Los Tres Amigos

2ND ANNUAL BORDER EMERGENCY PREPAREDNESS SUMMIT

CONFERENCE PROCEEDINGS

JUNE 22-23, 2006

Coordinating response to public health emergencies, especially pandemic influenza, in the three state, binational region of Chihuahua, New Mexico, and Texas.

2ND ANNUAL BORDER EMERGENCY PREPAREDNESS SUMMIT
CONFERENCE PROCEEDINGS
Los Tres Amigos

Thursday - June 22, 2006

Welcome

Tres Schnell, Director of the New Mexico Office of Health Emergency Management (OHEM) of the New Mexico Department of Health (NMDOH) welcomed participants on behalf of Secretary Michelle Lujan Grisham. She thanked participants for their attendance and noted that NMDOH was honored to host this event. Ms. Schnell acknowledged the participation of representatives of three Border States – New Mexico, Texas and Chihuahua. She then reviewed the agenda and conference logistics, stressing the opportunity for ongoing collaborative work.

Opening Remarks

Marjolaine Greentree, Director of New Mexico's State Office of Emergency Management (OEM), explained the importance of working across jurisdictions and across disciplines with OEM as a critical partner. She applauded the fact that New Mexico's collaboration with Texas and Mexico was getting stronger. Ms. Greentree related the importance of this collaboration to her experience with the International Red Cross.

Arthur Alvarado, an Epidemiologist with the Texas Department of State Health Services (DSHS), spoke on behalf of Dr. Luis Escobedo and the Department, thanking New Mexico for hosting the Summit. Mr. Alvarado emphasized the unique challenges facing the Border area in terms of emergency preparedness, including diverse populations, different response plans, and other issues. The agency welcomes the collaboration and looks forward to working together with New Mexico and Chihuahua.

Dr. Jorge Magaña, Director of the El Paso City-County Health and Environment District, introduced the concept of ***Los Tres Amigos*** – Cd. Juarez, El Paso, and Las Cruces (Chihuahua, Texas, and New Mexico). Dr. Magaña noted that this region is probably the only place where two countries and three states meet together frequently to find solutions to public health issues. He explained that the states face a common enemy – pandemic influenza – but it is unknown when or how it will impact the border. Dr. Magaña stressed that the primary purpose of the Summit is to coordinate plans to fight this common enemy. While much has been done and there may be some capacity to at least slow down a pandemic influenza event, it is necessary to be vigilant. Planning needs to extend beyond health and medicine and consider the possible impact of pandemic influenza on the economy, schools, and mortuary facilities. Dr. Magaña concluded that together, ***Los Tres Amigos*** can accomplish a lot. The audience was particularly appreciative to have a banner for these efforts - ***Los Tres Amigos*** – and the theme then continued throughout the Summit.

Dr. Hector Puertas, Director of Health Services of Cd. Juarez, Chihuahua, thanked the conference coordinators for inviting the attendees to participate and become more prepared. Health Services of Cd. Juarez has a plan they would like to share with participants and work with ***Los Tres Amigos*** to be better prepared.

Summit Overview

Anne Pascarelli Barraza, Population Outreach Manager for the NMDOH Office of Health Emergency Management, thanked all the conference planners, and provided an overview of the conference and its primary goals. Ms. Barraza explained that the Summit planners looked at a host of topic areas, reflecting the breadth of this area, and selected five as high priorities. These include building capacity to handle medical surge and mass prophylaxis; isolation and quarantine; handling mass fatalities; epidemiology and disease surveillance; and emergency medical services. Materials on other topics were provided in the participant packets. Ms. Barraza stated that the Summit will establish a framework for future dialogue and collaborative planning.

Overview of Federal Pandemic Influenza Response Plans

Mexico

Dr. Gumaro Barrios, Director of Epidemiology for the State of Chihuahua, welcomed participants on behalf of Chihuahua Health Services and presented an overview of pandemic influenza, including the status of the current avian flu and its impact in other countries. Dr. Barrios also presented data on previous pandemic events and explained that the current threat, if it occurs, could affect between 10 and 25% of the population of Mexico.

Dr. Barrios then presented Mexico's National Plan for the Preparation and Response to Pandemic Influenza ("Mexico Plan"). The goal of the Mexico Plan, which follows the World Health Organization (WHO) pandemic alert stages, is to protect the population, respond immediately, and reduce mortality. The components of the Mexico Plan include:

1. Public information, education, and social motivation, including:
   - media involvement;
   - population and personal responsibility;
   - sensitization of specific groups; and
   - training of individuals in strategic locations (for example, airports, ports, border crossings, tourist sites).
2. Coordination – Coordination is fundamental, including local, state, regional, federal, and international, and especially important among our three states;
3. Epidemiology – It is critical to recognize the agent; this step includes training of health workers, continued monitoring, increased lab capacity and agreements with counterparts (especially Texas, Chihuahua, and New Mexico);
4. Prevention – At this point in time, there is a need to develop proper vaccines, understand how this disease progresses in birds and humans and learn strategies for impeding the contagion;
5. Self-care strategies – These include reduction of social contact, limitation of movement of the population and instruction in personal hygiene;
6. Medical attention – This includes training of health care providers, especially how to identify those who are not sick and can go home;
7. Strategic reserves of pharmaceuticals and other items – Significant reserves are not yet available, however, the Mexican government is addressing this issue and negotiating agreements with pharmaceutical companies;
8. Research and development – This is directed towards antiviral production, new production techniques for vaccines and alternative treatments.

Dr. Barrios described the challenges in Mexico, including operationalizing the plan at the state and local level and implementing exercises to test response capacity. The Mexican Plan has been sent to all the States in Mexico to assist with building their capability to face the threat.

For more information, go to: http://www.dgepi.salud.gob.mx/pandemia/pandemia.htm

Contact: Dr. Gumaro Barrios Gallegos
Subdirector de Epidemiología
Servicio de Salud Chihuahua
bgumaro@hotmail.com

United States

Todd Wilson, Officer in Charge of the Centers for Disease Control (CDC) El Paso Quarantine Station of the U.S. Department of Health and Human Services (HHS), presented an overview of the HHS Pandemic Influenza Plan ["HHS Plan"]. Mr. Wilson explained that seasonal influenza causes 250,000 to 500,000 deaths a year globally, with 36,000 deaths and over 200,000 hospitalizations in the Unites States. As he explained, pandemic influenza is different than seasonal influenza. He identified concerns specific to pandemic and explained how a pandemic strain emerges. One concern is that El Paso, Las Cruces, and Chihuahua are in the avian flyway which originates in Southeast Asia. Other concerns include the likelihood of rapid global spread, potentially high rates of infection, high morbidity and mortality, shortages and delays in availability of vaccines and antiviral medications, an increased burden on hospitals and outpatient care systems and disruption of community infrastructures.

