of the 2008 'Federal Guidance to Assist States in Improving State-level Pandemic Influenza Operating Plans,' New Mexico designed and implemented a planning strategy that required that all New Mexico Government agencies participate in the creation of a comprehensive plan. While many states delegated the majority of the responsibility for writing the plan to a single or a limited number of agencies, New Mexico decentralized the planning process and distributed the task across all state agencies. The editing and compilation of agency responses was managed by the New Mexico Department of Health Pandemic Influenza Strike Team. The Strike Team, composed of epidemiologists, health emergency planners, administrators, clerical staff and human resource specialists, provided oversight of the planning process. The Team, convened under the leadership of Dr. C. Mack Sewell, New Mexico State Epidemiologist, was assigned responsibility for guiding completion of the New Mexico Pandemic Influenza Operational Plan (PIOP).

The decentralization strategy was designed to accomplish three objectives:

1. **Increase the emergency planning capacity of participating state agencies**. While planning is part of state agency managerial activities, planning to address threats to continuity of operations is not often addressed. Decentralizing the planning process offered an opportunity to familiarize agency participants with continuity of operations planning (COOP) principles and strategies.

2. **Integrate state agency emergency planning activities**. Too often, state agencies plan in isolation, creating silos, rather than planning collaboratively, which encourages a systemic integration of effort. New Mexico's planning process required agencies to identify downstream and upstream "supply chains" affecting the production and continuity of agency essential functions. This activity allowed state agencies to create supply stream *interdependencies inventories*. These inventories most often consisted of lists of *other* state agencies. Nearly every agency's critical essential functions were dependent upon the essential functions of a sister agency. It became obvious that collective planning benefited the entire state agency system.

3. **Communicate the state's "Last Mile" status in emergencies.** During extreme emergencies that threaten the health and safety of a state's population, the possibility of infrastructure failure is always a threat. Under extreme emergency circumstances, social order, as well as public and private infrastructure, is often at risk. If and when the usual array of social, economic, and health systems becomes overloaded (or fails), it is the responsibility of state and local government to carry the load the "last mile." Planning for continuity of state operations is critical to last mile success. State agencies came away from this planning effort with a greater understanding of how their functions contributed to the state's ability to protect and serve its population in an emergency.

As is characteristic of any effort to decentralize a planning project, the quality of the responses to planning assignments varied. Many of the agency submissions were excellent. Several, however, lacked the specificity and clear accountability requested by the Guidance. While all agencies used specially constructed templates detailing the required content, the form and structure of the agencies' responses within the templates varied widely at times. All responses have been included with minimal editing.

New Mexico views the PIOP as a living document and understands that it will benefit from successive and more sophisticated revisions. Not all state agencies chose to participate in the planning process. Twenty-seven of thirty critical agencies participated. The absence of contributions from those not participating weakens this plan. Strategies for assuring their participation during future iterations have been developed.

The Strike Team organized a "Pandemic Influenza Summit" that was held on April 25, 2008. The purpose of the one-day Summit was to educate, orient and engage New Mexico Government agencies' leadership. Over thirty state agencies sent delegates to the Summit. The Summit provided the following information and resources:

1. Information regarding the basics of pandemic influenza
2. Information regarding the anticipated disruption in services that a pandemic will engender
3. Information related to each agency's responsibility to develop agency-specific pandemic influenza continuity of operations plans
4. Discrete direction regarding specific agencies' responsibility in developing sector-specific pandemic influenza plans (e.g., transportation, public education, public safety) and expertise

Each agency also received a 'PIOP Toolkit' that included:

1. Planning templates that related specifically to each agency's assigned responsibilities
2. Worksheets that assisted in formulating responses to the planning templates
3. Information regarding how to access technical assistance from the Strike Team members throughout the response period
4. Reference and educational materials

Each agency was informed that a Strike Team Technical Assistant would contact them within one week following the summit to schedule on-site technical assistance sessions. During these sessions, the Technical Assistant reviewed summit materials and assisted in completing planning worksheets and templates. Assistance was tailored to the agency's specific mission and area of sector responsibility. Each agency was given a deadline for submission of planning templates.

