NEW MEXICO DEPARTMENT OF HEALTH

New Mexico Department of Health
All-Hazard Emergency Operations Plan
Hazard Annex F: Outbreaks

Coronavirus Pandemic Plan

February 7, 2020

Purpose, Scope, Situation and Assumptions

Purpose

It is the purpose of this plan to define the actions and roles necessary to provide a coordinated response within the State of New Mexico. This plan provides information for NMDOH with a general concept of potential emergency assignments.

A pandemic is unpredictable; therefore, this plan must be flexible. For this plan to stay relevant, it is important to review and revise the information on a regular basis to ensure that new scientific evidence and lessons learned are incorporated.

This plan is designed to protect the life and health of the population of the State of New Mexico. It outlines preparations to ensure that the NMDOH is adequately equipped to deal with a pandemic of any degree of severity and to respond in a coordinated and efficient manner to minimize the impact of a pandemic on the people and infrastructure of New Mexico.

This plan provides guidance for the response to the current outbreak of the 2019 Novel Coronavirus (2019-nCoV) should it evolve to a widespread pandemic.

Scope

This plan applies to all participating departments and agencies of the jurisdictions contained within the geographical boundary of the State of New Mexico.

NMDOH incorporates the Access and Functional Needs (AFN) populations throughout public health and hospital preparedness planning. The goal is for a community-based statewide level of preparedness that promotes resiliency and inclusion of all residents of New Mexico.

When circumstances create an actual or potential public health emergency, the NMDOH coordinates health and medical personnel, facilities, supplies, and equipment; collects, evaluates, and disseminates public health surveillance information; maintains the health of the public through disease prevention and control; coordinates public information regarding health risks of the public, education, and services; manages mass fatality response; collaborates with federal, state, local, tribal, non-governmental and private sector response entities, and providers.

This plan is an annex to the NMDOH All-Hazards Emergency Operations Plan (EOP)[1] and describes the roles, activities, and coordination associated with responding to a pandemic, should it occur.

Situation Overview

An outbreak of pneumonia of unknown etiology in Wuhan, Hubei Province, China was first identified on December 31, 2019. At the time, many cases reported a common exposure to the Huanan Seafood Wholesale Market in Wuhan, indicating animal-to-human spread. Further laboratory testing isolated a novel coronavirus (2019-nCoV) on January 7, 2020, while known pathogens such as influenza, Severe Acute Respiratory Syndrome coronavirus (SARS-CoV), Middle East Respiratory Syndrome coronavirus (MERS-CoV) were ruled out.

[1] http://nmhealth.org/publication/view/plan/958/

China has since reported thousands of confirmed cases and confirmed cases have been exported to at least twenty-four other countries, including the U.S. Sustained human-to-human spread has been confirmed in China, and limited human-to-human spread among close contacts has been documented in a number of other countries, including the U.S.

This emerging virus is part of a large family of coronaviruses, which commonly infect many species including bats, camels and cats. Rarely, these viruses jump from animal reservoirs to humans, as was the case with SARS-CoV, MERS-CoV, and 2019-nCoV.

Much is still unknown about 2019-nCoV. International epidemiology teams are investigating how efficiently the virus spreads among people, the clinical severity of symptoms, and where the virus originated; e.g., what is the primary and intermediate animal reservoir. The number of cases subsequently infected by a case is currently estimated to be between 1.5-3.5 (Influenza is between 1.3-2.1).

NMDOH is monitoring the global situation regarding the spread of 2019-nCoV. As of February 6, 2020, the 2019-nCoV does not constitute a pandemic. To reach this designation, sustained person-to-person spread must be occurring on two or more continents or in many countries. Currently, sustained spread is only occurring in China.

NMDOH is preparing for the possibility that 2019-nCoV may become a pandemic with widespread transmission worldwide. However, it is difficult to predict how quickly the virus will spread, and how severely it will affect particular segments of the population. Even with intensive planning, during a crisis there will be adjustments and changes to and clarification of the processes and resources that have been prepared under normal conditions. Planning must anticipate adjustments and must account for factors that include: how quickly the pandemic develops and scarcity of resources (availability of protective equipment, negative pressure isolation rooms, intensive-care beds, and ventilators).

Planning Assumptions

- Sustained human-to-human transmission of a novel respiratory virus in multiple regions of the world such as 2019-nCoV may signal a pandemic.
- A severe pandemic may result in the rapid spread of infection; therefore, communities across New Mexico could be simultaneously impacted.
- Communities may experience multiple waves of different magnitudes of a pandemic, each wave may last several months.
- The health care response to a severe pandemic may present extraordinary operational and ethical challenges.
- The number of ill people requiring treatment could overwhelm the healthcare system.
- Asymptomatic or minimally symptomatic people may transmit infection.
- The typical incubation period (interval between infection and the onset of symptoms) for coronaviruses is 2-14 days. The preliminary average incubation period for 2019-nCoV is 5.2 days.[2] On average, infected people will transmit the virus to 1.5 to 3.5 other people.[3]

[2] Li, Q., Guan, X., Wu, P., et al. (2020). Early Transmission Dynamics in Wuhan, China, of Novel Coronavirus–Infected Pneumonia. *New England Journal of Medicine*. http://www.nejm.org/doi/10.1056/NEJMoa2001316

[3] https://www.imperial.ac.uk/mrc-global-infectious-disease-analysis/news--wuhan-coronavirus/

- The lack of vaccine and antiviral medicine will place greater emphasis on social distancing, infection control, and public education to control the spread of the disease.
- Increased hospitalizations, secondary complications, and mortality are expected to vary widely among vulnerable population groups and communities.
- A pandemic virus may cause higher case fatality rates in certain populations.
- There may be significant disruption of public and critical infrastructure including: transportation, commerce, utilities, public safety, agriculture, and communications.
- A severe pandemic may overwhelm the mortuary services in New Mexico.
- Supply constraints are expected for diagnostic devices, respiratory protective devices, and possibly antiviral drugs or other therapeutics needed to detect and treat coronaviruses.

Concept of Operations and Response Capabilities

The Epidemiology and Response Division (ERD) is the lead NMDOH Division for the coordination of services and support for response to a public health emergency.

During a pandemic response in New Mexico, the NMDOH All-Hazard Emergency Operations Plan (EOP) would be implemented and the Department Operations Center (DOC) would be activated.

Please see the NMDOH All-Hazard EOP and Concept of Operations for specific activation procedures and organization.[4]

Surveillance and Epidemiologic Investigation

During a pandemic, early identification of the initial outbreak is instrumental to activating other aspects of this plan and to contain the spread of disease. This can be accomplished by adapting the various influenza surveillance systems used by NMDOH, including: hospital and outpatient clinic, laboratory, and mortality surveillance. The NMAC 7.4.3. requires immediate reporting of confirmed or suspected illnesses or conditions of public health significance, which includes 2019-nCoV.[5]

Epidemiological investigations provide vital information about the potential spread of the disease, as well as, identification of the most high-risk populations. Statewide surveillance can provide important information regarding the severity, burden, geographic spread of disease, and the characteristics of the circulating viruses.