Mr. Wilson explained that the HHS is currently addressing local practices, including limitation of close human contact with poultry and the culling of flocks. The latest CDC Situation Report indicates widespread and spreading prevalence of avian influenza in migratory birds and that 51 counties are involved, continued outbreaks among domestic poultry, evidence of mammalian infection; evolution of the virus and sporadic human cases with some human to human transmission.

The HHS Plan Supports the National Strategy for Pandemic Influenza, outlines planning assumptions and doctrines for health sector pandemic preparedness and response, provides public health guidance for state and local partners and includes 11 supplements with detailed guidance in various areas.

The planning assumptions of the HHS Plan are:

- Containment is unlikely. A pandemic influenza would spread from Asia to the U.S. in 1-2 months. It may be possible to delay the spread by 1-4 weeks through enforcement of severe travel restrictions.
- The incubation period is 1-4 days (although it could be as long as 10 days). People may be infectious before they are symptomatic and remain infectious for ± 10 days.
- On average, each person will transmit influenza to two other individuals.
- An outbreak could last 6-8 weeks and include multiple waves.
- Absenteeism could approach 40%.
- Countermeasures (*i.e.*, vaccine) would probably not be available for the first two waves.
- Fifty percent or more of those who become ill will seek medical care. The number of hospitalizations and deaths will depend on the virulence of the virus.

The primary doctrine of the HHS plan is saving lives, with the belief that a threat anywhere is a threat everywhere. The intent is to 'quench' first outbreaks by detection and containment where the virus emerges, if feasible. This will require:

- international collaboration
- front line detection and response, and rapid lab diagnosis
- isolation and quarantine (Mr. Wilson pointed out that there are 317 international ports of entry into the U.S. and only 18 CDC quarantine stations, including the one in El Paso)
- social distancing and other self-care measures
- prevention and slowing the introduction of the virus to the U.S. based on a "one continent" approach. It is unlikely that international borders would be closed, although there may be travel advisories and exit and entry screening of travelers

Non-pharmaceutical interventions would be used to flatten the outbreak peak but not shorten the duration. There is no data showing that the use of masks in the community would be effective, therefore, mask use is not recommended at this time.

The plan involves community mitigation through "Targeted Layered Containment" (TLC):

- Home isolation of ill patients not needing hospitalization
- Voluntary home quarantine for household contacts
- Social distancing measures
    - School closure and protective sequestration of children may have a profound impact on spread of contagion
    - Workplace Continuity of Operations Plans (COOP), including liberal leave for employees vs. closure
    - Limitation or cancellation of public gatherings
- Personal infection control measures
    - Hand hygiene and cough etiquette
    - Mask use for ill persons
- Disinfection of contaminated surfaces
- Antivirals for treatment and targeted prophylaxis

The HHS plan also emphasizes partnerships, including local, state, federal and international; multi-sector; public/ private, etc.

Mr. Wilson closed by discussing what individuals can do to:

- Decrease influenza transmission and respiratory infections
    - Avoiding close contact with ill people
    - Staying at home when sick
    - Covering of mouth and nose with a tissue when coughing or sneezing
    - Washing hands
    - Avoidance from touching eyes, nose, or mouth
- Decrease transmission of avian influenza
    - Avoidance of contact with sick or dead birds and chickens
- Decrease transmission of human influenza
    - Compliance with vaccination orders, if indicated
- More information on individual and family preparedness is available at: *www.ready.gov*

For more information, go to www.cdc.gov; www.pandemicflu.gov; www.ready.gov; and www.listo.gov.

Contact: Todd Wilson
Officer in Charge
El Paso Quarantine Station
twilson@cdc.gov

U.S./Mexico Border Health Commission Activities

Dr. Salvador Gómez, Coordinator of the Early Warning Infectious Disease Surveillance (EWIDS) project for the Mexican Section of the U.S.-Mexico Border Health Commission, presented an update on activities and accomplishments. Dr. Gómez emphasized that the first step in preparedness for pandemic influenza is diagnosis. Mexico, the U.S., and Canada participate in the Security and Prosperity Partnership (SSP) of North America*, whose agenda includes a continental approach to emergency preparedness in North America for both natural and intentional disasters. There is a Health work group of the SSP focused on sharing of human and material resources across borders, cross-border infectious disease surveillance, and prevention and control of diseases such as pandemic influenza. In addition, the U.S. and Mexico are working on protocols for the transportation of samples and the SSP wants to expand the use of standardized protocols. A part of the Mexico plan addresses increased laboratory capacity and a standardized identification and notification system, including veterinary and viral epidemiology. Currently there is an established protocol through the Early Warning Infectious Disease Surveillance (EWIDS) project for diagnostic/early warning tests for influenza.

*Spanish: Alianza para la Seguridad y la Prosperidad de America del Norte (ASPAN)

Contact: Dr. Salvador Gómez
Coordinator, EWIDS, Mexico Section
U.S.- Mexico Border Health Commission
sgomez@borderhealth.org

Website:
U.S. – Mexico Border Health Commission
www.borderhealth.org

Overview of State Pandemic Influenza Plans

New Mexico

Anne Pascarelli Barraza, Population Outreach Manager for the NMDOH Office of Health Emergency Management, presented the New Mexico plan. She explained that New Mexico's plan is essentially a *response* plan which follows the outline of response topics in the HHS Plan. New Mexico's plan addresses response according to World Health Organization (WHO) pandemic influenza phases, i.e., the inter-pandemic (current), pandemic alert, and pandemic phases.

Ms. Barraza explained that New Mexico is in the process of developing a number of attachments that will expand upon the basic response plan. These attachments include, among others, ethics guidance, a sufficiency of care document, a psychosocial response plan, and an overview of the NM Modular Emergency Medical System (NM-MEMS). She explained that the prototype MEMS system was created in 1996 by the U.S. Department of Defense and other federal agencies, including the U.S. Department of Health and Human Services. The intent was to create a response model to events involving biological and chemical weapons through a flexible system of care with modular functions. New Mexico is adapting this model for all public health emergencies. Ms. Barraza went on to explain that there are still several areas needing attention, including legal issues (in-state, multi-state and international), the care of mass fatalities, and the requirements of the HHS Plan as they apply to states.

Ms. Barraza reported on the activation of Unified Command for Pandemic Influenza Planning in New Mexico. Unified Command commenced in February 2006 and includes the State Office of Emergency Management (OEM), the New Mexico Department of Health (NMDOH), the New Mexico Emergency Managers Association (NMEMA), the Indian Health Services (IHS), and tribal emergency managers. Unified Command is currently in its second operational period and incident action plan. Unified Command has allowed New Mexico to institutionalize the use of Incident Command System (ICS) principles to organize and monitor goals, tasks, and outcomes.

Through CDC supplemental pandemic influenza funding, New Mexico is allocating money to its 33 counties, the City of Albuquerque, and to 22 Native American Tribes for the purpose of local pandemic influenza planning. This funding will provide local emergency managers resources to lead planning and exercises in their communities, including both local and hospital-based exercises.

