Norfolk County-8 Coalition

Volunteer Handbook

TABLE OF CONTENTS

Welcome 4
Introduction 5
Overview of the Medical Reserve Corps 5
Benefits to the Community 5
What Can MRC Volunteers Do? 5
Mission Statement 6
Goals 6
Purpose 6
Governance and Local Plan Coordination 7
Unit Membership 10
Application Procedures 10
Volunteer Roles and Responsibilities 10
Communications 11
NC-8 MRC Responsibilities to the Volunteer 12
Volunteer Safety 12
Identification and Uniforms 13
Volunteer Recruitment 13
Activation, Deployment, and Demobilization 13
Conflict Resolution 15
Drug Free & Violence Free Workplace 15
Media Communications 15
Liability & Worker's Compensation 16
Disciplinary Procedures 17
MRC Training and Education 18
MRC Core Competencies 18
Norfolk County-8 MRC Training Plan 20
MRC TRAIN 25
NC-8 MRC Contact Information 26
Appendix A: What to Bring During Local Activation 27
Appendix B: Personal Preparedness 28
Appendix C: Volunteer Time Log 29
Appendix D: Volunteer Agreement 30
Appendix E: Release of Photos/Video 31
Appendix F: Training Summaries 32

Acronyms

ARC	American Red Cross
CDC	Centers for Disease Control & Prevention
CORI	Criminal Offender Record Information
EDS	Emergency Dispensing Site
EMAC	Emergency Management Assistance Compact
EOS	Emergency Operations Centers
FEMA	Federal Emergency Management Agency
HMCC	Health & Medical Coordinating Coalitions
HVA	Hazard Vulnerability Assessment
IAP	Incident Action Plan
ICS	Incident Command System
JAS	Job Action Sheet
JITT	Just-in-Time Training
LBOH	Local Board of Health/Health Department
MAVEN	Massachusetts Virtual Epidemiologic Network
MCM	Medical Countermeasures
MDPH	Massachusetts Department of Public Health
MD	Medical Doctor
MEMA	Massachusetts Emergency Management Agency
M.G.L.	Massachusetts General Laws
MRC	Medical Reserve Corps
NACCHO	National Association of County & City Health Officials
NIMS	National Incident Management System
PFA	Psychological First Aid
PHF	Public Health Foundation
PIO	Public Information Officer
PODS	Points of Dispensing
PPE	Personal Protective Equipment
PTSD	Post-Traumatic Stress Disorder
RN	Registered Nurse
SEOC	State Emergency Operations Center
SORI	Sex Offender Registry Information
SNS	Strategic National Stockpile
U.S.C.	United States Code (law)
VSOS	Validated Sex Offender Search

WELCOME

Dear Norfolk County-8 (NC-8) Medical Reserve Corps Volunteer,

On behalf of the NC-8 Medical Reserve Corps (MRC), welcome and thank you for joining our volunteer team. The NC-8 MRC covers 8 municipalities in the Metro-Boston area including Canton, Dedham, Milton, Needham, Norwood, Walpole, Wellesley, and Westwood.

Volunteers of the NC-8 MRC use their skills, talents, and knowledge to support public health initiatives throughout our region. These may include medical and non-medical support of annual flu clinics, health screenings, or other public health events. The NC-8 MRC volunteers are also active during times of emergencies and/or disasters which could include extreme winter weather, mass-casualty events, mass-vaccination clinics (Emergency Dispensing Sites-EDS), or other public health emergencies.

With the help of our Region 4AB MRC colleagues, this handbook serves to provide you with information to help maximize your volunteer experience. Please take the time to read through the material and refer back to it as questions arise.

Always feel free to contact the NC-8 Medical Reserve Corps with any questions, comments, or concerns. You can reach the NC-8 MRC Coordinator by email at NorfolkCounty8@gmail.com.

Once again, thank you for joining the NC-8 Medical Reserve Corps, and welcome!

Sincerely,

Norfolk County-8 Medical Reserve Corps

INTRODUCTION

OVERVIEW OF THE MEDICAL RESERVE CORPS

After September 11, 2001, the federal government identified several ways that citizens could participate in emergency preparedness activities at the local, state, and national levels. The first grants to fund the creation of local Medical Reserve Corps (MRC) organizations were issued in July of 2002.

The MRC is a national network of volunteers, organized locally to improve the health and safety of their communities. The MRC network comprises approximately 175,000 volunteers in roughly 850 community-based units located throughout the United States and its territories.

MRC volunteers include medical and public health professionals, as well as community members without healthcare backgrounds. As a unit, MRCs strengthen public health, improve emergency response capabilities, and build community resiliency. They prepare for and respond to natural disasters, such as wildfires, hurricanes, tornados, blizzards, and floods, as well as other public health emergencies, such as disease outbreaks.

The NC-8 MRC is a federally recognized unit and a member of the Massachusetts Emergency Preparedness Region 4B.

BENEFITS TO THE COMMUNITY

- Bolsters public health and emergency response infrastructures by providing supplemental personnel
- Enables communities to meet specific health needs
- Allows the local community more autonomy by not being as reliant on state and national resources
- Gives community members the opportunity to participate in developing strategies to make their communities healthier and safer
- Provides mechanisms for information sharing and coordination between all partner organizations
- Provides a dialogue between emergency management and public health agencies
- Allows national recognition of local public health and emergency response efforts

WHAT CAN MRC VOLUNTEERS DO?

MRC units support local public health, while advancing the priorities of the U.S. Surgeon General by:

- Promoting disease prevention
- Improving health literacy
- Eliminating health disparities
- Enhancing public health preparedness

- Assisting local hospitals and health department with surge personnel needs
- Participating in mass prophylaxis/vaccination exercises & community disaster drills
- Training with local emergency response partners
- And more…

MISSION STATEMENT

The mission of the Norfolk County-8 Medical Reserve Corps is to create a group of trained volunteers, both non-medical and licensed medical professionals with verified medical credentials, who are available to support local, sub-regional, regional, state, and federal public health personnel in responding to an event or emergency that threatens the public health of participating communities or surrounding areas.

GOAL

The goal of the NC-8 Medical Reserve Corps is to recruit, credential, train, and maintain a group of community-based public health volunteers, who can mobilize and deploy to assist in local, regional, state, or national public health emergencies and assist with public health needs throughout the year.

PURPOSE

The NC-8 MRC works with local municipalities to develop and maintain a pool of qualified volunteers who will be available to respond to local and regional public health emergencies and to support community services activities that promote public health.

The NC-8 MRC recruits and credentials volunteers, coordinates the distribution of training information. Although NC-8 is a collaborative, each municipality maintains their own database of MRC volunteer information.

MRC volunteers may be deployed for:

1. *Public Health Emergencies*- events that threaten public health, such as a disease outbreak or toxic chemical release;
2. *Mass Casualty Incidents*- emergencies that cause injury or threats to large numbers of people. These include a building collapse, fire, storm, flood, or other events that displace residents who must be moved to emergency shelters;
3. *Community Service Activities*- opportunities to foster the well-being of local residents, such as annual flu clinics, health fairs, blood pressure clinics, or training programs; and
4. *Community Preparedness Activities*- opportunities to encourage preparedness and resiliency in the local community, including sharing information with community groups and/or within their neighborhoods.

GOVERNANCE AND LOCAL PLAN COORDINATION

Most municipalities organize their public health duties with a local board of health (LBOH). However, some use a health department. A health department must include a commissioner and an advisory council as required by ***MGL Ch111 ss26a-e.*** In this training packet, the acronym LBOH will be representative of the roles and responsibilities of both local boards of health and health departments.

LBOH members, whether elected or appointed, are usually community residents who come from a range of backgrounds and experiences. As a board, they are legally responsible for implementing certain rules and regulations. LBOH generally meet on a regular basis to conduct the business necessary to address public health issues in their city or town. The figure below is helpful in explaining how the different backgrounds and disciplines work together to maintain a functioning public health department. Additionally, the table on the following page provides examples on the different program areas that fall under the health department's duties.

https://www.masslocalinstitute.info/orientationtoLPH/OrientationtoLPH3.html

Program Area	Sample Activities
Disease case management	Investigate cases of disease, develop patient care plans, screen contacts
Building Community Partnerships	Coalition building, for example, Norfolk County-8 to support various public health programs and campaigns. Examples include advocacy, leadership, social justice, social determinants of health, community assessment, and cultural humility
Disease surveillance	Monitor specific diseases and conditions, such as tuberculosis case management, communicable diseases (such as COVID-19), report in MAVEN (Massachusetts Virtual Epidemiologic Network), implement control measures
Health promotion in communities and the workplace, disease prevention	Adopt local regulations to promote health (i.e., youth access to tobacco), provide health education, support school and community health initiatives, and manage Drug Free Community Grants
Immunizations	Vaccinate individuals, offer clinics, maintain records, provide vaccine information statements
Air quality - indoor and outdoor	Enforce smoking and indoor ice rink regulations, investigate environmental hazards (i.e., asbestos removal, nail salon odors, and idling vehicles)
Animal and vector control	Adopt and enforce local regulations, nominate Animal Inspector, prevent the spread of rabies and vector-borne diseases and control wildlife (i.e., mosquitos, ticks, beavers)
Body art	Adopt and enforce local regulations (as there are no state regulations), investigate complaints
Drinking water	Adopt and enforce local regulations, issue boil water orders, oversee public water supplies
Food protection	Enforce food establishment regulations, investigate foodborne illness and other complaints, review plans and records
Hazardous and medical waste	Adopt and enforce local regulations, operate household hazardous waste and sharps collections, participate in waste site cleanup actions (i.e., 21E sites)

Housing	Enforce housing and campground regulations, conduct lead determinations, review subdivision plans, hoarding and housing court to resolve hoarding
Nuisances	Adopt and enforce local regulations, investigate complaints, issue abatement orders
Recreational camps for children	Enforce camp regulations at residential and day camps, review plans and records
Recreational waters (swimming pools and bathing beaches)	Enforce pool and beach regulations, collect water samples, monitor beach closings, review plans and records
Solid waste and recycling	Adopt and enforce local regulations, promote home composting and recycling, site landfills and transfer stations
Tanning facilities	Enforce tanning regulations, review plans and records
Wastewater	Enforce on-site wastewater regulations, witness soil evaluations and percolation tests, review plans and Title 5 official inspection forms

Now that you have an idea of how health departments work in your community, the information below will discuss local MRC plan coordination.

