

ALBUQUERQUE EMERGENCY OPERATIONS PLAN
ANNEX 6
HEALTH AND MEDICAL

I. PURPOSE

The Health and Medical Annex establishes an all-hazards strategy for managing the health and medical consequences of any emergency event occurring within the City of Albuquerque. The goal is to effectively provide a coordinated response for medical care and treatment for the ill and injured, as well as to address and mitigate life and safety issues, incident management, chemical or biological agent identification, scene stabilization, patient treatment, patient transport, and the distribution of supplies and pharmaceuticals that result from accidental or deliberate acts. When necessary, and if resources allow, we will assist in addressing these issues in adjacent jurisdictions.

II. SITUATION AND ASSUMPTIONS

A. Situation

As a major metropolitan area, the City of Albuquerque is exposed to many possible hazards, many of which have the potential a catastrophic event resulting from natural, technological, national security hazards which would stress emergency medical services and for cause health and medical problems in the City and the surrounding communities. The development of a viable plan and the coordination of available resources are essential components in the successful response to medical and health issues that may arise in the metropolitan area.

The existing Albuquerque Health and Medical Response system includes alert and activation procedures, as well as with existing response and hospital capabilities. The system is coordinated through the activation of the Incident Command System (ICS) and the utilization of the City’s Emergency Operations Center.

This Annex directs the emergency Health and Medical operational response to emergencies including, but is not limited to, the following:

Hazard Summary for Medical Emergencies

Weapons of Mass Destruction (WMD) related or accidental chemical exposures
WMD related or naturally occurring Infectious disease outbreaks
WMD related or accidental radiological or nuclear exposures
WMD related or accidental mass trauma incidents
Food – Air – Water Contamination
Hazardous Materials Incidents
Infrastructure failures or threats and other related impacts

Most of the response options outlined in this annex assume an incident that occurs or begins at a specific site or sites at which the ill and injured are given initial treatment and are transported to medical facilities for additional care. The duration of such incidents is presumed to be relatively short, usually 24 hours or less. Most responses to emergencies will involve conventional and well understood procedures and will be carried out using existing routines by traditional first responders: police, fire, and emergency medical services. The involved facilities are presumed to be conventional as well: hospitals, primary care clinics (See Attachment 1), and other emergency facilities.

The annex also mentions but does not develop in great detail those incidents that occur at many sites at once, affect the whole community at one time, or are of such intensity or duration that persons needing treatment may converge on treatment facilities from many points, on their own without transport, transported by volunteers, without initial treatment or screening, possibly for a considerable period of time. The duration of such incidents is presumed to be relatively long term lasting longer than 25 hours and in some cases of public health emergencies up to months. Responses to such incidents may range from the conventional to the unconventional and may not be well understood and likely will be carried out by many different health care providers and other actors: doctors, nurses, emergency services personnel, pharmacists, public health personnel, volunteers, or clergy. The involved facilities are presumed to range from the conventional to the unconventional too: hospitals, primary care clinics (See Attachment 2), schools, neighborhood centers.

B. Assumptions

1. A Health or Medical Emergency can occur as 1) an obvious, immediate event with corresponding victims and casualties, or 2) a slowly progressing or unapparent event that degrades healthcare services over a period of days or weeks.
2. An emergency resulting in multiple casualties beyond normal limits from any cause will stress the metropolitan health care system and likely result in degradation of response and treatment capabilities and capacities.
3. This annex applies primarily to large-scale emergency and disaster events that would cause sufficient casualties and/or fatalities to overwhelm local medical, health, and mortuary services capabilities. Any such event would require the full coordination and efficient use of these resources.
4. The Albuquerque Emergency Operations Center (EOC) will be the point of contact for coordination among and support for all hospitals and other medical facilities during any incident. The Health and Medical and Mass Care ESFs will be staffed by the City Environmental Health Department.
5. The city/county area has the largest concentration of health care resources in the State of New Mexico. This includes practitioners in most specialty areas.
6. There are nine acute-care hospitals currently located in the Albuquerque/Bernalillo County. There is a designated Trauma Center in Albuquerque that is part of the

state's trauma system. Urgent care and other facilities (See Attachment 2) located in the metropolitan area can conduct patient triage, and can act as temporary clearing stations or treatment centers prior to the transportation of individuals to more adequate medical facilities during or following a disaster.

7. During a disaster, available staff will augment all the major area hospitals in order to concentrate resources and personnel on the two most critical areas of public concern – Medical Care and Control of Disease spread. In the event of an emergency, unemployed, retired, or partially employed persons who possess medical experience may be called upon to augment regular personnel at the acute-care hospitals. In 2002, the NM Legislature enacted Sections 12-10-11 through 13, NMSA 1978 re: NMDOH and the New Mexico Department of Public Safety approval of in-state and out-of-state licensees to act on behalf of the State during a declared emergency.
8. During a disaster hospitals may experience a critical shortage of trained medical staff that could be mitigated by volunteers. However, volunteer health care providers need to be managed to ensure an orderly augmentation of personnel resources.
9. Mutual aid agreements -- among area regional medical, health, and mortuary services -- will provide for the mutual use of resources during the disaster situation. This includes a standing agreement among area hospitals for receipt of patients evacuated from other facilities (See Attachment 3).
10. It may be necessary to relocate hospital facilities under extraordinary conditions to contingency field hospitals, or to permanent or temporary buildings that will provide patients and medical staff adequate protection from the effects of the disaster.
11. Consumable medical supplies are available through local hospitals and the numerous pharmacies in the city and county. Normally, the hospitals have a two to three day stock of medical supplies on hand that can be used during a disaster. They need re-supply after this time.
12. In the event that a gross relocation of the Albuquerque/Bernalillo County area is required, an adequate amount of all pharmaceuticals and medical supplies must be transported to the various relocation sites.
13. Certain disaster situations may immediately exhaust on-hand supplies or require specific supplies that are not on hand. In these cases, it is presumed that other state or federal resources will be available.
14. Hospital personnel availability and transportation may affect hospital readiness. During an emergency, sustainability of surge capacity may affect hospital readiness and the continuity of facility management.
15. The local hazardous materials response units have the capability to identify the presence of some chemical, radiological, or biological agents. Some local hospitals have the capacity to detect the presence of chemical, radiological, or biological agents through the precautionary screening or decontamination of any patients prior to treatment. The Scientific Laboratory Division of the New Mexico Department of

Health has the capability to confirm the presence of chemical, radiological, or biological agents and in time can identify many specific agents. Commercial reference labs and the CDC will provide backup capability for identification of unusual substances.

16. Water runoff that results from a hospital's decontamination of victims who may have been contaminated with a radiological agent will be contained according to the hospital's Hazardous Materials and Waste Management Plan.
17. Local EMS transportation resources may not be able to meet the needs of a large-scale event or other emergency incident. They may be degraded or exhausted quickly and other resources may need to be requested from the state or other authorities or through mutual aid agreements. If a need arises for a complex mix of transportation resources coordination and further contact will occur through the CABQ EOC.
18. The local fire, police, and emergency transport have interoperable radio communications. Other jurisdictions may not have radio communication facility with local authorities. Assignment of radio frequencies and communication patching will be handled by the City EOC.
19. The Public Health Division, District 1 Office of the New Mexico Department of Health located in Albuquerque serves the seven counties: Bernalillo, Sandoval, Los Lunas, Valencia, Torrance, Cibola, McKinley, and San Juan. This resource is available for appropriate local response.
20. The Medical Investigator assigned to the County from the State Medical Investigator's Office coordinates coroner and mortuary service.

III. CONCEPT OF OPERATIONS

A. Objective

The primary Health and Medical tactical priorities are as follows:

1. The coordination of health and medical care and EMS support during emergency situations.
2. The identification of weapons, materials or agents.
3. The coordination of the collection, identification, and disposition of deceased victims.
4. The inspection of food and water supplies to ensure public safety.

B. General

1. The first component of an enhanced HazMat response capability will involve the New Mexico State Police. New Mexico law requires an Emergency Response Officer (ERO) from the State Police to act as Incident Commander for any Hazardous Materials Incident, either Level 2 or 3. Although the ERO will bring no immediate response resources to the scene, the immediate response by Albuquerque's Fire, Police, and Environmental Health Departments provide the ERO with any resources necessary to deal with a Health and Medical Incident.
2. The City of Albuquerque Office of Emergency Management (OEM) maintains liaison with the State Emergency Operations Center (State EOC), of the New Mexico Department of Public Safety Office of Emergency Management. During a large-scale Health and Medical incident the Albuquerque EOC would contact, the State EOC. Depending on the level of the activation, the State EOC brings together representatives of principal municipalities in New Mexico, various state and federal agencies and the NM National Guard.
3. The State Office of the Medical Investigator (OMI) coordinates activity related to the handling of the deceased, both on-scene and at hospitals. An OMI representative can coordinate the deployment of a temporary mortuary, and can assure the proper collection of criminal evidence from the deceased. OMI would also coordinate with federal Disaster Mortuary Operations Response Teams (DMORT) (See Attachment 4).
4. The Poison/Toxicology representative from the Poison Control Center at the University of New Mexico Health Sciences Center provides medical toxicological research to support the agent identification process for the Hazardous Material Team, and advises the Decontamination and Treatment Sectors on antidote administration and patient treatment in the field. This representative also advises hospitals regarding decontamination and treatment. The Poison/Toxicology representative draws on expertise from the Poison Center at UNM for support in information dissemination, population risk assessment, tracking the clinical course of patients, and a computerized database for clinical effects of Hazardous Material emergencies.
5. The New Mexico Department of Health (NMDOH) representative to the State EOC serves as the point of contact with State DOH resources from the State Office of Epidemiology, Office of Health Emergency Management Bureau, Behavioral Health Services, and the Scientific Laboratory Division.
6. In the case of suspected biologic agents, the Scientific Laboratory Division (SLD) of the New Mexico Department of Health will identify the suspected agent. SLD may request assistance from the Centers for Disease Control and Prevention and other laboratories.
7. Responsibility for overall public health resides with the New Mexico Department of Health (NMDOH), which operates public health offices in all regions of New Mexico -- including Albuquerque. NMDOH can provide epidemiological and other public health guidance related to biological/bioterrorism incidents. In most

circumstances, this will be done in collaboration with the City of Albuquerque Environmental Health Department (AEHD).

8. Following an Emergency Declaration from the New Mexico Governor's Office. The NMDOH is empowered under the New Mexico Public Health Act to involuntarily detain persons infected with a threatening communicable disease prior to the declaration of a public health emergency. If the Governor issues an Executive Order declaring a public health emergency under the NM Public Health Emergency Response Act, NMDOH can involuntarily isolate or quarantine individuals infected with or exposed to a threatening communicable disease. NMDOH is also prepared to provide mass prophylaxis and immunization. In addition, under the NM Public Health Response Act, the NMDOH can "utilize, secure, or evacuate health care facilities" or "inspect, regulate or ration health care supplies

C. Operational Guidance

1. Initial Response.

The basic first response capability is the Incident Command System, wherein all first-responder personnel have training in incident awareness and recognition. This component of first-response capability, exists for all personnel on all shifts, and is the basis from which the Incident Command System will be built. For this deployment, the front line in recognizing a potential incident is the trained dispatcher. If there is no sense of a threat at dispatch, then the Responding Agency Officer first on-scene surveys signs and symptoms that may indicate the need for activation and begins the process of building the ICS and alerting the nine acute-care area hospitals via EMSsystem® capable of receiving patients both from the scene and those who self-admit or walk-in. If the situation is considered an emergency, a command post may be set up and determination made whether to activate the EOC will be made by the City's Emergency Manager acting on notification from the Incident Commander.

2. Implementation of ICS.

The Incident Command System (ICS) and the City Emergency Operations Center (EOC) are each critical components of the Albuquerque Health and Medical Annex. The EOC will contact Health and Medical personnel who represent specialized skills and resources relevant to incidents. This capability is employed as it becomes needed in an incident. To allow for the timely notification of Health and Medical personnel (and their alternates) relevant to the initial situation assessment, a current call down list is maintained in the AFD dispatch center. The EOC maintains a more detailed list of Health and Medical personnel resources.