Legal Authority

Each agency was asked to cite in their response(s) the appropriate legal authorities that support and mandate the essential services the agency provides. These citations are included with the agencies' responses in the PIOP.

Pandemic Triggers, Phases and Intervals

The 2008 Federal guidance for preparation of pandemic influenza operational planning specified that states should define when different parts of the state's operational plan will be implemented/triggered based on HHS and CDC and WHO defined pandemic influenza phases and intervals. As the lead agency for purpose of pandemic influenza preparedness, NMDOH has attempted to incorporate these principles into its continuity of operations and pandemic preparedness planning. It is important to note that New Mexico has one centralized health department that oversees the entire state. <u>There are no county or independent local health jurisdictions in New Mexico</u>.

Other state agencies who engaged in constructing this plan agreed to follow NMDOH's recommendations regarding when to implement their continuity of operations plans and mitigation strategies. In essence, this means that the other state agencies involved in the construction of the PIOP have not defined intradepartmental triggers, but will instead await instruction and notification from NMDOH and the Secretary of Health, in consultation with the New Mexico Department of Homeland Security and Emergency Management (DHSEM) and the Office of the Governor, about when in the evolution of the pandemic to initiate certain common aspects of their plans.

NMPIOP Concept of Operations

Throughout the development of New Mexico's Pandemic Influenza Operating Plan (PIOP), staff endeavored to align the PIOP with the CDC Public Health Emergency Preparedness (PHEP) and the ASPR Hospital Health Preparedness (HPP) cooperative agreements that have been managed by the NMDOH Epidemiology and Response Division (ERD) since their inception.

Operations Plans Principles (see page 3 of <u>Federal Guidance to Assist States in Improving State-Level Pandemic Influenza Operating Plans)</u>

Since both the CDC PHEP and ASPR HPP focus on health emergency preparedness, with an emphasis on pandemic influenza, the State, rather than designing new measurements, will be performing ongoing assessment of the PIOP against existing goals, objectives, and measures of these two programs. For areas of the PIOP that are peripheral to the health areas, i.e. those that are included in parts of Goal A and Goal C, the State will develop performance measures to be integrated into overall measurement of statewide health emergency preparedness. In addition, all training in and exercise of the PIOP and its components have been integrated into the State's

annual Blue Print for Training and Exercise. The Blue Print is established each year to identify a definitive list of statewide health emergency training and exercise activities, avoid duplication of effort, ensure coordination of multiple partner agencies, and enable identified objectives to be completed. In this year's CDC PHEP application, the State has added a new Priority Project entitled "Implementation of the State Pandemic Influenza Operating Plan." The goal of this Project is to undertake a systematic review of the PIOP and design an implementation plan that will identify a process for its ongoing assessment and revision in the future.

Planning Fundamentals (see pages 7-11 of Federal Guidance…)
New Mexico is committed to the planning fundamentals as stated in the Federal Guidance.

To date, the State does not have a Governor-appointed Cabinet-level committee for homeland security or pandemic planning. However, NMDOH made every attempt to work closely with all State agencies in the development of the PIOP. While a coordinator from the Governor's Office is not available, NMDOH leadership for the pandemic preparedness activity is provided by the State Epidemiologist and the Secretary of Health, who has direct access to the Governor's Office.

The State has considered pandemic a community-wide, all-sector planning issue since the inception of its preparedness program. The NMDOH ERD Bureaus of Health Emergency Management (BHEM) and Infectious Disease Epidemiology (ID EPI) partner with a wide variety of health, non-health and private entities on an ongoing basis to accomplish the State's preparedness goals. These partners include but are not restricted to all acute care hospitals in the state, and other health care providers such as primary care, hospice, home care and long term care organizations; Community Health Councils, tribal Community Health Representatives, and lay health providers such as promotoras; health and non-health emergency responders, including local and tribal emergency managers, tribal personnel from the 22 Native American tribes and pueblos in the State; the business community; critical infrastructure entities and others.