Pandemic surveillance monitors trends for overall burden of disease, illness severity, and for the identification of factors that may place people at high risk for complications. These surveillance data are used to target prevention resources and guide policies to reduce morbidity and mortality, as well as, minimize social and economic disruption. A pandemic caused by a respiratory virus differs from seasonal influenza in frequency, scope, and potentially severity. The NMDOH plans to enhance influenza surveillance to detect the entry of a novel respiratory virus into the State, track the spread, and characterize the epidemiology and impact of the virus in order to optimize the response.

[4] http://nmhealth.org/publication/view/plan/958/
[5] http://164.64.110.134/parts/title07/07.004.0003.html

Routine Surveillance Systems

The NMDOH utilizes a 24/7/365 on-call service at 505-827-0006 to receive reports and inquiries from healthcare and the public regarding notifiable conditions and public health emergencies. Health Alert Network messages to the healthcare community and press releases to the public identify the special conditions associated with the 2019-nCoV outbreak that should be brought to the on-call service. When a commercial assay is available to diagnose 2019-nCoV in routine medical practice, notifiable condition reporting by fax and electronic laboratory reporting will provide aggregate counts of new diagnoses. NMDOH manages reports for confirmed cases, patients under investigation (PUIs), asymptomatic travelers, and contacts of confirmed cases through secure data bases.

The NMDOH Influenza-Like Illness (ILI) Sentinel Surveillance System conducts year-round surveillance from hospitals and outpatient clinics throughout the state and reports the data to CDC. Weekly reports to the NMDOH provide information on the proportion of all sentinel site visits of patients experiencing ILI signs and symptoms. On a weekly basis, sentinel sites submit up to 5 respiratory specimens from ILI patients to the NMDOH Scientific Laboratory Division (SLD) for influenza testing. This surveillance system can be adapted to monitor ILI in the state caused by both influenza and a novel virus. While numbers reported each week will only look at ILI, the specimens submitted to SLD can be tested for both influenza and 2019-nCoV to determine the percentage of ILI caused by each pathogen. The Bureau of Vital Records and Health Statistics (BVRHS) tabulates deaths due to pneumonia and influenza on a weekly basis to track trends in severe respiratory infections.

The New Mexico (NM) Emerging Infections Program (EIP) is part of FluSurv-NET (a population-based surveillance system for influenza related hospitalizations in children and adults). Active population-based surveillance is conducted for laboratory-confirmed influenza related hospitalizations in seven New Mexico counties: Bernalillo, Chaves, Donã Ana, Grant, Luna, San Juan, and Santa Fe. Every week, de-identified data are sent to the CDC, and are used to estimate weekly age-specific hospitalization rates for people hospitalized with influenza illness. Incidence rates for the counties included in the surveillance catchment area are calculated by utilizing the National Center for Health Statistics (NCHS) population estimates. This surveillance system can be adapted for surveillance for laboratory-confirmed, hospitalized patients with 2019-nCoV. In this way, New Mexico will be able to report aggregate numbers of hospitalized 2019-nCoV, and if necessary, complete case report forms for these patients to characterize their clinical course of infection.

The Office of the Medical Examiner (OMI) will support the detection and reporting of respiratory viral infection-related deaths that undergo an autopsy investigation. This will include standardized laboratory testing, nasopharyngeal laboratory testing, and sending specimens to the Scientific Laboratory Division (Virology Section) for culture and Reverse Transcription-Polymerase Chain Reaction (RT-PCR) for influenza virus (Influenza A, Influenza A H1 seasonal and novel H1, Influenza A H3, Influenza B, and Influenza A H5), and 2019-nCoV in autopsy cases with flu-like symptoms. Cases will be reported to the ERD on-call epidemiologist and an in depth case review will occur monthly at the Infectious Disease Death Review Team (IDDRT) meeting, which is attended by Infectious Disease Epidemiology Bureau (IDEB) and OMI staff. Autopsy cases with an infectious cause of death are reviewed at this meeting, and are identified with standardized laboratory testing including respiratory viral pathogen testing.

Data collected from NM surveillance is compiled into weekly NM influenza reports, which can be adapted to include 2019-nCoV.[6]

Laboratory Response

The Scientific Laboratory Division (SLD) will perform testing on specimens that are submitted and approved by Epidemiology and Response Division (ERD) for 2019-nCoV using the kit and reagents provided by CDC. Testing will be performed following requirements specified by the Emergency Use Authorization (EUA) granted by the Food and Drug Administration (FDA). Reverse transcriptase-polymerase chain reaction (RT-PCR) testing will be performed on the upper respiratory and lower respiratory specimens that are submitted from individuals who meet the criteria for testing. Any additional specimens that are submitted such as serum, stool and urine will be held pending instructions from CDC.

Shipping and handling of specimens would be coordinated through ERD and SLD. A statewide courier is in place for shipping of specimens to the SLD. Supplemental grant funds were requested to augment this capacity. Available grant funds will be used to purchase reagents and consumables for 2019-nCoV testing. CDC provides kits and extraction and amplification reagents for 2019-nCoV RT-PCR testing through the International Reagent Resource.

Molecular Biology and Virology/Serology staff will coordinate the management of specimens for testing and send out to CDC when required. Additional trained staff from both sections will be utilized if the specimen volume increases beyond the capability of the Molecular Biology section.

The SLD Laboratory Information Management System (LIMS) is Public Health Laboratory Interoperability Project (PHLIP) compliant and operational with the New Mexico Health Information Collaborative (NMHIC). In addition, all 2019-nCoV testing will be reported through PHLIP to CDC and be transmitted to NM ERD through NMHIC. Protocols are in place between SLD and ERD for the reporting of unusual isolations, novel strains and any other notifiable diseases with public health implication. SLD reports all notifiable information to the ERD.

Four Biological Sciences Bureau staff are on call (outside of normal business hours) to respond to emergency situations and outbreaks. If emergency testing was requested, SLD would contact the Epidemiology and Response Division for approval. On condition of approval, trained staff needed to perform the requested testing would be recruited. If a 2019-nCoV presumptive positive was detected, the specimen would be sent to CDC for confirmation and a call would be placed to ERD. An algorithm plan for call down is in place within the SLD. This plan is also used for bio-terrorism/chemical-terrorism response and has been proven to work very effectively. Updated on-call lists with contact information are provided to the SLD answering service that can be reached at 505-260-7295. ERD and SLD staff are available 24/7/365.