New Mexico's Pandemic Influenza Response Plan, as well as additional information about New Mexico's efforts in emergency preparedness, can be found at: http://health.state.nm.us/ohem.

Contact: Anne P. Barraza, Population Outreach Manager
Office of Health Emergency Management, New Mexico Department of Health
Anne.pascarelli@state.nm.us

Texas

Cynthia Morgan, Ph.D., R.N., Pandemic Influenza Program Coordinator for the Texas Department of State Health Services (DSHS) explained that DSHS works in 11 health service regions and 64 local health offices, which are relatively autonomous. CDC supplemental funding will flow through the regions based on flat rates per county.

In January 2004, Texas became one of eleven states to complete and publish a Draft Pandemic Influenza Plan. The plan was revised later that year to reflect newly published guidance from the U.S. Department of Health and Human Services. This plan sits as an appendix to the Texas State Emergency Plan. The Texas plan follows the WHO pandemic alert phases and includes sections on Planning and Coordination, Situation Monitoring and Assessment, Prevention and Containment, Health Systems Response, and Communication. The appendices address several key topics: Personal Protective Strategies, Home Care, Population Level Public Health Interventions, Vaccine and Antiviral Priority Lists, Death Care for Managing Mass Fatalities, and School Prevention and Control.

The Department also created Pandemic Influenza Plan Operating Guidelines (PIPOG), and will eventually draft a smaller, more response-oriented plan. The PIPOG was developed with

extensive stakeholder input and has been vetted with many individuals, especially in terms of three priority populations: ethnic groups, people with disabilities, and rural populations. The PIPOG outlines detailed expectations for Texas' Health Service Regions as well as independent Local Health Departments. The PIPOG follows Incident Command System guidelines and includes:

- Antiviral Medications: Use, Dose, and Cost Comparisons
- Personal Protective Strategies
- Taking Care of an Influenza Patient at Home
- Population Level Public Health Interventions
- Laboratory Response Network
- DSHS Vaccine and Antiviral Priority
- Vaccine and Antiviral Purchase, Allocation, and Distribution Plan
- Antiviral Availability and Use Inventory
- Pneumococcal Vaccine
- Sample Standing Delegation Orders
- Death Care for Managing Mass Fatalities
- School Prevention and Control: Interim Guidance
- Infectious Disease Specialists and Influenza Experts
- Algorithm for Determining Risk of Highly Pathogenic Avian Influenza
- Surveillance and Required Reporting
- Vaccine and Antiviral Allocation Form Plan for Vaccine and Antiviral Tracking

Texas sponsored a Pandemic Influenza Summit on business continuity planning, which includes schools, faith-based organizations, community-based organizations, and health care. In the future, Texas will focus on several other issues, including antiviral purchases and priorities.

Contact: Cynthia Morgan, Ph.D., R.N.
Pandemic Influenza Program Coordinator
Texas Department of State Health Services
Cynthia.morgan@dshs.state.tx.us

Website: http://www.dshs.state.tx.us/idcu/disease/influenza/pandemic/

Overview of Work Group Topic Areas

1. Building Capacity to Handle Medical Surge & Mass Prophylaxis

Mary Ann Shaening, Ph.D., President, Shaening & Associates, Inc., Consultant to NMDOH

Dr. Shaening explained that this work group will respond to the need to plan for and manage medical surge, including a surge in hospitalizations and a surge in fatalities. She stressed that many medical and public health resources need to be coordinated along the border, including coordinating on mass prophylaxis activities. The work will be based on several key assumptions:

- Pandemic influenza will affect large numbers of people and will cross national and international boundaries – the surge in hospitalizations in the ***Los Tres Amigos*** area would be at least 10,000 patients*; the number of deaths will minimally reach 2,000.*
- Medical and public health surge may quickly overwhelm the system and there will be a scarcity of medicine, equipment, personnel, and other healthcare resources.
- Hospitals, in collaboration with other healthcare providers, have to be the focal points to provide for medical surge; alternative *in-hospital* inpatient and outpatient areas must be considered, as well as patient transport.
- Coordination with local emergency management is also critical.

Dr. Shaening explained that it is necessary to acquire the most capacity possible to deal with the greatest number of ill individuals requiring care. She offered the following broadly accepted definitions to guide these efforts:

- Medical Surge is a complex or mass casualty medical incident that creates demands that exceed the capacity of the medical infrastructure in an affected community.
- Surge *capacity* is the ability to respond to a markedly increased number of patients. This is more than an issue of beds and requires resource identification, resource movement, and resource management.
- Surge *capability* is the ability to address unusual or very specialized medical needs. It is also the ability to intervene to protect medical providers, other patients, and the integrity of the medical care facility.

Dr. Shaening reviewed the Medical Surge Capacity and Capability (MSCC) Management System, developed by the U.S. Department of Health and Human Services (HHS) and the CNA Corporation, as a framework for organizing a workable management system.** The MSCC Management System is based on the Incident Command System (ICS) and addresses the coordination of six tiers of response:

Tier 1: Individual healthcare facility

- Serves as a primary site of hands-on medical evaluation and treatment.
- Includes hospitals, integrated healthcare systems, clinics, alternative care facilities, private practitioner offices, nursing homes with medical services, hospice, rehabilitation facilities, psychiatric and mental health facilities, and EMS.
- Needs an Emergency Operations Plan at each facility.

Tier 2: Coalition of health care providers

- Forms a single functional entity of healthcare facilities and other healthcare assets to maximize capacity and capability in a defined geographic area.

- Coordinates prevention, preparedness, response, and recovery actions of medical and health providers.
- Facilitates mutual aid support.
- Serves as a unified platform for medical input to jurisdictional authorities.

Tier 3: Jurisdiction

- Allows integration of healthcare facilities with fire/EMS, law enforcement, emergency management, public health, public works, and other response agencies.
- Provides structure and support necessary for medical assets to maximize capacity and capability.
- Directs input from medical health care coalition in planning and decision-making.
- Links local medical assets with State and Federal support.

Tier 4: State

- Identifies state agencies that are responsible for emergency management, public health, and public safety preparedness and response.
- Oversees situations in which the State is considered the lead incident management authority.
- Oversees situations where the State coordinates multi-jurisdictional incident management.

Tier 5: Interstate

- Collaborates and manages interstate planning and response activities.
- Ensures each State is responsible for the safety and welfare of its citizens.
- Allows in an emergency or disaster, that States share information and resources for a coordinated response.

Tier 6: Federal

- Provides federal health and medical assets.
- Organizes for response to federally declared public health and medical emergencies or disasters.
- Coordinates through the U.S. Department of Health and Human Services federal public health and medical assistance for State, tribal, and jurisdictional response.

Along the international border, it may be necessary to consider a Tier 7 that addresses binational coordination and management of planning and response.