D. Incident Command System

Command and Control is accomplished through the Incident Command System (ICS) and the City Emergency Operations Center (EOC). This unified system coordinates the nine major area hospitals capable of receiving contaminated walk-in victims of an incident. Unlike a traditional, separate "strike force," the Health and Medical Annex is a

capability built within the Albuquerque Incident Command System (which includes the EOC). A principle consequence of ICS is to unify command and control and to make all resources of the City potentially available for every incident. Resources are provided automatically, as the response escalates to meet the demands imposed by the incident, as assessed by the Incident Commander. Another distinction of the Albuquerque Health and Medical Annex lies in the fact that building a response capability into the ICS requires a broad training effort that includes the majority of Albuquerque Fire Department (AFD) employees, as well as employees of other City departments, other government agencies, and private sector organizations such as hospital personnel. Furthermore, incident management, response strategy, and tactics will be integrated into the AFD Standard Operating Procedures, thereby institutionalizing the capacity to deal with such events.

The Albuquerque Health and Medical Annex will use the Incident Command System (ICS), a standardized emergency management system developed by the National Interagency Fire Center for organizing and responding to emergencies at the site of an emergency. The Albuquerque EOC also incorporates ICS within its organization.

E. ICS and EOC Interface

The structure of the EOC is characterized by a group of personnel with special expertise who report to the EOC and expand the Health and Medical Support Function. This group represents not only health and medical personnel, but may include representatives from area hospitals, poison control (toxicology), the Office of the Medical Investigator, the University of New Mexico Health Sciences Center, the New Mexico Department of Health (providing epidemiological, EMS, behavioral health services, State Laboratory expertise), and liaisons from the New Mexico National Guard and the National Disaster Medical System. These personnel resources are available on a "call up" basis. A phone tree listing of personnel from each department (with alternates listed three-deep) is maintained at the Albuquerque Fire Department (AFD) dispatch center. As described above, Health and Medical members are represented in the EOC, but may also be deployed to the scene, if appropriate. When the EOC is activated and Health and Medical personnel are needed at the scene, additional personnel will be called up to ensure that each agency maintains a representative at the EOC.

Health and Medical personnel may be activated and deployed in many ways. In large incidents, or in those that are especially threatening, Health and Medical personnel may be assembled in the EOC as described above. In this case, the EOC itself will be activated. Under most circumstances, such activation will come from the on-scene Incident Commander (who will use the Fire Chief's authority to activate). Health and Medical support may be activated through EOC channels if an incident threat is received. In these cases, once assembled in the EOC, situation analysts will determine whether Health and Medical specialists will be needed at the scene, and which specialties will be required. If on-scene presence of any specialist is required, they will be deployed and their respective successors will be called to the EOC. In smaller scale

incidents, the Incident Commander may request specific Health and Medical expertise to the scene. The City EOC may or may not be activated.

F. Detection and Activation

At overt incidents where multiple patients are present, the Incident Commander will establish a scene and the most pertinent scenario should be followed. If perpetrators **warn authorities** that an agent will be or has been disbursed in a given area, a scene exists and activation of the Health and Medical Annex would again follow the ICS. In the event there is a warning or notification of an exposure, but no scene is identified or the agent was released in the past, it is most likely that authorities would assemble personnel at the EOC to determine which actions and resources are appropriate. In this latter case, NMDOH will send a representative to the EOC to provide consultative support and authority in directing an appropriate public health response.

A covert event arises when the health or medical impact of a diffused agent is gradual and there is no clear scene of action, or when there is a warning that a response should be mounted at some specified geographic location. This scenario will most likely involve the use of a naturally occurring disease outbreak or biological agent. The silent exposure of individuals who subsequently exhibit symptoms and seek medical care can produce a threat that is detectable through one of two mechanisms. First, if a pattern of medical calls to the AFD dispatch center produces evidence of "signs and symptoms" consistent with an infectious disease or biological or other agent, the Albuquerque Office of Emergency Management will be notified. After consultation with local hospitals, to which patients were transported, New Mexico Department of Health, poison and toxicology experts, and the Albuquerque Office of Emergency Management will decide the appropriate role of Health and Medical resources needed to respond to the event. The EOC would be activated to coordinate the required resources, and to provide public information. In the event of a suspected intentional attack, the FBI would become the lead agency and would provide advice on Health and Medical involvement. The NMDOH is a crucial part of response in on-scene incidents, but has particularly critical responsibilities in non-scene or "silent" exposures. Especially in the latter case, the Public Health System must determine the need for a written order of mass prophylaxis or treatment of the public. As described in connection with the Albuquerque EOC structure, the decision for an order would be made after consulting with the local public health officer representing the New Mexico Department of Health. It would be issued by the NMDOH, Office of Epidemiology in conjunction with the Governor's Disaster Declaration.

A second mechanism for detection of health and medical emergencies lies in the public health system. Detection of "signs and symptoms" consistent with a WMD threat or a large natural outbreak can occur in at least three arenas:

1. A pattern of symptoms across patients may be recognized by hospital emergency department staff (physicians, nurses).
2. The pattern may be noticed by hospital infection control personnel.

3. A pattern may be detected by the New Mexico Department of Health epidemiologists who process routine reports from hospitals or from laboratory reports of infectious disease surveillance.

Regardless of the path by which such identification is achieved, recognized or suspected, use of terrorism agents require notification of law enforcement. The activation of the Health and Medical Annex when there may be violations of federal or state statutes must be determined through consultation with the New Mexico Departments of Health and Public Safety, the City of Albuquerque Department of Environmental Health, and the Albuquerque Office of Emergency Management. Hospital and public health personnel may be required to collect, protect or avoid interfering with evidence.

The possible Health and Medical responses to infectious disease or bioterrorism events include simple notification of the medical community of the threat (with instructions on patient treatment and sources for further support); the provision of specialized equipment and pharmaceuticals, if appropriate, to hospitals; or the provision of specialized advice on diagnosis and treatment to hospitals. It is understood that statutory authority in such cases lies with the Public Health System, and Health and Medical personnel and resources would be in a support role.

Notification of local and regional hospitals, as well as the medical community at large, can be discretely accomplished by telephone through the Albuquerque Office of Emergency Management or EOC, via EMSsystem®, through EOC-controlled public information releases and by the NMDOH-administered Health Alert Network.

G. Management of Public Affairs

As soon as possible, the on-scene Incident Commander will establish an information sector, staffed by a Public Information Officer (PIO), to deal with mass media and to provide standard information that will be needed to accurately report the situation. In addition to the standard Public Information responsibilities under ICS, the Public Information Officer will inform the media about local hospitals that are capable of receiving persons who have been affected by the incident but are able to self-admit. When the EOC is activated, the on-scene PIO will refer all public information issues to the Emergency Public Information Support Function at the EOC.

1. The EOC Public Information Officer (PIO)

The Emergency Public Information Support Function in the EOC, represented by a Public Information Officer (PIO), is particularly critical during an incident. The EOC PIO forms a joint information center (JIC) to receive information from all other PIO's, including those from federal agencies and the FBI Joint Operations Center. The PIO will coordinate the release of information about the incident and management of the incident. The EOC PIO will also control the release of information deemed necessary to inform and protect the public. The PIO will establish a meeting location near the EOC for media representatives and will hold regular scheduled briefings. The identified location will be close enough to the EOC as to be convenient for media representatives, while not interfering with EOC activity.

2. Provision of Accurate and Timely Information

The on-scene PIO at an incident will work closely with the Incident Commander to ensure that Incident Command speaks with "one voice" when releasing information about the event to the public. When the Albuquerque EOC is activated, all on-scene PIO's will provide information to the Emergency Public Information Support Function in the EOC for public dissemination.

3. Centralized Communication Control

An 800-mhz radio network has been established with each of the nine major hospitals and represents the primary hospital communications link with AFD EMS and with the EOC when activated. The EOC will receive radio traffic through the EOC Communications Room and an expanded Health and Medical Support function with additional radios. The EOC Health and Medical Support Coordinator will determine the need for hospital liaisons in the EOC.

4. Control of Transportation Assets

The Health and Medical Support Coordinator in the EOC will coordinate pharmaceuticals and medical supplies, including air deliveries from the Centers for Disease Control (CDC) Strategic National Stockpile (SNS). The ICS Resource Sector officer and representatives from area hospitals will collect and transport cache items to the incident scene and to hospitals.

5. Transportation of Medical Supplies and Equipment from Caches

At the onset of an event, AFD will provide, through the on-duty personnel, the transport drugs, supplies, and equipment to the incident scene. As the scope of the incident grows or when the EOC is activated, City Municipal Development transportation resources will be used to transport personnel authorized to handle drugs that are identified as "controlled substances," and other needed items from caches or from the Albuquerque airport. The process for movement will involve prepackaged products both directly to the scene and to hospitals. If security is an issue, Albuquerque Police units will either transport supplies or escort fire personnel in the transportation process.

IV. ORGANIZATION AND ASSIGNMENT OF RESPONSIBILITIES

A. Department of Health Representative

The overall public health function resides with the State Department of Health (NMDOH) that operates public offices in four regions of New Mexico, including Albuquerque. The local NMDOH representative to the EOC will also provide epidemiological and other public health emergency preparedness and response guidance related to the incident. The DOH has the power to declare a public health emergency, as well as to impose quarantine on those suspected of having been exposed to a communicable disease or condition that poses a threat to public well-being. The state can also require isolation and observation of people who are infected with a threatening communicable disease to prevent transmission to others. A state of public health emergency may be declared by the Governor after consultation with the secretary of health. The Public Health Emergency Response Act of 2003, lists the requirements for isolation and quarantine and the rights of those affected by such an action.

B. Management Augmentation of Medical Personnel

The Health and Medical Support Function Coordinator in the EOC will coordinate medical resources and augmentation. This representative should be knowledgeable of the coordination required for incidents in the EOP, and will provide interpretation and specialized information to the EOC Coordinator and EOC Operations Section Chief regarding the incident response, needed resources, event consequences, and other issues. They will report directly to the EOC Operations Section Chief.

The Health and Medical Support Function Coordinator will coordinate the use of organized health professional volunteer organizations, including response teams from the National Disaster Medical System (NDMS) or organization from within the City or State. Working in partnership with the Departments of Health and Human Services (HHS), Defense (DoD) and Veterans Affairs (VA), the NDMS Section serves as the lead Federal agency for medical response under the National Response Plan.

With authorization from the EOC Operations Section Chief, the Health and Medical Support Function Coordinator may also interact with the Incident Commander as appropriate throughout the event, or coordinate with either the Fire or Law Enforcement Function Coordinators in the EOC. The County Public Health Officer may be available for EOC staff should an incident be large enough to require their presence at the City EOC. The local public health officer of the New Mexico DOH is not required to be present at the EOC, but in a very large event, or where a particularly virulent biological agent is involved, the local public health officer will assist the Health and Medical Support Function Coordinator.

C. Management of Medical Supplies and Pharmaceuticals

For the purpose of this Annex, Medical Supplies and equipment are divided into two categories:

1. Mass Casualty, Supplies and Equipment
2. Emergency Pharmaceuticals.
3. Other Pharmaceuticals

Mass Casualty Supplies and Equipment items used for mass casualty and associated incidents are typically items such as airway management supplies, wound dressings, and related equipment. Emergency Pharmaceuticals are drugs specifically used to treat symptoms of chemical and biological exposures.

Both of these categories are stored either for immediate use or for re-supply in strategically located caches in Albuquerque. Access information will be detailed in the Emergency Operation Center. Because of shelf life considerations and available space, one or both categories may be co-located.

A representative of the Albuquerque Department of Environmental Health will monitor the status of the stored emergency pharmaceuticals and will track expiration dates.

In addition, those pharmaceuticals needed for a public health emergency are kept on hand by hospitals but, as noted above, they may have only a 2 or 3 day supply. As they approach depletion hospitals should notify the City's Medical ESF at the EOC. This support will contact state and other resources to assist in re-supply.

V. ADMINISTRATION AND LOGISTICS

A. Cache Management

To reduce the risk of loss and increase utilization, medical supplies, equipment, and pharmaceuticals have been geographically dispersed throughout the Albuquerque area. The Albuquerque locations include major hospitals, HazMat units, the EOC, and a pharmaceutical supply warehouse. To speed response time, AFD controls one WMD Mass Casualty Supplies and Equipment cache and one Emergency Pharmaceutical cache for initial or immediate re-supply at the incident scene or at selected hospitals.

The strategic dispersal of the caches provides a measure of security, reducing the probability that an attack could be directed against available supplies (especially pharmaceuticals). It will also reduce the time needed for additional supplies to arrive at the incident scene. The EOC and AFD HazMat units will maintain current lists of cache locations, contents, and access information.

B. Chemical Incidents

Chemical incidents will likely require an immediate supply of antidotes and medical supplies both on-scene and at hospitals. Based on the availability of antidotes to treat the symptoms of chemical agents, Albuquerque hospitals have a supply of antidote auto-injectors and kits for nerve and cyanide agents in the distributed caches. These antidote auto-injectors and kits can be stored in hospital kits at room temperature for five years. At the end of five years, the Albuquerque OEM will assess replacement needs.