Community Mitigation/Limiting the Spread of the Disease

Preventing the 2019-nCoV from spreading may be difficult. Adherence to infection control measures, non-medical interventions such as social distancing, isolation and quarantine, restriction of travel, and the provision of vaccine and antiviral medication (if/when they become available), can reduce the spread of the disease. The transmissibility of the pandemic virus

[6] https://nmhealth.org/about/erd/ideb/isp/data/

and the severity of illness it causes will guide the implementation of social distancing measures.

Pandemic Severity Assessment[7]

A respiratory virus pandemic can range from mild to extremely severe in terms of clinical severity and transmissibility. In the weeks after the emergence of a novel virus, it can be difficult to accurately assess the attack rate and case-fatality rates of the virus due to variations in care seeking patterns, laboratory testing practices, and the capacity of the location where the virus emerges. Severe cases may be more likely to be reported, which may result in an over-estimation of hospitalization rates and case-fatality rates. Generally, more accurate estimates can be made 4-8 weeks after the emergence of the virus. To account for the difficulty in assessing the severity and transmissibility of a novel virus soon after emergence, the CDC has developed two tools that can be used to assess a novel influenza virus, or novel respiratory virus. These tools take into account case-fatality ratios, case-hospitalization ratios, and deaths-hospitalizations ratios to measure clinical severity, and secondary household attack rates, school attack rates, workplace attack rates, community attack rates, as well as rates of emergency department and outpatient visits for ILI to assess viral transmissibility. On the basis of these assessments, recommendations can be made for appropriate non-pharmaceutical interventions (NPI) to implement.

Non-pharmaceutical Interventions (NPI)/Social Distancing

Social distancing strategies such as closing schools, community centers and other public gathering points, as well as interrupting mass transit and canceling public events can be used to decrease and delay the transmission of infection and lessen the surge impact on healthcare. Decisions about what interventions will be used during a pandemic are based on the observed severity and transmissibility of the event; the impact on specific populations; the expected benefit of the interventions; the feasibility of success; the direct and indirect costs, as well as, the consequences on critical infrastructure, healthcare delivery, and society.

Everyday Personal Protective Measures

Actions to control seasonal respiratory virus spread are also effective during a pandemic. These actions include:

- Avoiding contact with people who are sick
- Washing hands with soap and water often and for at least 20 seconds
- Avoid touching your mouth, nose, and eyes with unclean hands
- Staying home when ill
- Covering coughs/sneezes
- Cleaning frequently touched surfaces where sick people have been

Community-wide Measures used in Pandemics[8]

Studies have shown that Americans are willing to make major changes in their lives and cooperate with public health recommendations to limit spread of a pandemic if appropriate community engagement was used to develop the recommendations. Clear and consistent

[7] Qualls N, Levitt A, Kanade N, et al. Community Mitigation Guidelines to Prevent Pandemic Influenza — United States, 2017. MMWR Recomm Rep 2017;66(No. RR-1):1–34. https://www.cdc.gov/mmwr/volumes/66/rr/rr6601a1.htm

[8] Qualls N, Levitt A, Kanade N, et al. Community Mitigation Guidelines to Prevent Pandemic Influenza — United States, 2017. MMWR Recomm Rep 2017;66(No. RR-1):1–34. https://www.cdc.gov/mmwr/volumes/66/rr/rr6601a1.htm

communication will be provided by NMDOH regarding the community-wide measures and the reasons for them, as well as reinforcement by community leaders and role models.

School Closure

For influenza, children are infected more often and are infectious longer than adults, although we have not seen this yet for the 2019-nCoV. Since school is a place of close contact and mixing it serves as a common place for respiratory infections to be spread and then taken into the home and community. Depending on pandemic conditions, this can apply to institutions of higher learning as well. School closures can be preemptive (before significant illness in the community, selective (e.g., at schools serving students at high risk for complications), or reactive (when student and staff absenteeism are high). Reactive closures are unlikely to affect community-wide transmission since it is already peaking.

Through the Public Health Emergency Response Act § 12-10A-1, et seq., NMSA (1978) and the Public Health Act § 24-1-1, et seq., NMSA (1978) the Governor of New Mexico has the power to cancel public gatherings. This could include temporarily closing schools if children are becoming ill and a source of 2019-nCoV spread.

Additionally, the Public Education Department requires each school in New Mexico to submit a school-level safety plan inclusive of pandemic influenza preparedness as part of the school district (or state charter school) safe school plan. The expectation of the site-specific plan includes the involvement of stakeholders (e.g., the lead emergency response agency, district administrators, local public health representative, school health and mental health professionals, teachers, food services directors, and parent representatives). The plan includes opportunities to provide education to staff, students, and families on current and reliable pandemic information. The plan should also delineate the communication process in the event of a coronavirus pandemic. During the 2009 influenza pandemic, NMDOH worked closely with the Public Education Department (PED) and school district superintendents regarding the need for school closures, and will do so in the event of a coronavirus pandemic.

Social Distancing

Social distancing consists of measures put in place to reduce the frequency and duration of social contact among persons of all ages. Direct evidence of the impact of these measures is limited, yet it is intuitive that limiting face-to-face contact (for respiratory droplet transmission), will result in fewer infections. Encouraging telework and virtual meetings will reduce face-to-face contact while allowing work productivity. Depending on the pandemic severity, intermediate measures such as reducing density of people in schools and the workplace (e.g., alteration of workplace environment and schedules to decrease social density and preserve a healthy workplace without disrupting essential services) may suffice without full closure. Canceling or postponing mass gatherings should be considered because outbreaks of respiratory virus infections have been documented in mass gathering events (e.g., sports, cultural events, fairs, camp gatherings) and allow seeding of infections back to a wider community. Discontinuing mass transit is being applied in China during the current outbreak of 2019-nCoV, although we do not know the impact of this measure, or the negative consequences, but mass transit does increase contact between people and high-touch surfaces that could become contaminated. In the event of a novel coronavirus pandemic, NMDOH will provide recommendations regarding social distancing on the basis of the pandemic severity, transmissibility assessment, and CDC guidance.

Risk Communication

Disseminating information to the public, government agencies, the media, and other stakeholders during a public health emergency is critically important.

Effective emergency and risk communication is essential to supporting the public health response and to help build public trust, confidence, and cooperation. A pandemic will generate an intense and sustained demand for information from the public, health care providers, policy makers, and the news media. It is essential to provide timely, accurate, consistent, and appropriate information. Communication with community leaders and the news media helps to maintain public awareness, avoid social disruption, and provide information about the evolving pandemic response activities. Mechanisms to assure well-coordinated risk communications include the following:

Joint Information System (JIS)

The ability to create a single message from multiple response agencies, to ensure delivery of timely and accurate information.