Dr. Shaening presented the New Mexico Modular Emergency Medical System (NM-MEMS) as one approach to managing medical surge. NM-MEMS was developed by adapting the MEMS model *** to an all-hazards, all eventuality, approach.

NM-MEMS:

- Focuses on augmenting medical surge capability within or closely associated with existing hospital facilities through the development of alternative in-hospital inpatient care and outpatient care areas.
- Addresses community mobilization, psychosocial needs and resilience and recovery in the model.

- Addresses persons with disabilities and other populations with special response needs
- Addresses advance planning for public information and risk communication, including self-care.
- Outlines the roles of hospitals, primary care, long term care, home health care, and EMS.
- Includes fatality management.
- Incorporates guidelines on altered standards of care (currently referred to as "sufficiency of care.").

The eleven components of NM-MEMS include:

- Alternative In-hospital Inpatient Area(s)
- Alternative In-hospital Outpatient Area(s)
- Patient Flow Protocols
- Points of Dispensing (PODs)
- Capacity for Quarantine and Isolation
- Community Outreach Network
- Psychosocial Network
- Transport System
- Mass Fatality Plan
- Public Information and Risk Communication
- Medical Command and Control

The NM-MEMS model includes roles delineated for the New Mexico Department of Health as well as guidelines for local planning, hospitals, primary care, long term care, home health and EMS.

Information on the NM-MEMS model and guidelines, as well as considerable additional resource material, can be found in the New Mexico Briefing Book prepared for local pandemic planning at: http://health.state.nm.us/ohem.

Contact: Michael Richards, M.D.
Center for Disaster Medicine
University of New Mexico
School of Medicine
mrichards@salud.unm.edu.

* Figures derived from Flu Aid 2.0 and FluSurge, software from the CDC that models the impact of pandemic influenza to a given community

**CNAC Medical Surge Capacity and Capability Handbook
http://www.cna.org/domestic/healthcare/studies.aspx

***Modular Emergency Medical System
http://accem.org/pdf/mems_copper_book_pdf

2. Isolation and Quarantine

Kenneth Gonzales, U.S. Attorney's Office, Las Cruces, NM

Mr. Gonzales explained to the Summit that U.S. Attorneys have been directed by the President to get involved with anti-terrorist efforts at the local level. That involvement translates well to the community-level response that is an emphasis of this Summit. There are four key issues and points of discussion for the work group:

- Governmental authority to order quarantine: The U.S. federal government has the authority to order isolation (physical separation for medical care of exposed individuals) and quarantine (physical separation of people who may have been exposed from others) under existing commerce laws (interstate and foreign travel). State governments have broader authority to address public health emergencies, including authority to order quarantine and isolation measures. Both New Mexico and Texas, for instance already have enacted law that specifies decision-making and delegation authority.
- Individual Liberties: Significantly, one challenge in the event of a public health emergency related to balancing the important governmental interest in protecting the health of the public by slowing or stopping the spread of disease and the individual's liberty to move and travel freely. This issue is addressed in the proposed federal rule discussed below.
- Jurisdictional Issues: Potential jurisdictional issues exist between federal, state, and local governments. Along the U.S./Mexico international border area, the jurisdictional challenges exist between the Border States and the two Border Countries, as there are different laws, authorities, and regulations.
- Notice of Proposed Rule Making: Notice of the new proposed rule on Control of Communicable Disease* was issued in the Federal Register in November 2005. The rule puts forward very specific authorities regarding the spread of a finite list of communicable diseases, including federal authority to approach and detain persons with communicable diseases. (For example if a plane arrives with a passenger aboard whom the crew believes has a communicable disease, there is authority to quarantine everyone on the plane. The proposed rule requires notification of health officials one hour before arrival.) Although broad voluntary compliance is expected, non-compliance is also anticipated. Both federal and state law provide criminal penalties for non-compliance of quarantine and isolation orders.

Mr. Gonzales explained that collaboration is critical in all four of these areas. Collaboration is required to deal with issues in advance and avoid potential litigation. Lessons learned from other disasters need to be heeded, including the need for:

- open lines of communication;
- measures to assure trust; and
- awareness on the part of law enforcement as to how people may react.

*CDC, Division of Global Migration and Quarantine
Control of Communicable Disease Proposed 42 CFR Part 70 and 71
http://www.cdc.gov/ncidod/dq/index.htm

Contact: Kenneth Gonzales, U.S. Attorney's Office
Las Cruces, NM
Kenneth.gonzales@usdoj.gov

3. Handling Mass Fatalities

Carole Shirreffs, New Mexico Office of the Medical Investigator (OMI)

Ms. Shirreffs explained that in New Mexico, the Office of the Medical Investigator (OMI) handles all *reportable* deaths (*i.e.*, deaths which are unexpected, undetermined, and/or unattended). With a large number of reported deaths in one jurisdiction, a local investigator first responds to determine the agent involved and the extent of the geographic area affected. If additional help is needed, the OMI Central Office in Albuquerque will ensure that as many state assets as necessary can be made available, from other counties or statewide. If the situation exceeds the capacity of the State and a Presidential Declaration has been issued, a formal request for federal assets, including assistance from a Disaster Mortuary Operational Response Team (DMORT) would be initiated by the State Office of Emergency Management in Santa Fe.

Ms. Shirreffs explained that death from influenza currently is not a required *reportable* situation and the handling of these fatalities will be largely a hospital responsibility. Natural, in-hospital deaths do not fall under the jurisdiction of the New Mexico OMI, and remain the responsibility of the hospital. In addition, natural deaths occurring in nursing homes do not fall under the jurisdiction of the New Mexico OMI. Thus, nursing homes will be facing the same issues as hospitals. Hospitals must identify and transport the body to a funeral home, as requested by next of kin, in a timely manner. In a pandemic, agencies such as law enforcement and the Mexican Consulate from bordering states could be involved to identify decedents, and find and contact next of kin.

Local hospitals in New Mexico have limited capacity in a surge event for body storage. In Las Cruces, for example, the total cold storage capacity of hospital and funeral homes combined is limited to ten bodies. The New Mexico OMI and the New Mexico Department of Health have thus been working with the New Mexico Funeral Service Association (NMFSA) to develop a plan to assist hospitals with overflow of bodies when multiple fatalities occur. This planning effort with funeral service personnel might well be expanded across all three border states.

Transporting bodies to and from Mexico, when infectious disease is involved, may also be problematic. The NMFSA will be encouraged to work with the Mexican Consulate on this issue, as well as with funeral agencies in Texas.

The New Mexico OMI has a long-standing relationship with the Mexican Consulate offices in Albuquerque and El Paso. They work together to ensure that OMI cases in New Mexico and involving Mexican citizens are handled expeditiously and cooperatively. The New Mexico OMI also has a long-standing relationship with the Texas Medical Examiner Offices, particularly in El Paso.