Albuquerque stores enough cache items to treat 1,000 victims of a chemical exposure. Each of the nine major hospitals stores an initial supply of WMD Mass Casualty supplies and Equipment and emergency pharmaceuticals sufficient to treat up to twenty-five victims of an exposure. The AFD Hazmat Response units will carry an initial supply of Mass Casualty Supplies and Equipment and emergency pharmaceuticals sufficient to treat up to fifty victims of an exposure. The remaining supplies are divided into two caches; one will be at the EOC, the other will be with a Hazmat unit for re-supply to responding units and affected hospitals.

C. Biological Incidents

Biological incidents may develop slowly and may not involve a specific incident scene. Hospitals will initially use normal stocks of antibiotics. Albuquerque retail pharmacies have agreed to serve as an on-call supply resource for any oral antibiotics or drugs that are exhausted at hospitals during an emergency. The primary local drug wholesale warehouse has additionally agreed to negotiate a re-supply of antibiotics and supplies for the Albuquerque area until more supplies arrive from the CDC. The Strategic National Stockpile may be activated in incidents where local and state stockpiles are insufficient. The New Mexico poison control center periodically inventories supplies of drugs useful in biological incidents held by hospitals and commercial pharmacies.

D. Drug Supply and Re-supply

Emergency Pharmaceuticals are divided into two categories according to their use in a Health or Medical Emergencies. They will be identified and divided as either chemical or biological essentials.

E. Cache Structure

Each cache will contain Mass Casualty Supplies and Equipment and Emergency Pharmaceuticals in tamper-evident packages. Packages will be clearly labeled to show appropriate use according to WMD agent, and the maximum number of victims that can be treated from each package.

F. Albuquerque Fire Department

The AFD, through the incident commander, will manage the immediate WMD Mass Casualty Supplies and Equipment and WMD Pharmaceutical needs of the incident scene. The HazMat Team will draw on AFD OEM-controlled stores of these items.

G. Health & Medical Emergency Support Function (ESF) Coordinator

The EOC Health and Medical ESF Coordinator will work with the ICS Resource Sector on-scene, as well as with those agencies with personnel authorized to handle controlled drug items, and with the EOC Municipal Development Support Coordinator, to coordinate the transportation of Mass Casualty Supplies and Equipment and Emergency Pharmaceuticals from caches to the incident scene and to hospitals. City Municipal Development will be responsible for providing the transportation in a timely manner. Using pre-event call lists contained in the All-Hazard EOP, the EOC Health and Medical Support Coordinator will contact local and statewide drug and medical equipment suppliers to arrange supplemental resources and re-supply as the incident progresses.

H. Distribution of Cache Items

The Resource Support and Municipal Development Coordinators will support the on-scene Resource Sector officer or the EOC Health and Medical ESF Coordinator during an EOC activation. They will coordinate the physical transport of cache items and personnel authorized to handle drugs that qualify as "controlled substances" using City Municipal Development transportation resources. Personnel authorized to handle drugs will come from AFD EMS or other pre-identified agencies.

Additional pharmaceuticals in "Push Packages" are available from the Strategic National Stockpile (SNS) controlled by the CDC, within twelve hours of a request by the Governor and obtaining federal approval. The Albuquerque EOC will make the request to the State EOC for additional pharmaceuticals, upon verification that there are no other available pharmaceutical caches in the state, the NMDOH representative and the state EOC director will make the request to CDC for the SNS. The SNS will be delivered to a predetermined location in the state and will be distributed to designated locations, e.g. DOH Public Health Service Sites (PHSS), Hospitals, and other locations as determined. In addition, Vendor Managed Inventory (VMI) packages can be tailored for the suspected or confirmed agents in a particular incident. VMI packages can be shipped in 24-36 hours.

I. Emergency Management of Legal Issues and Credentials

A representative of the City of Albuquerque Attorney's Office will report to the Policy Group in the EOC during an incident involving an intentional event to provide legal guidance. In addition coordination will be effected with the Governor's Authorized

Representative (GAR), the New Mexico Attorney General and the DPS, NMDOH, and Governor's Office of Homeland Security's Legal Representatives.

The EOC will coordinate through the hospitals contact with volunteer personnel who are properly credentialed and who can be called on to augment medical treatment capability in the Albuquerque area. Medical personnel at the incident scene or hospitals can check the list of properly credentialed medical personnel by calling the EOC Health and Medical ESF Coordinator or using the Medical Information Tracking Incident System (MITIS) described in Attachment 1 when it is up and running.

The NM Public Health Emergency Response Act (PHERA) governs the role of the state in case of public health emergency. The DOH Office of General Counsel can be contacted to assist in interpreting the law as it applies to the state's role and to the City of Albuquerque.

J. Emergency Management of Outpatient Tracking and Record Keeping

The nine acute-care Albuquerque-area hospitals will establish a medical record for any patient of an incident if they receive medical services. Each hospital's staff will monitor in some manner the medical status of treated but un-admitted patients and will then report any change in the patient status to the NMDOH, and City. After a medical emergency, the Albuquerque OEM will convene regular meetings of those who would normally staff the EOC Health and Medical ESF to determine the overall status of victims.

If the planned MITIS is deployed, patient tracking will be done through this system. Each hospital's staff will register and track patients through MITIS. This system will allow medical providers and staff of each hospital to track the medical status of all patients in the hospital facility and on the scene. Rather than 'admit' these patients into the hospitals regular information system, MITIS will be used for all patients triaged during the emergency event. Patients entered into this system would not be proprietary to a particular hospital system. The NMDOH and the EOC will have access to MITIS to monitor any change in patient status. The Albuquerque OEM would use MITIS for follow up, debrief, any necessary reports

K. Augmentation of Epidemiological Services and Support

The University of New Mexico (UNM) Health Sciences Center and the New Mexico Department of Health will provide epidemiological consultation services and support during an incident. The EOC Health and Medical ESF Coordinator or the Albuquerque OEM may request support services from the New Mexico DOH or from the CDC through the State EOC or State OEM.

L. Laboratory Support

In the case of suspected biologic agents, the Scientific Laboratory Division of the New Mexico Department of Health (alone or through the CDC) will confirm the identification of the agent. This laboratory will also confirm the identification of chemical and/or radiological agents.

M. Crowd Control

The Albuquerque Police Department is responsible for providing on-scene security at events involving Health or Medical Emergencies at the nine acute care Albuquerque-area hospitals. They will be assisted by the New Mexico State Police and Bernalillo Sheriff's Department.

N. Protection of Treatment Facilities and Personnel

All of the major hospital systems in Albuquerque which operate the nine major hospitals have agreed to participate in an Albuquerque response.

When local hospitals receive an incident alert, the hospital administration will direct hospital security resources to "lock down" or secure all entries into the hospital to prevent contamination from walk-in victims of the incident. Hospital security will direct all persons arriving at the hospital to the Decontamination Station reception area near the hospital's emergency department. Personal Protective Equipment (PPE) reserved for Hospital security is available in the Hospital kit.

The Hospital Kit is provided at no cost to each of the nine acute-care area hospitals. Each kit includes equipment, supplies, system installation, and procedures for mass decontamination and outside triage operations, and is secured in a storage locker at the hospital. The kit contains PPE for personnel in triage, decontamination, and security. It is equipped with built-in instructions, a quick deploying decontamination station shelter, and a Hospital Decontamination Station reference binder. As a precaution, the kits are self-contained and characterized by tamper-evident systems.

The Hospital MMRS Kit includes communications equipment, such as two-way handheld radios for communicating with outside hospital personnel in the decontamination area and with security personnel. The kit also includes bullhorns for instructing crowds. Complete Hospital Kit details are detailed in the attached Appendix, "Preparing Hospital and Health-care System Management for an Incident".

Hospital staff in the Decontamination Station reception area will determine the need for decontamination or triage, or will provide individual passes to enter the hospital.

The Albuquerque Police Department will dispatch two officers to assist hospital security personnel in maintaining order at each receiving facility. This includes

isolation and management of self-referrals awaiting decontamination. Two sets of PPE for law enforcement officers will be reserved in each Hospital Kit.

O. Establishing A Schedule Of Exercises

The OEM will establish a schedule for quarterly field inspections of the equipment and procedures and for semi-annual drills to maintain readiness. The OEM will also conduct an EOC functional exercise involving a Health or Medical Emergency scenario at least annually.

The OEM will produce and distribute a written After Action Report of findings for each equipment and procedure inspection, drill, or exercise to appropriate agencies.

P. Mental Health Services

Behavioral and Mental-Health In an incident involving health and medical issues, there is a strong need for attention to the behavioral and mental health needs of victims and/or their survivors. These needs will be met through existing AFD EMS and other resources identified at the EOC. These personnel will identify those who may need mental health support and will provide specialized help for victims and responders traumatized by the disaster. In addition to regular AFD resources, a current call roster details back-up AFD personnel, as well as local non-profit mental health organizations that are trained in responding to behavioral health situations, including, the Red Cross the Injury Prevention and Emergency Medical Services (IPEMS) Bureau and the Behavioral Health Services Division of NMDOH.

Q. Coordination of Behavioral Health Needs

The EOC Health and Medical Coordinator will coordinate behavioral health needs and resources. The EOC will maintain a current list of mental and behavioral health resources. The on-scene Behavioral Health Sector operates under the ICS Medical Branch and is expected to be present (in appropriate PPE) at the decontamination line, in the treatment areas, and at the Transportation Branch. The mission of these personnel is to attend to the critical mental health needs of victims, thereby assuring smooth operation and continuous flow of patients through decontamination, treatment, and transportation.

As needed, the EOC will deploy behavioral health personnel to receiving hospitals to support hospital behavioral health professionals in caring for short-term victim needs, including debriefings. If mass shelters are established for victims, behavioral health personnel will provide similar services at those locations. During the incident, behavioral health personnel will be available to address short-term crisis needs of victim family members. After the incident, the AFD will continue to serve as a resource to victims and families, directing those in need to appropriate community resources and otherwise providing referrals for medical or mental health care.

R. Proper Examination, Care and Disposition of the Deceased

The State Office of Medical Investigations (OMI) representative in the EOC Health and Medical ESF will coordinate all actions related to handling of deceased victims (either on-scene or at hospitals) and the transportation of victims from the scene (See Attachment 4). OMI will also ensure the proper collection of criminal evidence from the deceased.

The State OMI maintains a central facility in Albuquerque for performing autopsies. OMI will initially supervise security for bodies and await assistance from a DMORT. If necessary, OMI resources will establish a temporary on-scene morgue and will coordinate with AFD HazMat units to decontaminate the deceased, and will then coordinate the transportation of bodies to a central facility. An on-call refrigerator truck is available, if needed. The AFD HazMat units will provide PPE for up to six OMI personnel at the scene.

If a federal disaster is declared, the EOC OMI representative will coordinate federal DMORT resources. A hangar at Kirtland Air Force Base -- in a location separate from National Disaster Medical System (NDMS) operations -- is available for additional housing of the deceased.

V. AUTHORITIES & REFERENCES.

Quality service is sustained through the maintenance -- by all health care providers -- of licensure, certification, and training mandated by, and in compliance with, state and national standards for basic and advanced life support emergency medical service, hazardous materials control, and other emergency responses.

VI. DEFINITIONS & TERMS. See Basic Plan

Annex 6 Health and Medical Attachment 1 Medical Incident Tracking Information System (MITIS)

I. SYSTEM DESCRIPTION

The MITIS application will be based on a true, three-tier information model, emphasizing the value and efficiency of server-centric processing as a means to efficiently serve a large user community. This system will be based on a model that is currently operational in health, social service and behavioral organizations in Central New Mexico. This technology also minimizes software distribution costs and logistics, using a Netscape or Microsoft standard browser as client software, where possible. This system will be used only in an emergency medical event when the EOC has been activated. Access to this system will be limited to medical providers and staff of the nine acute care hospitals, NMDOH and EOC personnel involved in the handling of the incident.