The NC-8 MRC is one of four federally recognized MRC units that cover the 28 communities within the Massachusetts Emergency Preparedness Region 4B. The four federally recognized units include Brookline MRC, Newton MRC, Norfolk County 8 MRC, and the Metro East MRC.

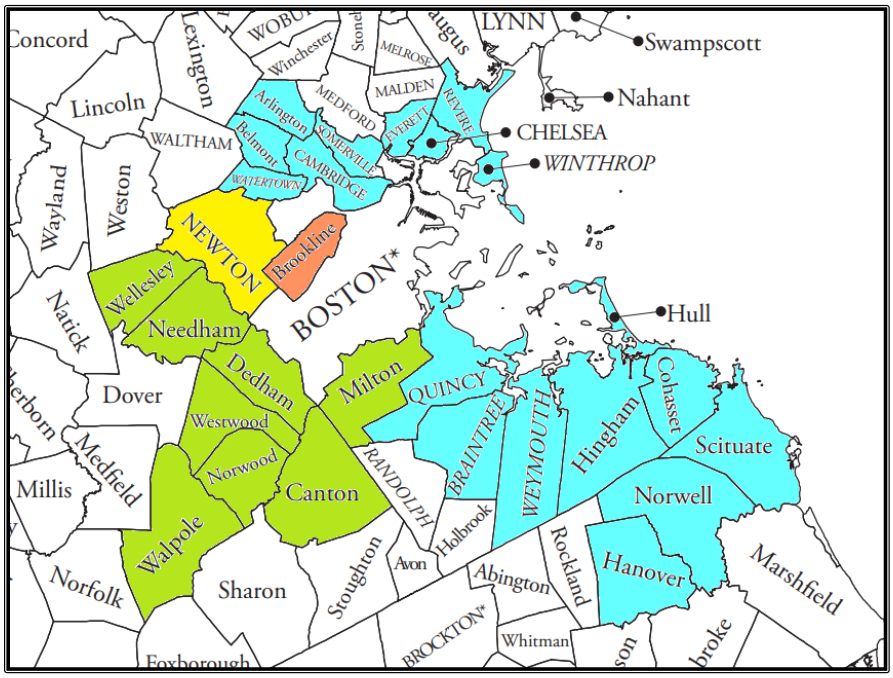
When a regional activation is requested, the MRC Coordinator will contact their communities to inform them of the need for volunteers. This contact will be communicated via email or in some cases a text and/or phone call. Requests for additional volunteers outside of NC-8 and Region 4b will be coordinated through the ESF-8 desk at MEMA when the SEOC is activated and follow the Cross-Jurisdictional Protocol located in Appendix D. The Region 4AB HMCC duty officer will be notified of any requests so that he/she is kept apprised of the situation. Volunteers should NEVER self-deploy. Doing so could be grounds for dismissal. No unauthorized person should ever try to deploy individual volunteers directly.

Metro East MRC: Arlington, Belmont, Braintree, Cambridge, Chelsea, Cohasset, Everett, Hanover, Hingham, Hull, Norwell, Quincy, Revere, Scituate, Somerville, Watertown, Weymouth, Winthrop

Brookline MRC

Newton MRC

Norfolk County 8 MRC: Canton, Dedham, Milton, Needham, Norwood, Walpole, Wellesley, Westwood



UNIT MEMBERSHIP

APPLICATION PROCEDURES

The Norfolk County-8 MRC application form at minimum, will collect:
-Name
-Address
-Contact information (at least one telephone number)
-Email address (if available)
-The volunteer's town or community affiliation, and
-Licensure information for licensed health care professions wishing to provide volunteer services within the scope of their professional licenses.

In addition to an application form, applicants must submit a signed authorization allowing the MRC to conduct a CORI and VSOS/SORI check and a copy of an acceptable photo ID (e.g. a driver's license).

All information related to the application, CORI and VSOS/SORI checks, and licensure verification will be kept confidential, and will be stored in locked file cabinets with restricted access.

The forms are available either through your local health department or from the MRC Unit Coordinator.

VOLUNTEER ROLES AND RESPONSIBILITIES

The NC-8 MRC seeks volunteers from various professional and non-professional backgrounds, including medical and non-medical, behavioral, public health, and support staff. The NC-8 MRC will offer flexibility and allow volunteers to choose their desired level of participation and commitment.

We request the following from all NC-8 MRC volunteers:

- Strive to meet the Core Competencies set by the National MRC (see Training and Education)
- Do their best to become active members of the NC-8 MRC by attending events, trainings, and exercises
- Keep their contact information, credentials, and other pertinent information up to date within their towns
- Dress appropriately for the setting and the task at hand, wear the proper identification badge, vest, or other required materials throughout all events, exercises, and activations
- Carry out responsibilities in a safe, responsible way
- Refrain from participating in a response effort if using any medical prescription or other drug that has the potential to render them impaired, unfit, or unable to carry out their emergency assignment
- Possess the required liability insurance for any private vehicles, vessels, boats, or aircraft being used in any activation, training event, or other authorized activity unless specifically directed otherwise by an authorized official in accordance with current law
- Maintain the confidentiality of information revealed to you regarding clients and coworkers
- Be amenable to serving all people regardless of race, gender, age, religion, sexual orientation, or disability
- Adhere to the guidelines of your job description/scope of practice
- Check-in and check-out with the appropriate on-scene official when activated
- Not accept or seek on behalf of themselves or any other person, any financial advantage or gain that may be offered because of the volunteer's affiliation with the MRC
- Not operate or act in any manner that is contrary to the best interest of the MRC

COMMUNICATIONS

Communities in NC-8 use a variety of methods to contact MRC volunteers.

Non-Emergency Events: NC-8 MRC volunteers may be notified through email, text, or phone call. This may include supporting local public health entities and departments during local public health events such as flu clinics, staffing events, and providing community education.

Emergency Events: NC-8 MRC volunteers may be notified through email, text, or phone call when requested by the NC-8 MRC. This may include emergency sheltering operations, warming/cooling centers, medical countermeasure emergency dispensing sites, missing person searches, disaster medical support, or other emergency support operations.

Communication sent to MRC volunteers will include: dates when volunteers are needed, locations with address included, timeframe/shift(s) needed (ex. 8am-8pm, 9am-12pm, etc.), how many volunteers needed for each timeframe/shift, type of volunteer needed (ex. MD, RN, non-medical, etc) for each timeframe/shift, who to respond to if the volunteer is available (ex. MRC Coordinator or Board of Health staff), and how to respond if volunteers are available (ex. email and/or call back). These messages are aimed towards **credentialed volunteers only**. If you are not credentialed, please do not show up.

NORFOLK COUNTRY-8 MRC RESPONSIBILITIES TO THE VOLUNTEER

The NC-8 MRC will provide in-person and online training opportunities for all interested MRC volunteers.

The NC-8 MRC will provide appropriate equipment and supplies, as needed, for the volunteer, including an MRC Volunteer Identification Badge, and when activated, a vest.

The NC-8 MRC will not share volunteers' contact information with outside sources. However, other MRC units may share this information in the event of an emergency for coordination purposes only.

The NC-8 MRC will strive to provide volunteers with opportunities to work within their own fields of expertise during an emergency event where the MRC has been activated.

The NC-8 MRC will ensure each volunteer has adequate training and information to carry out their assignments, clear directions, recognition and appreciation for contributions, opportunities to offer feedback, and respect in your work environment.

The NC-8 MRC will not have volunteers practice outside of their scope of practice or comfort.

VOLUNTEER SAFETY

Volunteer safety is the highest priority for the NC-8 MRC, and no job is considered to be so important or urgent that it cannot be done safely. As a NC-8 MRC volunteer, you have a responsibility for your own safety and health. You must notify your supervisor of any physical condition such as drowsiness due to medication, illness or emotional strain, which may affect your performance and safety. You are expected to immediately report all work-related accidents and/or injuries to the appropriate supervisor during a response. Your mental health and well-being is also a concern and at any time you feel you need to talk to a counselor, please tell your supervisor and this will be arranged.

All volunteers will receive safety training that is appropriate to their function. It is recommended that all volunteers who may be working with patients have current immunizations, including tetanus, influenza, and hepatitis B. Anyone unfamiliar with Blood Borne Pathogens, Personal Protective Equipment, and Fit Testing must be trained in these areas before deploying to emergencies requiring these considerations.

IDENTIFICATION AND UNIFORMS

The NC-8 MRC will issue Volunteer Identification Badges to each volunteer and identification vests will be distributed during activation.

All Volunteer Identification Badges remain the property of your local MRC and should be only be used for official MRC business. Badges are issued following the successful completion of CORI/VSOS/SORI background checks, and license(s) verification, if applicable. Medical volunteers must renew their badges every year, non-medical volunteers must renew their badge every two years. Badges shall be immediately returned to your local MRC Coordinator following volunteer resignation or removal from the program. The NC-8 MRC reserves the right to otherwise request the return of an issued badge.

NC-8 MRC Volunteer Identification Badges must be worn and visible at all times during an activation, community event, or exercise. The badge should be work on the MRC lanyard provided for this purpose.

VOLUNTEER RECRUITMENT

Volunteer recruitment strategies include the following: local and regional MRC trainings/information sessions, community events, posting MRC information in public areas, social media, radio/television, newspaper, word of mouth, and NC-8's website.

NC-8 MRC Website: norfolkcounty8.org
Local and regional events can be found in the event calendar on our website.

For local events in NC-8 communities, please check your town's website.
Canton: https://www.town.canton.ma.us/calendar.aspx
Dedham:https://www.dedham-ma.gov/services/advanced-components/site-specific-pages/town-calendar
Milton: https://www.townofmilton.org/calendar
Needham: https://www.needhamma.gov/Calendar.aspx
Norwood: http://www.norwoodma.gov/calendar.php
Walpole: https://www.walpole-ma.gov/calendar/month
Wellesley: https://wellesleyma.gov/Calendar.aspx
Westwood:https://www.townhall.westwood.ma.us/how-do-i-/advanced-components/calendar-meeting-list

ACTIVATION, DEPLOYMENT, AND DEMOBILIZATION

There are three cardinal rules for deploying the MRC:

1. MRC volunteer activation is to only be done by an authorized agency, typically the Local Board of Health.
2. Volunteers should never self-deploy. Self-deployment is grounds for dismissal.
3. No unauthorized person should ever deploy individual volunteers directly.