Contact: Steve Nuñez, Program Manager
New Mexico Office of the Medical Investigator
Albuquerque, New Mexico
Snunez@salud.unm.us

4. Epidemiology & Disease Surveillance

David Selvage, Physician Assistant, NMDOH, Epidemiology and Response Division, Infectious Disease Epidemiology Bureau

Mr. Selvage began his presentation on infectious disease epidemiology and surveillance at the border by offering a definition of surveillance: "the ongoing, systematic collection, analysis, and interpretation of health-related data essential to the planning, implementation, and evaluation of public health practice, closely integrated with the timely dissemination of these data to those responsible for prevention and control."

Mr. Selvage presented the basic approach and steps to surveillance in public health and explained that the purposes include:

- Guiding immediate response actions
- Assessing public health status (monitoring disease trends, detecting outbreaks, identifying populations at risk, and detecting emerging conditions)
- Defining infectious disease priorities and prioritizing the allocation of health resources
- Guiding program planning and policy development in the prevention and control of disease
- Stimulating research
- Collecting standardized data to describe the disease course and to evaluate intervention and prevention techniques
- Detecting changes in health practice

Mr. Selvage went on to explain that there are multiple uses of infectious disease surveillance, including:

- Estimating the magnitude of the problem
- Determining the geographic distribution of illness
- Portraying the natural history of a disease
- Detecting epidemics (defining a problem)
- Generating hypotheses and stimulating research
- Evaluating control measures
- Monitoring changes in infectious agents
- Detecting changes in health practices
- Facilitating planning

Several examples of border infectious disease surveillance efforts were briefly presented, including Border Infectious Disease Surveillance (BIDS), Early Warning Infectious Disease Surveillance (EWIDS) and Ten Against TB.

Mr. Selvage described how the New Mexico Department of Health is organized. It is highly centralized with only one health department. There are 33 counties in five regions that house many public health offices, all of which are administratively State-level. Almost all reportable infectious diseases are reported to the Infectious Disease Epidemiology Bureau in Santa Fe and then assigned to investigators in the regions. This, he explained, is very different from Texas and which is more decentralized.

The issues that should be considered by the work group and others in terms of border epidemiology and surveillance include:

- *Communication:* Are there protocols in place to facilitate effective, rapid communication?
- *Relationships:* Have the appropriate technical partners been identified, if an event occurs?
- *Systems:* Is there mutual understanding of how the systems work on each side of the Border?
- *Best Practices:* What is already working that can be nurtured and replicated?

Contact: David Selvage
NMDOH Epidemiology and Response Division
David.selvage@state.nm.us

5. Emergency Medical Services (EMS)

LeeAnn Phillips, Executive Director, New Mexico Region II Emergency Medical Services

Ms. Phillips began her presentation by explaining that Emergency Medical Services (EMS) respond well, but not as successful at planning and preparation. EMS providers will need assistance from planners and managers to prepare and be able to do what they do best, i.e., respond. EMS roles include:

- First response in true emergencies, perceived emergencies, and false emergencies
- Primary care
- Emergency preparedness

The challenges facing EMS in terms of response to pandemic influenza include:

- Personnel resources that are highly centralized
- A mixture of paid and volunteer personnel
- Large uncovered/underserved rural areas
- Communication limitations, including technology
- Inadequate equipment and vehicles
- Minimal surge capacity

The work group and others were encouraged to address:

- Identifying communities with best practice approaches
- Developing a model of how to integrate EMS into local pandemic plans, including rescuer care, secondary care, training, and communication
- Prioritizing attention to rural and frontier areas, border Port of Entry communities and other high priority areas
- Providing for public and health system education

Contact: LeeAnn Phillips, EMS Region II
Las Cruces, New Mexico
leeannp@region2ems.com

Friday - June 23, 2006 – Work Group Sessions

Summit participants were assigned to five work groups on the topics that were discussed during the prior day. Each group was instructed to develop a list of priorities to be addressed in the coming months and identify a roster of individuals who would be willing to participate in future activities.

Work Group: Building Capacity to Handle Medical Surge & Mass Prophylaxis

Work Group Priorities

1. How can healthcare resources be coordinated and aligned? How can coalitions from existing groups be built to collectively "manage" medical surge and mass prophylaxis? How can planning be performed for staffing, including altered scopes of practice, the role of medical and other healthcare students, family members, primary care, etc. How can training and education be provided before an event as well as "just in time?"
2. How can public information and communications (including technology) be coordinated? How can information about self care, social distancing, and related matters be disseminated? How can outreach to all populations be provided? How can opportunities for two way communication be created?
3. How do the States coordinate and align at the jurisdiction level? How can involvement of all sectors be achieved, i.e., emergency managers, public safety, transportation and business, public utilities, schools, community organizations, and others? How will medical command and control be established?
4. How can exercises to facilitate this work be coordinated, including building upon the Sunland Park event of last year? *
5. How can the legal and financial issues involved with working as ***Los Tres Amigos*** be resolved?

Work Group Discussion

The group discussed the reality that addressing medical surge and mass prophylaxis was similar to addressing a massive triage task. People need to have access to skilled personnel that can decide to send them home, to vaccine and antivirals, to in-patient hospital services and alternative sites, to out-patient hospital services and alternative sites, to psychosocial and mental health services, to transportation resources, to public information resources, and so forth.

Currently, planning is taking place along the border. El Paso is giving consideration to alternate sites such as hotels and motels, grouping people by similar care needs. New Mexico is promoting the NM-MEMS approach with local emergency managers in its counties and with tribes. Mexico is working on plans to employ primary care services and providers in managing surge. In Cd. Juarez and the State of Chihuahua, the Protección Civil serves as part of the National Committee for Health Security to coordinate a wide range of institutions and organizations.

Staffing is acknowledged by all as a major issue. It was suggested that "altered standards of care" be understood as "sufficiency of care" standards based on there likely being inadequate

resources of all types. It is also acknowledged that pandemic flu will reduce the workforce in medical and public health environments and there is general agreement that medical first responders be prioritized for antivirals and vaccine. This also means that the acquisition, use and ownership of antivirals cross-border needs to be clarified. Plans need to be developed now on moving healthcare provider resources between environments and across borders. Plans need to be developed on how to operate with a skeleton crew at healthcare sites. Roles of family members and other caregivers, medical and other healthcare students, community volunteers, the military, EMS, and so forth need to be articulated. Planning for the utilization of the local workforce needs to take place at the local level.

Most participants acknowledged the need for alternate care sites (in or outside of hospitals) that require less medical expertise (including lay personnel), a different span of control (but based on consistent standards), with patients of similar acuity. On a related matter, it was noted that legal considerations need to be addressed, particularly with altered standards and licensing requirements (State, JCAHO, and other).

Most participants also acknowledged that traditional services need to be maintained and that the integrity of acute emergency care Emergency Departments and specialty care environments (trauma centers) need to be preserved.