Joint Information Center (JIC)

The physical location where public information professionals from agencies and organizations, involved in the incident response activities join to exchange critical emergency information, conduct public affairs functions and external communications.

Health Alert Network (HAN)

The HAN is a system that provides information and updates on health threats or outbreaks throughout the State to health care professionals, emergency managers, public safety, and other responders across the state.

Public Information

During a crisis or emergency, communication to the public may include media releases, website content, talking points for spokespeople, interviews, social media, and public service announcements. Determination of populations at greater risk will allow the most appropriate methods to reach the target audiences. Communications seek to provide accurate and timely information and address misconceptions, misinformation, and rumors. During the 2009 influenza pandemic, NMDOH was the lead for communications and held regular weekly updates for the press on the status of the pandemic in New Mexico. NMDOH has implemented the development of weekly press releases and key talking points for novel coronavirus and plans to continue to do so in the event that the outbreak becomes a pandemic.

Medical Care and Countermeasures

The impact of a pandemic on the health care system could be overwhelming. The number of ill people requiring outpatient medical care and hospitalization could require hospitals and clinics to modify operationals to respond to high patient volumes and maintain functionality of critical systems. The medical workforce may experience absenteeism. The demand for inpatient beds and ventilators could increase above the normal rate and patients would need to be prioritized for services. The use of alternate care sites may be implemented to relieve demand on hospital emergency departments, and to care for people who do not require hospital admission. The demand for home care and social services could increase dramatically. Emergency medical system (EMS) responders could have extremely high call volumes and may also have a

reduction in available staff. The number of fatalities could overwhelm the resources of the morgues and funeral homes.

Infection Control and Prevention

Management of novel coronavirus patients should be done under contact and airborne precautions with eye protection. These precautions will require the use of personal protective equipment (PPE): gloves, gowns, face shields or goggles, and respiratory protection including surgical masks, N95 respirators, or powered air-purifying respirators (PAPRs). In the event of a shortage of PPE, emergency authorizations of use may be implemented to allow for use of expired materials or extended use of materials. PPE use protocols will be based on CDC guidelines and will likely change depending on the phase and severity of the pandemic. There are currently no vaccines or treatments for a novel coronavirus, and the primary goals in managing cases will be to sustain life and prevent transmission. If vaccines or treatments become available during a pandemic, their availability will be limited and infection control and containment efforts will be the primary response to controlling spread.

Emergency Medical Services (EMS)

The possibility exists that an EMS agency may be asked to transfer a suspected or confirmed 2019 coronavirus patient between healthcare facilities. This transfer should be planned to assure the safety of the patient, transfer crews, hospital personnel, and the public. Prior to the scheduling of the transfer, the physicians and other care team members from the sending facility, the receiving facility, and the EMS agency must have coordinated the transfer, working with the New Mexico Department of Health. The patient will be confirmed to be stable enough for transfer, and all treatment the patient will require during the transfer will be defined (medications, ventilator, and other modalities). This will allow for assurance that the care needed does not exceed the scope of practice of the caregivers of the EMS agency, and if so, make arrangements for a critical care unit or additional clinicians who can perform the necessary care. No special preparation of the ambulance patient care compartment is necessary. Initiate standard contact and airborne precautions (gloves, gown, N95 respirator) and eye protection (goggles) for EMS clinicians. If possible, place a surgical mask on the patient. Use caution with aerosol generating procedures. Clean and disinfect using EPA registered disinfectants with known effectiveness against human coronaviruses. Dispose of any biohazardous waste per your standard policy for medical waste (red bag, etc.).

Emergency Use Authorization

The use of the pandemic diagnostic devices, vaccines, and therapeutics may be without FDA licensure. An Emergency Use Authorization (EUA) permits the FDA Commissioner to allow medical countermeasures to be used in an emergency to diagnose, treat, or prevent serious or life-threatening diseases where there are no adequate, approved, and available alternatives. An existing antiviral treatment may be authorized by the FDA Commissioner under an EUA for use in treating novel coronavirus. An EUA may also be granted to extend the expiration date of eligible stockpiled medical countermeasures or medical devices such as personal protective equipment (PPE) in the case of shortages.[9]

Patient Surge

NMDOH recognizes the need to reduce the impact on the healthcare system during a pandemic. In addition to novel coronavirus, other illnesses tend to be prevalent in the winter,

[9] The draft January 2017 guidance document on EUA can be found at http://www.fda.gov/RegulatoryInformation/Guidances/ucm125127.htm

such as influenza, respiratory syncytial virus (RSV), pneumonia, strep throat, norovirus, and the common cold. The surge in patients associated with a pandemic in addition to these other illnesses can lead to increased patient volume throughout.

As part of their emergency operations plans, hospitals have mechanisms to to manage a surge of patients. NMDOH will advise the following conventional internal surge strategies:

- Increasing and expanding normal clinic hours to include evening and weekends to keep clinic patients from coming to the emergency department
- Planning for early discharge, including using discharge holding areas
- Canceling elective procedures to free up beds for emergency department admissions
- Transitioning some patients to care in observation areas (or the Post Anesthesia Care Unit, for example)
- Using geri-chairs rather than full beds for short-term/observation admissions and for administering hydration, bronchodilators, and similar treatments Converting private rooms licensed as semi-private rooms to accommodate two patients
- Opening closed but licensed additional beds or units (see below)
- Using supervisors or teaching staff to provide direct patient care
- Canceling training or classes to increase staffing
- Being able to flex staff to changing needs

Additionally, public messaging will be utilized to direct the 'worried well' and low risk symptomatic cases to stay at home. NMDOH will work with insurance carriers and hospitals to identify and publish nurse triage lines. CDC currently operates a Flu-On-Call line that may be utilized for pandemic coronavirus.

Crisis Standards of Care (CSC) Activation[10]

A pandemic coronavirus may require transitions across the continuum of care from conventional standards of care to contingency standards of care to crisis standards of care (CSC).

Statewide activation of CSC may occur during a coronavirus pandemic impacting multiple hospitals/healthcare facilities in a large geographical area or densely populated urban area.

Criteria describing a situation that indicates the need for CSC activation:

- Resources are unavailable, or undeliverable to health care facilities
- Patient transfer is not possible
- Medical countermeasures are limited or unavailable
- Local, regional, state resource caches (e.g., equipment, supplies, medications) have been distributed and no short-term resupply is available
- Multiple healthcare access points within a community or region are impacted

Crisis care is what a prudent healthcare provider practices with scarce resources; this does not imply substandard care. Ethical and emotional issues may surface from the need to promote public health priorities over the level of care provided to individuals.

