Final Report of the
New Mexico Task Force
on Emergency Preparedness and Response
for Targeted Populations

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■ List of Acronyms Used In This Report

Acronym	Title/Description
BHC	Behavioral Health Collaborative
BHEM	Bureau of Health Emergency Management
BHPC	Behavioral Health Planning Council
BHSD	Behavioral Health Services Division
CCP	Crisis Counseling Program
CMHS	Center for Mental Health Services
COOP	Continuity of Operations Plan
CORD	Consumer Organization Recognizing Diversity
CYFD	Children Youth and Family Department
DDPC	New Mexico Developmental Disabilities Planning Council
DHSEM	Department of Homeland Security and Emergency Management
DOH	New Mexico Department of Health
FEMA	Federal Emergency Management Administration
HIPAA	Health Insurance Portability and Accountability Act
HSD	Human Services Department
ISP	Immediate Services Program
LC	Local Collaborative
LISW	Licensed Independent Social Worker
LPCC	Licensed Professional Clinical Counselor
MHP	Mental Health Professional
PED	Public Education Department
PFA	Psychological First Aid
PHERA	Public Health Emergency Response Act
PHI	Public Health Information
RSP	Regular Services Program
RTC	Residential Treatment Center
SAMHSA	Substance Use and Mental Health Services Administration
SBHC	School Based Health Center
SE	Statewide Entity
SNS	Strategic National Stockpile

■ Executive Summary

In December of 2006, the State Director of the Department of Homeland Security and Emergency Management (DHSEM) formalized the **New Mexico Task Force on Emergency Preparedness and Response for Targeted Populations**. The mission of the Task Force was "to ensure functional needs of targeted populations are recognized and fully integrated into emergency preparedness and response in New Mexico." Letters of endorsement were sent to Cabinet Secretaries and Directors of public and non-profit organizations requesting their support and a commitment of staff participation to examine plans and identify issues for specific targeted populations.

The Task Force created four Work Groups to explore existing plans and activities as they speak to the functional needs of different populations requiring additional assistance in a state emergency or disaster. They addressed the needs of the following populations:

- Individuals Housed in Institutions and Wards of the State
- People with Disabilities
- People with Chronic Mental Illness and/or Substance Use Disorders
- Other Vulnerable Populations (i.e., the healthy elderly, homeless, and children not with their parents or guardians at the time of a disaster, i.e. "unaccompanied children"

After an initial orientation to emergency management policies at the Federal and State levels, the Work Groups met periodically to review current plans, including the **New Mexico Department of Health Emergency Operations Plan** and its **Pandemic Influenza Emergency Response Appendix**, and the **New Mexico All-Hazard Emergency Operations Plan**. They were to identify gaps and make recommendations to address those gaps. The Work Groups then presented their findings to the Task Force. This report presents those findings and recommendations.

Five cross-cutting issues emerged from their deliberations:

1. the need to identify individuals with specific response needs before an event occurs;

2. the need for pre-disaster planning by organizations and individuals to ensure uninterrupted services and supplies;

3. the need to identify and bring into the planning process community resources as partners;

4. the need for public education and risk communication addressing potential threats and hazards with training in individual, family and emergency preparedness; and

5. the need to reduce or eliminate ambiguity in organizational roles and responsibilities in supporting and delivering services to the targeted populations.

The recommendations contained in this report highlight needed changes in written policies across numerous state agencies, as well as practices and services of emergency management agencies and other organizations.

For these recommendations to be put into practice, two things are necessary.

1. A detailed implementation plan that identifies specific agencies and individuals who have statutory authority to implement the changes.

2. A mechanism to coordinate and facilitate the implementation of recommendations.

■ Background

Introduction

The Task Force on Emergency Preparedness and Response for Targeted Populations was the result of two prior events.

- **Working Conference on Emergency Management and Individuals with Disabilities and the Elderly:** Representatives from New Mexico's Department of Health (DOH), Aging and Long-Term Services Department (ALTSD), the Department of Homeland Security and Emergency Management (DHSEM), the Developmental Disabilities Planning Council and the University of New Mexico's Center for Development and Disability served as state delegates or speakers at the *Working Conference on Emergency Management and Individuals with Disabilities and the Elderly* in Washington DC sponsored by the U.S. Department of Health and Human Services and the U.S Department of Homeland Security in 2006.

  The conference brought together Governor-appointed State teams with key disability and aging experts to work toward the integration of efforts within state emergency management policies and plans. After returning to New Mexico, conference participants met to create a process to assess the extent to which state emergency management plans incorporated the needs and priorities of people with a wide range of physical and cognitive disabilities.

- **First New Mexico Task Force:** Many of those who had participated in the *Working Conference* had also been members of a DOH Task Force that had assessed the extent to which the needs of people with a wide range of physical and cognitive disabilities were being included in statewide emergency preparedness planning activities. The 2004 report of the first Task Force[1] made a number of recommendations for changes to existing policies as well as new activities to ensure that these needs were addressed. A new Task Force will build upon the work of the earlier group to identify progress that had been made as well as gaps that remained.

Stage agency emergency roles and responsibilities are identified by DHSEM within the ***New Mexico All-Hazards Emergency Operations Plan***. DHSEM has the authority to task other state agencies during state emergencies or disasters. DHSEM's State Director fully endorsed the Task Force on Emergency Response and Preparedness for Targeted Populations. In soliciting support from the Cabinet Secretaries and Directors of public and non-profit organizations, he asked that one or more staff members serve on the Work Groups to examine emergency plans and identify issues for specific targeted populations.