The MITIS system will be accessed via web-based technology. Changes and updates can be made and information is available real time. Access to the system will be through a secure portal with logons and passwords validated and will be accessible to PDA users as well. The MITIS system will be developed under the direction of the Health and Medical Annex Steering committee. The core functionality of the system will be to share patient medical records with medical providers in the event of an emergency. The system will be used to provide up-to-date and confidential information necessary to provide care in a hospital setting or on the scene. The shared information will include but not be limited to:

- A. Patient Visits
- B. Medical records including labs, prescriptions and basic diagnosis
- C. Online list of credentialed medical personnel

II. Financing and Development Team

The team developing the MITIS system will be led by current Health and Medical Annex Steering Committee members. Since the model is already developed, funding will be used to support the modifications necessary for the stand-alone MITIS system. Technology will be used to create interfaces that transfer data from each of the provider systems. Once developed, the team will organize the training necessary for potential system users. These sessions will be coordinated with other scheduled exercises.

**Annex 6 Health and Medical
Attachment 2
Albuquerque Primary Care Clinics**

ALBUQUERQUE HEALTH CARE FOR THE HOMELESS 505-766-5197
Administration Office
Medical and Dental Clinic
Children's Outreach
1217 1st Street NW
Albuquerque, NM 87102
Fax: 505-242-3521

FIRST CHOICE COMMUNITY HEALTH CARE 505-873-7400
Administration Office
Medical and Dental Clinic
South Valley Health Center
2001 North Centro Familiar SW
Albuquerque, NM 87105
Fax: 505-873-7473

FIRST CHOICE COMMUNITY HEALTH CARE 505-890-1458
Medical Clinic
Alameda Health Center
7704 2nd Street NW
Albuquerque, NM 87107
Fax: 505-890-1599

FIRST CHOICE COMMUNITY HEALTH CARE 505-831-2534
Medical Clinic
Alamosa Health Center
6900 Gonzales SW
Albuquerque, NM 87121
Fax: 505-831-4123

FIRST CHOICE COMMUNITY HEALTH CARE 505-345-3244
Medical Clinic
North Valley Health Center
1231 Candelaria NW
Albuquerque, NM 87107
Fax: 505-344-4056

FIRST CHOICE COMMUNITY HEALTH CARE 505-768-5450
Medical Clinic
South Broadway Health Center
1316 Broadway, SE
Albuquerque, NM 87102
Fax: 505-842-1185

FIRST CHOICE COMMUNITY HEALTH CARE 505-452-8633
Medical and Dental Clinic
Los Padillas Health Center
2127 Los Padillas Road SW
Albuquerque, NM 87105
Fax: 505-873-5278

FIRST CHOICE COMMUNITY HEALTH CARE 505-873-0220
School Based Clinic
Rio Grande High School
2300 Arenal Rd SW
Albuquerque, NM 87105

FIRST CHOICE COMMUNITY HEALTH CARE 505-833-0024
Dental Clinic
Westside Dental Care
111 Coors Road NW, Suite E-2
Albuquerque, NM 87121
Fax: 505-831-4476

FIRST NATIONS COMMUNITY HEALTHSOURCE 505-262-2481
Administration Office
Medical Clinic
5608 Zuni SE
Albuquerque, NM 87108
Fax: 505-262-0781

FIRST NATIONS COMMUNITY HEALTHSOURCE 505-262-6541
Dental Clinic
5608 Zuni SE
Albuquerque, NM 87108
Fax: 505-262-0781

**Annex 6 Health and Medical
Attachment 3
Hospital Memorandum of Understanding**

**MEMORANDUM OF UNDERSTANDING
AND
AGREEMENT TO ACCEPT EVACUATED PATIENTS**

This Memorandum of Understanding is entered into by and between the undersigned Hospitals in the Albuquerque area to set forth guidelines under which each Hospital will transfer or accept patients in the event of a partial or total Hospital evacuation in an emergency situation. The evacuation of any of the participating Hospitals would occur only in extreme emergencies which would render a participating Hospital, or a portion of a participating Hospital, unusable for patient care. (Examples of such situations requiring evacuation and transfer of patients to other Hospitals would include a major fire or an environmental hazard.)

Definitions:

"Hospitals" will refer to all of the undersigned Hospitals entering into this Memorandum of Understanding.

"Transferring Hospital" will refer to a Hospital being evacuated, which must transfer its patients.

"Receiving Hospital" will refer to a Hospital receiving patients which are evacuated from a Transferring Hospital.

NOW, THEREFORE, in order to provide for continuation of care of patients of the Hospitals within the area, the Hospitals hereby mutually agree as follows:

Agreements:

1. Subject to medical capability and space availability, each Hospital agrees to accept a Transferring Hospital's patients in the event of an evacuation.
2. The Receiving Hospital will provide medically necessary healthcare services as may be required by patients transported to the Receiving Hospital at the Receiving Hospital's then-prevailing rates. Each of the Hospitals will follow their standard procedures for admission of patients and their standard protocols for providing care to patients. The Transferring Hospital shall not be obligated to pay any charges imposed by the Receiving Hospital unless such liability would exist separate and apart from this Agreement. The Receiving Hospital will collect such charges from the patient or the patient's third party payer.
3. The Transferring Hospital will be responsible for arranging for transportation of any evacuated patients to the Receiving Hospital.

4. The Transferring Hospital will provide the Receiving Hospital with as much advance notice as possible of any patients requiring evacuation to a Receiving Hospital by calling the Receiving Hospital and providing as much information as possible under the circumstances. If the Receiving Hospital does not have the medical capability and space available, it may decline to accept a particular patient.

5. The Transferring Hospital will assist the Receiving Hospital in obtaining proper consents for care.

6. The Transferring Hospital will send to the Receiving Hospital at the time of transfer such identifying administrative, medical and related information as may be necessary for the proper care of the transferred patients. To the extent it is able to do so, the Transferring Hospital will communicate by telephone with a Receiving Hospital staff member to provide the following information:

- The name of the Transferring Hospital staff member making the call,
- Patient's name and other identifying information (medical record number, address, social security number, etc., if known),
- Type of injury or illness,
- Patient's medical condition,
- Name of treating and referring physician(s),
- Anticipated time and date of departure from the Transferring Hospital,
- Method of transfer (ground or air ambulance),
- Anticipated time of arrival at the Receiving Hospital, and
- Patient's third part payer, if information is available.

7. As soon as possible under the circumstances, the Transferring Hospital will compile and send to the Receiving Hospital copies of all available records and supporting data related to the transferred patient's condition (e.g., x-rays, laboratory reports, and treatment notes), to facilitate continuity of care by the Receiving Hospital.

8. The Transferring Hospital will send with each patient at the time of transfer (or as soon thereafter as possible) all of the patient's personal effects and any information relevant thereto. In the event that personal effects cannot be sent with an alert and competent patient, the Transferring Hospital may elect to secure such personal effects until the crisis is over. The Transferring Hospital will remain responsible for such items until receipt thereof is acknowledged by the Receiving Hospital.

9. This Memorandum of Understanding does not require a Transferring Hospital to transfer patients to any Hospital. The Transferring Hospital may transfer patients to facilities other than the Hospitals.

10. The Receiving Hospital may discharge patients in accordance with its standard procedures.

11. The Transferring Hospital will agree to accept return of a transferred patient to the Transferring Hospital after treatment at the Receiving Hospital, when the patient's medical condition is stable and the Transferring Hospital is capable of providing the level of care required by the patient.

12. No party to this Memorandum of Understanding will base a decision to transfer or accept a Transferring Hospital's patients on the patient's financial status.

13. Neither party, by virtue of this Memorandum of Understanding, assumes any liability for any debts or obligations of either a financial or legal nature incurred by another party to this Memorandum of Understanding.

Miscellaneous:

1. This Memorandum of Understanding shall be governed by the laws of the State of New Mexico, except to the extent that any Federal provider is governed by Federal law and regulations.

2. The invalidity of any provision of this Memorandum of Understanding shall not affect the validity of the remainder hereof.

3. This Memorandum of Understanding represents the entirety of the agreement of the parties with respect to the subject matter hereof and may not be amended except by written instrument signed by the affected parties.

4. The Receiving Hospital will accept the Transferring Hospital's patients without regard to race, color, religion, age, sex, sexual orientation, ancestry, physical or mental disability, or national origin, in accordance with federal and state laws and regulations, provided admission requirements are met and bed space is available to accommodate the patient.

5. Nothing contained herein is intended to permit practitioners who have not been granted privileges to practice within a particular Hospital the right to practice therein without first having obtained clinical privileges from the Hospital in accordance with its customary procedures. Each Hospital, however, agrees to work cooperatively to ensure that patient care is not unduly interrupted, and will work to coordinate care between their respective medical staffs, or to grant temporary privileges to practitioners pursuant to its standard procedures.

6. As between the parties, each party acknowledges that it will be responsible for claims or damages arising from personal injury or damage to persons or property to the extent they result from negligence of that party's employees. The liability of the Regents of the University of New Mexico will be subject in all cases to the immunities and limitations of the New Mexico Tort Claims Act, Sections 41-4-1 et seq. NSMA 1978, as amended.

7. The parties will maintain professional and general liability coverage adequate to provide coverage for the actions contemplated by this Agreement. The insurance coverage for the Regents of the University of New Mexico will be coverage required by the New Mexico Tort Claims Act.

8. Nothing in this Memorandum of Understanding, expressed or implied, is intended to confer any rights, remedies, claims or interest upon a person not a party to this Memorandum of Understanding.

Term and Termination:

As to each Hospital, the term of this Agreement will commence on the date that this Agreement is signed by the Hospital, and will continue in full force and effect unless terminated or modified by mutual written agreement of all of the Hospitals. An individual Hospital may elect to terminate its participation in this Memorandum of Understanding by providing thirty (30) days written notice to the other Hospitals of its intent to terminate.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement on the day and year written below.

PRESBYTERIAN HEALTHCARE SERVICES:
(On behalf of Presbyterian Hospital
and Presbyterian Kaseman Hospital)

By: _____

Date: _____

REGENTS OF THE UNIVERSITY OF
NEW MEXICO:
(On behalf of University Hospital,
Mental Health Center,
Carrie Tingley Hospital, and
Children's Psychiatric Hospital)

By: _____

Date: _____

HEART HOSPITAL OF NEW
MEXICO, LLC

By: _____

Date: _____

INTEGRATED SPECIALTY HOSPITAL

By: _____

Date: _____

ST. JOSEPH HEALTHCARE:
(On behalf of St. Joseph Medical
Center, St. Joseph West Mesa, St.
Joseph Northeast Heights, and St.
Joseph Rehabilitation Center)

By: _____

Date: _____

NEW MEXICO VA HEALTH CARE
SYSTEM

By: _____

Date: _____

LOVELACE MEDICAL CENTER

By: _____

Date: _____

Annex 6 Health and Medical Attachment 4 Mortuary Services

MORTUARY SERVICES

- A. NOTIFICATION: In the event of an emergency or disaster with fatalities, the person becoming aware of such an event shall report it immediately to the Office of the Medical Investigator's (OMI) local representative or Field Deputy Medical Investigator (FDMI).
1. A LOCAL FDMI CAN BE REACHED VIA DISPATCH AT: 505-272-3053
 2. IN THE EVENT THAT A LOCAL FDMI CANNOT BE CONTACTED, AN ALTERNATE NUMBER WOULD BE IN ALBUQUERQUE AT: 505-277-2241 (UNM PD)
- B. REMOVAL OF THE LIVING: Police, fire and rescue agencies will be the initial groups responding to the scene of a disaster and will have primary responsibility for removal of the living and security of the scene prior to the arrival of a representative of the OMI.
- C. OMI RESPONSE: The first member of the OMI who is notified will initiate the OMI response protocol and respond to the Emergency Operations Center or appropriate meeting location to make an initial assessment and contact the Albuquerque Central Office of the OMI.
- D. COMMUNICATION: The OMI does not provide local field staff with emergency communication equipment, therefore, every effort should be made by the emergency operations center/on-site commander to facilitate communication between the local representative and the Albuquerque OMI Central Office as communication may be difficult.
- E. SCENE SECURITY: The Emergency Operations Center or the Incident Commander will insure that the disaster/emergency site will be properly secured and protected to prevent loss/theft using local, State, and/or Federal resources as appropriate. No examination, photographing, removal of clothing or effects, or handling of bodies in any manner whatsoever except that necessary for preservation of lives and safety of others shall be performed.
- F. JURISDICTION ISSUES: It should be understood by all responding agencies that a disaster/emergency with fatalities is considered a crime scene - even in natural disasters, the potential for foul play continues to exist. By State Statute, this requires a response and investigation by the appropriate law enforcement agency and the NM OMI - (24-11-5 NMSA 1978).