A NC-8 MRC volunteer may choose to be deployed, when activated, locally (within their community); sub-regionally (within their community and neighboring cities and town); regionally (within their community and any of the other communities in Region 4B); or outside the region (e.g. as part of a statewide or federal deployment). Volunteers are never required to activate/deploy. As a reminder-volunteers should NEVER self-deploy. Doing so could be grounds for dismissal. No unauthorized person should ever try to deploy volunteers directly.

The NC-8 MRC may be contacted by local health departments in order to request MRC volunteers. In addition, requests for MRC volunteers may come from local officials, local emergency management officials, ext. for assistance in an emergency, incident, and/or disaster. Requests for an intra-regional activation may come from the three other federally recognized MRC units within Region 4B. Regional (or larger) activations will be coordinated though the ESF-8 desk at MEMA when the SEOC is activated.

Relevant information for all levels of activation will be disseminated from your local government to the volunteers through email, text, or phone call. Volunteers will be instructed to check-in with a specific individual when on-site. All volunteers must sign-in and sign-out from their responsibilities at the scene. Roles will be assigned upon arrival.

It is important that all volunteers have the chance to share observations following activation. These comments should be written in your post-deployment questionnaire and submitted to a site staff member. Opportunities will be made available to meet with mental health professionals, if warranted.

According to Incident Command System (ICS) procedures, volunteers should respond according to the following checklist:

- ✓ Receive volunteer incident assignment from the MRC. This should include reporting location and time, expected length of assignment, job action sheet, and a designated communications plan if necessary.
- ✓ Bring any specialized supplies or equipment required for the job. Be sure to have adequate personal supplies (such as prescription medication, change of clothes, or special diet items) to last for the duration of the assignment.
- ✓ Sign in and out at the scene, for safety reasons as well as accountability.
- ✓ Obtain a briefing from their immediate supervisor and ensure they completely understand their assignment.

- ✓ Work within the scope of their professional license and physical abilities. It is a MRC member's responsibility to notify their immediate supervisor within the ICS structure if they are not able to safely or adequately perform their assigned duties.
- ✓ Acquire necessary work materials, then locate and set up their workstation.
- ✓ Organize and brief any subordinates assigned to the volunteer.
- ✓ Brief their replacement at the end of the shift, and at the timey they are demobilized from the incident.
- ✓ Complete required forms and reports, delivering them to the appropriate supervisor or the documentation unit before leaving.
- ✓ Demobilize according to the plan.

CONFLICT RESOLUTION

Open communication allows for the exchange of information that results in early identification of problems, effective resolutions, involvement of staff and volunteers, timely response to questions, and appropriate information sharing. Resolution of issues between volunteers or between MRC staff and volunteers should first be dealt with directly by the individuals experiencing the difficulty through direct, tactful communication that does not blame or attack. If the conflict is not resolved, the person raising the issue should approach the MRC Supervisor at the response for assistance.

DRUG FREE & VIOLENCE FREE WORKPLACE

The NC-8 MRC is committed to providing a harassment/discrimination free work environment in which all individuals are treated with respect and dignity. Each individual has the right to work in a professional atmosphere that promotes equal opportunities and prohibits discriminatory practices, including harassment. It is the policy of the MRC that harassment based on race, color, religion, age, gender, sexual orientation, national origin, marital status, disability, veteran status, or any other basis is strictly prohibited.

Any harassment, whether verbal or physical, is unacceptable and will not be tolerated. It is the intent that all MRC volunteers will work in an environment free from discrimination and/or harassment by any individual for any reason. Discriminatory conduct in any form undermines morale and interferes with productivity.

If a volunteer believes that they may have been the subject of discrimination or harassment, they should report it immediately. Any reports of discrimination or harassment will be examined impartially and resolved promptly. The MRC undertakes its responsibility to prevent workplace harassment seriously. To achieve this goal, the MRC presents all new volunteers with this policy during orientation; it is included here for reference.

MEDIA COMMUNICATIONS

During an emergency, only the Public Information Officer (PIO), designated through Incident Command, is authorized to speak with the media or other outside agencies. MRC volunteers must refer any requests or inquiries to their supervisor. **Under no circumstances should a NC-8 MRC volunteer offer any opinions or information to the media; post on social media; take and/or post photos without expressed permission.**

LIABILITY AND WORKER'S COMPENSATION

This information constitutes both federal and state liability protections for a volunteer. Should a volunteer have any questions regarding liability protection, they should speak with the MRC Coordinator or the Supervisor during an event.

- **Federal Volunteer Protection Act:** (42 U.S.C. § 14501 et seq.) Provides immunity from liability for negligence for people who volunteer for a government entity or a non-profit organization. The volunteer is not liable to a person they harm, BUT the organization that the volunteer is working under may still sue the volunteer personally for negligence. Volunteer must be properly licensed, certified, or authorized, and must act within the scope of their authority in the organization. Negligence arising from operation of a motorized vehicle is NOT covered. Protection only extends to UNPAID volunteers. There is NO workers compensation protection.
- **Good Samaritan Laws:** These state laws protect health care workers from liability when they render emergency care or treatment. Coverage depends on there being an emergency. The emergency need not be declared, but it is not clear whether the concept of "emergency" extends beyond an immediate, urgent need. Care must be provided in good faith. There is NO workers compensation protection.
- **Massachusetts Tort Claims Act:** (M.G.L c. 258) Public employees are protected from liability for negligent acts or omissions if they acted within the scope of their employment. Ask your select board or Mayor to appoint you and all the other MRC volunteers as Special Municipal Employees. This will provide additional liability coverage for MRC volunteers when acting under the direction and control of the MRC during a response.
- **Liability for Medical Professionals:** (M.G.L. c.112, s12B) No physician, physician assistant, or nurse who, in good faith, as a volunteer and without fee, renders emergency care other than their ordinary course of practice, shall be liable for their acts under emergency conditions.
- **Liability Protection for Doctors & Nurses in Public Health Programs:** (M.G.L. c. 112, s12C) Provides immunity from liability for physicians and nurses "administering immunization or other protective programs under public health programs" (i.e. government-sponsored programs). Covers both paid and unpaid

doctors and nurses. Not limited to emergency situations. There is NO workers compensation protection.

- **State Emergency Declarations:** During a large-scale emergency, there will most likely be special legislation or Executive Orders to help assure volunteers that they will have liability protection, but not likely Worker's Compensation Insurance.
- **Worker's Compensation:** Volunteers are not provided Worker's Compensation benefits.

DISCIPLINARY PROCEDURES

Disciplinary action may be initiated to correct inappropriate performance, work-related behavior, or behavior which reflects adversely upon the NC-8 MRC or Region 4B. The degree of disciplinary action shall relate to the gravity of the improper performance or conduct. Suspension or dismissal shall include the involvement of the MRC Coordinator and/or the local Health Director.

Any of the following constitute cause for disciplinary actions:

- Work outside the scope of certification/licensure/job description
- Breach of confidentiality
- Neglect of duty
- Dishonesty
- Possessing, dispensing, under the influence, or impaired by alcohol or an illegal substance while on duty, except in accordance with medical authorization
- Commission or conviction of a felony or a misdemeanor, reflected on a CORI check or committed while an MRC volunteer
- Discourteous treatment of the public
- Willful disobedience of personnel policies, rules, and regulations
- Misuse of MRC property
- Seeking to obtain financial, sexual, or political benefit from another employee, volunteer, or client obtained by the use of force, fear, or intimidation
- Falsifying of records
- Any other improper conduct or performance that constitutes cause for disciplinary action

NC-8 MRC volunteers agree that the MRC unit and/or Region 4B may at any time terminate the volunteer's relationship with the MRC based on the preceding disciplinary procedures. The MRC volunteer may at any time, for whatever reason, decide to sever their relationship with the MRC. Notice of such a decision should be communicated to the MRC Coordinator as soon as possible.

MRC TRAINING & EDUCATION

MRC CORE COMPETENCIES

The Medical Reserve Corps Competencies mirror the Core Competencies for Disaster Medicine and Public Health and are grouped into four learning paths: Volunteer Preparedness, Volunteer Response, Volunteer Leadership, and Volunteer Support for Community Resiliency. These paths represent a baseline level of knowledge and skills that all MRC volunteers should have, regardless of their role within the MRC unit.

LEARNING PATHS TO MEET THE MRC CORE COMPETENCIES			
Volunteer Preparedness	**Volunteer Response**	**Volunteer Leadership**	**Volunteer Support for Community Resiliency**
Demonstrate personal and family preparedness for disasters and public health emergencies Demonstrate knowledge of personal safety measures that can be implemented in a disaster or public health emergency	Demonstrate knowledge of one's expected role(s) in organizational and community response plans activated during disaster or public health emergency Communicate effectively with others in a disaster or public health emergency Demonstrate knowledge of surge capacity assets consistent with role in organizational, agency, and/or community response plans Demonstrate knowledge of principles and practices for the clinical management of all ages and populations affected by disasters and public health emergencies in accordance with professional scope of practice	Demonstrate situational awareness of actual/potential health hazards before, during, and after a disaster or public health emergency Demonstrate knowledge of public health principles and practices for the management of all ages and populations affected by disasters and public health emergencies	Demonstrate knowledge of ethical principles to protect the health and safety of all ages, populations, and communities affected by a disaster or public health emergency Demonstrate knowledge of legal principles to protect the health and safety of all ages, populations, and communities affected by a disaster or public health emergency Demonstrate knowledge of short- and long- term considerations for recovery of all ages, populations, and communities affected by a disaster or public health emergency

The MRC Core Competencies serve as the national training standard for MRC volunteers and provide a "common language" to communicate volunteer capabilities with other MRC units and partner organizations. These competencies represent a baseline level of knowledge and skills that all MRC volunteers should have, regardless of their role within the MRC unit. Each competency should be understood at a basic level, with the recognition that more information and skill can be gained in each competency with additional training and experience. In addition to the training courses in the following sections, training summaries for "required" courses can be found in Appendix F.