Mission, Goals, Organization and Mandate of the Task Force

The mission, goals, organization and mandate of the Task Force were developed in the context of New Mexico's emergency management system. The concept of operations is in alignment with the National Incident Management System (NIMS) and Incident Command System (ICS) that describe how the state will respond in an emergency.

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[1] Marcy Davis and Anthony Cahill, ***Including The Needs and Priorities Of People With Disabilities, Seniors, People Who Are Chronically Mentally Ill And People Who Are Chronic Substance Abusers In Public Health Emergency Preparedness***. Albuquerque: Center for Development and Disability, 2004.

Mission

The mission of the Task Force was to ensure functional needs of targeted populations are recognized and fully integrated into emergency preparedness and response in New Mexico.

Goals

The Task Force developed three primary goals:

1. to assess existing plans for preparedness and response to determine whether they adequately incorporate the needs of multiple groups that will require additional functional and/or medical support during an emergency;

2. to make recommendations for changes to these plans where necessary in order to better meet the needs of citizens who will require such support; and

3. to ensure implementation capacity through identifying specific parties accountable, action steps required, and training and exercise integrated into existing emergency management activities

In developing goals, objectives and work plans, the Task Force considered the emerging definition of "special needs" by the U.S. Department of Homeland Security (DHS), which has been endorsed by the U.S. Department of Health and Human Services (HHS).

Draft Definition of "Special Needs" April 2007
Developed by the DHS/NRP (National Response Plan) Special Needs Work Group and endorsed by HHS

"Before, during and after an incident members of this population may have additional needs in one or more of the following functional areas: maintaining independence, communication, transportation, supervision, and medical care. Individuals in need of additional response assistance may include those who:

- *have disabilities;*
- *live in institutionalized settings;*
- *are elderly;*
- *are from diverse cultures;*
- *have limited English proficiency or who are non-English speaking;*
- *are children; or*
- *are transportation disadvantaged."*

Individuals in these groups often have specific disaster-related needs requiring additional assistance or capabilities. This definitional framework is a function-based approach that allows planners to plan for a predictable and specific set of functional support needs and establishes parameters for resource allocation. Notably, this definition satisfies a key recommenda-

tion from the Department of Homeland Security's ***Nationwide Plan Review*** [2] calling on the federal government to develop a consistent definition of the term 'special needs'

This approach establishes a flexible framework that addresses a broad set of common function-based needs irrespective of specific diagnosis, statuses, or labels (e.g., children, the elderly, etc.). For example:

- **Maintaining Independence –** Individuals in need of support that enables them to be independent in daily activities may lose this support during the course of an emergency or a disaster situation. This may include lost or damaged durable medical equipment (wheelchairs, walkers, scooters, and essential supplies —catheters, ostomy supplies, etc.). By supplying needed support/devices individuals will be able to maintain their independence.

- **Communication -** Individuals who have limitations that interfere with the receipt of and response to information will need that information provided in formats they can understand and use. They may not be able to hear verbal announcement, see directional signage, or understand how to get assistance due to hearing, vision, speech, cognitive or intellectual limitations, or limited English proficiency

- **Transportation –** Individuals who cannot drive due to the presence of a disability or who do not have a vehicle will require support for successful evacuation such as, availability of accessible vehicles (e.g., lift equipped or vehicle suitable for transporting individuals who uses oxygen) or information about how/where to access mass transportation used to assist in evacuation.

- **Facilitation and Supervision** – Before, during, and after an emergency or a disaster, individuals may lose the support of caregivers, family, or friends or may be unable to cope in a new environment; have conditions such as dementia, Alzheimer's Disease and psychiatric conditions (schizophrenia, intense anxiety); and unaccompanied children will require supervision to make decisions affecting their welfare.

- **Medical Care** - Individuals who are not self-sufficient or do not have or have lost adequate support from caregivers, family, or friends may need assistance with: managing unstable, terminal or contagious conditions that require observation and ongoing treatment; managing intravenous (IV) therapy, tube feeding, and vital signs; receiving dialysis, oxygen, and suction administration; managing wounds; and operating power-dependent equipment to sustain life. These individuals require support of trained medical professionals.

Organization

Roles and responsibilities of the Task Force and the Work Groups were clearly defined.

As the coordinating body, the Task Force:

1. Identified leaders of each work group;

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[2]   U.S. Department of Homeland Security, ***Nationwide Plan Review Phase Two Report***, 2006.

2. developed their scope of work;

3. ensured they had a basic understanding of emergency operations before beginning their work;

4. determined common areas of assessment between the groups to avoid duplication of effort;

5. served as a resource for Work Group chairs and members; and

6. integrated recommendations into this final report.

The Task Force created four Work Groups, each co-chaired by a member of the Task Force and a subject matter expert. These were:

Work Group One: Individuals Housed in Institutions and Wards of the State: individuals incarcerated in state and local penal institutions; individuals incarcerated in juvenile detention centers and other youth centers; foster children in foster homes; and children in group homes managed by the Children, Youth and Families Department;

Work Group Two: People with Disabilities: individuals with a variety of cognitive and physical disabilities residing in the community and in institutions such as nursing or group homes who will require additional functional and/or medical support;

Work Group Three: People with Chronic Mental Illness and/or Substance Use Disorders: people living in the community and group homes who have chronic mental illness and/or substance use disorders; and,

Work Group Four: Other Vulnerable Populations: groups including elderly individuals living in the community who may require additional assistance during an emergency; children under the age of consent not living at home or not with their parents or legal guardians at the time an emergency occurs; pregnant women; and, the homeless.