The CSC goals when dealing with a catastrophic emergency are:

- Minimize death and serious illness by distributing resources to those who have the greatest opportunity to benefit

[10] https://nmhealth.org/publication/view/plan/4877/

- Maximize appropriate care for the largest number of individuals
- Maximize care that the public may be able to provide for themselves through education and messaging

During CSC, decisions must be made to balance the needs for lifesaving care for those in triage categories who will likely benefit from treatment, while providing comfort care to those for whom lifesaving care is likely futile.

Strategies

- Support critical functions
- Identify alternate care sites with suitable infrastructure to support acute care of ill patients
- Request 1135 Waiver from Centers for Medicare and Medicaid Service (CMS), to temporarily waive or modify certain Medicare, Medicaid, and Children's Health Insurance requirements including the Emergency Medical Treatment and Labor Act (EMTALA)
- Send requests to New Mexico licensing boards for waivers for licensing, documentation, and other requirements to expand available healthcare provider staffing
- Stock sufficient supplies to maintain care for at least 96 hours
- Prioritize personal protective equipment (PPE) and other preventative measures for clinical and nonclinical healthcare personnel to maintain staffing levels_

Ethical Distribution of Scarce Medical Resources

Ethical considerations must be integrated throughout the process. A successful response to a pandemic depends on the ability to incorporate ethical principles in a way that is understood and supported by responders and the community at large. Transparency of the processes used to establish, manage, and coordinate the system for health care delivery is critical in achieving community support.

Availability of Hospital Beds and Equipment

The inventory of the number/type (i.e., isolation/pediatric) of available hospital beds and the status of specific resources (i.e., Personal Protection Equipment (PPE)/ventilators) is requested and tracked through the State HAvBED system. Data received from participating hospitals is displayed on the HAvBED report, which is available on an ongoing basis. The HavBed system links hospitals with Emergency medical service (EMS) transport agencies, the New Mexico Department of Homeland Security and Emergency Management, and the NMDOH.

NMDOH has a process that allows acute care facilities to adjust facility licensed bed types to adapt to patient surge needs. Facilities contact the Emergency Operations Center Representative who notifies the NMDOH Division of Health Improvement (DHI) of the need for the licensed bed adjustment. The facility then provides DHI with the following:

- A description of the situation requiring the adjustment to the bed numbers on the facility license
- A description of any barriers or issues the facility is having that is making this change necessary
- How many beds of a given type will need to be changed to a new type
- How long is this change anticipated to be in place?
- What is the plan on how to handle the surge and what the plan is on how the bed changes will be made

- Include a contact person for the facility with phone numbers, email addresses, cell phone numbers, etc.

Because the Health and Human Services (HHS) Secretary has declared a federal disaster around novel coronavirus, the HHS Secretary is authorized to take certain actions in addition to regular authorities. Examples of these 1135 waivers or modifications include possible relaxing of the following:

- Conditions of participation or other certification requirements
- Program participation and similar requirements
- Preapproval requirements
- Requirements that physicians and other health care professionals be licensed in the State in which they are providing services, so long as they have equivalent licensing in another State (this waiver is for purposes of Medicare, Medicaid, and CHIP reimbursement only – state law governs whether a non-Federal provider is authorized to provide services in the state without state licensure)
- Emergency Medical Treatment and Labor Act (EMTALA)
- Stark self-referral sanctions
- Performance deadlines and timetables may be adjusted (but not waived).
- Limitations on payment for health care items and services furnished to Medicare Advantage enrollees by non-network providers

Alternate Care Sites

NMDOH has worked with many acute care facilities in the state to identify alternate care sites (e.g., long-term care facilities, veterinary hospitals, surgery centers). These sites can be utilized for triage of novel coronavirus cases as well as treatment. Decisions will be made to determine the need for alternate care sites will be based on bed availability data and staffing and supplies available to support the alternate care site location.

NMDOH Staffing

NMDOH has a continuity of operations plan (COOP) in place that will be utilized to identify additional response staff. The COOP can be used to establish priorities for staff and reassign them from their daily duties to a response role. The COOP ensures that the department's critical business functions and essential services continue during an emergency or a disaster. Additional response staff can hired as temporary staff using emergency funding received by the federal government or state funds. Additional information on mechanisms can be found in the administrative preparedness and volunteer management plans.

In the case that the NMDOH on-call line is receiving a surge in calls, ERD has the ability to channel calls regarding novel coronavirus to a select group of epidemiologists. Training sessions with epidemiologists on how to handle 2019-nCoV calls are occurring, and this pool of epidemiologists can expand as needed.

NM MRC Serves

Recent natural and man-made catastrophic events have demonstrated the need for volunteer healthcare professionals and lay volunteers to supplement and enhance response and recovery capabilities during and after such events. The potential for widespread consequences from these events often cross jurisdictional lines. As a result, public health preparedness initiatives that include pre-credentialed and pre-trained volunteers have been developed to address local, regional, multi-state and federal collaboration.

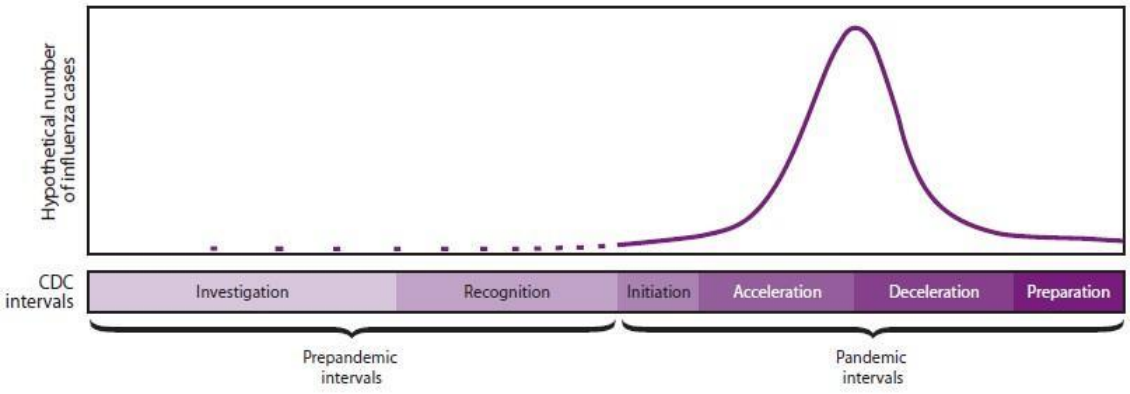
Upon receipt of a request for volunteers, NM MRC Serves registry staff will: (1) produce a list of requested volunteers within 2 hours of the request; (2) contact potential volunteers; (3) within 24 hours, provide the requestor with a verified list of volunteers for deployment.

In the event of a coronavirus pandemic in the State, NM MRC Serves volunteers will be notified via the City Watch/Health Alert Network (HAN) and email.