MRC Volunteer Tier Levels		
Level	**Deployable**	**Description**
MRC Level 3	EMAC* Intrastate Local	1. Meet the standards for Level 2 2. Demonstrated experience in non-emergency activations of emergency deployments 3. Capable of serving supervisory roles 4. Background check
MRC Level 2	Intrastate Local	1. Meet the standards for Level 1 2. Demonstrated experience through trainings/exercises 3. Demonstrated participation in unit activities and non-emergency events 4. Background check
MRC Level 1	Local	1. Limited training or participation in unit activities 2. Background check
	Non-deployable	1. Registered with the MRC but have not completed MRC unit on-boarding process or orientation 2. Can be converted to Level 3 during an emergency if they receive a JITT orientation, role-specific JITT, and meet MRC unit administrative requirements for deployment

*Emergency Management Assistance Compact (EMAC) system

TRAINING PLAN TO MEET THE MRC CORE COMPETENCIES						
Learning Path: Volunteer Preparedness *(2 courses required)*						
Core Competency	**NC-8 Suggested Trainings**	**Tier Level**	**Course Descriptions**	**Time**	**Modality**	**CEUs?**
1.0 Demonstrate personal and family preparedness for disasters and public health emergencies	**Required**: RIDOH (Rhode Island Dept. of Health) *Personal Preparedness for Public Health Workers*	*3*	*Basic personal preparedness. Topics covered include:* 1. Emergency and Hazard Overview 2. Basic Principles of Personal/Family Preparedness 3. Emergency Kit Considerations 4. Planning Essentials 5. Mechanisms for Staying Informed 6. Special Considerations and Personal Safety	1-2 hrs	Web based	No
	Supplemental: Disaster Health Core Curriculum: Competency 1- Personal and Family Preparedness	*3*	*Learning Objectives:* 1. Identify the impact of personal and family preparedness on your role as a health professional. 2. Describe a personal and family disaster plan. 3. Summarize necessary disaster supplies/equipment consistent with a personal/family plan. 4. Practice your personal/family disaster plan annually. 5. Describe methods for enhancing personal resilience, including the physical and mental components of disaster preparation and planning.	15 min	Web based	Yes, passing combined assessment with Disaster Health Core Curriculum: Competency 2
5.0 Demonstrate knowledge of personal safety measures that can be implemented in a disaster or public health emergency	**Required**: Personal Protective Equipment	*3*	*After completing this course, the learner will be able to:* 1. Identify types of hazards that may be encountered at an emergency scene. 2. Describe common injuries that can be sustained during a disaster including physical injuries, chemical exposures, and infectious diseases. 3. Understand the psychological impacts of disasters. 4. Describe how to prepare and protect oneself before, during and after an emergency response	1 hour	Web based	No
Learning Path: Volunteer Response *(4 courses required)*						
2.0 Demonstrate knowledge of one's expected role(s) in organizational and	**Required:** IS-100.C: Introduction to the Incident Command System	*3*	*At the completion of this course, you should be able to:* 1. Explain the principles and basic structure of the Incident Command System (ICS). 2. Describe the NIMS management characteristics that are the foundation of the ICS. 3. Describe the ICS functional areas and the roles of the Incident Commander and Command Staff. 4. Describe the General Staff roles within ICS. 5. Identify how NIMS management characteristics apply to ICS for a variety of roles and discipline areas.	2 hrs	Web based	No

community response plans activated during a disaster or public health emergency	**Supplemental:** Disaster Health Core Curriculum: Competency 2 - Expected Roles in Organizational & Community Response Plans During a Disaster or Public Health Emergency	*3*	In this lesson you will learn about organizational and community response plans and how public health personnel properly function within these plans.	25 min	Web based	Yes, passing combined assessment with Disaster Health Core Curriculum: Competency 1
4.0 Communicate effectively with others in a disaster or public health emergency	**Required:** Disaster Health Core Curriculum: Competency 4- Communication	*3*	*Can be completed by non CEU seeking volunteers. CEU professionals need to pass the quiz if they want credit* In this lesson you will learn relevant, actionable guidance on applied principles and practices of crisis risk communication in public health emergencies and disasters.	1 hr	Web based	Yes
6.0 Demonstrate knowledge of surge capacity assets consistent with one's role in organizational, agency, and/or community response plans	**Required:** PODs (Points of Dispensing): Public Health Training for Staff and Volunteers	*2*	*Upon successful completion of the training, participants will be able to describe*: 1. The important role that staff and volunteers will play in a large public health emergency 2. Key issues that staff and volunteers should understand in advance of an emergency, and where additional information can be found 3. Why mass dispensing is a national priority for planning, training, and exercises 4. How the federal Strategic National Stockpile, or SNS, fits into overall public health emergency response 5. Challenges to operating mass dispensing sites 6. Basic site design and patient flow in a mass dispensing site 7. The types of positions that must be filled for effective POD operation 8. The command structure used to manage sites	30 min	Web based	No
	Supplemental: Disaster Health Core Curriculum: Competency 6- Surge Capacity	*3*	*Learning Objectives:* 1. Describe the potential impact of a mass casualty incident on access to and availability of clinical and public health resources in a disaster or public health emergency. 2. Identify existing surge capacity assets which could be deployed in a disaster or public health emergency.	25 min	Web based	Yes, passing combined assessment with Disaster Health Core Curriculum: Competency 7
7.0 Demonstrate knowledge of principles and practices for the clinical management of all ages and populations	**Required:** Psychological First Aid (PFA): A Minnesota Community Supported Model	*2*	*Learning Objectives:* 1. Demonstrate knowledge of the principles and techniques of PFA as they apply to a disaster response 2. Identify common physical, emotional, behavioral, cognitive, spiritual, and sensory reactions to a traumatic event in adults and children 3. Demonstrate knowledge of the concept footprint of disaster as a model for the impact of a disaster on people physically and emotionally over time	45 min	Web based	No

affected by disasters and public health emergencies, in accordance with professional scope of practice			4. When provided with scenarios and profiles select and provide appropriate PFA responses to individuals presenting with common reactions, positive coping strategies, maladaptive coping strategies and severe reactions to traumatic events 5. Demonstrate knowledge of responder stressors and principles of self-care as they apply to a personal crisis or a disaster deployment before, during and after an event 6. Apply knowledge and understanding of principles of self-care to the development of a printable personal resiliency plan.			
7.0 Demonstrate knowledge of principles and practices for the clinical management of all ages and populations affected by disasters and public health emergencies, in accordance with professional scope of practice	**Supplemental trainings:** Disaster Behavioral Health *Or* Effect of Disasters on Mental Health: Awareness Level	*3*	Disaster Behavioral Health: *After completing this course, you should be able to:* 1. List three of the common psychosocial phases of a community-wide disaster. 2. Describe the various individual behavioral health outcomes that usually occur in the aftermath of disasters. 3. Identify abnormal reactions to disaster that might indicate a need for a psychological evaluation. 4. Describe how the Washington State mental health disaster response plan incorporates local, state and federal agencies. Effect of Disasters on Mental Health: Awareness Level: This Awareness Level course is intended for anyone who will come into professional contact with disaster victims, including DMAT, hospital workers, EMTs, primary care providers and public health workers. 1. Define disaster, trauma 2. Describe how proximity to the event affects the potential for traumatic response 3. Describe the brain and how each part of it functions during a traumatic event, automatic response to trauma: flight or fight, freeze, social engagement 4. Describe 4 major components in the psycho-physiological response to trauma: somatic, emotional, behavioral, and cognitive 5. Describe the epidemiological triangle in relation to the effect of disasters on mental health and analyze a disaster and its effect on victims using the epidemiological triangle Describe the use of the Haddon Matrix in prevention, mitigation and intervention of disasters and their effect on mental health	1 hr for both	Web based for both	No for both
Learning Path: Volunteer Leadership (*2 courses required)*						
3.0 Demonstrate situational awareness of actual/potential	**Required**: Disaster Health Core Curriculum: Competency 3- Situational Awareness	*3*	*Learning Objectives:* 1. Identify general indicators and epidemiological clues that may signal the onset or exacerbation of a disaster or public health emergency. 2. Describe measures to maintain situational awareness before, during, and after a disaster or public health emergency.	25 min	Web based	Yes

health hazards before, during, and after a disaster or public health emergency	**Required**: You are the Help Until Help Arrives	*3*	*Can be completed by non CEU seeking volunteers. CEU professionals need to pass the quiz if they want credit* "Life-threatening emergencies can happen fast. Emergency responders aren't always nearby. You may be able to save a life by taking simple actions immediately. You Are the Help Until Help Arrives is a program designed to educate and empower the public to take action in emergency situations and provide lifesaving care before professional help arrives"	25 min	Web based	No
8.0 Demonstrate knowledge of public health principles and practices for the management of all ages and populations affected by disasters and public health emergencies	**Required:** Cultural Awareness: Introduction to Cultural Competency and Humility	*3*	*Course Objectives:* 1. Increase awareness and appreciation for the cultural diversity of Wisconsin. 2. Define and understand concepts of culture, cultural awareness, cultural humility, and cultural competence. 3. Identify how to incorporate cultural humility into public health through practical application. 4. Highlight capacities and skills necessary to work effectively across diverse cultures.	30 min	Web based	No
Learning Path: Volunteer Supports Community Resiliency (*3 courses required)*						
9.0 Demonstrate knowledge of ethical principles to protect the health and safety of all ages, populations, and communities affected by a disaster or public health emergency	**Supplemental:** Disaster Health Core Curriculum: Competency 9- Ethical Principles	*3*	*Learning Objectives:* 1. Discuss ethical issues likely to be encountered in disasters and public health emergencies. 2. Describe ethical issues and challenges associated with crisis standards of care in a disaster or public health emergency. 3. Describe ethical issues and challenges associated with allocation of scare resources implemented in a disaster or public health emergency.	40 min	Web based	yes, complete quiz at the end of module for credit
10.0 Demonstrate knowledge of legal principles to protect the health and safety of all ages, populations, and communities affected by a	**Required:** Public Health and the Law: An Emergency Preparedness Training Kit	3	Training kit to enhance local public health professionals' and their legal counsel's knowledge of the legal authorities and issues that shape their ability to prepare for, respond to, and recover from public health emergencies. Curriculum can be customized by jurisdictions, designed to prepare local health departments, public health practitioners, emergency managers, their respective counsel, and partners to understand and effectively address the changes in the legal environment and authority that occur as a result of a public health emergency.	1 hr	Web based	no
	Supplemental: Disaster Health Core Curriculum:	*3*	*Learning Objectives:* 1. Describe legal and regulatory issues likely to be encountered in disasters and public health emergencies.	1 hr	Web based	yes, complete quiz at the end of module for credit