Mandate

The Work Groups were asked to develop the following:

Needs Assessment: Each Work Group was asked to assess the extent to which existing emergency response plans addressed the needs of the target populations of the Work Group and to identify gaps in those plans.

Recommendations: Based on the needs assessment, each Work Group was asked to develop recommendations for changes to existing plans that would address identified gaps. Work Groups were asked to develop recommendations that were actionable and had measurable indicators.

■ Conclusion

While the subject areas of the four Task Force Work Groups were significantly different, a number of cross-cutting issues are clearly evident.

Identification of Individuals: Identification of individuals with specific response needs, where they are located, and how best to serve them during an emergency is a critical issue. Options include a community-based approach, use of information from health care and durable medical equipment providers, and use of client lists from state health and disability program listings.

Pre-Disaster Planning: Planning by agencies is a crucial need for all of the targeted populations discussed in this report. Third party payers, pharmacies, health care and behavioral health providers, disability organizations, correctional institutions and others must develop specific emergency response plans to support their clients with uninterrupted services, including provision of medications. In addition, individuals and/or their caretakers should have personal preparedness plans to mitigate the effects of the disaster.

Inclusion of Community-Based Organizations: Existing community-based resources can play a valuable role in the preparedness, response and recovery phases of disasters. These resources need to be identified and integrated into existing state emergency response plans.

Public Education: Public information and risk communication are critical elements of effective disaster response. Individuals, families, caregivers, and staff of institutions need information concerning how to prepare for emergencies, including evacuation and sheltering-in-place.

Organizational Issues: Clarification of roles and responsibilities of response agencies to ensure that targeted populations are supported efficiently in emergencies.

The recommendations contained in this report highlight needed changes in written policies across numerous state agencies, as well as practices and services of emergency management agencies and other organizations. For these recommendations to be put into practice, two things are necessary.

1. A detailed implementation plan needs to be created that identifies specific agencies and individuals who have statutory authority to implement the changes. In cases in which applicable statutory authority is not already identified, a decision has to be made concerning what organization will be given responsibility for implementing the change.

2. A mechanism needs to be created to coordinate and facilitate the implementation of recommendations that have relevance to more than one targeted population.

■ Annexes

The Annexes of this report contain the findings of each of the Work Groups. Because each Work Group examined different sets of documents and developed differing priorities, the focus of each Work Group as well as the format of their report varies. However, each section identifies gaps in current knowledge as well as recommendations to address those gaps.

Annex 1, Work Group One
Individuals Housed in Institutions and Wards of the State

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■ Introduction

In reviewing the issues involved in emergency preparedness and response among the population of Individuals housed in institutions as well as wards of the State, it was soon understood that the initiative went beyond seeing how these sub-populations fit into an existing plan. The Work Group decided to refocus its activities on assessing the integrity of multiple institutional plans, and defining how that might be accomplished. [Note: In this report, the term "Facilities" refers to institutions managed and operated by the State of New Mexico.]

■ Issues, Gaps and Recommendations

Issue One: Are Facilities' emergency plans current and adequate?(Preparedness)

Gap:

Do all Facilities have an emergency plan? Are the plans current? Are they updated regularly? Do the plans address all hazards, sheltering-in-place, evacuations, etc.? Are there any regulations, requirements, or guidelines that determine what these plans should address?

Recommendations:

1.   Research Federal regulations, policies and guidelines concerning Facility emergency plans.

2.   Review and update the emergency plans using these documents.

3.   Establish a revision schedule for the plans

4.   Develop a training program for shelter managers and others involved in sheltering that incorporates policy changes and guidance from federal agencies regarding the inclusion of individuals.

Issue Two: Links Between the New Mexico All Hazard Emergency Operations Plan (NMEOP) and Individual Facility Emergency Plans (Preparedness)

Gap:

Are Facilities' emergency plans in alignment with the NMEOP? Does the NMEOP adequately address issues, such as evacuation and sheltering-in-place, in Facility plans?

Recommendation:

5.   Review Facility emergency plans and the NMEOP. If needed, revise Facility plans to address all hazards identified in the NMEOP and/or revise the NMEOP to address Facilities' issues such as evacuation and sheltering-in-place.

Issue Three: Training (Preparedness)

Gap:

Are staff at each Facility trained on the emergency plan?

Recommendation:

6.   Conduct training each year to familiarize staff with the Facility's emergency plan and conduct drills and exercises each year to test Facility plans.

Issue Four: Evacuation (Response)

Gap:

Do Facility plans describe evacuation procedures, including possible evacuation locations? Are any agreements (such as Memoranda of Agreement or MOAs) needed to use other facilities during an evacuation? Are there procedures to bring back-up copies (digital or hard copy) of Facility and individual vital records during an evacuation?

Recommendation:

7. Assess Facilities' emergency plans to ensure that they describe evacuation procedures, including adequate transportation and evacuation locations. Identify evacuation locations and complete Memorandums of Agreement for alternate Facility use. Ensure Facilities' plans include vital records issues.

Issue Five: Sheltering-in-Place (Response)

Gap:

Do Facility plans describe shelter-in-place procedures, including procurement procedures for supplies, medications, etc.? Do plans address staffing issues for an extended incident?

Recommendations:

8. Assess plans to ensure that they contain shelter-in-place procedures, procurement procedures, and staffing policies. Develop checklist of supplies and medications needed. Ensure procurement procedures are in place.