NMDOH ERD staff has collaborated on health emergency preparedness planning activities in the tri-state binational area of Paso del Norte that is comprised of communities along the US-Mexico international border in the States of New Mexico, Texas and the Mexican State of Chihuahua. A cross-border influenza surveillance project begun last year with Cd. Juarez was successful in its attempt to obtain reliable influenza-like illness (ILI) data in this geographic area. The project will be expanded next year to additional Mexican communities. A tri-state summit has been conducted annually for four years to develop increased partnerships for and collaboration in bi-national pandemic planning. Upcoming in July is a conference on the economic consequences of pandemic influenza in the business community along the international border. In addition, New Mexico participates in ongoing health emergency and pandemic planning activities with its sister States in the federal Health and Human Services (HHS) Region VI. Currently, the States are exploring implementation of Federal Medical Stations as one option to address patient and medical surge caused by a catastrophic incident, as well as Region-wide adoption of New Mexico's framework for responding to surge, known as the New Mexico Modular Emergency Medical System (NM MEMS). Below is a description of the Region VI collective planning strategy that is included in the State's FY08 CDC PHEP application.

Activity Name:	Operational Strategy to increase information and resource sharing among Region VI states (Texas, Arkansas, Louisiana, Oklahoma, and New Mexico
What:	To develop common, interoperable, core operational strategies among the Region VI (TALON) state partners to ensure timely resource sharing with trust.
Why:	Execution of a cohesive interstate strategy is imperative for building and implementing public health and medical efforts that leverage all state resources within Region VI. The best approach to coordinate efforts is to fully understand the efforts being made by each state in the arena of health and medical preparedness within selected areas so that resources might be shared. During the last TALON annual meeting held in San

	Antonio, TX in April 2008, preparedness staff from the five states identified 5 workgroups where collaborative efforts and resource sharing could be further coordinated and operational efficiencies gained. The following five areas and their related activities were identified as important aspects of preparedness where information/resources could be easily shared among the five states: **Evacuation Planning** At Risk populations/categorizations Patient tracking Patient transport Medical records **Community Mitigation** Countermeasures Strategic National Stockpile (SNS) Antivirals Chempack Non-pharmaceutical interventions **Human Resource Management** ESAR-VHP Medical Reserve Corps (MRC) Public health staff (assessment & typing) **Regional Resources** Emergency Operations Center (EOC) interoperability State contact lists – key staff/Points of Contact (POCs) Action Request Forms **Public Information/Messaging** Pre-Event messages Single/coordinated messages Joint Information System By working together, preparedness partners of the five Region VI states, will be able to leverage needed resources during an event/disaster. Results and recommendations from these workgroups will be shared at the April 2009 meeting in Louisiana.
How:	Each state Director of Public Health Preparedness (DPHP) will designate a leader for one of the five workgroups: Evacuation Planning (Texas – Martha Gonzales) Community Mitigation (Louisiana – Stacy Hall) Human Resource Management (New Mexico – Valli Wasp) Regional Resources (Oklahoma – Ed Kostiuk) Public Information/Messaging (Arkansas – Ann Wright) Workgroups will be assembled to develop an action plan which includes common definitions; standardization of activities where possible; identification of uniform strategies; opportunities to leverage funds and resources; establishment of milestones, meeting times and timelines; and opportunities for joint training, exercise and evaluation. Work group members will use current resources, develop SMART goals/deliverables, outline what can be accomplished in one year, and/or outline a multi-year strategy. The accountability for the workgroup outcomes rest with each state director of public health preparedness and the designated staff.

Collaboration with and inclusion of local government, the faith-based community and other community organizations is ongoing and growing. For four years, NMDOH ERD staff have conducted "The Prepared Community," a initiative for county-based Community Health Councils (CHCs) and local partners such as schools, service providers for at-risk populations and emergency responders. The initiative has provided training in community resiliency and community outreach, and has focused on the CHCs has the "connector" between the local emergency response system (emergency managers, fire and law enforcement personnel) and the community. A CDC PHEP Priority Project is focusing on recruitment of individuals from faith-based organizations to serve as volunteers in their communities. NMDOH ERD staff and the State's Department of Aging and Long Term Services have collaborated to include the elderly in preparedness efforts.

NMDOH ERD staff has consulted with Region VI federal officials throughout the development of this PIOP. The State is grateful for their assistance and availability.