disaster or public health emergency	Competency 10- Legal Principles		2. Describe legal issues and challenges associated with crisis standards of care in a disaster or public health emergency. 3. Describe legal issues and challenges associated with allocation of scare resources implemented in a disaster or public health emergency. 4. Describe legal statutes related to health care delivery that may be activated or modified under a state or Federal declaration of disaster or public health emergency.			
11.0 Demonstrate knowledge of short- and long-term considerations for recovery of all ages, populations, and communities affected by a disaster or public health emergency	**Required:** Disaster Health Core Curriculum: Competency 11- Short -and Long-term Considerations for Recovery	*3*	*Can be completed by non CEU seeking volunteers. CEU professionals need to pass the quiz if they want credit* *Learning Objectives:* 1. Describe clinical considerations for the recovery of all ages and populations following a disaster or public health emergency. 2. Discuss public health considerations for the recovery of all ages and populations following a disaster or public health emergency. 3. Identify strategies for increasing the resilience of individuals and communities affected by a disaster or public health emergency. 4. Discuss the importance of monitoring the mental and physical health impacts of disasters and emergencies on responders and their families.	20 min	Web based	yes

"MRC TRAIN"

TRAIN is a national learning network powered by the Public Health Foundation (PHF) that provides thousands of quality, web-based trainings aimed at protecting and improving public health. Users can register for courses, create a personal learning record, have access to continuing education credits, and have access to hundreds of public health and emergency preparedness courses from nationally recognized course providers.

In order for volunteers to be prepared for deployment, it is essential that volunteers take the time to complete NC-8's Training Plan. Training summaries to supplement these courses can also be found throughout this packet. Without prior training, response efforts can be impacted and your capability to support your community may be limited.

To Begin: Go to www.mrc.train.org

1. Click "Create Account" under "Login"
2. Agree to TRAIN policies
3. Fill out necessary information on subsequent pages

Norfolk County-8 Training Course: https://www.train.org/mrc/training_plan/4827

NORFOLK COUNTY-8 MRC CONTACT INFORMATION

Unit Coordinator:
Karen Contador
Email:
NorfolkCounty8@gmail.com

Canton
Email: bohdirector@town.canton.ma.us

Dedham
Email: jetracy@dedham-ma.gov

Milton
Email: ldellechiaie@townofmilton.org

Needham
Email: publichealthnursing@needhamma.gov

Norwood
Email: health@norwoodma.gov

Walpole
Email: Pfisher@walpole-ma.gov

Wellesley
Email: lizzo@wellesleyma.gov

Westwood
Email: health@townhall.westwood.ma.us

APPENDIX A: WHAT TO BRING
(LOCAL ACTIVATION)

Recommended Items to Bring During Local Activation

When you are notified to report to a local incident site, you should be prepared to be on site for at least 12 hours. Therefore the following are some recommended items you may want to bring with you to make your experience more comfortable

Security Items:

- ✓ Volunteer Identification Badge and Lanyard
- ✓ At least one (1) additional form of photo identification

Clothing:

It is important to be prepared for both indoor and outdoor working conditions

- ✓ Comfortable, light-weight clothing
- ✓ Long pants
- ✓ Long-sleeve shirts
- ✓ Hat
- ✓ Boots or comfortable walking shoes
- ✓ Warm jacket
- ✓ Rain gear
- ✓ Gloves
- ✓ Layers!

Personal Items:

- ✓ Cell phone and charger
- ✓ Sunglasses
- ✓ Nonperishable snacks
- ✓ Bottle of water
- ✓ Sun block
- ✓ Lip balm
- ✓ Contact lenses, lens cleaner, and eye glasses protective case
- ✓ Anything else you would need in a 12-hour period, such as medications, etc.

APPENDIX B: PERSONAL PREPAREDNESS

Step 1: Visit www.ready.gov to get checklists, plans, and more to start the process

Step 2: Identify possible threats and disasters for your community (ex. Floods, outbreaks, ice storms)

Step 3: Stay informed!

Step 4: Develop an emergency supply kit that will last for 3 days and include materials for special needs and pets.

Step 5: Develop a family communications plan.

Step 6: Develop an evacuation and shelter-in-place plan

Items to consider for your Go Bag:

- ✓ Water
- ✓ Non-perishable food
- ✓ Flashlight, batteries, light sticks
- ✓ Portable radio and batteries
- ✓ Extra keys to house and car
- ✓ Cash
- ✓ Medications, glasses, contacts, and other medical supplies
- ✓ Clothing, shoes, jacket, raincoat
- ✓ Whistle
- ✓ Pocket knife or multi-tool
- ✓ Emergency phone list and out of state contact number
- ✓ Copies of important documents
- ✓ First aid kit
- ✓ Toiletries (toilet paper, toothbrush, lotion, sunscreen, ext.)
- ✓ Zip-lock bags
- ✓ Games, books, playing cards
- ✓ Blanket
- ✓ Dust mask and N-95 mask
- ✓ Shovel, flares, maps, matches, basic tools
- ✓ Pet supplies
    - Blanket, food, water, toy, ID tags, pet carrier, vet contact info, leash and collar, vaccination records

APPENDIX C: VOLUNTEER TIME LOG

Norfolk County-8 Medical Reserve Corps
Volunteer Time Log

Name: _____

Location: _____

Title/Position: _____

DATE	TIME IN	TIME OUT	ACTIVITY

Total Hours: _____

Volunteer Signature: _____ Date: _____

Form Verified By: _____ Date: _____

Title: _____

Notes/Comments:

APPENDIX D: VOLUNTEER AGREEMENT

Code of Conduct: The purpose of this code is to establish standards of conduct for all NC-8 Medical Reserve Corps volunteers by identifying those acts or actions that are compatible with the best interest of the individuals served by this agency.

_____ I have read and understand the Volunteer Handbook.
_____ I agree to attend volunteer orientation training, either in person or online.
_____ I have read and understand the Confidentiality Agreement.
_____ During an activation, drill, or other MRC event:
- ✓ I will dress in a neat and clean fashion in a manner appropriate to my assigned duty.
- ✓ I will wear the ID badge provided to me by my local MRC at all times.
- ✓ I will conduct myself in a professional manner.

_____ I will respect the rights and dignity of all volunteers and clients while representing the NC-8 MRC.
_____ I will promptly address any issues/concerns with NC-8 MRC administration.
_____ I will perform tasks within my scope of knowledge and skill and license/credentials while representing the NC-8 MRC.
_____ I understand that I am making a commitment to participate in trainings, drills, and other NC-8 MRC activities according to my chosen level of involvement.
_____ I understand I must adhere to the Incident Command System (ICS) and the National Incident Management System (NIMS) and that I must take the appropriate Incident Command System courses for my level of involvement.
_____ I will not speak to the press unless authorized to do so.
_____ I will participate in debriefings and provide feedback following an incident in which I participate.
_____ I understand that I am subject to disciplinary action or dismissal.

Confidentiality Statement: In the course of volunteering with this agency, I recognize that it is my responsibility to maintain the confidentiality of all information that identifies a client, or disclose any information about the client; and to comply with the Health Insurance Portability and Accountability Act (HIPAA) standards. I agree that I will not share any information I may obtain in verbal or written form. I also agree that I will not share any client information even if the information is available through other means. I further acknowledge that the confidentiality policy applies after termination as a volunteer with this agency.

I, (print your name) _____ have read this document, and agree to provide volunteer services in accordance with these standards.

Signature: _____ Date: _____

APPENDIX E: RELEASE OF PHOTOS/VIDEOS

I certify that I am over 18 years of age and I hereby grant to the Norfolk County-8 Medical Reserve Corps the irrevocable and unrestricted right to edit, duplicate, exhibit, broadcast, copyright, use, and publish photographs and/or video recording of me, or in which I may be included, for any purpose and in any manner or medium. I hereby waive and release the NC-8 MRC, its officials, officers, agents, and employees from any and all rights, claims, and liability I may have relating to said photographs and video recordings. I understand that I will not receive compensation from the NC-8 MRC for said photographs and video recordings.

Name: _____

Signature: _____

Date: _____

APPENDIX F: TRAINING SUMMARIES

(click on links to access summary)

1. Personal Preparedness
2. Personal Protective Equipment
3. Incident Command System (ICS)-100
4. National Incident Management System (NIMS)
5. Risk Communication
6. Points Of Dispensing (PODs)
7. Psychological First Aid (PFA)
8. Situational Awareness
9. You Are The Help
10. Cultural Awareness
11. Public Health and the Law
12. Short and Long-Term Recovery Considerations

Training Summary:
Personal Preparedness for Public Health Workers

I. Assembling an Emergency Kit

Types of Potential Events. Some of the situations most likely to occur in our communities are:

- Natural disasters, such as hurricanes, winter storms, and flooding
- Naturally occurring illnesses, such as influenza and foodborne illness
- Technological disasters, such as major power outages or transportation accidents
- Any other event that may limit access to essential resources

How prepared should you be? Intend on being able to survive comfortably, on your own, for at least 3 days following an incident. Effective preparation should involve the entire family, making sure everyone is familiar with what the plan is. Preferably have two kits: one larger, more complete for the home, and a smaller kit with the basics to take with you if a sudden evacuation is needed. Also consider having a kit in your office and/or car.

What should your Emergency Kit include?