- G. RECOVERY OF REMAINS AND PERSONAL EFFECTS: Once the disaster/emergency site has been declared safe, The OMI working under the Incident Command System, will coordinate with the Emergency Operations Center, the Incident Commander, and the appropriate law enforcement agency to insure that a plan for documenting and recovering evidence, remains and personal effects from the site can be coordinated and conducted using all available resources.
- H. A team which may comprise local FDMIs and/or other identified medical investigator personnel will meet with the Incident Commander and law enforcement to develop an appropriate strategy.
- I. EXAMINATION OF REMAINS: The OMI is responsible for the safety and security of all recovered remains and personal effects. Personnel and resources will be identified to document, collect, store, transport, and examine as necessary.
- J. RELEASE OF REMAINS: The OMI will continue to hold remains/personal effects until identifications have been made. The OMI will initiate death certificates and release remains and personal effects as required by law.
- K. MEDIA: The OMI will coordinate all public information through the University of New Mexico Department of Public Affairs under the Incident Command System.
- L. WORKING WITH VICTIM'S FAMILIES: The OMI will coordinate with other agencies to insure that communication with deceased members' families is established so that information can be collected and disseminated as appropriate. Limited grief counseling services for families may be available through the OMI, however, other resources may exist to assist in this area.

Annex 6 Health and Medical Attachment 5 Decontamination

I. Decontamination at Receiving Hospitals

All of the health care systems for the nine major receiving hospitals in Albuquerque have agreed to operate decontamination stations for walk-in patients. Decontamination stations are part of the MMRS Hospital Kit installed at each of the nine hospitals.

Non-ambulatory patients will be stripped and decontaminated by decontamination personnel, separately, to avoid slowing progress of ambulatory victims through the decontamination process. As part of decontamination, victims will be scanned to confirm that the decontamination process has been effective. Scanning equipment is available from the EOC MMRS resupply cache.

Hospital decontamination process and procedures will be standardized for quick deployment, simple training maintenance, and reinforcement of other hospitals.

II. Ability to Triage Victims and Provide Primary Care Prior To Their Transportation to a Definitive Medical Care Facility

A. Triage

The objective of triage is to sort victims so that the maximum number of lives may be preserved through rapid and effective utilization of medical treatments. Triage is handled by the ICS Triage Sector of the EMS branch at the scene. In an NBC incident, depending upon the agent, victims will be triaged in terms of those most likely to respond to medical treatment and antidotes.

B. Triage Tags

Triage tags indicating patient classification will be used. The tag also identifies injuries and any treatments administered in the field. The tag will become the tracking base for patients. In the event of a large number of victims, triage may be indicated initially by marking the priority on the patient's forehead with the felt pen. In such cases, the triage tag will be attached as soon as feasible. Albuquerque Fire Department and participants in the mutual and automatic aid system use the Simple Triage and Rapid Transport System (START) triage criteria and classification system. Features include the use of NATO colors and added tear-off, numbered information and locator sections for improved patient tracking. The added tear-off strips allows tracking of patients into the NDMS system and through the hospital system (where triage tags and numbers become attached to the patient treatment record in the hospital Emergency Department, and are continued with the record if the patient is admitted).

III. Emergency Medical Transportation of Patients

A. Transport from the Scene

The **ICS Transport Sector** at the scene will handle movement of patients from the scene to receiving hospitals or to shelters as treatment personnel at the scene deem appropriate. Only **patients who have been decontaminated will be transported**. All vehicles used to transport victims will be decontaminated after the incident.

Decontaminated, uninjured patients may be released or transferred to mass shelter locations as determined to be appropriate by the EMS branch officer.

The Incident Commander will designate zones in or near treatment areas to serve as collection points for patients to be transported. Ambulatory victims, once given initial assessment, decontamination and treatment, can be transported en mass on designated vehicles such as busses and other multiple patient transports belonging to the City or available through formal agreements. Patients who may be contaminated will be transported to medical facilities via AFD/EMS ambulance. If appropriate and such transport will not further disperse the agent, air transportation may be used, although air emergency carriers usually decline to transport patients who may be contaminated due to confined space on the aircraft and flight logistics.

The **Albuquerque Fire Dept. Emergency Medical Services (AFD EMS)** and other City vehicle resources will transport victims from the incident scene to hospitals and other medical facilities in the Albuquerque area. Victims will be transported in a variety of vehicles, depending upon their condition and medical need. This will include ambulances, multiple occupant vehicles including busses, and, if appropriate, by air. Movement and loading of vehicles at the scene will be managed by the **ICS Transport Sector**, with escort support from the **Albuquerque Police Department** as appropriate. The ICS Transport Sector and the EOC will coordinate the acquisition of additional vehicles and equipment. All patients, without regard to mode of port or level of injuries, will be tracked through the triage tag system.

IV. Emergency and Inpatient Services In Hospitals That Have the Capacity and Capability to Provide the Definitive Medical Care Required

The **nine major receiving hospitals in Albuquerque** that have full-service emergency departments and regularly accept ambulance transported emergency patients are New Mexico VA Health Care System, University Hospital, Lovelace Medical Center, Presbyterian Hospital, Albuquerque Region Medical Center, Presbyterian Kaseman Hospital, Women's Hospital, West Mesa Medical Center, and The Heart Hospital of New Mexico. These nine major receiving hospitals have agreed to receive a standardized MMRS contingency kit that contains immediate action procedures, equipment and a decontamination station system for mobilizing hospital staff to receive walk-in patients including those who may be contaminated. Kit Procedures will include treatment protocols for various WMD agents and job descriptions for managing MMRS operations.

V. Transportation to Pre-Designated, Off-Site Treatment Facilities

The Albuquerque medical community maintains a network of alternate medical treatment facilities throughout the state that are ready to accept overflow victims. The Health and Medical Annex of the Albuquerque All-Hazard EOP at the EOC contains a comprehensive list of all New Mexico hospitals and clinics and well as transportation resources. The Albuquerque Hazmat response unit SOP will list those hospitals in the Albuquerque area, ranked by readiness level that will receive victims from the scene.

VI. Management of Patients Arriving At Hospitals without Prior Field Treatment/ Screening or Decontamination

A. “Walk-In” Patients at Hospitals

In addition to patients transported from the scene, particularly in a large event, hospitals may encounter “walk-ins” or patients transported by themselves or others to the facilities. The nine major receiving hospitals have agreed to decontaminate, triage and treat such patients. Decontamination procedures will follow those used at the scene and will differ slightly in keeping with the agent. Hospitals will handle medical triage for walk-ins and assume tracking responsibility for patients not processed through the scene.

B. “Worried-Well” Patients at Hospitals

Citizens who worry that they may be victims of an incident but who do not show symptoms are considered to be “worried-well” and need information about potential treatment. Most of the patients who arrive at a hospital may be worried-well. When worried-well patients arrive at hospitals, hospital personnel will separate worried-well patients from patients with symptoms at the initial triage area before decontamination, according to the MMRS kit procedures.

To help reduce the number of worried-well patients at hospitals and other medical facilities, the Albuquerque EOC will make frequent public service announcements by radio and TV regarding locations situated away from hospitals and other medical facilities where people can go for medical assessment. These locations or “Casualty Collection Points” are part of the Albuquerque MMRS Infrastructure Of Temporary Facilities that can be activated during a WMD event and are detailed in “Managing the Health Consequences of a Biological WMD,” Albuquerque MMRS, Deliverable No. 7. The City of Albuquerque owns and operates over 20 community centers throughout the City that can serve as casualty collection locations. The EOC will dispatch personnel from call down lists to set up each temporary facility using facility activation Kits stored at the EOC. The EOC will maintain a call down list of qualified personnel from the local medical community to staff each location.

C. Receiving Areas Outside the Facility

Depending upon conditions and the specific agents involved, hospitals will make a decision to receive patients outside the facility or to set up receiving areas inside the facility. Some combination of the two options may also be elected. Factors in the decision are expected to include the potential for facility contamination by victims, the number of victims, the types of treatment/antidote administration required, the nature of injuries, and weather and staffing.

All equipment needed for decontamination at area hospitals will be stationed using standardized, easy-to-use MMRS Contingency Kits. Each kit will contain simple instructions for setting up a hospital decontamination station and reception areas and include PPE and supplies for hospital personnel in labeled storage lockers.

Hospital MMRS Kits will be used for annual hospital training as well as for actual incidents. The **Albuquerque Office of Emergency Management** will periodically inspect MMRS Hospital Kits for readiness and will maintain backup kit components at the EOC as a reserve for emergency replacement.

Annex 6 Health and Medical Attachment 6 Procurement and Provision of Appropriate Pharmaceuticals, Equipment and Supplies for 1,000 Victims

I. Procurement of Appropriate Pharmaceuticals, Equipment and Supplies

A. Pharmaceuticals

Pharmaceuticals are drugs specifically used to treat symptoms of chemical and biological agents. The basic strategy for procuring pharmaceuticals to treat 1,000 victims is to 1) purchase pharmaceuticals for the immediate treatment of 1,000 victims of a chemical attack and 2) identify local sources of pharmaceuticals for treating the affected population of a biological attack for the first 24 hours after detection. The CDC will supply

The following table shows the general plan for supply and resupply of drugs:

	0 Hour	+ 0 - 1 Hour	+ 1 - 24 Hours	+ 24 Hours
	Immediate Initial Supply	Resupply of Exhausted Initial Supply	Resupply for the first 24 hours after WMD event	Resupply after first 24 hours after WMD event
Chemical WMD Event	1) MMRS Hospital Kits 2) Cache in Responding Hazmat Team	1) Resupply Cache in Hazmat Unit 2) Resupply Cache in EOC	Resupply Cache at local drug wholesaler warehouse	CDC Push Package
Biological WMD Event	Hospital pharmacies	Resupply from Local retail pharmacies	Local drug wholesaler warehouse	CDC Push Package

A WMD event that has immediate impact such as a chemical attack will require rapid delivery of drugs to victims. The Immediate Initial Supply will be composed primarily of auto-injectors and kits for dealing with the initial effects of nerve and cyanide agents. Additional auto-injectors and kits for re-supplying the exhausted Initial Supply will be stationed at the AFD Hazmat Unit and at the EOC. As the emergency progresses, the local drug wholesale warehouse will supply drugs for the

continuing treatment of victims at medical facilities from a prearranged cache. Additional Pharmaceuticals in “Push Packages” are also available from the National Pharmaceutical Stockpile, controlled by the Centers for Disease Control, within 12 hours of Federal approval. The EOC will maintain lists of additional drug resources. Responders to a biological incident scene will have more time to ensure that victims receive needed drugs. Victims of a known biological attack at a scene will be transported to local hospitals for treatment. The EOC will coordinate local retail pharmacies and the local drug wholesale warehouse in providing needed drugs for the first 24 hours after a WMD event is detected.

The Immediate Initial Supply of drugs for a chemical attack are manufactured kits that can be stored at room temperature and have a shelf life of five years. At the end of five years, the Albuquerque Office of Emergency Management will assess the WMD threat and purchase fresh drugs, if appropriate.

B. Medical Equipment and Supplies

Medical Equipment and Supplies include items typically used for mass casualty incidents such as airway management supplies, wound dressings and related equipment. Albuquerque MMRS will purchase **Mass Casualty Equipment and Supplies** to treat 1,000 victims of a chemical WMD incident. The EOC will maintain lists of additional resources.

II. Provision of Appropriate Pharmaceuticals, Equipment and Supplies

The basic strategy for providing pharmaceuticals and medical equipment and supplies to treat 1,000 victims is to 1) station a limited amount of items for immediate use with responding agencies including HazMat units and hospitals and 2) reserve the remainder in **caches** located at the Hazmat Unit, EOC and local drug wholesale warehouse for resupply within the first 24 hours after a WMD event.

Cache items include 1) Mass Casualty Equipment and Supplies and 2) Pharmaceuticals. Cache items will be located in secured rooms with activation information detailed in the **All-Hazard Emergency Operations Plan** at the EOC and HazMat unit SOP’s.

The **Albuquerque Office of Emergency Management** will monitor the status of the secured pharmaceuticals and track expiration dates.

III. Responsibilities

A. Albuquerque Fire Department

The **AFD HazMat Response Unit** will carry an initial supply of Mass Casualty supplies and equipment and pharmaceuticals to manage the immediate needs of up to 50 victims at a chemical WMD incident scene or impacted hospital. The HazMat Unit

will draw additional cache items from AFD-controlled caches at the Hazmat Unit and the EOC.