Another urgent matter discussed was communication – everything from public information (especially self-care) and risk communication to health alerts and communications between responders. As an example, Health Alert Network (HAN) services need to be extended to Chihuahua. Risk communication plans must be tri-state and consistent. They must involve neighborhoods and faith communities and provide methods to reach populations not traditionally served by the media.

It was suggested that this planning could take place by using the trauma regional structures and committees already in place. These groups could work on creating capacity for medical surge and mass prophylaxis. Their current emphasis is on the trauma system (including injury prevention, pre-hospital services, hospital rehabilitation, etc.). It was also acknowledged that one of the difficulties with cross-border planning derives from the incompatibility between Mexico's centralized federal infrastructure and the U.S.'s decentralized state and local system.

It was suggested that this work group should focus on planning in an area 100 kilometers/60 miles either side of the border. It was also recommended that planning involve additional stakeholders to include:

- Military
- Law Enforcement
- Public works – Electric/water
- Border Patrol
- Universities
- Transportation (public & private)
- Secretaries of State and other political leadership
- Hospitals, primary care and long term care providers, and others from surrounding areas
- Trauma community
- Community Health Councils
- Rural representation
- Promotores
- Media

- Catholic Dioceses and other faith based organizations
- Behavioral health workers
- Business community

*Early Warning Infectious Disease Surveillance (EWIDS) Tularemia Full-Scale Exercise
NM DOH Public Health Division/District 3 in coordination with the Doña Ana County/City of Las Cruces Office of Emergency Management, and City of Sunland Park, June 29, 2005

Work Group: Handling Mass Fatalities

Work Group Priorities

1. How can identification, record keeping, personal possessions, tracking of bodies and materials be performed?
2. How are decisions made about disposition of bodies, mass burials, timing, and authority?
3. How is the public informed?
4. How can multi-jurisdictional and multi-disciplinary resources, including transportation be brought together?
5. What are the trigger points? What trigger points do others use, and when do we decide that we are overtaxed, need resources, and/or need to implement altered practices?

Work Group Discussion

This group discussed a number of concerns, beginning with the issues of how to handle anywhere from 2,000 to 40,000 deaths. Topics included handling bodies and possessions, mass graves, decontamination, a possible 40% reduction in staff, identifying and tagging bodies, finding staging areas, temporary internment, designating cemeteries, etc.

The group also discussed the need to work with hospitals, long term care providers, other healthcare providers, funeral directors, and grief counselors.

A key question is what would be the trigger point to alert communities that there is pandemic. There is a difference between a pandemic and other mass fatality events, in terms of staff shortages.

In Cd. Juarez, the military and private sector are involved, transportation routes have been identified, and procedures have been written designating places to take bodies, decontamination, and paperwork. Overall, the federal government would give guidance on all operations and coordinate all sectors.

In the U.S., there are federal resources such as the Disaster Mortuary Operational Response Teams (DMORT), but it is unlikely that they would be available in a pandemic. In New Mexico, it is anticipated that hospitals will be overwhelmed and will not be able to handle fatalities. They will need assistance from the State Office of the Medical Investigator (OMI) and other resources. OMI in New Mexico can hold up to 300 bodies, and needs to be able to quickly process and move out the bodies. Doña Ana County is working with morticians and other agencies, and while there are some plans in place, the numbers could be overwhelming.

Overall there will need to be procedures to provide lists of cases, especially those from outside the area, that include gender, age, cause of death, etc. Basic bio-safety procedures will need to be in place and Personal Protective Equipment (PPE) made available.

In terms of tri-state and binational collaboration, it was noted that there were some basic differences in how hospitals manage deaths. In New Mexico, hospital deaths are typically not managed by OMI. In Texas, hospital deaths occurring within 24 hours [of admittance] are referred to the Office of the Medical Examiner. In Chihuahua, there are forensic experts who deal with homicide, suicide, unknown causes, deaths on the streets etc. In the event of a pandemic, where cause of death is known, much paperwork and red tape can be omitted. Autopsies are not required in mass fatalities.

Protocols for evaluation and decision-making in home cases need to be developed.

Additional resources need to be identified in advance, such as places to store bodies, places to triage, places to bury, warehouses, etc. Information is also needed about availability of resources such as coffins, embalming fluid, and body bags. The work group would like to know if surveys of such resources have already been done. Texas and New Mexico have begun this inventory process. In Mexico, the Protección Civil organizes communities in disasters and has knowledge of and access to resources. Support from the military is also a possibility. There needs to be Continuity of Operations Plans (COOP) addressing access to fuel and other infrastructure requirements.

The public needs to be informed, including information about altered practices. In Mexico, for example, there are no funerals on Saturday or Sunday and families may not come to claim bodies.

Guidelines are needed on performing mass cremations, mass burials, and developing altered standards that incorporate cultural and religious concerns regarding handling and disposition of bodies. It may be necessary to rely upon members of religious groups to handle such matters as preparation of bodies, notification of family etc. However, experience in Mexico shows that those traditions are sometimes set aside in disaster. Guidelines are also needed on handling deaths of individuals for whom neither family and funeral home are identified.

There are good working relationships already in place between the three states and two countries. These relationships can serve as the basis for continued planning on managing mass fatalities, transport issues, altered standards, and so forth.

In the United States, the Emergency Management Assistance Compact (EMAC) allows states to share resources when moving resources from one state to another. There is a need to understand how the virus may strike and spread and concentrate resources accordingly.

Planning for animals in a mass fatality situation is also required. Doña Ana County is working with its Sheriff's office, animal control office, and New Mexico State University (NMSU) to address this need. Mexico has designated municipal public works as the responsible party.

Additional research and information on best practices is needed, including lessons learned from Asia and Africa and any military protocols which could be helpful. There may be an institute affiliated with the El Paso Community College that will be providing training in handling of mass fatalities this Fall.

The work group identified the five priorities to be discussed in the future and identified additional stakeholders to be invited. These could include:

- Funeral directors and cemetery directors
- Companies with storage facilities, trucks, and other equipment
- Local Emergency Managers
- Protección Civil, the Red Cross, and Sentinela
- Health departments and public and private hospitals

Work Group: Isolation and Quarantine

Work Group Priorities

1. How can a mutual understanding of Isolation and Quarantine (I&Q) laws between the United States and Mexico, and across New Mexico, Texas and Chihuahua be achieved? What needs to be clarified relating to patient information sharing? How can stakeholders be educated on legal matters?
2. What are the logistical and legal mechanisms for transferring patients across jurisdictions? From Mexico to the United States and vice versa? From federal level to state level? From State to State? From federal detention centers to state or federal level? From other sectors?
3. How can I&Q facilities (for provisional I&Q and long term I&Q) be proactively identified? Who is going to provide logistical support?
4. Who is going to take responsibility for logistics and costs for I&Q at the federal level, state level, and in federal detention centers?
5. Who will enforce Quarantine Orders at the federal level and at state levels in both countries?
6. How can timely notification of ill passengers to health authorities be made (airplanes, buses, and other) in both countries?
7. How can adequate personal protective measures for public health and Customs staff be provided? How will disease notification and medical preventive measures be performed?