Organization and Responsibilities

The key response components across NMDOH will be the Epidemiology and Response Division, including the Director's Office, the Infectious Disease Epidemiology Bureau, the Bureau of Health Emergency Management, and the Bureau of Vital Records and Health Statistics; the Scientific Laboratory Division, including the Biological Sciences Bureau; the Public Health Division, including the Infectious Disease Bureau, Immunization Program, Director's Office, and Regional and Local Public Health Offices; and the Office of the Secretary, including the Communications Office.

Intervals for a Pandemic Response: this plan focuses on Recognition, Initiation, and Acceleration Phases for a Novel Coronavirus Response



Outbreak Recognition Interval (current condition)

State indicator: Increasing number of human cases of novel coronavirus illness are identified and the virus has the potential to spread from person-to-person. Public health actions include: contain community spread and treat sick persons

- Surveillance and Epidemiology
    - Conduct surveillance of patients meeting the case definition of Patients Under Investigation (PUI) via 24/7/365 on-call service at 505-827-0006
    - Distribute the current recommendations to health care partners about enhanced surveillance for the detection of the first cases of the novel coronavirus
    - Facilitate the collection and testing of appropriate specimens, as recommended, for early detection of the virus
    - Increase testing and the frequency of reporting virologic data. The most intense testing is necessary during the early stages of a pandemic in order to detect the introduction of the virus into the state, region, or new community
    - Sentinel provider sites continue weekly % of total visits due to ILI reports and submission of specimens to SLD
    - Establish an electronic case report form and report cases, for analysis and reporting as needed

- Emergency Operations
  - If Department Operations Center (DOC) is activated, coordinate and support NMDOH response activities from the DOC
  - Initiate rapid needs assessment and reconcile inventory of in-state caches of personal protective equipment (PPE) and available MCM, in preparation for a potential Strategic National Stockpile (SNS) request
  - Continue to coordinate with all partners
- Laboratory Response
  - Prepare collection kits for distribution to approved submitters
  - Test for cases of 2019 Novel Coronavirus as required using kits provided by CDC
  - Test and forward specimens as indicated by CDC
  - Send results electronically to CDC and ERD via the Laboratory Information Management System
- Community Containment
  - Conduct active monitoring of asymptomatic travelers and contacts of known cases during the 14-day incubation period
  - Communicate infection control precautions to healthcare providers
  - Provide universal messages for respiratory virus control (hand hygiene, cough etiquette, social isolation when ill) for the public
- Risk Communication
  - Disseminate risk communication messages, including: what is known, what is not known, and what is being done by public health officials
  - Disseminate messages for travelers, as well as, community mitigation messages; when to seek care, and how to care for ill persons at home as appropriate
  - Conduct briefings with local, regional, and state response partners; businesses; tribes, and health-care facilities; to include: the potential for escalation, response actions underway, and preparedness steps that partners should consider
  - Monitor/Update the NMDOH website and social media messaging
  - Provide information and update clinicians, Community Health Workers, Community Health Representatives and stakeholders through the state Health Alert Network (HAN)
  - Provide weekly press releases and talking points
- Medical Care and Countermeasures
  - Send updated infection control and treatment guidelines to providers and hospitals
  - Collaborate with pharmacies and healthcare partners to track availability of personal protective equipment and relevant supplies
  - Provide guidance to EMS agencies
  - Begin discussions with healthcare coalitions and hospitals regarding plans to deal with medical surge

Pandemic Initiation Interval

State indicator: Initiation of a pandemic wave in New Mexico; a novel coronavirus has the ability to spread in a sustained manner from person-to-person.

- Surveillance and Epidemiology
  - Continue surveillance of patients meeting the case definition via 24/7/365 on-call service at 505-827-0006

  - Distribute the current recommendations to health care partners for 2019 nCoV testing and care of patients
  - Facilitate the collection and testing of appropriate specimens, as recommended, for detection of the virus
  - Consider modifying testing frequency and criteria for reporting virologic data.
  - Sentinel provider sites continue weekly % of total visits due to ILI reports and submission of specimens to SLD
  - Continue use of electronic case report form for case reporting and analysis
  - Expand existing routine surveillance of hospitalized influenza cases (via Flu Surv-NET) to include hospitalized 2019 nCoV cases
- Emergency Operations
  - Activate Department Operations Center (DOC), if already activated, consider a higher level of activation
  - Consider declaring a public health emergency
  - Maintain situational awareness of medical countermeasure use and availability by conducting queries of pharmacies and healthcare facilities
- Laboratory Response
  - Prepare collection kits for distribution to approved submitters
  - Test for cases of 2019 Novel Coronavirus as required using kits provided by CDC
  - Test and forward specimens as indicated by CDC
  - Send results electronically to CDC and ERD via the Laboratory Information Management System
  - Be aware of any modification of testing guidelines sent by the CDC and ERD
  - Prepare for surge testing activities to include using multiple instruments, training additional personnel for testing and accessioning if necessary
  - Initiate planning for triaging testing for nCoV if numbers exceed testing kits consistent with ERD and CDC guidance
- Community Mitigation
  - Develop and provide recommendations about social distancing and personal protective measures
  - Distribute educational information about preventive measures such as voluntary home isolation of ill persons, respiratory etiquette, hand hygiene, and infection control
  - Determine if school closures should be recommended or not
- Risk Communication
  - Activate the NMDOH Communication Team
  - Coordinate regular internal NMDOH communication and information
  - Provide the public and partners with educational information on the following topics: social distancing, sheltering in place, nonpharmaceutical interventions, self-isolation when sick, when to seek care and how to care for ill persons at home
  - Provide information and update clinicians, community health workers, community health representatives, and stakeholders through the state health alert network
  - Conduct regular briefings with communication partners and stakeholders
  - Monitor/update the NMDOH website and social media messaging
  - Provide outreach and education to vulnerable populations
  - Provide weekly press releases and talking points
- Medical Care and Countermeasures: disseminate information to healthcare partners, including:

- Evolving clinical case definitions and epidemiologic information
- Updates regarding local clusters of disease, in the early stages of the pandemic
- Reporting requirements, that may change as the pandemic unfolds
- Infection control standards for the home, outpatient clinic, inpatient hospital, and institutional settings
- Clinical information regarding the evaluation and anticipated course of infection, based upon information from the WHO and the CDC
- Information about the availability and appropriate use of therapeutic modalities, if any
- Evolving information about the sub-groups of people that are most likely to experience serious complications from infection
- Recommendations for alterations in standards of care, which may become necessary if the healthcare resources become overwhelmed
- Survey existing clinical call lines to assess capacity for triaging patients to determine if they require a provider visit if healthcare resources become overwhelmed
- Recommendations to address medical surge

Pandemic Acceleration Interval

State Indicator: Consistently increasing rate of pandemic coronavirus cases identified in the State, indicating established transmission.