- Water: 1 gallon/person/day. Three to seven-day supply recommended.
  Store in sealed, unbreakable containers. Note storage date and replace every 6 months. Some individuals, like children, pregnant women, breastfeeding women, and those with chronic illness, require more water so plan accordingly
- Food: Non-perishable food. Three to seven-day supply to maintain caloric intake and minimize preparation. A manual can opener. Maintain sanitation and use fresh water for cooking. Include food suitable to support special diets (formula milk, gluten free foods, Phenylketonuria, etc.)

Training Summary:
Personal Preparedness for Public Health Workers

- Shelter: Use blankets/sleeping bags for warmth. Pillows, waterproof matches, small candle
- Clothing: A change of clothes, comfortable shoes and socks, layers of clothes for comfort and thermoregulation, raincoat/poncho, and a hat
- Basic supplies: Personal medications (at least 3 days supply), battery-powered/hand-cranked flashlight, spare batteries, pan for cooking, communication/ battery-powered radio, first aid kit, map, knife/utensils, whistle, dust mask, wrench or pliers to turn off water or gas, solar powered chargers, trash bags, scissors, duct-tape
- Personal hygiene: Bathroom tissue, deodorant, feminine products, soap, hand-washing materials, sunscreen, alcohol-based hand sanitizer in case running water is contaminated or unavailable
- Other key items: Cash and credit cards, personal Identification, extra glasses, contact lenses, supplies for pets

II. Making a family communication plan

Key considerations. Your family may not be together at home when an incident occurs and communication systems may be damaged or overwhelmed following a mass casualty event. Make sure everyone knows contact numbers and how to get in touch. Keep a list of emergency numbers near the phone at all times and include list of physicians/telephone numbers.

Make sure everyone is familiar with emergency plans at your workplace or at your children's schools, including procedures and notification for early dismissal during a crisis. Designate at least two meeting places to look for each other if separated during an emergency.

Training Summary:
Personal Preparedness for Public Health Workers

If an evacuation is required, and you do not have a car, make plans with a neighbor or another resource to carpool towards safety. When evacuating, be sure to take your emergency supply kit, lock your door, and don't forget your furry family members!

If you have older family members, or individuals with special needs, be sure your plan includes special accommodations.

III. Learning more about readiness

Essential planning elements. Be sure your family is familiar with the different types of emergencies and their appropriate responses. Reinforce local emergency plans, warning systems, radio stations, social media, and other emergency messaging resources in your community.

Healthcare provider considerations. Healthcare delivery systems will quickly reach maximum capacity and medical advice/physical examinations may be limited. Existing health conditions may be complicated during stressful situations. Only visit a hospital for a known exposure, trauma, or critical health event.

Advanced medical planning. Keep 3 days of prescriptions on hand at all times, have insurance information available, have immunization records handy, know style and serial number of medical devises (e.g. pacemakers), list known food and drug allergies, write down health conditions of your immediate family.

Additional safety considerations. Avoid downed power lines, stay out of floodwaters, do not consume food that is may be contaminated. You can also support your family by attending first aid and CPR classes prior to an emergency, skills your MRC can provide!

Training Summary:
Personal Preparedness for Public Health Workers

Acknowledgments

The information in this summary was provided by the *Rhode Island Department of Public Health* and *John Hopkins Center for Public Health Preparedness*.

Training Summary:
Personal Protective Equipment (PPE)

I. Importance of PPE

What are PPEs? Specialized clothing or equipment worn to protect against health and safety hazards and to protect many parts of the body such as eyes, face, respiratory system, head, face, body, hands, feet, and ears. Such hazards include chemical, radiological, physical, electrical, and mechanical. Personal protective equipment may include items such as gloves, safety glasses and shoes, earplugs or muffs, hard hats, respirators, or coveralls, vests and full body suits.

Why are they important? As an MRC volunteer, you may respond to a site that poses many potential health and safety concerns. Public health personnel should think of wearing PPE as a second nature. The extra seconds taken to apply gloves and other PPE can protect you, and the public, from additional harm. Examples include communicable diseases and bloodborne pathogens. Communicable diseases can be transmitted through liquids, food, body fluids, contaminated objects, and airborne inhalation. Bloodborne pathogens, microorganisms present in human blood that can cause disease in humans, can transmit hepatitis B virus (HBV), hepatitis C virus (HCV), human immunodeficiency virus (HIV) and many more.

II. Incidents, Hazards, and PPE

Levels of PPE.

Level A (highest): should be worn when the highest level of respiratory, skin, eye and mucous membrane protection is needed. Examples include high level of liquid splash potential, a toxic respiration and skin vapor hazard, or where there is an unidentified chemical agent.

Level B: for when the highest level of respiratory protection is needed, but a lesser level of skin and eye protection. It protects against agents that present no skin vapor hazard and where there is a low liquid splash potential.

Training Summary:
Personal Protective Equipment (PPE)

Level C: can generally provide adequate protection against airborne biological agents and radiological materials. For example, when the type of airborne substance is known, concentration measured, criteria for using air-purifying respirators met, and skin and eye exposure is unlikely.

Level D (lowest): Used when there is no respiratory or skin hazard. It requires only coveralls and safety shoes/boots. Other PPE is based upon the situation (types of gloves, etc.).

PPE Limitations. To work effectively, PPE must be matched to the hazard.

- PPE reduces but does not completely eliminate the possibility of infection.
- PPE is only effective if selected and used correctly and at all times when exposure may occur.
- All potential routes of exposure must be considered when selecting PPE.
- Used PPE must be placed in prescribed receptacles and disposed of or sterilized/decontaminated per policy.
- The use of PPE does not replace basic hygiene measures such as handwashing, which is still essential to prevent transmission. Wash hands thoroughly with soap and water or use an alcohol-based hand rub immediately after removing PPE and in-between patient contact.

III. Donning (putting on) and Doffing (taking off) PPE

Gown: Donning

- Select appropriate type and size
- Opening is in the back
- Secure at neck and waist
- If gown is too small, use two gowns
- Gown #1 ties in front
- Gown #2 ties in back

Figure 1

Figure 2

Training Summary:
Personal Protective Equipment (PPE)

Gown: Doffing

- Unfasten ties
- Peel gown away from neck and shoulder
- Turn contaminated outside toward the inside
- Fold or roll into a bundle
- Discard

Masks: Donning

- Place over nose, mouth and chin
- Fit flexible nose piece over nose bridge
- Secure on head over nose bridge
- Adjust to fit

Masks: Doffing

- Untie the bottom, then top, tie
- Remove from face
- Discard

Respirators: Donning

- Place over nose, mouth and chin
- Fit flexible nose piece over nose bridge
- Secure on head with elastic
- Adjust to fit
- Perform a fit check
  - Inhale - respirator should collapse
  - Exhale - check for leakage around face

Respirators: Doffing

- Lift the bottom elastic band over your head first
- Then lift off the top elastic band
- Discard

Training Summary:

Personal Protective Equipment (PPE)

Goggles: Donning

- Position goggles over eyes
- Secure to the head using the ear pieces or headband

Goggles: Doffing

- Grasp ear piece or headband with ungloved hands
- Lift away from face
- Place in designated receptacle

Face Shields: Donning

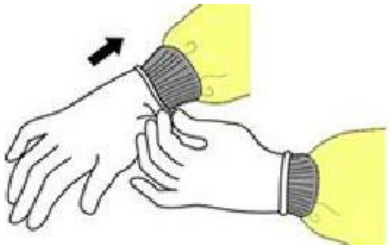
- Position face shield over face
- Secure on brow with headband
- Adjust to fit comfortably

Face Shields: Doffing

- Grasp headband with ungloved hands
- Lift away from face
- Place in designated receptacle

Gloves: Donning

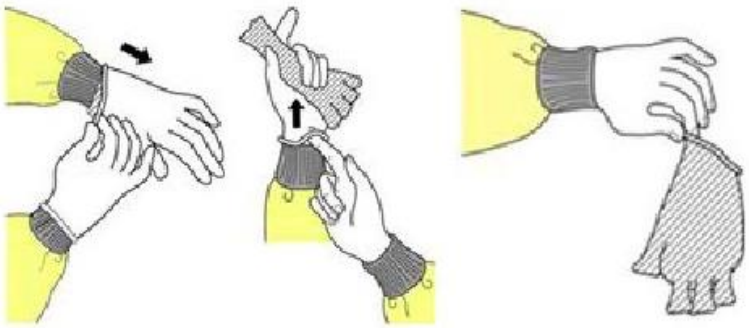
- Don gloves last
- Select correct type and size
- Insert hands into gloves
- Extend gloves over isolation gown cuffs



Training Summary:
Personal Protective Equipment (PPE)

Gloves: Doffing

- Grasp outside edge of first glove near wrist
- Peel away from hand, turning glove inside-out
- Hold the first glove in opposite (still gloved) hand
- Slide ungloved finger under wrist of the remaining glove
- Peel off from inside, creating a bag of both gloves
- Discard gloves and wash hands

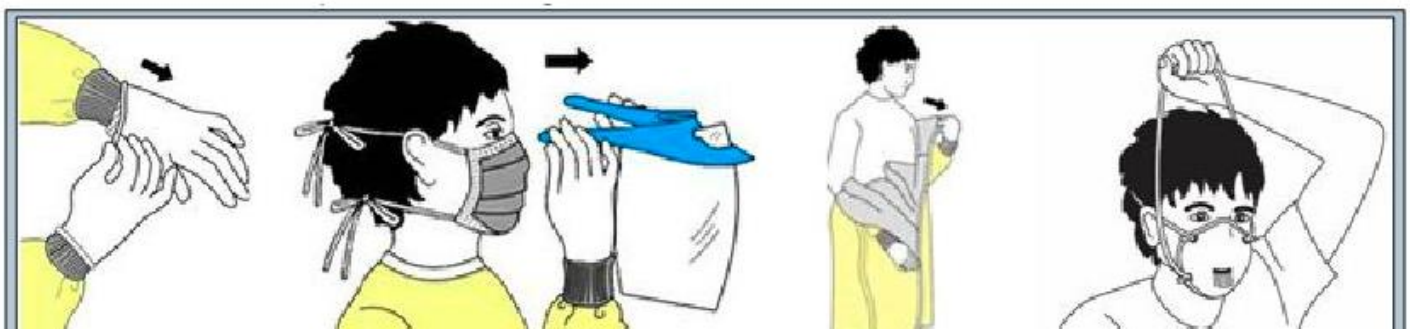


CDC-Recommended Sequence for Donning PPE

1. Don the gown.
2. Don the mask or respirator. Make sure the mask is properly adjusted and fit-check the respirator.
3. Don the goggles or face-shield.
4. Don the gloves.