B. Albuquerque EOC

The **Health & Medical Emergency Support Function Coordinator** in the EOC coordinates with the ICS Resource Sector on scene, agencies with personnel authorized to handle controlled drug items, and the **EOC Municipal Development Support Coordinator** to re-supply incident scene responders and hospitals. **City Municipal Development** vehicles will transport Mass Casualty supplies and equipment and pharmaceuticals from caches to responding units and impacted hospitals in a timely manner. Using pre-event call lists contained in the All-Hazard EOP, the EOC **Health & Medical Support Function Coordinator** will contact local and statewide drug and medical equipment suppliers to arrange supplemental resources and long-term resupply of caches as the incident progresses.

C. Hospitals

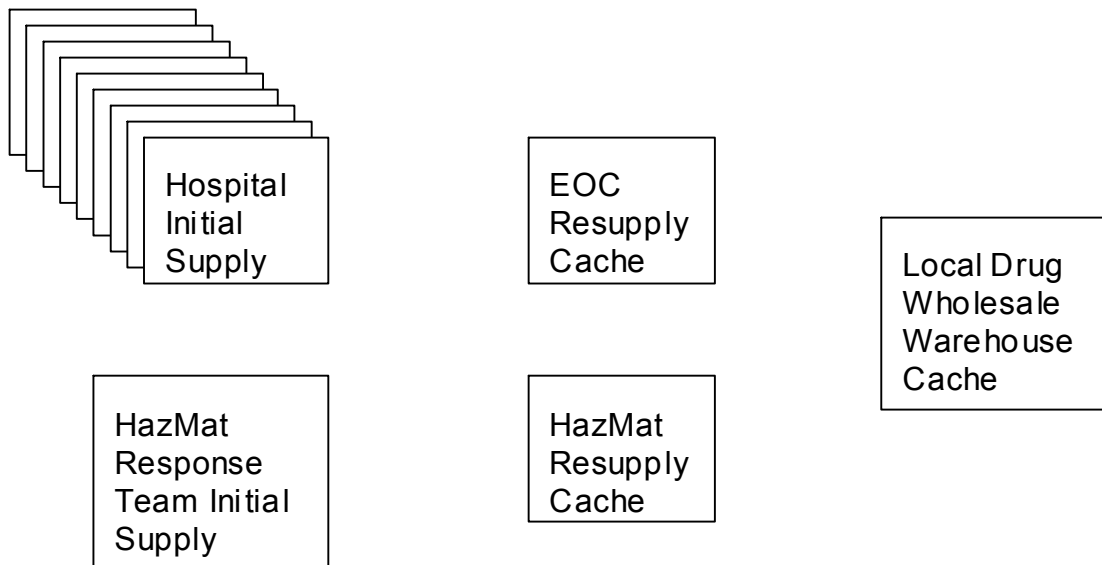
Each of the **nine major hospitals** have agreed to store an initial supply of Mass Casualty supplies and equipment and pharmaceuticals in an MMRS Hospital Kit, sufficient to manage the immediate needs of up to 25 arriving victims of a chemical WMD incident.

IV. Cache Management

A. Cache Locations

To reduce the risk of loss, cache items will be divided into immediate supplies among hospitals and in the Hazmat Team, with resupply caches at the Hazmat Unit location, EOC and local drug wholesale warehouse. Dispersal serves a security function to reduce the probability that an attack could be mounted easily to destroy all available supplies (especially pharmaceuticals) simultaneously and serves to place cache materials at different City locations to reduce time needed for additional supplies to arrive at the scene.

Locations of Local MMRS Drug Caches & Initial Supplies



The Albuquerque cache locations will include the nine major local hospitals, the Hazmat Unit, EOC, and the local pharmaceutical supply warehouse. To speed response time, **AFD** will control the Mass Casualty supplies and equipment and pharmaceutical caches at the Hazmat Unit and the EOC for initial or immediate resupply at the incident scene or at selected hospitals.

The **EOC** and **AFD HazMat** Unit will maintain a current list of cache locations, contents, and activation information.

B. Cache Structure

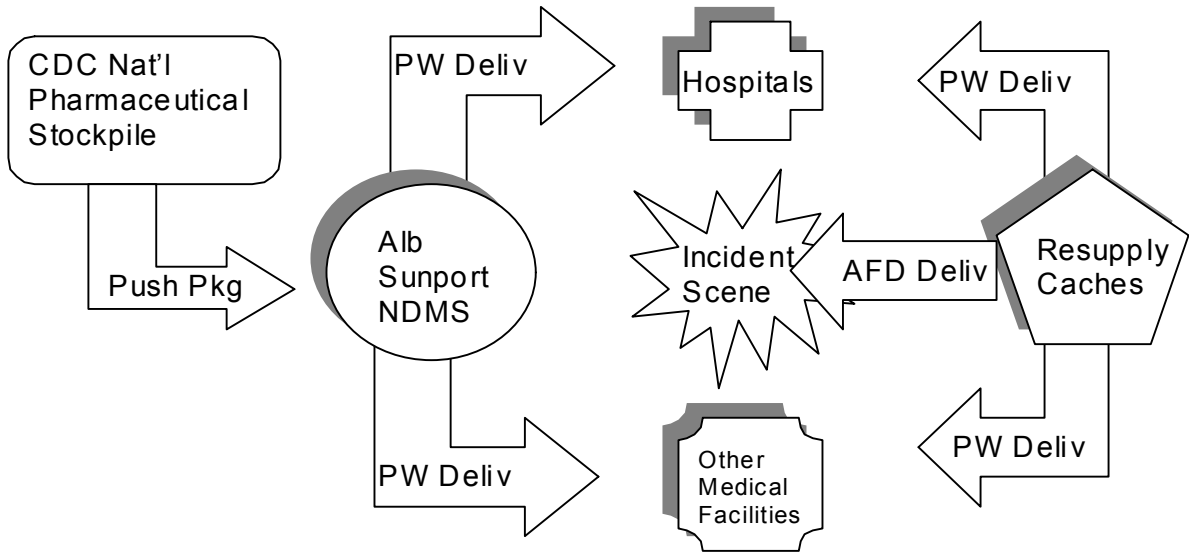
Each cache will contain prepackaged Mass Casualty supplies and equipment and separate prepackaged pharmaceuticals. Packages will be clearly labeled to show appropriate use according to chemical agent or injury and the maximum number of victims that can be treated from each package.

C. Distribution of Cache Items

The Resource Sector at the scene or the EOC Health & Medical Support Function Coordinator supported by the Resources Support and Municipal Development Coordinators will coordinate the physical transport of cache items and personnel authorized to handle pharmaceuticals using City Municipal Development (MDD)) transportation resources and, if shorter response time is needed, AFD resources.

Personnel authorized to handle pharmaceuticals that qualify as “controlled substances” will come from AFD/EMS or other response agencies.

Additional pharmaceuticals in “Push Packages” are available from the National Pharmaceutical Stockpile, controlled by the Centers for Disease Control within 12 hours of Federal approval. A representative from the State of New Mexico in coordination with the Albuquerque EOC will receive the Push Package at the Albuquerque Sunport. City Municipal Development will provide transportation for pharmaceutical handlers from the Albuquerque Sunport to area hospitals and other medical facilities.



Annex 6 Health and Medical Attachment 7 Biological Agent Surveillance and Response

Overview

An effective response to a bioterrorism event depends upon early recognition that a biological agent has been released. Early recognition of a bioterrorism event provides time for resources to be mobilized, prophylactic measures to be taken, and first response to be addressed in a deliberate, organized manner. Early recognition, however, presents the greatest challenge to the response community since the release of a biological agent may be silent, and the first human signs may be non-specific, influenza-like illnesses.

A combination of activities and strategies will be used to meet the early recognition challenge through:

I. Law enforcement activities

- A. By receipt of a credible threat
- B. By discovery of a suspected material
 - 1. Crime Scene Handling and Investigation

II. Surveillance

- A. Albuquerque Environmental Health (AEHD) & N.M. Department of Health (NMDOH) proactive environmental surveillance
- B. By laboratory detection/confirmation
- C. By non-specific indicators such as:
 - 1. Hospital bed availability
 - 2. Emergency medical services runs
 - 3. Unusually high medication purchases
 - 4. Deaths due to unknown infectious etiology
- D. By laboratory diagnosis

III. Dissemination of Early Recognition Information

This approach to early recognition will require timely reporting and thorough dissemination of information to health care providers, response agencies, and a variety of private and governmental institutions. AEHD maintains direct link with N.M. Scientific Laboratory Division (SLD) of DOH and is working to better define the significance of nonspecific

community health indicators (i.e., bed availability, EMS runs, etc.) as well as, building relationships with nontraditional health partners (e.g., New Mexico State Veterinary Association, Albuquerque Veterinary Association, Albuquerque Biological Park etc.).

Detail and Responsibilities

I. Law Enforcement Activities

When a biological terrorism threat against the City of Albuquerque is identified, defining whether the threat is credible will guide the response. The FBI will be the lead Federal agency for crisis management. The Albuquerque Police Department (APD) will be the lead local law-enforcement agency and will work closely with the FBI on the Federal level to interdict the terrorists and prevent the release of any biological materials.

Information obtained by law enforcement agencies may lead to early recognition of a bioterrorism event by the following:

A. Receipt of a Credible Threat

The FBI is primarily responsible for determining the credibility of a threat to use a weapon of mass destruction - including a biological agent against the City of Albuquerque. Once the credibility and nature of the threat has been established, the FBI will notify AEHD, NMDOH, APD, Albuquerque Fire Department (AFD) and the City of Albuquerque EOC. The City of Albuquerque's EOC Manager will coordinate the City's efforts to prepare for and mitigate the consequences of such an attack.

A low-credibility threat is treated similar to a telephonic bomb threat. Initially, there is no obvious physical evidence to substantiate the threat. These incidents will require the dispatching of a single AFD Company to assist the police in evaluating the threat and if necessary implementing initial hazardous materials scene protocols (isolate, deny entry, and call for assistance). Dispatchers will consult with field units via call phone or landline to provide dispatch details.

When a determination is made that a credible threat exists (prior intelligence information, a device, a suspect package or physical evidence is found, or a release of an unknown substance has occurred) the incident will be treated as a crime scene involving hazardous materials. These incidents will require the dispatching of a Hazardous Materials response, in addition to Police resources.

B. Discovery of Suspected Materials

The discovery of biological material or the receipt of a package suspected of containing a biological agent will lead to the use of both field assays and sampling the material for analysis at laboratories. The Albuquerque Fire Department will be the Incident Commander for the purposes of assaying, sampling, and containing the material, patient care, and decontamination at the scene of a biological incident. The Albuquerque Police

Department, in coordination with the FBI, will be the lead local law-enforcement agency for transporting the field sample and crime scene operations.

The FBI, APD, AFD, AEHD, NMDOH, MMRS and the City of Albuquerque Emergency Operations Center (AEOC) will form an Interagency Task Force to define the nature of the threat to the City of Albuquerque. This task force, using the strategies below, will determine the appropriate level of resource mobilization needed to respond to the threat and may recommend any of the following actions:

1. Access the National Threat Assessment Group through the FBI;
2. Activate the AEOC and/or Declare a local State of Emergency;
3. Enhance AEHD surveillance and recognition activities throughout the City;
4. Request assistance from NMDOH-SLD for lab testing;
5. USPHS may be requested to alert the National Disaster Medical System (NDMS) in order to prepare for relocating patients from the City of Albuquerque;
6. Determine priorities for pharmaceutical distribution;
7. Requests DoD to deploy assets such as the Marine Corps' Chemical/Biological Incident Response Force (CBIRF), the U.S. Army's Technical Escort Unit, as well as medical and logistical support units;
8. Request pre-positioning of Federal assets, (such as CBIRF, DMAT, NDMS);
9. The New Mexico National Guard may be asked to mobilize personnel and equipment, especially those units specializing in logistical operations;
10. Alert hospitals and health-care providers of the threat;
11. Ask hospitals to prepare to activate their external disaster plans;
12. NMDOH may request Centers for Disease Control (CDC) to deploy epidemiologists (2 per hospital) to assist with patient monitoring;
13. Prepare to open Points of Distribution for the distribution of medications;
14. Prepare to open Alternate Care Facilities, (i.e. hospital parking lots, community centers, etc.);
15. Contact and notify Bernalillo County Medical Examiner (and those of other counties) and have them prepare to open alternate morgue sites;
16. Task the AFD with alerting field providers to the possibility of patients presenting with diseases caused by rare and potentially dangerous pathogens;
17. AFD may be asked to enhance emergency medical services field operations, including but not limited to additional tours, limiting leave, revising call triage protocols, and activating mutual aid plans;
18. Task the AFD with closely observing call volume and call types for any suspicious changes;

19. APD may be tasked with enhancing security at hospitals and other facilities and the Strategic National Stockpile (SNS);
20. AEHD, BC & NMDOH will request CDC epidemiological assistance and staff support.