Issue Six: Revisions to Facility Emergency Plan After an Incident (Preparedness)

Gap:

Are Facility emergency plans revised after an incident to reflect lessons learned?.

Recommendations:

9. Develop procedure to ensure that Facilities complete an After Action Report & Improvement Plan after each incident to capture lessons learned. Revise the Facility emergency plan to incorporate best practices and areas for improvement, as described in the After Action Report & Improvement Plan, from the incident.

Annex 2, Work Group Two
People With Disabilities

■ **Work Group Members**

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■ Introduction

Some 20%, or about 300,000 of adult, non-institutionalized New Mexicans report having some type of physical or cognitive disability. Of these, about 80,000 report requiring assistance.

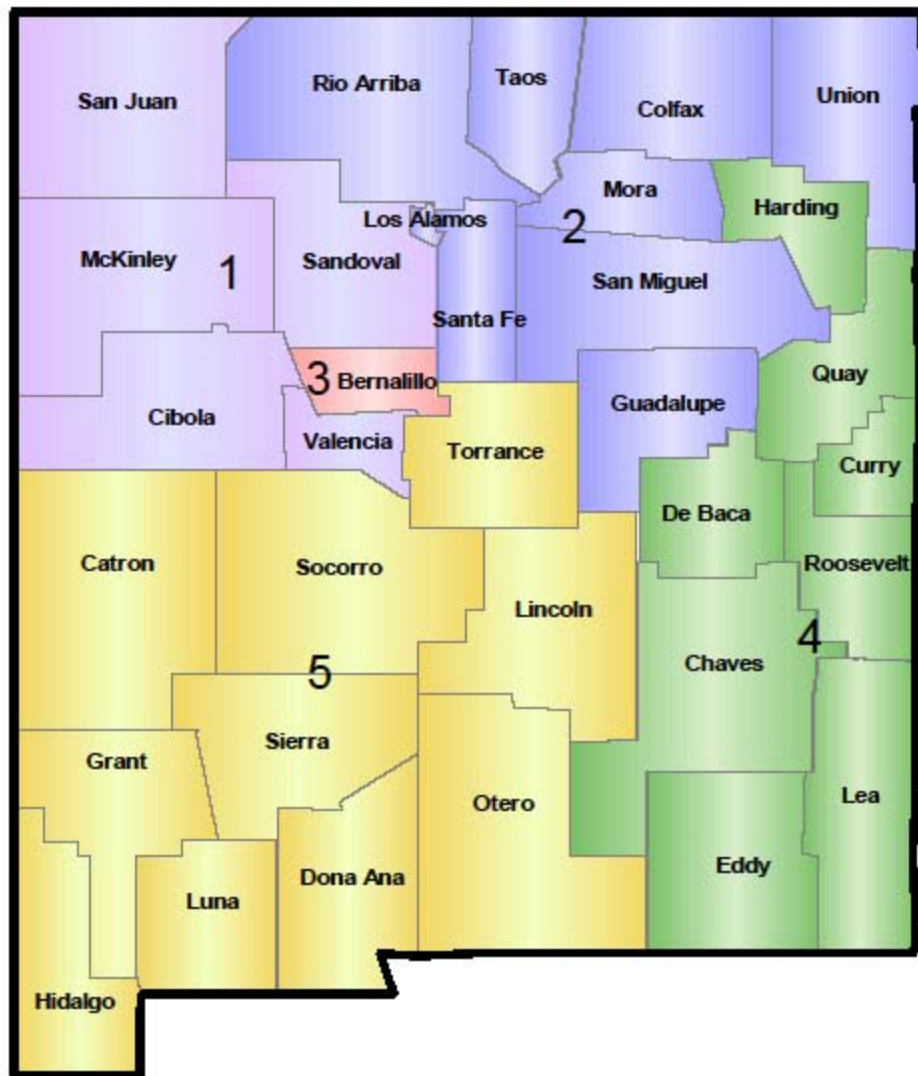**Figure One: Disability in New Mexico**
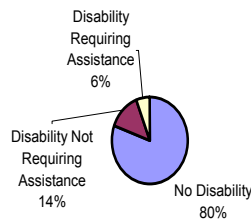
Disability is more-or-less equally distributed throughout New Mexico's population.

Figure Two: Disability In New Mexico's Public Health Regions And Bernalillo County

Northeast: 25.1%
Southeast: 26.3%
Southwest: 24.4%
Bernalillo County 24.2%
Northwest: 24.5%

PHD Regions

Region 1: San Juan, McKinley, Sandoval, Cibola and Valencia;

Region 2: Rio Arriba, Taos, Colfax, Union, Los Alamos, Santa Fe, Mora, San Miguel and Guadalupe;

Region 3: Bernalillo County;

Region 4: Harding, Quay, DeBaca, Curry, Roosevelt, Chaves, Eddy and Lea;

Region 5: Torrance, Catron, Socorro, Lincoln, Grant, Sierra, Hidalgo, Luna, Doña Ana and Otero.

Effective July 1, 2005

Work Group Activities – Summary

       Work Group Two of the Task Force on Emergency Preparedness for Targeted Populations convened to assess the needs for persons with disabilities during emergency preparedness and response, and to review existing plans for gaps.

       The Work Group divided its recommendations into three categories; Preparedness, Response, and Recovery, consistent with the phases of disaster. Findings indicate identification of individuals, especially by emergency managers, is extremely difficult and one of the most pressing concerns of responders. Other major challenges included continuity of services without interruption during an emergency, re-unification of individuals separated by an emergency, and re-establishment of daily routines and services.

Recommendations of the Work Group follow.