CDC recommended Sequence for Doffing

1. Doff the gloves.
2. Doff the goggles or face-shield.
3. Doff the gown.
4. Doff the mask or respirator.



Training Summary:
Personal Protective Equipment (PPE)

Acknowledgments

This information in this summary was provided by the *Iowa Department of Public Health, Institute for Public Health Practice,* and *University of Iowa.* Content from the *Centers for Disease Control* was also included.

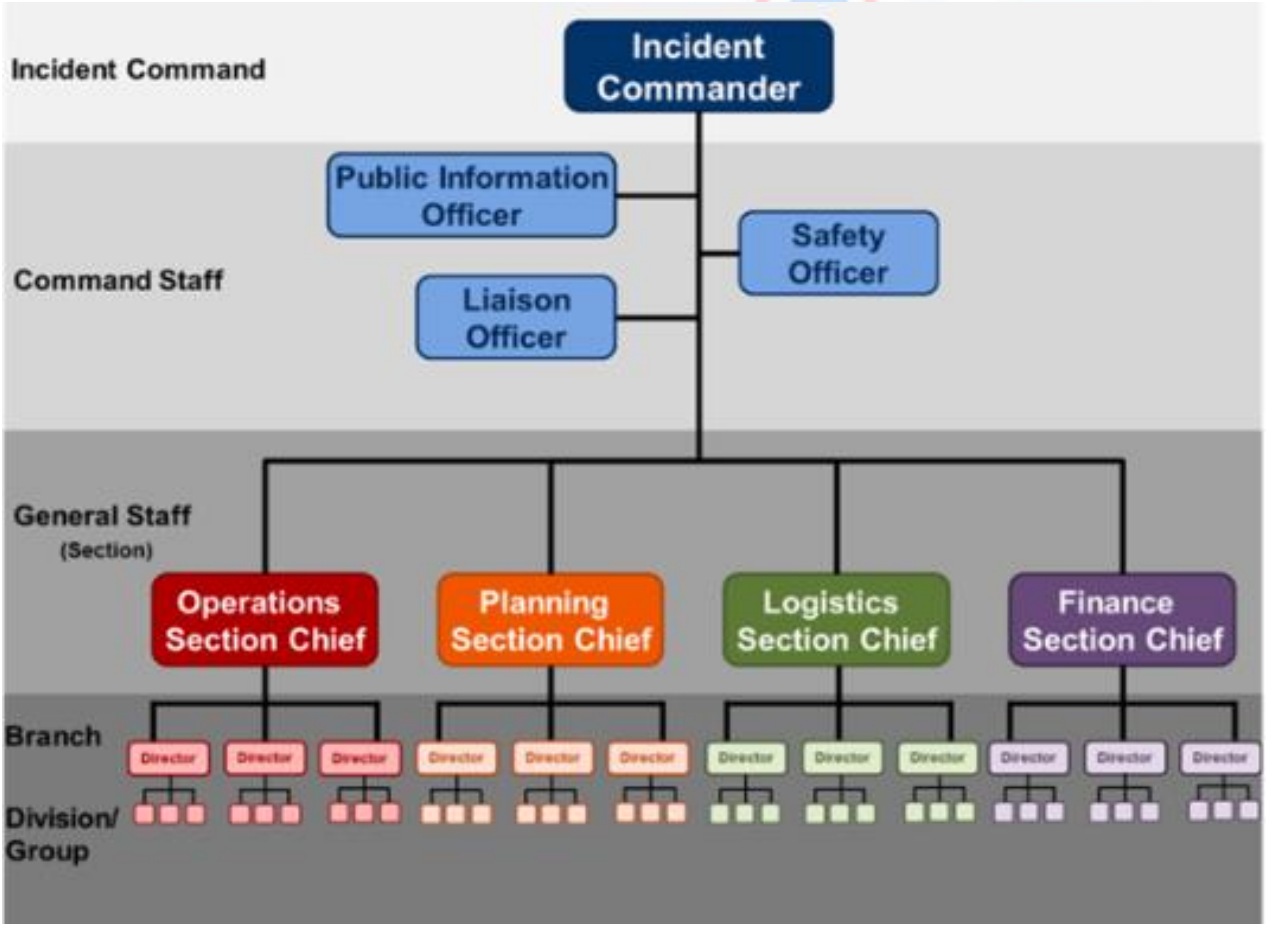
Training Summary:

Incident Command System (ICS)-100

I. ICS background

Why was ICS developed? Previous incident management had weaknesses, such as lack of accountability, poor communication, lack of a planning process, and no methods to integrate interagency requirements. Such disorganization led to wasteful use of resources and personnel.

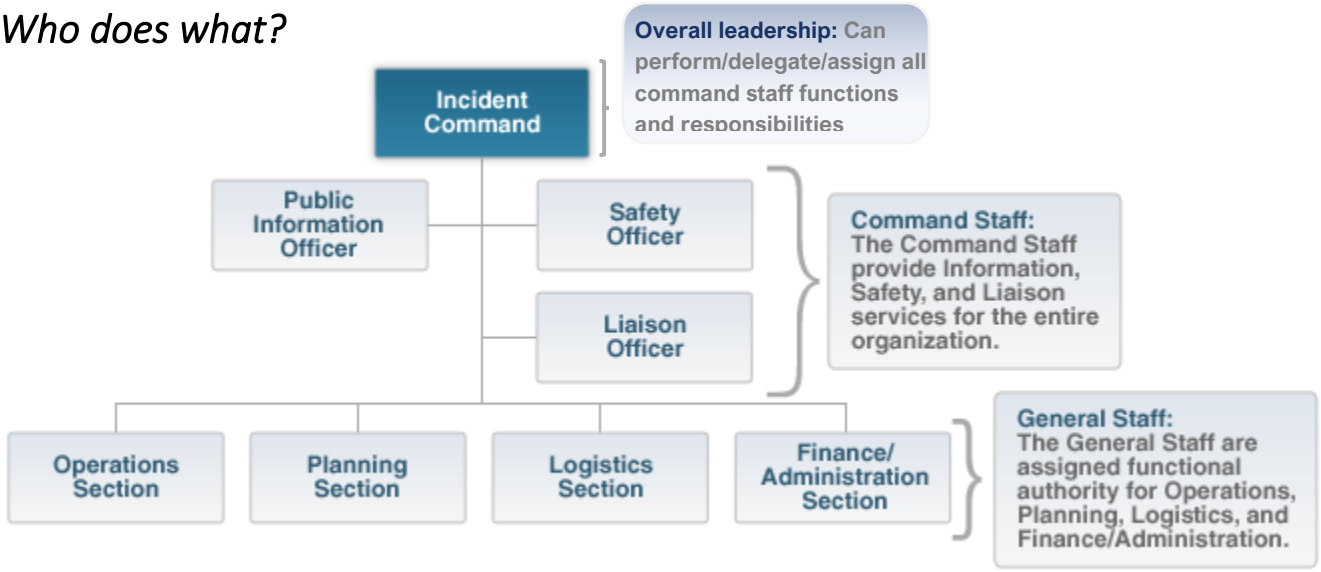
Structure. The ICS is the organizational tool used by Police departments, Fire departments and Emergency Managers. Having a basic understanding of emergency response 'language' will ensure that everyone within the ICS organization has a clear understanding of what needs to be accomplished. The ICS organizational structure uses 'standard position titles' to have similarity across many types of agencies/organizations.



Each community/agency has the flexibility to add or remove certain 'standard position titles', but the bulk of the ICS will be similar across emergency response groups.

Training Summary:
Incident Command System (ICS)-100

Who does what?



II. Flow of command

Unity of command. The principle of unity of command is that all personnel on scene will be designated **one** supervisor. You will receive work assignments **only** from **your** supervisor. If someone else asks you to do something outside your role, check with your supervisor first.

Chain of command. It provides an orderly line of authority within the ranks of personnel responding to the incident. All requests for resources, or staffing, must follow the proper chain of command. The ICS charts above outline the chain of command, starting with the Incident Commander.

Span of control. Refers to the number of staff members that one supervisor effectively manages during an incident. Safety and accountability are a top priority, so it's important to maintain a manageable span of control. The recommended ratio is one supervisor to five staff members.

Accountability. All responders must check-in upon arrival to receive an assignment. At check-in, you will be assigned a specific role, with one designated supervisor. This supervisor is your key contact for questions. Personnel & equipment should respond only when requested or dispatched.

Training Summary:
Incident Command System (ICS)-100

III. Incident facilities

Six basic ICS facilities

- Incident command post (ICP): Incident commander oversees all incident operations from here. Can be located in a vehicle, trailer, tent, or building, and may change locations during the event. All incidents must have an ICP
- Staging area: Temporary locations where available personnel & equipment are waiting for assignments. Should be close enough for quick response, but far enough away to be out of immediate impact zone
- Base: Primary logistics & administrative functions are coordinated from here. One base per incident and designated by incident name. Established & maintained by Logistics Section, may be located in the ICP
- Camps: Resources may be kept here if a Base isn't accessible. Multiple Camps may be used, but not all incidents will have a Camp. Temporary locations within the general incident area to provide food, water, sleeping areas, & sanitary services. Designated by geographic location or number

IV. Dispatch/Deployment (bringing resources into effective action)

When should you help? Only deploy to an incident when requested or when dispatched by an appropriate authority. NC-8 uses e-mail to request MRC volunteers if needed.

If you are deployed, what information should you expect? Make sure you receive a complete deployment briefing that includes:

- Descriptive location & response area
- Incident check-in location
- Specific assignment
- Reporting time

Training Summary:
Incident Command System (ICS)-100

- Communications instructions
- Special support requirements
- Travel arrangements

V. Demobilization (The process of winding down a response)

What is your role during demobilization? Follow incident and agency check-out procedures, including completing required forms/reports. Communicate pass-off information to replacements and supervisors. Return incident-issued equipment and supplies.