C. Crime Scene Handling and Investigation

The APD would probably be the first law enforcement agency on-scene. They are not qualified to handle a biohazard, and would rely on the APD Bomb Squad and/or AFD HAZMAT Team to survey and circumscribe all parts of the scene that could contain contamination. The role of the APD would be to establish and maintain perimeter security from the designated cold zone boundary to protect against unauthorized entry. It would then be up to technical experts assembled by the FBI to handle all processing of the crime scene, and to collect and secure evidence.

AFD Hazardous Materials Team members and APD Bomb Squad members are trained to recognize potential evidence. They also have sufficient familiarity with evidence collection procedures to ensure they don't inadvertently disturb, destroy or spoil potential evidence or interfere with the FBI's ability to establish a clean chain of custody. Once evidence is collected, it will be up to the FBI to decide where it should go for laboratory examination. A local option for biological specimens is the N.M. Scientific Laboratory Division upon notification of NMDOH-EPI.

II. Epidemiological Surveillance

Mass care decisions will be based on the number and location of victims involved in the incident. Early epidemiological recognition is therefore critical to the success of this plan. Tools used to identify the affected population will vary depending upon whether the release is announced through a threat, or unannounced and subsequently determined by one of the elements identified in the early recognition plan.

Unusual or unexplained disease patterns or clusters of patients may be the first indicator of a bioterrorist incident. Features that may be indicative of a suspicious outbreak include:

1. A rapidly increasing disease incidence (e.g., within hours or days) in a normally healthy population.
2. An epidemic curve that rises and falls during a short period of time.
3. Unusual increases in the number of people seeking care, especially with fever, respiratory, or gastrointestinal complaints.
4. An endemic disease rapidly emerging at an uncharacteristic time or in an unusual pattern.
5. Lower attack rates among people who had been indoors, especially in areas with filtered air or closed ventilation systems, compared with people who had been outdoors.

6. Clusters of patients arriving from a single locale. Large numbers of rapidly fatal cases.
7. Any patient presenting with a disease that is relatively uncommon and has bioterrorism potential (e.g., pulmonary anthrax, tularemia, or plague).

The Director of Albuquerque Environmental Health Department is responsible for activating the MMRS Biological Response Plan when a bioterrorism event is suspected. Decision for activation will be based on alerts, threats, and suggestive evidence collected by other MMRS components or as a result of current surveillance activities within Bernalillo County. These activities include:

1. AEHD & BC Surveillance
2. Laboratory Detection/Confirmation
3. Non-Specific Indicators
4. Laboratory Diagnosis

A. Albuquerque Environmental Health and Bernalillo Co. Surveillance

SEE ATTACHMENT 8: “Albuquerque Biological Terrorism Strategic Plan: Preparedness & Response”

The New Mexico Administrative Code, through the Office of Epidemiology, identifies reportable diseases within the State. Incidences of CDC designated, Category A diseases i.e. Anthrax, plague, smallpox and Tularemia are required to be reported immediately to the agency.

If no warning or discovery occurs through law enforcement agencies, the City will rely on its' Biodisease Advance Warning System and epidemiological surveillance to detect the release of a biological agent. The Biodisease Advance Warning System consists of ongoing surveillance utilizing wild and domestic animals as sentinels for disease within the environment. In an actual event, AEHD, BCDOH and NMDOH will determine the affected population through an epidemiological investigation, which may include:

1. Locations and numbers of diseased animals
2. Interviews of affected patients to help establish the release point.
3. AEHD Air Quality Division - track meteorological conditions such as wind speed and direction to help determine where and how far a biological agent has been dispersed.
4. Plot the symptom onset time to track how fast a release may be dispersing through a population.

B. Laboratory Detection/Confirmation

The N.M. Scientific Laboratory Division (SLD) is located within the City of Albuquerque and is a Biosafety Level 3 laboratory. They currently work with AEHD on the detection and laboratory confirmation of naturally occurring diseases such as plague, tularemia, rickettsia, and encephalitis. SLD has expertise for screening and confirmation of a wide range of potential bioterrorism agents. When a bioterrorism event is suspected or appropriate diagnostic testing requested, the SLD can provide rapid identification of the bioterrorism agents.

C. Non-Specific Indicators

In an emerging epidemic, monitoring emergency medical service transports, hospital admissions/bed availability, or unexplained deaths helps a community gauge morbidity and the changing health status of its population. Like a common household "smoke detector", these indicators are nonspecific and will not always identify a "fire" or emerging epidemic. They are nonspecific tools that sound an alarm. Like a fire alarm, when heard, it warrants further investigation. Much of the monitoring and analysis of these non-specific indicators is still completed manually. Activity is currently underway to automate tracking and alarms for these indicators through the MMRS.

D. Laboratory Diagnosis

When a patient is diagnosed with a disease caused by any of the biological agents of concern or when a laboratory presumptively identifies any of these agents, New Mexico Department of Health (NMDOH) will initiate a focused epidemiological investigation. The two most important objectives of that investigation will be the determination of whether this is likely a naturally occurring or a human- initiated event, and the potential scope of the incident. Law enforcement officials may conduct a concurrent criminal investigation. NMDOH will notify APD of their findings. City of Albuquerque's EOC will be notified, as well as, all appropriate agencies of the occurrence of a potential incident.

III. Dissemination of Early Recognition Information

The N.M. Scientific Laboratory Division (NMSLD) is a member of the Public Health Laboratories Resource Network, a joint project with the Centers for Disease Control and Prevention that help link local health departments, private testing laboratories, State Health Departments and the CDC together for improved public health.

To ensure consistency, "action triggers" will be formally set by the Albuquerque EOC Manager in consultation with the Chiefs of APD and AFD and the Director of AEHD. Detection by the Biodisease Advance Warning System and/or a rise in generic city "health indicators" may provide the only early information that indicates a public health response is necessary. When city health indicators are exceeded, the EOC Manager or their designee will alert the State EOC that an action trigger has been exceeded. The purpose of this "alert" is to ensure key components of the MMRS, who are field operational (i.e., public

safety, emergency rooms, infection disease specialist, State veterinarians, etc.) to raise their level of alert and serve as the "eyes and ears" of the EOC in the field. This will encourage communication of unusual findings or incidents and insure that they are communicated to the EOC for consideration during investigation, (i.e. unusual patterns of illness, clusters of dead animals/birds, discovery or investigation of clandestine labs, etc.).

Once the APD/AFD investigation has been completed, the Chiefs or their delegates will notify the City of Albuquerque EOC to have MMRS components stand down or take additional actions.

IV. Augmentation Activities

A. Syndromic Surveillance

Disease-specific surveillance (i.e., Plague, Tularemia etc.) is in place, however, in an unannounced bioterrorism event, early victims may present with vague non-specific symptoms (i.e., fever, cough, and malaise). Clinically, these conditions will be difficult to rapidly diagnosis and require reliance on laboratory identification and existing paper reporting systems. These systems may not always allow for timely recognition, investigation, or public health actions to reduce the spread of an infectious agent.

Greater reliance on syndromic surveillance (e.g., monitoring influenza-like illness, diarrheal disease, etc.) rather than laboratory confirmation or physician diagnoses should improve early recognition of an epidemic, within our "window of opportunity" for implementing public health actions, and more rapidly energize the Metropolitan Medical Response System (MMRS).

Unlike influenza, seasonality cannot be accurately predicted for a bioterrorism incident therefore year round monitoring of influenza-like illness (ILI) and other syndromic conditions must be established.

Reporting of absenteeism at schools is incomplete. Barriers to full reporting have not been clearly identified or addressed. In addition, no criteria for reporting absenteeism make interpretation of this data difficult.

B. Establish Action Triggers for Non-Specific Indicators

As with any first warning system, establishing the appropriate level of sensitivity is critical. If action triggers are set too high, officials are called into action too late. If action triggers are set too low and alarms sound for every insignificant pattern deviation they are soon ignored. Simple "health indicators" need to be adopted, action thresholds validated, and communications linkages formalized to ensure all components of the MMRS (i.e., public health, hospitals, EMS, fire, EOC, law enforcement, city officials, etc.) are moved to a heightened vigilance and information exchange.

C. Reporting Systems

After a biological exposure, illnesses and death may have an explosive escalation accompanied by a short incubation period. Non-electronic or paper-based reporting systems are frequently too slow and not widely distributed enough to ensure a quick and effective preventive action.

Annex 6 Health and Medical Attachment 8 Albuquerque Biological Terrorism Strategic Plan: Preparedness and Response

Including Recommendations of the CDC Strategic Planning Workgroup

The U.S. national civilian vulnerability to the deliberate use of biological and chemical agents has been highlighted by recognition of substantial biological weapons development programs and arsenals in foreign countries, attempts to acquire or possess biological agents by militants, and high-profile terrorist attacks. Evaluation of this vulnerability has focused on the role public health will have detecting and managing the probable covert biological terrorist incident with the realization that the U.S. local, state, and federal infrastructure is already strained as a result of other important public health problems.

INTRODUCTION

An act of biological or chemical terrorism might range from dissemination of anthrax spores to food product contamination and predicting when and how such an attack might occur is not possible. However, **the possibility of biological terrorism should not be ignored**. Preparing the nation to address this threat is a formidable challenge, but **the consequences of being unprepared could be devastating**.

The public health infrastructure must be prepared to prevent illness and injury that would result from biological terrorism, especially a covert terrorist attack. As with emerging infectious diseases, **early detection and control of biological attacks** depends on a strong and flexible public health system at the local, state, and federal levels.

Combating biological terrorism will require capitalizing on advances in technology, information systems, and medical sciences. Preparedness will also require a re-examination of core public health activities (e.g., **disease surveillance**) in light of these advances. **Preparedness efforts by public health agencies and primary health-care providers to detect and respond to biological terrorism will have the added benefit of strengthening the U.S. capacity for identifying and controlling injuries and emerging infectious diseases.**

I. OVERT VERSUS COVERT TERRORIST ATTACKS

In the past, most planning for emergency response to terrorism has been concerned with overt attacks (e.g., bombings). **Chemical terrorism** acts are likely to be overt because the effects of chemical agents absorbed through inhalation or by absorption through the skin or mucous membranes are usually immediate and obvious. Such attacks elicit immediate response from police, fire, and EMS personnel.

In contrast, attacks with biological agents are more likely to be covert. They present different challenges and require an additional dimension of emergency planning that involves

the public health infrastructure. **Covert dissemination of a biological agent in a public place will not have an immediate impact because of the delay between exposure and onset of illness (i.e., the incubation period).** Consequently, the first casualties of a covert attack probably will be identified by physicians or other primary health-care providers. **Thus, the critical need for advance warning prior to the onset of human disease.** For example, in the event of a covert release of a biological agent, patients will appear in doctors' offices, clinics, and emergency rooms during the first or second week, complaining of fever, back pain, headache, nausea, and other symptoms of what initially might appear to be an ordinary bacterial or viral infection. **By the time patients begin to die, the terrorists would be far away and the disease disseminated throughout the population.**

Only a short window of opportunity will exist between the time the first cases are identified and a second wave of the population becomes ill. During that brief period, public health officials will need to determine that an attack has occurred, identify the organism, and prevent more casualties through prevention strategies (e.g., mass vaccination or prophylactic treatment). As contamination continues, successive waves of transmission could carry infection to other localities. **Early detection though an advance warning system is, therefore, critical to reduce catastrophic casualties.**

II. FOCUSING PREPAREDNESS ACTIVITIES

Early detection of and response to biological terrorism is crucial. Without special preparation at the local and state levels, a large-scale attack with biological agents could overwhelm the local and perhaps national public health infrastructure.

Preparedness for terrorist-caused outbreaks and injuries is an essential component of the U.S. public health surveillance and response system, which is designed to protect the population against any unusual public health event (e.g., influenza pandemics, contaminated municipal water supplies, or intentional dissemination of *Yersinia pestis*, the causative agent of plague). **Surveillance methods, diagnostic techniques, and physical resources** are required to detect and investigate unusual or unknown diseases, as well as syndromes or injuries caused by biological attacks.

State and local health-care agencies must have enhanced capacity to investigate unusual events and unexplained illnesses, and diagnostic laboratories must be equipped to identify biological agents that rarely are seen in the United States.

III. KEY FOCUS AREAS

A. **CDC's strategic plan** is based on the following five focus areas, with each area integrating training and research:

1. Preparedness and prevention;
2. Detection and surveillance;
3. Diagnosis and characterization of biological and chemical agents;
4. Response and communication.