- Surveillance and Epidemiology
  - Plan for shift from individual case investigations to aggregate case counts using the EIP Flu-Surv-NET program as a basis for hospitalized case reporting
  - Adapt surveillance tools for larger volume case counts (i.e., more efficient databases)
  - Prepare for electronic laboratory reporting as commercial assays for novel coronavirus become available
  - Analyze and report data from surveillance systems to identify changes in coronavirus epidemiology in New Mexico
- Emergency Operations
  - Activate Department Operations Center (DOC), if already activated, consider a higher level of activation
  - Consider declaring a public health emergency
  - Maintain situational awareness of medical countermeasure use and availability by conducting queries of pharmacies and healthcare facilities
- Laboratory Response
  - Prepare collection kits for distribution to approved submitters
  - Test for cases of 2019 Novel Coronavirus as required using kits provided by CDC
  - Test and forward specimens as indicated by CDC
  - Send results electronically to CDC and ERD via the Laboratory Information Management System
  - Be aware of any modification of testing guidelines sent by the CDC and ERD
  - Address testing surge by using multiple instruments, training additional personnel for testing and accessioning if necessary. New temporary staff could be hired to perform testing and address testing surge
  - Triage testing for nCoV if requests for specimen analysis exceeds testing and testing kit capacity consistent with ERD and CDC guidance
- Community Mitigation

- Consider implementing social distancing measures such as:
  - Temporary closure of child care facilities
  - Temporary closure of schools
  - Encouraging telework and alternate schedules for workplaces
  - Postpone or cancel mass gatherings
  - Interrupting mass transit
- Update educational information about preventive measures

- Risk Communication
  - Continue prior activities with increased frequency and intensity
- Medical Care and Countermeasures
  - Maintain health care services, while addressing a potential surge in patients and sustain essential services
  - Emphasize infection control measures in all health care facilities
  - Address an increase in demand for health care services by:
    - Modifying admission/discharge policies
    - Implementing visitor guidelines to minimize unnecessary exposure
    - Deferring or canceling elective procedures
    - Prioritizing laboratory and radiology services
    - Creating alternate triage locations; Opening alternate care facilities; and Increasing security
  - Be aware of illness and absenteeism among NMDOH staff, and monitor absenteeism in health care workers, as demands for health care resources and services increase
  - Receive requests from community-based organizations that report difficulty sustaining critical services and providing assistance to the access and functional needs population
  - During overwhelming patient surge conditions and or conditions with limited and insufficient resources, procedural decisions will be made, including:
    - Identification of essential clinical services, including elements of critical care delivery and prophylactic treatment that will continue during medical surge
    - Use and allocation of pharmaceuticals and equipment
    - Criteria for determining the prioritization of patients to receive the limited and available medical resources
    - Criteria for the care of patients who qualify for essential clinical services
    - Criteria for patients who are terminally ill or mortally injured and may require palliative care
    - Policies and procedures for documentation of financial expenditures and other costs resulting from response to patient surge
- Mortuary Service and Mass Fatality Management
  - Planning for many potential fatalities from a pandemic is a challenge at many levels. Considerations:
    - Identification and documentation of victims
    - Management of temperature for decedents
    - Options other than cold storage units
    - Controlled holding facilities
    - Release of remains to family members
    - Temporary internment of mass fatalities
    - Cremation and burial of mass fatalities

- Legal requirements for autopsies or other processes (such as deaths at home)
- Local transport of remains from home or collection point directly to morgue
- Security measures at the collection points
- Coordination with local authorities
- Database synchronization and networking to support information management

Appendix A

Legal Authority

Federal

The Robert T. Stafford Disaster Relief and Emergency Assistance,
Public Law 93-288, as amended (April 2013), 42 U.S.C. 5121 et seq.
Pandemic and All-Hazards Preparedness Reauthorization Act (PAHPRA), Public Law No.113-5 (March 2013)
Pandemic and All-Hazards Preparedness Act (PAHPA), Public Law No. 109-417 (December 2006)
Presidential Policy Directive (PPD) 8 National Preparedness, issued in March 2011

State

New Mexico All Hazard Emergency Management Act (AHEMA) §12-10-11 through 13, New Mexico Annotated (NMSA) (1978).
The New Mexico Public Health Emergency Response Act (PHERA), §12-10A-1.G and L., and Section 12-10-11 through 13 NMSA (1978).
New Mexico Public Health Act, Sections 24-1-1, et seq., NMSA (1978)
Section 24-1-15 Isolation Quarantine Protocol

Legal Authority for Isolation and Quarantine in New Mexico

Background

According to the Public Health Act, the New Mexico Department of Health (NMDOH) has the authority and responsibility to investigate, control, and abate the causes of disease, especially epidemics, sources of mortality and other conditions of public health (NMSA 1978 § 24-1-3.C). The NMDOH may establish, maintain and enforce isolation and quarantine (NMSA 1978 § 24-1-3.D). Isolation and quarantine help protect the public by preventing exposure to people who have or may have a contagious disease. Isolation separates and restricts the movement of sick people with a contagious disease from people who are not sick with that disease. Quarantine is the separation and restriction of movement of people who have potentially been exposed to a contagious disease, until it can be determined whether they become sick or no longer pose a risk to others (e.g., based on time elapsed from their potential exposure).

During a public health emergency, the Secretary of the NMDOH may isolate or quarantine a person as necessary by using the procedures set forth in the Public Health Act and associated regulations; including the Public Health Emergency Response Act (PHERA) (NMSA 1978 § 12-10A-8 to 12-10A-11). This approach would only be instituted if all other voluntary approaches were to fail. While broad public health police powers exist in New Mexico,

Limitations on those powers also exist and are respected by the NMDOH. NMDOH complies with the legal responsibility that “isolation or quarantine shall be by the least restrictive means necessary to protect against the spread of a threatening communicable disease or a potentially threatening communicable disease to others and may include confinement to a private home or other private or public premises” (NMSA 1978 § 12-10A-8). Legal job protections also exist, such that “an employer or an agent of an employer shall not discharge from employment a person who is placed in isolation or quarantine” (NMSA 1978 § 12-10A-16 (2003). New Mexico law also contains provisions for mandatory medical treatment (NMSA 1978 § 24-1-15.1).

Procedures

The secretary or a representative of the department whom the secretary designates may, by public health order, temporarily isolate or quarantine a person or group of persons if delay in isolating or quarantining would significantly jeopardize the secretary's ability to prevent or limit the transmission to others of a threatening communicable disease (NMSA 1978 § 24-1-15B).

In an event that involuntary detention is felt to be necessary, the following provides the legal authority for obtaining an Ex Parte Order or issuance of a Public Health Order.