Issue One: Identification of Individuals with Specific Emergency Response Needs (Preparedness)

Gap:

       Emergency managers currently have no way to identify individuals with specific response needs, where they are located, and what their response needs are. In Rio Arriba County for example, there is an option to include this information on county residential forms. However, there is no database or other resource that provides more complete or reliable information. How and where should information about people with disabilities gleaned from several disparate sources be kept and maintained?

       Questions that need to be addressed: include <u>WHO</u> (or what agency/ organization) collects the information, <u>WHAT</u> information is needed and <u>WHO</u> should maintain the information?

Recommendation 1-1:

       Information could be solicited via a "community approach" such as 911 call centers; or utility and equipment vendors. Also, information could be requested in monthly utility bills. Public transit systems usually have some information about individual transport needs.

       The State of New Mexico maintains a complete list of community provider agencies that serve people on the Developmental Disabilities (DD) Waiver and individuals on the DD Waiver. Other possible sources of data include home health care providers; medical equipment suppliers; county-based community health councils; NMDOH Aging and Long Term Services Department, Medically Fragile Waiver and, DD Supports Division (DDSD) Statewide Training Database at the Center for Development and Disability (CDD) at the University of New Mexico (UNM).

       Public transportation agencies, such as Santa Fe Ride, maintain records of individuals who have submitted Certification of ADA Paratransit Eligibility forms. The information on the form indicates if the individual is accompanied by service animals and/or service attendants, if a chair assistive device is required, if a func-

tional capacity study has been performed, as well as complete contact information including physical location and mailing address.

Work with multiple State agencies and selected county emergency managers to develop a pilot project that creates a database to identify and locate individuals with specific response needs. The database could also include a registry of county/community-based resources and services for the disabled population.

Gap:

There is a pressing need for connecting disabled individuals/groups and emergency responders.

Recommendation 1-2:

A campaign to persons with disabilities that poses questions, such as: "Do You Know your Emergency Manager, Fire Department, etc….?" or "What do local emergency responders need to know about YOU?"

Public Service Announcements and year-round marketing efforts to increase awareness that pre-disaster planning could be critical to one's chances of survival.

Gap:

Persons with disabilities need information about how to prepare for evacuation and how to shelter-in-place (short-term, i.e., snow storm vs. long-term, i.e., pandemic influenza)

Recommendation 1-3:

There are numerous sources of information to assist individuals and organizations with development of preparedness plans; there is no reason to reinvent the wheel. Efforts need to focus on dissemination and marketing campaigns, grass-roots training and technical assistance programs. The DOH Bureau of Health Emergency Management and the UNM Center for Development and Disability are collaborating on an outreach training program for county-based Community Health Councils that includes this topic.

Develop a PSA campaign; emphasize the need to reach out to a neighbor who has response needs; target the faith-based community to participate in the effort to identify individuals.

Issue Two: Services for Individuals with Specific Needs (Response)

Gap:

All individuals, especially those with disabilities, must have continuation of services without interruption during an emergency. For persons with disabilities, these would include Social Security, Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI), Medicare/Medicaid, prescriptions, medical supplies and equipment (i.e., oxygen, etc.), as well as availability or provision of basic subsistence items, such as food and water.

Recommendation 2-1:

Contact needs to be made with third party payers and pharmacies (chain and independent) to develop a process to prepare for emergencies and ensure uninterrupted services. Entities could work together to devise a strategy for ensuring that clients are permitted to have one month extra supply of prescriptions and other critical supplies.

The UNM Poison Center is performing a statewide inventory of pharmaceuticals and developing a "just-in-time" procedure for providing information on product availability that can be used during an emergency. Perhaps this activity can be integrated as one component of the solution to this gap.

Gap:

Persons with disabilities and their caretakers need to share a common denominator of skills needed during response, and when moving from response to recovery. Although persons with disabilities are always dealing with the unpredictable, the "newly" disabled would likely encounter more problems in a response situation than others.

Recommendation 2-2:

Emergency planners and managers, disability agencies and individual persons with disabilities could provide education about the specifics of preparedness, especially, the personal skills and required tasks required for mitigation of the effects of an emergency.

Each individual must identify <u>exactly what they need</u> and how to communicate these needs to the resources (services) and/or persons who can meet them.

Gap:

Inclusion of third party payers in this educational process is vital. A process for establishing two-way education between individuals and providers is needed.

Recommendation 2-3:

Education and continued dialogue about mass sheltering needs to be undertaken. In the near future, the Federal Emergency Management Agency (FEMA), rather than the American Red Cross will be the lead agency for this response function. At the federal level, a new Target Capability, *Functional and Medical Support Sheltering,* is near completion. Dialogue needs to continue with both agencies to ensure that "populations requiring support," to the extent possible, can be accommodated in the least restrictive environment (e.g., a general population shelter). When provision of such support cannot be reasonable accommodated, these individuals will be sheltered in a Functional and Medical Support Shelter (F&MSS)."

(From: ***Functional and Medical Support Sheltering,*** final draft, April 2007)

Issue Three: Transitioning from Response to Recovery   (Recovery)

Gap:

Re-establishment of personal contacts, daily routines and basic services, especially transportation, is critical to the ability to recover from an emergency

Recommendation 3-1:

Planning for recovery from a specific event should start at the beginning of response via the Incident Command System (ICS), used locally and at the State level, for managing emergencies. Specific training in the importance of early planning for recovery of persons with disabilities should be provided to local emergency managers and other responders at all levels. Responses to past events should be closely studied via review of available After-Action Reports and, as indicated, appropriate changes and amendments to State and local emergency operations plans should be implemented.