B. Preparedness and Prevention

Detection, diagnosis, and mitigation of illness and injury caused by biological terrorism are complex processes that involve numerous partners and activities. Meeting this challenge will require **special** emergency preparedness in all cities and states.

C. Detection and Surveillance

Early detection is essential for ensuring a prompt response to a biological attack, including the provision of prophylactic medicines, chemical antidotes, or vaccines. CDC will integrate **surveillance** for illness and injury resulting from biological terrorism into the **U.S. disease surveillance systems**, while developing new mechanisms for detecting, evaluating, and reporting suspicious events that might represent covert terrorist

D. Response

A comprehensive public health response to a biological terrorist event involves advance warning, epidemiological investigation, medical treatment and prophylaxis for affected persons, and the initiation of disease prevention or environmental decontamination measures.

To ensure the availability, procurement, and delivery of medical supplies, devices, and equipment that might be needed to respond to terrorist-caused illness or injury, CDC will maintain a **national pharmaceutical stockpile**.

1. **Because the initial detection of a covert biological or chemical attack will probably occur at the local level, disease surveillance systems at state and local health agencies must be capable of detecting unusual patterns of disease or injury, including those caused by unusual or unknown threat agents.**
2. Because the initial response to a covert biological or chemical attack will probably be made at the local level, epidemiologists at state and local health agencies must have **expertise** and **resources** for responding to reports of clusters of rare, unusual, or unexplained illnesses.

Steps in Preparing for Biological Attacks

- a. Enhance epidemiologic capacity to detect and respond to biological attacks.
- b. Supply diagnostic reagents to state and local public health agencies.
- c. Establish communication programs to ensure delivery of accurate information.
- d. Enhance bioterrorism-related education and training for health-care professionals.
- e. Prepare educational materials that will inform and reassure the public during and after a biological attack.
- f. Stockpile appropriate vaccines and drugs.

- g. Establish molecular surveillance for microbial strains, including unusual or drug-resistant strains.
- h. Support the development of diagnostic tests.

IV. CRITICAL BIOLOGICAL AGENTS

A. Category A

The U.S. public health system and primary health-care providers must be prepared to address varied biological agents, including pathogens that are rarely seen in the United States. High-priority agents include organisms that pose a risk to national security because they

- 1. can be easily disseminated or transmitted person-to-person;
- 2. cause high mortality, with potential for major public health impact;
- 3. might cause public panic and social disruption; and
- 4. require special action for public health preparedness

B. Category B

Second highest priority agents include those that:

- 1. Are moderately easy to disseminate;
- 2. Cause moderate morbidity and low mortality; and
- 3. Require specific enhancements of CDC's diagnostic capacity and enhanced disease surveillance.
- 4. A subset of List B agents includes pathogens that are food- or waterborne.

C. Category C

Third highest priority agents include emerging pathogens that could be engineered for mass dissemination in the future because of:

- 1. Availability;
- 2. Ease of production and dissemination; and
- 3. Potential for high morbidity and mortality and major health impact.

Preparedness for List C agents requires ongoing research to improve disease detection, diagnosis, treatment, and prevention. **Knowing in advance which newly emergent pathogens might be employed by terrorists is not possible; therefore, linking bioterrorism preparedness efforts with ongoing disease surveillance and outbreak response activities as defined in CDC's emerging infectious disease strategy is imperative.**

D. Status and Plan

The City of Albuquerque has established an Emergency Operation Plan to be implemented in case of an emergency or disaster. It can be expanded in a situation, which exceeds or is expected to exceed Albuquerque's response capabilities and resources. In this regard the City has adopted the National Incident Management System (NIMS) for managing EOC operations. The State Office of Emergency Management (OEM) will assist if necessary.

A Chiefs' Homeland Security Task Force meets weekly to discuss past, present and future Incident situations. Attendees include Chiefs of Police, Fire, Corrections, Open Space, and Airport, as well as the Director of Environmental Health or designee, EOC manager, representatives of FBI and other stakeholder agencies.

The City is interested in increasing its' capacity to respond to any catastrophic or serious disaster. The potential of calculated release of diseases, which may affect humans or livestock, is of serious concern including emerging diseases.

The **City's Environmental Health Department** is our first line of defense, as an Early Warning System, to detect, deter and report the presence of Biological contaminants or agents. Early Warning is critical to initiate an effective First Response.

An **Early Warning System** is imperative in relation to Biological Strategic Indirect Warfare in order to initiate an effective first response. The Environmental Health Department (EHD) has the unique capability of surveillance and detection of airborne contaminants, food borne diseases, groundwater contamination and environmental Biodisease. Further development and implementation of near real time decision-assisting tools for local and state-level disaster managers is necessary. **A prototype Biodisease Advance Warning System with standards for disparate data collection and dissemination, which can be replicated at the national level, has been deployed. Multiple methodologies and sampling techniques are utilized, including wild and domestic Animal Sentinels, sensors and technical equipment.**

A holistic approach to an Early Warning System involving Homeland Security is important in order to manage potential disease spread by both natural incidence and terrorist release. Disaster management systems (involving both contaminants and diseases) should be capable of full integration with a myriad of homeland defense and other Public Safety initiatives.

E. Biological Terrorism

1. Foreign entities have the desire to destroy the American nation
2. They do not have the means to mount a serious military offensive
3. They do have Biodisease agents stockpiled
4. They likely have personnel stationed in the U.S.

5. The calculated strategic release of Biodisease in the U.S. is an effective means to inflict mass casualties of humans and livestock affecting basic economy and infrastructure
6. First Responders must have notification of disease presence in order to initiate response
7. First responders are not immune and would be incapacitated along with general population

F. U.S. Health System

1. The system presently relies on humans as sentinels to detect disease
2. Epidemiologists presently track diseases only after human infection
3. Widespread dispersal of Biodisease – is likely to be so pervasive that the first responders (police, fire, health care workers, military) will be incapacitated

G. Albuquerque Environmental Health Department

1. Is the Primary line of defense against the insidious establishment of disease, which could migrate to urban areas and develop mass devastation to humans, livestock and the economy
2. This Early Warning Defense system and the availability of efficacious vaccines and antibiotics are required to avert the mortality, incapacitation, and disturbances caused by the intentional release of Biodisease into large and immunological naive human populations
3. Has expanded capability to detect and test for CDC priority diseases in animal populations
4. Has expanded concentric circles of environmental surveillance
5. Collects and correlates data from statewide locales
6. Has implemented animal sentinel programs i.e. wildlife, domestic livestock and stray pets

H. Food disease contamination

Food Manufacturers and Distributors are obvious stakeholders in relation to the potential utilization (by terrorists) of their infrastructure as a delivery mechanism for Biological agents. Our food distribution system could be visualized as a Weapon of Mass Destruction against the U.S. Military and Civilian population if utilized to contaminate and distribute biological agents.

One phase of the Environmental Health Department, Biodisease Advance Warning System is to educate stakeholders on the Bioterrorism threat and to provide threat prevention training/awareness to thwart or reduce the impact of a terrorist event in our local/regional area, as below.

1. Facility security training and procedural techniques have been provided concerning food establishment reporting methods, food distributor security involving facilities and personnel screening, and epidemiological information for first responders
2. Target – Human and Animal food manufacturing and distribution companies
3. Presentations by Kirtland Air Force Base (KAFB)
4. Notification and scheduling by Alb. Environmental Health Department (AEHD) – Consumer Health Protection Division (CHPD)
5. Topics – facility security, hiring practices, security breach indicators etc.

I. Biological contamination – groundwater

1. Presently monitor groundwater in various locations throughout the Albuquerque area.
2. Increase testing involving number of test wells, types of chemicals/biological material in the water
3. Increase frequency of sampling to provide advance warning of migrating contaminants, which could potentially affect the drinking water
4. Develop sampling protocol
5. Designate contaminant types to test
6. Designate testing lab
7. Native Reservations border the Albuquerque Metropolitan area and historically have had high vector populations
8. The Reservations (as well as nature reserves near urban areas) serve as a reservoir for vector-borne diseases
9. There are many habitat sites and refuges for wildlife
10. The majority of these sites are within/near residential areas
11. Reservations have minimal vector control
12. Without adequate disease surveillance and control, the probability of disease transmission increases
13. It is vital to coordinate a Biodisease surveillance and control program, which not only protects the resident Native American populations but also nearby communities
14. This effort would be initiated by the Indian Nations
15. Biodisease can spread like wildfire across any nation

J. Future

1. Develop network system with web page interface which would communicate with other local, state, and federal public health agencies
2. Improved data storage, data extraction, and access technology would be available to more effectively track and monitor Biodisease on a broader scale
3. Acquire a satellite downlink for long distance education and training. Links to local, state and federal agencies will provide up to date training for BDM staff and enhance competency in Biodisease incidence and manifestation and strengthen collaboration with public health agencies
4. Expand efforts to augment the utilization of GIS technology with the network system. This technology will enhance the efforts to determine Biodisease status and trends locally, statewide and nationally
5. Educate concerning the exposure of Biodisease
6. Expand BDM efforts to inform public schools, neighborhood associations, community organizations, government agencies, etc. on Biodisease management
7. development and printing of literature such as brochures to strengthen partnerships and prevent/reduce disease incidence
8. refine and update information on the website
9. develop and provide fact sheets on Biodisease to the community to enhance preventive and protective measures involving a terrorist attack
10. provide education and experience for case investigations involving Biodisease such as plague, tularemia, and arbovirus
11. Continue direct collaboration with CDC, USDA, UNM, NMSU, SLD, Sandia Labs, LANL, Health Care System, Veterinary System, KAFB, Food Production/Distribution System, Federal and Civilian entities
12. Responsibilities: surveillance, detection, data collection and correlation, monitoring, reporting, modeling, education, training, strategic planning and implementation

K. Biodisease Management Goal

To interpret data concerning key animal indicators to simulate and comprehend Biodisease trends in order to provide accurate and expedient advance warning prior to human onset of disease. Indicators may include diseased vectors, such as fleas, ticks, mosquitoes, rodents, birds and other insects and mammals. Evaluation, indication, documentation, correlation and communication concerning additional indicators i.e. animal illness, symptoms and deaths, will assist in determination of a Bio-warfare event and the modeling of time and distance of disease spread.

V. DETERMINING THE TYPE OF THE WMD INCIDENT & 1st RESPONDER CONCERNS

[Taken directly from tab D of FEMA, April 2001, Guide for All-Hazard Emergency Operations Planning, Chapter 6, Attachment G – Terrorism]

A. Indications. Indicators that a WMD incident involving biological agents has taken place may take days or weeks to manifest themselves, depending on the biological toxin or pathogen involved. The Centers for Disease Control and Prevention (CDC) recently developed the following list of epidemiologic clues that may signal a bioterrorist event:

1. Large number of ill persons with a similar disease or syndrome.
2. Large numbers of unexplained disease, syndrome, or deaths.
3. Unusual illness in a population.
4. Higher morbidity and mortality than expected with a common disease or syndrome.
5. Failure of a common disease to respond to usual therapy.
6. Single case of disease caused by an uncommon agent.
7. Multiple unusual or unexplained disease entities coexisting in the same patient without other explanation.
8. Disease with an unusual geographic or seasonal distribution.
9. Multiple atypical presentations of disease agents.
10. Similar genetic type among agents isolated from temporally or spatially distinct sources.
11. Unusual, atypical, genetically engineered, or antiquated strain of agent.
12. Endemic disease with unexplained increase in incidence.
13. Simultaneous clusters of similar illness in noncontiguous areas, domestic or foreign.
14. Atypical aerosol, food, or water transmission.
15. Ill people presenting near the same time.
16. Deaths or illness among animals that precedes or accompanies illness or death in humans.
17. No illness in people not exposed to common ventilation systems, but illness among those people in proximity to the systems.

B. First Responder Concerns

1. A possible method of initiating widespread infection using biological agents is through aerosolization, where fine particles are sprayed over or upwind of a target where the particles may be inhaled. An aerosol may be effective for some time after delivery, since it will be deposited on clothing, equipment, and soil. When the

clothing is used later, or dust is stirred up, responding personnel may be subject to “secondary” contamination.

2. Biological agents are able to use portals of entry into the body other than the respiratory tract. Animals may be used to spread the diseases. Individuals may be infected by ingestion of contaminated food and water, or even by direct contact with the skin or mucous membranes through abraded or broken skin. Use protective clothing or commercially available Level C clothing. Protect the respiratory tract through the use of a mask with biological high-efficiency particulate air (HEPA) filters.