Voluntary Isolation or Quarantine

A person with or having a substantial likelihood of having a threatening communicable disease shall be advised of the risks and rights and requested to voluntarily remain in isolation or quarantine. Only in the event that reasonable attempts to achieve voluntary isolation or quarantine fail, will legal steps be taken. Voluntary agreement should be executed under applicable statute (Public Health Act or Public Health Emergency Response Act).

Involuntary Isolation or Quarantine

A healthcare provider or law enforcement official will contact the New Mexico Department of Health at 505-827-0006, if they believe involuntary isolation or quarantine is necessary. The Epidemiology and Response Division will consult with the department's Office of General Counsel to determine whether to obtain an order for isolation or quarantine.

Involuntary Isolation or Quarantine - Public Health Emergency Not Declared

a. NMSA 1978 §24-1-15 (Health and Safety - Public Health Act – Isolation; quarantine; protocol indicates that:

   i. A public health official shall petition the court, and the court shall immediately grant a temporary ex parte order of protection to isolate or quarantine an individual if there is a substantial threat to the public health and safety. The petition must show that the individual:

      1. Is infected with, reasonably believed to be infected with or exposed to a threatening communicable disease; and
      2. Poses a substantial likelihood of transmission of the threatening communicable disease to others because of inadequate separation from others; and
      3. Has refused voluntary treatment, testing, evaluation, detention, or observation.

   ii. While in temporary isolation or quarantine a person shall be entitled to legal representation and permitted to communicate on any matter in a way that does not create a risk of infection for others.

   iii. An evidentiary hearing shall be held within 5 days. After the hearing, the court may continue the order of protection with regular review of the order within 90 days and every 90 days thereafter.

   iv. The order of protection shall be terminated, and the person released if:

      1. The person is certified by a public health official to pose no further risk to the public health;

2. At a hearing, it can no longer be shown that the person is infected with, reasonably believed to be infected with, or exposed to a threatening communicable disease, or that the person will not comply with voluntary treatment and contagion precautions; or,
3. There are exceptional circumstances which exist warranting the termination of the court order.

Involuntary Isolation or Quarantine – Public Health Emergency Declared pursuant to the Public Health Emergency Response Act.

b. NMSA 1978 § 12-10A-7 (Procedures for isolation or quarantine of persons) indicates:
   i. Before isolating or quarantining a person, the Secretary of Health shall apply for and obtain a written ex parte order of protection from a court.
   ii. Notice shall be given to the affected person(s) unless immediate and irreparable injury, loss or damage will result.
   iii. The court shall grant the ex parte order of protection if clear and convincing evidence exists that isolation or quarantine is warranted to respond to the public health emergency.
   iv. The petition must:
      1. state the specific facts justifying the isolation or quarantine;
      2. state the persons, group or class of persons affected;
      3. state that the affected person(s) have the right to a court hearing with legal representation; and
      4. be served as soon as practicable to persons isolated or quarantined.
   v. The Secretary of Health shall coordinate with the secretary of public safety and the state director of homeland security and emergency management regarding execution of the order.
   vi. A person who is isolated or quarantined can request a hearing at any time before the expiration of the ex parte order of protection. However, a person cannot be isolated or quarantined pursuant to an ex parte order of protection for longer than five days without a court hearing.
   vii. The isolation or quarantine shall automatically terminate when the order expires, or if the Secretary of Health notifies the court that it is no longer needed to protect the public.
c. NMSA 1978 § 12-10A-8 (Isolation or quarantine authorized; protection of a person isolated or quarantined) indicates:
   i. Conditions of isolation or quarantine:
      1. Isolation or quarantine is by the least restrictive means and may include confinement to a private home or other private/public premises;

2. Isolated persons are confined separately from quarantined persons;
3. Health status is monitored regularly to determine the need to continue isolation or quarantine;
4. There is a reliable means to communicate at all times with health officials, family and others, and to call for emergency health services;
5. If a quarantined person becomes actively infectious or presents a substantial likelihood of being infectious, they will be isolated pursuant to the Public Health Act or the Public Health Emergency Response Act;
6. Adequate food, clothing, shelter, sanitation, medication and treatment, and medical and mental health care, will be provided;
7. Methods of communication with others are provided, accommodations are made for religious practice, and updates on the status of the public health emergency are made available;
8. The premises used for isolation or quarantine are safe and hygienic and are designed to minimize the likelihood of transmission of infection or other injury; and
9. Forms are provided for the person to document consent or objection to the isolation or quarantine.

ii. A person who is isolated or quarantined may request a court hearing regarding treatment or the terms and conditions of isolation or quarantine pursuant to NMSA1978 § 12-10A-11. If such a petition is filed, a hearing must be held within seven days. A request for a hearing does not alter an order for isolation or quarantine.

iii. A person in isolation or quarantine has the right to refuse treatment, testing, examination, vaccination, specimen collection and preventive treatment programs; however, refusal may prolong isolation or quarantine.

iv. Unauthorized persons shall not enter the isolation or quarantine area, and if doing so creates danger to public health, those persons may be subject to isolation or quarantine.

v. Household or family members have a right to enter an isolation or quarantine area if they sign a consent form stating the potential health risks, the isolation and quarantine guidelines, and the consequences of entering the area, including possible isolation or quarantine, and the state shall not be held responsible for those consequences.

d. NMSA 1978 § 12-10A-9 (Temporary hold on secretary's order) indicates:

i. If a delay in isolating or quarantining a person will significantly jeopardize the department's ability to prevent or limit the transmission of a threatening communicable disease, then the secretary of health may

issue a public health order to isolate or quarantine a person without first obtaining court order.

ii. An ex parte order of protection must be applied for within 24 hours following the procedures of the Public Health Emergency Response Act. The petition must state the facts in support of the need to issue a temporary hold by public health order.

e. NMSA 1978 § 12-10A-10 (Court hearing to contest isolation or quarantine):

i. A person who is isolated or quarantined under a temporary hold, ex parte order, or continuing order may petition the court to contest detainment at any time prior to the expiration of the order or hold.

ii. A hearing shall be held within three days of the petition being filed but filing of a petition does not stay an order of isolation or quarantine.

iii. The secretary of health may petition the court to extend an order for isolation or quarantine beyond the time stated in the temporary hold, ex parte order, or continuing order. Notice of a hearing on the extension must be served at least three days prior to the hearing. A court may order an extension of isolation or quarantine if there is clear and convincing evidence that failure to do so would result in an imminent health threat to others.

iv. Isolation or quarantine shall not continue for longer than thirty days from the date of a court order unless the Secretary of Health petitions for an extension.

v. Isolation or quarantine will be terminated when the Secretary of Health notifies the court that the conditions warranting isolation or quarantine no longer exist.

f. NMSA 1978 § 12-10A-16 (Job protection for a person who is isolated or quarantined):

i. An individual who is isolated or quarantined pursuant to the Public Health Emergency Response Act may not be discharged from employment by an employer or agent of an employer.