In New Mexico, the recommended activities for achieving Citizen Preparedness have been fully implemented and continue to be improved. Preparedness staff is versed in the principles of EMAC, and had first hand experience with processing EMAC requests during Hurricane Katrina and Hurricane Dean. All preparedness staff are required to be familiar with the National Response Framework (NRF), especially Emergency Support Function (ESF) #8 Public Health and Medical Services. All employees must maintain currency in FEMA course, IS 800B on the fundamentals of the NRF, and IS 808 Public Health and Medical Services. This requirement is documented in annual performance evaluations.

NIMS compliance among NMDOH staff and partnering agencies statewide promoted by providing training and collaboration with the NM department of Homeland Security and Emergency Management (DHSEM). Via the ASPR HPP, NMDOH is actively promoting NIMS compliance in hospitals. Via the CDC PHEP, training in NIMS and ICS are provided to NMDOH staff on an ongoing basis. Preparedness staff statewide must maintain evidence of currency in ICS 100-400; 700.

Ongoing assessment of the State's response capabilities is managed by DHSEM, with involvement of other State agencies, as requested. NMDOH participates in the federal Dept. of Homeland Security annual capabilities assessment and NIMS compliance report.

The State has emphasized and included the needs of at-risk populations throughout the duration of its health emergency preparedness programs. A focused effort has been planning to ensure access to local emergency services for individuals with physical, cognitive, and chronic medical disorders, the 22 Native American tribes and pueblos in the State, and communities residing along the US-Mexico International Border.

During the past 2 years, NMDOH collaborated closely with DHSEM to convene a statewide multi-agency work group that is developing an at-risk population preparedness analysis which will be developed into a set of concrete recommendations and a community outreach approach. NMDOH has worked with the Center for Development and Disability at the University of New Mexico Health Sciences Center for several years to develop and provide The Prepared Community curricula (see #4), and prepare various information materials for at-risk populations, and emergency responders who provide services to individuals in these groups.

Lastly, NMDOH continues to address legal preparedness. In 2003, the Public Health Emergency Response Act (PHERA) was approved by the State Legislature. The PHERA sets forth the authorities of the Governor and the Secretary relating to declaration of a public health emergency and issuance of orders. NMDOH Legal Counsel is engaged in ongoing review of issues relating to health emergency response, including implementation of the PHERA locally and in tribal communities, and areas in question relating to dispensing of countermeasures, and liability and protection of professional and lay volunteers.

The 2008 New Mexico PIOP Content and Instructions for Document Navigation

What follows is the 2008 New Mexico PIOP. This document represents the Pandemic Influenza Strike Team's best effort in presenting a comprehensive, all-agency response to the 2008 Federal Guidance.

All agency responses have been organized in a Microsoft Word document that can be navigated from the table of contents **by agency and by goal Objectives and Sub-Objectives:**

A. **Goal A. 'Ensure Continuity of Operations of State Agencies & Continuity of State Government;'**
B. **Goal B. 'Protect Citizens;' and**
C. **Goal C. 'Sustain/Support 17 Critical Infrastructure Sectors and Key Assets.'** See Table below.

TABLE

Strategic Goal	Operating Objectives	Appendix
A. Ensure Continuity of Operations of State Agencies & Continuity of State Government	Sustain Operations of State Agencies & Support and Protect Government Workers	A.1
	Ensure Public Health COOP During Each Phase of a Pandemic	A.2
	Ensure Continuity of Food Supply System	A.3
	Ensure Ability to Respond to Agricultural Emergencies & Maintain Food Safety Net Programs	A.4
	Ensure Integration of Uniformed Military Services Needs & Assets	A.5
	Sustain Transportation Systems	A.6
B. Protect Citizens	Ensure Surveillance and Laboratory Capability During Each Phase of a Pandemic	B.1
	Assist with Controls at U.S. Ports of Entry	B.2
	Implement Community Mitigation Interventions	B.3
	Enhance State Plans to Enable Community Mitigation through Student Dismissal and School Closure	B.4
	Acquire & Distribute Medical Countermeasures	B.5
	Ensure Mass Vaccination Capability During Each Phase of a Pandemic	B.6
	Provide Healthcare	B.7
	Manage Mass Casualties	B.8
	Ensure Communication Capability During Each Phase of a Pandemic	B.9
	Mitigate the Impact of an Influenza Pandemic on Workers in the State	B.10
	Understand Official Communication Mechanisms for Foreign Missions, International Organizations, and Their Members in the United States	B.11
	Integrate EMS and 9-1-1 into Pandemic Preparedness	B.12
	Integrate Public Safety Answering Points into Pandemic Preparedness	B.13
C. Sustain/Support 17 Critical Infrastructure Sectors and Key Assets	Define CIKR Protection, Planning &Preparedness Roles & Responsibilities	C.1
	Build Public-Private Partnerships & Support Networks	C.2
	Implement the NIPP Risk Management Framework for a Pandemic	C.3
	Bolster CIKR Information Sharing & Protection Initiatives	C.4
	Leverage Emergency Preparedness Activities for CIKR Protection, Planning & Preparedness	C.5
	Integrate Federal & State CIKR Protection, Planning & Preparedness Activities	C.6
	Allocate Scarce Resources	C.7