There was concurrence that the following two items would need to be addressed jointly with the Epidemiology & Disease Surveillance group.

8. How the availability of diagnostic laboratory testing across borders be addressed? How access to the U.S. Laboratory Response Network for Mexico be achieved? How can access to the Chihuahua State Lab for the U.S. be achieved? How can rapid transfer of laboratory specimens across the border be performed? What mechanisms are needed for sharing results on a timely basis?
9. How will timely sharing of disease surveillance information across jurisdictions (U.S. and Mexico, state to state, and military to local/state/federal) be achieved?

Work Group Discussion

Due to the complexity of this topic, expansion of the morning presentation was provided to familiarize the group with some critical issues and provide a framework for discussion.

Review of Legal Issues

Many discussions of Isolation and Quarantine focus on the public health and logistical aspects of implementation vs. the legal requirements that must be in place to make the orders effective. Understanding of the legal underpinnings at the federal and state levels, and, in this discussion, in both the United States and Mexico is critical.

Given the following scenario, what are the legal implications?

"Late one Friday afternoon, a call is received at a public health office in the U.S. that is located near the US-Mexico Border. The individual is suspected of having a particularly virulent and highly contagious form of influenza, not seen before in the U.S. Local health officials confirm the diagnosis. The individual is a Mexican citizen living in the U.S."

In the U.S., there are multiple federal and state statutes for ordering quarantine. The existing federal statute has not been enforced since the early 1960s. With orders of quarantine or isolation, there is always tension between the government's interest in slowing the spread of disease and protection of the public's health versus an individual's personal liberties. Usually, there is compliance with these orders. However, anyone can contest an order and test the clinical reason for the order.

A "provisional" order for quarantine can be issued for a maximum of three days to perform diagnostic tests. A provisional order, in some instances, can be longer, but no longer than the incubation period of the suspected agent. It may be possible for an individual to challenge a provisional order with a writ of habeas corpus that is a petition filed with a court by a person who objects to his own or another's detention or imprisonment. With detainment of non-U.S. citizens, there is involvement of the Departments of State (DOS) and Homeland Security (DHS), Border Protection, and discussion about whether or not to return them to their countries and how to balance protection of the public with the necessity to uphold civil rights.

New proposed rules, published in the Federal Register, v.70, #229, 11/30/05,* discuss identification, introduction, transmission and spread of a communicable disease; recommendations for apprehension, detainment and conditional release of individuals with a communicable disease; and include protection of personal rights. The federal Department of Health and Human Services (HHS), including the Centers for Disease Control (CDC) are updating rules, as are most States. The final rule is forthcoming pending analysis of public comments.

In the above scenario, the non-US citizen is hospitalized in the U.S. Resolution of this situation would be under the State's control with assistance provided by the CDC. There may be Embassy involvement, but the role is not clear at this time.

While there is a very high level of traffic across the Border and an ongoing threat of public health emergency situations, it is believed that reciprocal understanding of each country's regulations is currently limited.

The proposed new rules also include methods for collecting data on travelers that depend upon cooperation of airlines, shipping companies, etc. Currently, there is an Memorandum of Agreement (MOA) between the Departments of Homeland Security (DHS) and Health and Human Services (HHS) that provides authority to HHS to contact the Embassy. The CDC Quarantine Stations have clear authority to detain individuals and restrict them from inter-state travel. CDC does not have authority to detain individuals from intra-state travel; this authority rests with local health authorities.

CDC is committed to working with the States to quickly resolve these situations and to transition individuals who are detained to their appropriate destinations. States need to be current with policies and regulation, and be prepared to act quickly as well.

*Control of Communicable Disease Proposed 42 CFR Parts 70 and 71

Texas

Texas differs from New Mexico, in that there is a decentralized public health system comprised of a variety of State and local health departments. In each health department, there is a physician who is in charge of control measures. When legal assistance is required, local clinicians should use local attorneys. Authority also resides at the State and Regional health levels to enact control measures. Currently, orders are issued, usually for individual cases of tuberculosis.

Current federal quarantine legislation relates to individuals or a small group of individuals who are located on a common carrier, i.e., airplane, ship, etc., a defined property, and involves quarantine of a specific area that can be defined as a political unit. The proposed legislation relates to large numbers of individuals and will be a legislative nightmare to enforce. In addition, how the proposed new rules will apply to land borders is yet to be determined.

Constitutional Issues

Multi-national agreements can only be made by the federal government. The treaty between the United States and Mexico ensures rights of individuals to contact an Embassy's Charge d'Affaires relating to criminal charges. It is unclear if this right extends to quarantine or to situations involving communicable disease. Usually, confirmation of disease is required before there is legal involvement. With a declaration of a public health emergency, this requirement may change.

For the sake of clarity:
Isolation refers to the detention of a person who has the illness.
Quarantine refers to the detention of a person who has been exposed, but who has not yet displayed symptoms.

New Mexico

An individual exhibiting symptoms of the suspected agent will be hospitalized and the case reported to the New Mexico Department of Health. The person would be detained briefly and only until confirmation that the case did not indicate an emergent public health situation. If there is evidence of an emergent situation, the Governor would declare a public health emergency. This authority is articulated in the New Mexico Public Health Emergency Response Act, passed by the State legislature in 2003. Logistical issues such as care during quarantine and isolation and follow-up of individuals have not yet been developed.

A major issue to be addressed is "who" (what agency, provider, etc.) will pay for care and other services that will be required for persons who have been quarantined or isolated.

Group Discussion Points:
There is an apparent need for widespread education for healthcare providers, responders, and local officials, in several areas, including:

1. Existing and proposed legislation at all jurisdictional levels. Generally, there is confusion about which laws to follow in emergency vs. non-emergency situation. Some laws apply in both cases; others apply to one or the other.
2. Clear articulation of the compliance requirement of healthcare facilities. What are the limits of "forcing" treatment versus an individual's right to refuse treatment?
3. Both New Mexico and Texas can order the use of a federal, state, or local facility within their boundaries in a declaration of a public health emergency. This information needs to be promulgated.

Mexico
The group discussed the situation of U.S. citizens who become patients in Mexico. Mexico's health system is tightly centralized at the federal level, with federal representatives in the lead. Currently, there is no Mexican statute for quarantine and isolation. An individual can sign a document if he or she wishes to refuse treatment. However, in a public health emergency situation, a person can be detained under other statutes [not defined].