Recommendation 3-2:

Planning for recovery, in general, should be incorporated immediately into statewide emergency planning efforts. Local governments, service providers, responders, and emergency management personnel need to make a special effort to incorporate the needs of persons with disabilities in this activity.

Annex 3, Work Group Three
People with Chronic Mental Illness and/or Substance Use Disorders

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Introduction

Effective July 1, 2007, the Behavioral Health Services Division (BHSD) administered by the New Mexico Department of Health (NMDOH) was transferred to the NM Human Services Department (NMHSD). This transfer was the result of House Bill 371a: "Transfer Behavioral Health Services Division" that was approved by the State's legislature and signed by Governor Richardson. With this action, HSD was identified as the new entity to provide oversight of state-provided behavioral health services and assumed the role of State Mental Health Authority (SMHA). Management of substance abuse prevention services remained within DOH.

The purpose of this transfer was to ensure inclusion of mental health and substance abuse services as part of the State's strategy to close the uninsured gap and to create more options for use of Medicaid funding for behavioral health services. The transfer of responsibilities from DOH to HSD is part of Governor Bill Richardson's initiative to help streamline mental health and substance abuse services for adults.

The State behavioral health system consists of the Interagency Behavioral Health Purchasing Collaborative ("The Collaborative"), the State's statutory legal entity charged with oversight of New Mexico's behavioral health delivery system. The Collaborative represents the 17 State entities that were individually providing behavioral health services prior to 2004 when the new system was created. It is a unique public policy initiative intended to mitigate fragmentation of services, increase service quality and improve consumer outcomes. The Collaborative replaces oversight of services via several departments with coordination via a single entity, and replaces multiple advisory bodies into one statutory advisory body, the Behavioral Health Planning Council (BHPC). The Collaborative also consolidates multiple contracting mechanisms and administrative infrastructures under a single service provider Statewide Entity (SE), currently ValueOptions of New Mexico. The SE is responsible for maintaining the New Mexico behavioral health provider network and managing the service delivery system

The Collaborative supports development of local behavioral health collaboratives in each of New Mexico's 13 judicial districts, plus a number, as appropriate, for the State's tribes and pueblos. Local Collaboratives create and sustain partnerships among customers, family members, advocates, local agencies, and community groups. They also identify service needs, help develop a range of resources, and ensure the responsiveness and relevance of behavioral health services for those affected by behavioral health concerns.

Work Group Activities - Summary

Work Group Three of the Task Force on Emergency Preparedness for Targeted Populations convened to assess the needs for persons with serious mental illness and substance use disorders during emergencies, and the consequences of gaps in services.

Findings of the Work Group indicate a need for closer collaboration of individual State agencies with the Behavioral Health Collaborative. Development of a strategic plan is recommended with assurance that the strategic plan can be translated into an active work plan. This work plan should address the needs not only of individuals currently utilizing mental health services, but also all individuals who may experience emotional effects from a disaster and need to be returned to their pre-disaster level of functioning. It is necessary to have clear delineation of agency roles and plans to ensure that behavioral efforts are well coordinated.

Recommendations of the Work Group follow.

■   Issues, Gaps and Recommendations

Issue One: Psychosocial Response Annex to the New Mexico DOH Emergency Operations Plan

Gap:

To date, the ***Psychosocial Response Annex*** *to* **the** ***New Mexico Department of Health Emergency Operations Plan*** has not been finalized. Identification of response agencies and their specific roles and responsibilities have not been defined. Populations affected by the ***Annex*** are individuals with serious mental illness and/or substance use disorders, either in recovery or needing recovery services, as well as members of the general population who have experienced emotional effects of a disaster.

Because the roles and responsibilities of the HSD Behavioral Health Services Division, DOH Bureau of Health Emergency Management, Behavioral Health Collaborative, the Statewide Entity and other response agencies are not articulated, there may be confusion among responders, and delay or interruption of services for consumers of behavioral health services.

Recommendation One:

The development of a standing Work Group on Disaster Behavioral Health Planning is recommended. Members of the Group would include representatives from the above entities, the State's Department of Homeland Security and Emergency Management (DHSEM), and others, as appropriate. The Group would provide technical assistance with development of the ***Psychosocial Response Annex.*** One of the first activities of the Group would be identification of the agencies statewide to provide psychosocial services in a disaster, and the roles and responsibilities of each. Due to transfer of the State Mental Health Authority (SMHA) to HSD, another important activity is identification of the lead agency for development and maintenance of the ***Psychosocial Response Annex.***

Issue Two: Articulation of Response Roles and Responsibilities of Statewide Entity

Gap:

Response roles and responsibilities of the Statewide Entity must be fully articulated in its contractual obligations with the State.

Recommendation Two:

Behavioral health disaster response roles and responsibilities must be specified in the contract between the State and the Statewide Entity (SE) for administration and management of State-provided behavioral health services. Performance of these roles and responsibilities should be monitored and assessed annually by the Collaborative. This information should be developed by the agencies, cited above, in Recommendation One.

Issue Three: Relationship between Tribal Entities and State behavioral health response planning

Gap:

   The State's ***Psychosocial Response Annex*** does not address how behavioral health response will be provided to tribal members in New Mexico. Clarification of federal and state relationships relating to emergency response with the tribes and Indian Health Service is needed.

Recommendation Three:

   The Disaster Behavioral Health Work Group should include representation from the local tribal collaborative to address this issue. Compliance with the State's Tribal Consultation Policy should be considered during deliberations.