The reader can go directly to the agency listed in the Table of Contents by placing the cursor on an agency name and simultaneously depressing the control key and left clicking the computer mouse. In addition, a reader can navigate directly to a listed Objective or Sub-Objective by placing the cursor on the listed Objective or Sub-Objective and simultaneously depressing the control key and left clicking the computer mouse.

The reader will also find hyperlinks to the supporting documentation in the NMPIOP Word document. For example, the following hyperlink will take the reader to the New Mexico Strategic National Stockpile Interim Plan on page 328 in the supporting documentation file by clicking on the hyperlink: **New Mexico Strategic National Stockpile (SNS) Interim Plan**

Finally, the reader will find a separate file on the CD containing **Supporting Documentation** and attachments that are cited in the NM PIOP.

In compliance with the Federal guidelines for submission, the accompanying Excel spreadsheets contain:

1. the title acronym of this document (**NM PIOP**);
2. the NM PIOP page number of each agencies' response to the Federally defined supporting activities; and
3. the first five words of each agencies' response.

These are included on the CD.

If the reviewer encounters problems with the document content or how the document is arranged, or simply has questions about the navigation instructions, please contact Donald Torres, Pandemic Influenza Senior Planner, at (505) 476-8241 or email Don at Donald.Torres@state.nm.us.

NEW MEXICO AGENCIES CONTRIBUTING TO THE 2008 PIOP

Agency	Name	Signature
Aging & Long Term Services Department	Fred W. Schaum	
Attorney General Office	Paul Noskin	
Department of Agriculture	Tom Bagwell	
Children, Youth & Families Department	Anthony Salazar	
Corrections Department	Capt. Candis Stoddard	
Department of Cultural Affairs	David Soveranz	
Division of Vocational Rehabilitation	Michael S. Pino	
Energy Minerals & Natural Resources Department	Renee Manley	Jill Bertram for Renee Manley
Environment Department	Kenneth M. Smith	
General Services Department	Stephan J. Mindham	

Health Department	Alfredo Vigil MD	Alfredo Vigil MD
Department of Homeland Security & Emergency Management	Timothy Manning	Timothy W. Manning
Higher Education Department	Brandon Trujillo	
Human Services Department	Susan J. Eastman	Susan J. Eastman
Department of Information Technology	William McMahon	[illegible]
New Mexico Livestock Board	Dave Fly DVM	[illegible]
Office of Medical Investigator	Kurt B. Nolte MD	Kurt B. Nolte MD
Department of Military Affairs	Lt. Col. John Fishburn	
Public Employees Retirement Association	Terry Slattery	
Public Education Department	Cynthia Marrieta	Cynthia L. Marrietta
State Records & Archives	John Martinez	
State Personnel Office	Kenneth Giles	K Giles

Tax & Revenue Department	Lynette Trujillo	[illegible]
Treasurer Office	Wilbert Ryan	Wilbert Ryan
Workers' Compensation Administration	Alfonso Otero	Alfonso Otero
Department of Tourism	Marian D. VanderSys	Marian D. VanderSys
Department of Transportation	Tom Trowbridge	[illegible]