Department of Homeland Security - Border Protection
DHS repatriates individuals world-wide. Agents must accompany these persons but are not allowed to use N95 masks, leaving them vulnerable to exposure. Past experiences include detention and transportation of a patient with tuberculosis who could have exposed other fellow passengers. There is also the problem of a single individual re-entering the country multiple times without detection.

Based upon the discussion, the group identified the priorities noted above that require future exploration.

The work group also suggested the following stakeholders be added:

- Mexican Embassy, U.S. Department of State
- Mexico's External Relations Department
- Federal and State Health Departments from the U.S. and Mexico
- Zoonotic Disease Control Experts

Work Group: Epidemiology & Disease Surveillance

Work Group Priorities

1. What is the standard exchange of data between local reporting levels and state collection agency?
2. Who are the individuals who can attend meetings at higher levels for more interaction?
3. How can surveillance systems and communication in rural areas be improved?
4. What are the capabilities of smaller hospitals to communicate? What is the level of accessibility to the internet?
5. How can the protocols for transfer of specimens, samples, reagents, equipment and resources be operationalized?

Work Group Discussion

The work group discussed the need to standardize the exchange of data between local reporting levels and State agencies. This would include patients and physicians and involve local, regional, state, interstate, and binational exchange. The major problem appears to be between reporting agencies, especially when there is frequent staff turnover. It was recommended that there be standardized formats in Spanish and English across **Los Tres Amigos**.

There needs to be better communication. Attention needs to be directed to the local level so that data that are collected can be used at that level. For example, physicians fill out forms but do not receive a response from the agency they reported to. Information flow is currently unidirectional. There also needs to be better mechanisms to communicate across the three States and two Countries. Relationships and systems must continue to be built. There needs to be a focus on how surveillance systems and communication in rural areas can be improved and how to determine the capabilities of smaller hospitals to communicate. In Mexico, only large hospitals have internet access. In New Mexico, most hospitals have internet access. In Texas, smaller hospitals have computers, but not internet access. Some people feel that the telephone is more reliable.

Protocols for transfer of specimens, samples, reagents, equipment, and resources need to be operationalized. Recent experience shows that protocols exist, but the ongoing change of personnel at Customs often means that samples are refused or not processed.

There is a need to focus on the capability of staff to respond in case of a pandemic and training to improve capacity to respond, especially to a binational incident. Local systems that work should be identified and replicated. A website to track these and other border meetings should be developed.

Additional stakeholders should include:

- Regional public health representatives
- EWIDs
- State and Regional lab personnel
- Public information and risk communication staff
- Veterinarians and others engaged in zoonotic control
- Key players in school districts

Work Group: Emergency Medical Services (EMS)

Work Group Priorities

1. How can EMS agencies be prepared internally to respond to a pandemic?
2. How can continuity of operations in EMS in the event of a pandemic be created?
3. How can the community be educated on the appropriate use of EMS in non-emergency times and in various stages of emergency?
4. How could EMS training be standardized?
5. How can equipment sharing, including supplies, equipment, communications technology, and vehicles be improved?

Work Group Discussion

EMS provides a range of services currently, including response to 9-1-1 calls and primary care services. There is a perception of a high level of public trust in EMS.

There is a need to educate the public, particularly high risk target populations, on the proper role and use of EMS. This could involve promotores in a number of border communities as well as high level public information messages from the Mexico Ministry of Health and the States' Departments of Health.

EMS agencies should engage in two levels of planning – continuity of operations and response. EMS entities need to recognize unique roles in rural communities where they tend to be in close proximity to disease vectors.

Plans that already exist and best practices need to be researched and identified. Translated materials and bilingual response guides are needed. The group should reconvene in two months. Existing planning groups including the Regional Advisory Committee (RAC), the Binational Health Councils in Luna, Presidio, and El Paso, the Local Emergency Planning Committees, and other local health organizations.

At a later point, the issue of hospital closures and their impact on EMS, alternatives to EMS, and issues of equipment and other assets need to be explored.

Conclusion: Upon conclusion of the Work Group reports to all participants, a strategy to continue these activities was agreed upon. Each Work Group will be contacted and convened by Albert Sanchez, NMDOH Border Health Coordinator and Patricia Luna, NMDOH Contractor. These meetings will commence in early August and each group will begin to identify procedures for addressing their priorities. Tentatively, in early October, there will be a meeting in El Paso of the coordinators and the Work Group Leaders to discuss progress, challenges encountered, and future plans.

These proceedings and the ongoing activities of the Work Groups will be posted on the NMDOH Office of Health Emergency Management web site at: www.health.state.nm.us/ohem

2nd Annual Border Emergency Preparedness Summit
Work Group Participant Lists

Building Capacity to Handle Medical Surge & Mass Prophylaxis
Mary Ann Shaening, Ph.D.
Consultant to NMDOH

Lee Golden
Tom Townsend
Rosalinda Garcia
Sandra Byrd
Burton Berry
Charles Bennett
Danny Medrano
Martha Sanchez
Salvador Gómez
Jennifer Jennings
Virginia Zamarripa
Lois Blough
Kathleen Hales
Jose Luis Mendoza
Cynthia Morgan
Greg Bloom
Marjolaine Greentree
Pilar Campos
Robyn Rehbein
Wynn Brannin

Isolation and Quarantine
Kenneth Gonzales, U.S. Attorney's Office

Clinton J. Johnson
Ron Burick
Ronald Taylor
David Kolberson
Sonia Montiel
Steve Cordova
Tony Elsworth
Al P. Romero
Blanca Serrano
Gumaro Barrios
Bill Morrill
Freddy Gray
Todd Wilson
E. Chris Swager
Adrian Dominguez
Monty Waters
Barbara Byrne
Anne Pascarelli Barraza

Handling Mass Fatalities
Carole Shirreffs
NM OMI

Paul Shrode, M.D.
Debra Davis
Tim Zagorski
Art Alvarado
Mario Holguin
Virginia Arroyo
Mario H. Bonilla
Antonio Armendariz
Dr. Ralph Magaña

Epidemiology and Disease Surveillance
David Selvage
NMDOH
Infectious Disease Epidemiology Bureau

Trinidad Jeronimo Castaño
Frances Scappaticci
Judy Creegan
Neil Pascoe
Dr. Jesus Manuel Rodriguez
Juan Cavazos
Gumaro Barrios
Salvador Gómez
Joy Truesdale
Magre Jimenez
Silvia Estela Trevino
Rosalinda Maestas
Sonia Montiel

Emergency Medical Services

LeeAnn Phillips
NM Region II Emergency Medical Services
Macario Carrasco
Don Berger
David Lujàn
Michelle M. Fournier
Pilar Gandara
Albert Sànchez
Irene Rivas
Bea Martinez
David Porras Jr.
Donna Holguin
Tony Quintela
Mike Sebastian
Robert Garcia
Alex Rodriguez
Jorge Luis Felix Morales
Joaquin Andres Gutierrez Sandoval
Ralph Davis