Issue Four: Provider Plans for Emergency Preparedness

Gap:

   It is not known which, if any, behavioral health providers maintain emergency response plans. If no plans are in place, there may be problems and delays with service delivery and continuity of care for consumers in need of behavioral health services during an emergency.

Recommendation Four:

   Providers who have emergency response plans in place should be identified, and their plans reviewed. An emergency response plan template should be developed and training provided statewide in plan development, maintenance, and testing. The template should be posted on the websites of the Collaborative and the Statewide Entity. A mechanism for ongoing review of plans to maintain consistency among providers' protocols statewide and with State-level response plans should be developed and implemented.

Issue Five: Opioid Treatment Plans

Gap:

   Opioid treatment plans, based upon the State's Opioid Treatment Program Regulations, are not included in the State's ***Psychosocial Response Annex***. The potential impact of this gap could be a disruption in service to clients and duplication of efforts by providers.

   *[Definition: Opioid */opi·oid/ (o´pe-oid)*
   1. Any synthetic narcotic that has opiate-like activities but is not derived from opium.
   2. Any of a group of naturally occurring peptides, e.g., enkephalins, that bind at or otherwise influence opiate receptors, either with opiate-like or opiate antagonist effects.

   Sources:
   Dorland's Medical Dictionary for Health Consumers. Saunders, 2007.
   The American Heritage® Medical Dictionary, Houghton Mifflin Company. 2007.**]**

Recommendation Five:

   The State Methadone Authority and its project leader for Opioid Replacement Treatment should develop a plan to provide uninterrupted dispensing of medication during an emergency. This plan should be included in the ***Psychosocial Response Annex*** Individual provider response plans should include procedures for dispensing of opioids consistent with the State's Opioid Treatment regulations and the ***Psychosocial Response Annex.***

Issue Six: Distribution of Medications during an Emergency

Gap:

Related to Issue Four, there are also no existing plans for dispensing of behavioral health-related medication during an emergency. This is of particular concern for individuals with behavioral health disorders who have complex medication regimens.

Recommendation Six:

The lead agencies cited in Recommendation One need to develop policies and procedures for providing uninterrupted access to medications for individuals with behavioral health disorders in order to mitigate the psychological effects of the disaster. This information should be included in and consistent with the ***Psychosocial Response Annex***

Issue Seven: Peer Networks and Supports Plan

Gap:

Inclusion and participation of consumers and consumer-operated services are not reflected in current disaster behavioral health response planning.

Recommendation Seven:

Consumer leaders should be included in statewide disaster behavioral health response planning. Groups and individuals who could participate in this planning include, but are not restricted to: the Statewide Entity, Recovery and Resiliency services; the HSD Office of the Behavioral Health Ombudsman; consumers working in State agencies that coordinate services relating to substance use, co-occurring disorder; and others.

Issue Eight: Consumer Preparedness

Gap:

There is a lack of personal preparedness among consumers of behavioral health care services. In the case of significant medical surge, lack of personal consumer preparedness may result in extreme hardship, disorientation, substance use relapse, psychosis, and potential violent reaction to responders.

Recommendation Eight:

Training in personal preparedness, including development of evacuation and transportation plans, and identification of locations for re-unification of separated family members should be developed and provided on a regular basis throughout the Behavioral Health Regions. Recipients of training could be behavioral health provider agencies, consumers, community networks, family members, peer specialists, Behavioral Health Planning Council and other entities, as appropriate. This training could be developed collaboratively by the lead agencies with participation of other appropriate entities, and conducted by Local Collaboratives in their geographical areas. Personal preparedness can provide self-sufficiency during the first hours and days of an emergency.

Issue Nine: Crisis Counseling Training

Gap:

One goal of the Federal Emergency Management Agency (FEMA) and Substance Abuse and Mental Health Services Administration (SAMHSA) Crisis Counseling Program (CCP) is to develop State cadres of individuals to serve as regional contacts or leads for delivery of the FEMA/SAMHSA model of crisis counseling services in the event of a federally-declared disaster. The CCP supports short-term interventions with individuals and groups experiencing emotional reactions to disasters. Presently, there are no CCP crisis counseling teams in New Mexico.

Recommendation Nine:

It is recommended that representatives from the following organizations, and others, as appropriate, be invited to participate in statewide Crisis Counseling training:

1) Statewide Entity provider network; 2) Local Collaboratives; 3) Peer Specialists and Consumers; and, 4) Faith-Based Organizations. These individuals should be indigenous to their communities and culturally connected to the populations they would be serving.

Development of training should be coordinated by the lead agencies with participation of Local Collaboratives. Teams should be registered in the State's health emergency worker registry, NMserves, which is managed by the DOH Bureau of Health Emergency Management.

Issue Ten: Psychological First Aid

Gap:

Few individuals in New Mexico are trained in Psychological First Aid, a federally recognized model for providing emotional support that is similar in concept to First Aid for physical health and a component of the FEMA/SAMHSA Crisis Counseling model (see: Recommendation Nine). It is used immediately following an emergency or disaster to mitigate increased or future emotional reactions. Any individual may be trained in Psychological First Aid; it is not limited to licensed or trained behavioral health professionals. The lack of individuals who are familiar with Psychological First Aid diminishes the ability of New Mexicans to emotionally support family, friends and community members in the event of an emergency or disaster

Recommendation Ten:

In tandem with Recommendation Nine, a plan to provide Psychological First Aid training statewide should be developed. Trained individuals who are willing serve as volunteers in a disaster should be registered in the State's emergency health worker registry, NMserves.

Issue Eleven: Public Information

GAP:

There is a need for pre-disaster development of targeted public information for individuals with behavioral health needs, their families, support networks, and providers. This

information needs to address how to provide self-care, how to access information, and how to be included in response services.

Potential barriers to effective communication with persons with behavioral health disorders revolve around isolation and difficulties with comprehension or interpretation.

Recommendation Eleven:
The lead agencies should develop information and messages targeted to behavioral health consumers, their families and providers that can be included in the State's risk communications plans. Training should also be provided to the State Public Information Officers (PIOs) about the importance of this information and methods for its dissemination.

Issue Twelve: Health Insurance Portability and Accounting Act (HIPAA) – Personal Health Information

Gap:
It is not known if there are plans in place for the preservation of and access to personal health information for those who need to access behavioral health services during an emergency.

Recommendation Twelve:
State HIPAA Coordinators should review policies and procedures to determine if there are continuity of operations protocols to protect personal health information and to continue uninterrupted access to this information during an emergency. If plans do not exist, they should be developed and disseminated to consumers and providers.

Issue Thirteen: Incident Command Structure for Behavioral Health Response

Gap:
Behavioral health is not integrated into the State's incident command infrastructure for emergency management.

Recommendations Thirteen:
The Disaster Behavioral Health Work Group should work with the Department of Home land Security and Emergency Management (DHSEM) to determine the appropriate roles and responsibilities of behavioral health authorities within the State's response infrastructure. Training in the Incident Command System (ICS) is also recommended lead behavioral health agencies and for individual behavioral health responders.

Issue Fourteen: Behavioral Health Responder Preparedness

Gap;
In the event of an emergency, behavioral health responder capacity may be impacted due to anxiety about their families, personal work obligations or other matters. There is a lack of information and training relating to the importance of personal safety and health of responders.

Recommendation Fourteen:

>Training in personal emergency preparedness and stress management needs to be developed and provided to behavioral health responders statewide.

Issue Fifteen: School Response Plans

Gap:

Few guidelines exist for responding to the disaster–related behavioral health needs of children in the New Mexico schools.

Recommendation Fifteen:

The NM Public Education Department (PED), in collaboration with the DOH Office of School and Adolescent Health, and the agencies listed in Recommendation One should provide guidance to school districts in development of disaster behavioral health plans.

Issue Sixteen: Behavioral Health Response Planning for clients of NM Children, Youth and Families Department (CYFD)

Gap:

>CYFD provides services and support to multiple populations of children, youth and families who may experience a range of disaster-related behavioral health needs.

Recommendation Sixteen:

>CYFD should have representation on the Work Group on Disaster Behavioral Health Planning and be an integral partner in behavioral health response planning.

Annex 4, Work Group Four
Other Vulnerable Populations

■   **Work Group Members**

Lynne Anker-Unnever (Co-Chair)
New Mexico Aging & Long-Term Services Department

Judy Baca
New Mexico Children, Youth & Families Department

Lynn Christiansen
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Joie Glenn
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Jeff Repichowski
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Jennifer Rodgers
New Mexico Public Education Department

Julie Rosen
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■   **Introduction**

As part of New Mexico's Task Force on Emergency Preparedness & Response for Targeted Populations, the Work Group on Other Vulnerable Populations focused on individuals living in the community who may require additional assistance during an emergency. The Work Group's target populations included children who are not with their parents or legal guardians at

the time an emergency occurs; the elderly; persons experiencing homelessness; and persons receiving public assistance.

The group included representatives from the Aging & Long-Term Services Department, Children, Youth & Families Department, Human Services Department, Public Education Department, Department of Health, NM Association for Home and Hospice Care, and Albuquerque Health Care for the Homeless.

The group was charged with reviewing two documents – the ***NM Pandemic Influenza Emergency Response Appendix (to the NM DOH Emergency Operations Plan***) and the ***NM All-Hazard Emergency Operations Plan.*** The group conducted a review of these two plans to determine if they sufficiently addressed the needs of the Work Group's target populations and to identify any gaps that existed in the plans. The Work Group made recommendations regarding changes and additions that could be made to the existing plans to address the identified gaps. The Workgroup's recommendations are as follows.

"***A nation is judged by how it treats its most vulnerable citizens".***

■ Recommendations

Specific recommendations were made for each of the reviewed plans and forwarded to the respective organizations. It was recognized that many of the identified gaps transcended any particular plan. In addition to recommending that the Department of Homeland Security and Emergency Management and the Department of Health make revisions to annotate sections, the group recommended that their observations be considered within the context of all emergency plans.

Hence, the overriding recommendation to address the needs of other vulnerable populations is that all responsible parties assess and review their emergency plans with particular attention to:

1. **Education Regarding Emergency Preparedness**:
   Childcare providers
   Homecare providers
   Parents and families

2. **Identification of Vulnerable Population Groups with Special Functional Needs (relating to closure, evacuation, continuity of services, alert notification) in the following categories:**
   Senior Centers
   Schools
   Border Area
   Homeless
   Home Health Care

3. **Ensuring Continuity of Services:**
   Distribution Plans (i.e., medicine, vaccines, antivirals)
   Altered Standards of Care

Needs of Vulnerable Populations in Group Centers/Homes
Coordinated Use of Volunteers

4. **Developing Communication Systems:**
   Contingency mechanisms (i.e., for homeless, if network goes down, etc.)
   and in Care Centers
   Conveyances for sign language

5. **Training of State Personnel:**
   Emergency Operations Plans