Acknowledgments

The information in this summary was provided by the *ZAHP Fusion Center, FEMA, Crawford County Health Department,* the *Homeland Security Affairs Journal,* and the *Boston Public Health Commission.*

Training Summary:

Introduction to the National Incident Management System

I. What is the National Incident Management System (NIMS)?

The National Incident Management System, or NIMS, provides the foundation needed to ensure that we can work together when our communities and the Nation need us the most.

While many incidents are managed effectively at the local level, jurisdictions and organizations work together to share resources, integrate tactics and act collaboratively.

Incidents that may require a collaborative approach includes personnel from:

- Multiple jurisdictions
- A combination of specialties or disciplines
- Several levels of government
- Nongovernmental organizations
- The private sector

NIMS applies to all incidents, regardless of cause, size, location, or complexity, from planned events to traffic accidents and to major disasters.

It provides the shared vocabulary, systems, and processes to successfully deliver the National Preparedness System capabilities.

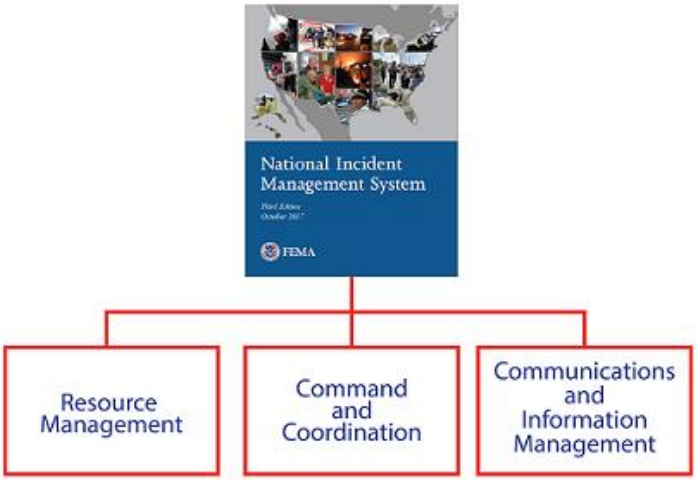
NIMS Is	NIMS Is Not
• A comprehensive, nationwide, systematic approach to incident management, including the command and coordination of incidents, resource management, and information management	• Only the Incident Command System • Only applicable to certain emergency/incident response personnel • A static system
• A set of concepts and principles for all threats, hazards, and events across all mission areas (Prevention, Protection, Mitigation, Response, Recovery)	• A response plan
• Scalable, flexible, and adaptable; used for all incidents, from day-to-day to large-scale	• Used only during large-scale incidents
• Standard resource management procedures that enable coordination among different jurisdictions or organizations	• A resource ordering system
• Essential principles for communications and information management	• A communications plan

Training Summary:

Introduction to the National Incident Management System

II. NIMS Framework: Major components

Jurisdictions and organizations involved in the management of incidents vary in their authorities, management structures, communication capabilities and protocols, and many other factors. The major Components of NIMS provide a common framework to integrate these diverse capabilities and achieve common goals.



What is NIMS Resource Management? Prior to an incident, resources are inventoried and categorized based on the characteristics of capability, category, kind and type. Mutual aid partners exchange information about resource assets and needs. Resource readiness and credentialing are maintained through periodic training and exercises.

Resource management planning should consider resources needed to support all mission areas: Prevention, Protection, Mitigation, Response and Recovery.

Resource management strategies for planners to consider include:

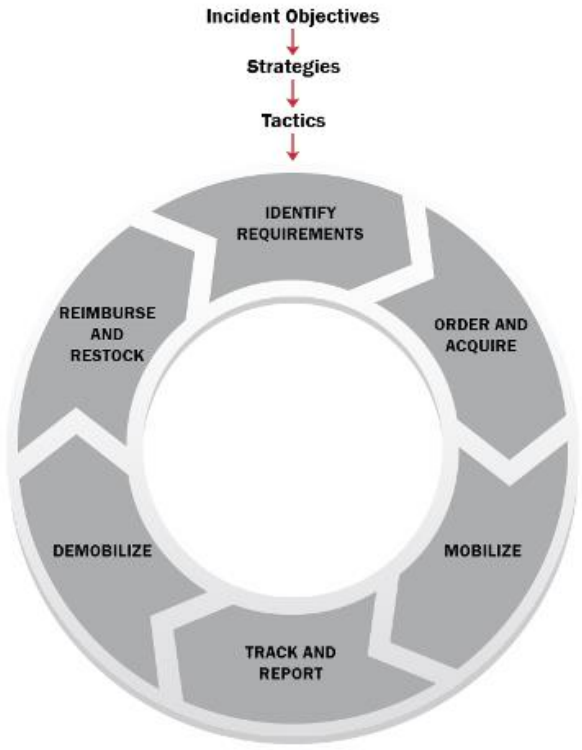
- Stockpiling resources
- Establishing mutual aid agreements to obtain resources from neighboring jurisdictions
- Determining how and where to reassign resources performing non-essential tasks
- Developing contracts to acquire resources from vendors

Estimating resource needs is a key activity in resource planning that enables jurisdictions to assess their ability to take a course of action.

Training Summary:

Introduction to the National Incident Management System

While in a small incident the Incident Commander may order resources directly, in more complex incidents the Incident Commander relies on the resource management process and personnel to identify and meet resource needs. The graphic depicts the resource management process during an incident; this process describes the six resource management tasks performed in an incident.



NIMS Management Characteristics. NIMS bases incident command and coordination on fourteen NIMS Management Characteristics. These fourteen characteristics are building blocks that contribute strength and efficiency to the National Incident Management System.

Training Summary:
Introduction to the National Incident Management System

III. Four major NIMS structures

The four NIMS Structures are:

- the Incident Command System (ICS)
- Emergency Operations Centers, (EOC)
- the Multi-Agency Coordination Group (MAC Group)
- the Joint Information System (JIS)

Incident Command System. The Incident Command System, or ICS, is a standardized, on-scene, all-hazard incident management concept. ICS allows its users to adopt an integrated organizational structure to match the complexities and demands of incidents.

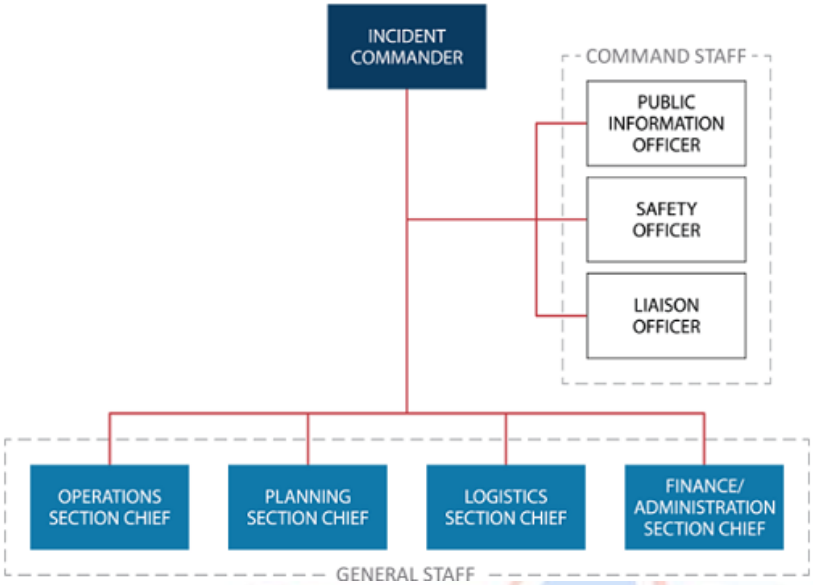
Emergency Operations Centers. As an incident becomes more complex, multiagency coordination and the need for additional resources becomes increasingly important. Emergency Operations Centers (EOCs) support on-scene incident command from off-site through multiagency coordination and resources.

Multi-Agency Coordination Group. MAC Groups are high level multiagency coordination bodies that support ICS and EOCs through policy and scarce resource allocation.

Joint Information System. The final Command and Coordination element is the Joint Information System (JIS). The Joint Information System ensures coordinated and accurate public messaging among the ICS, EOCs and MAC Group.

Training Summary:
Introduction to the National Incident Management System

IV. Incident Command System (ICS) (more can be found in the ICS-100 Training Summary)



Command Staff positions are established by the Incident Commander (IC) or Unified Command (UC) as needed to support the management of an incident. Command Staff report directly to the Incident Commander or Unified Command and are assigned assistants as necessary to perform their duties.

The ICS Command Staff typically includes:

- The Public Information Officer (PIO) who interfaces with the public, media, and others needing incident information
- The Safety Officer who monitors incident operations and advises the Incident Commander or Unified Command on matters relating to health and safety
- The Liaison Officer who serves as the incident command's point of contact for organizations not included in the Incident Command or Unified Command

The General Staff is a group of incident management personnel organized according to function. The ICS General Staff consists of 4 Sections:

- Operations
- Planning
- Logistics
- Finance/Administration

Training Summary:

Introduction to the National Incident Management System

Each ICS General Staff Section is led by a Section Chief who reports directly to the Incident Commander or Unified Command.

These individuals are responsible for managing tasks within their functional area. The Incident Commander or Unified Command activates these section chiefs as needed. The Incident Commander or Unified Command is responsible for performing each General Staff function until a section chief is assigned to manage that function.

The Operations Section plans and performs tactical activities to achieve the incident objectives established by the IC/UC. Incident objectives typically focus on

- Saving lives
- Reducing the immediate hazard
- Protecting property and the environment
- Establishing situational control
- Restoring normal operations

Planning Section personnel collect, evaluate, and disseminate incident information to the Incident Commander/Unified Command and other incident personnel.

- Prepare status reports
- Display situation information
- Maintain the status of assigned resources
- Facilitate the incident action planning process
- Prepare the Incident Action Plan (IAP) based on input from the General Staff, Command Staff and Incident Commander/Unified Command guidance

Logistics Section personnel are responsible for providing services and support for the incident.

- Facilities Security (of the incident command facilities and personnel)
- Transportation
- Supplies
- Equipment maintenance and fuel
- Food services
- Communications and information technology support
- Medical services for incident personnel

Training Summary:

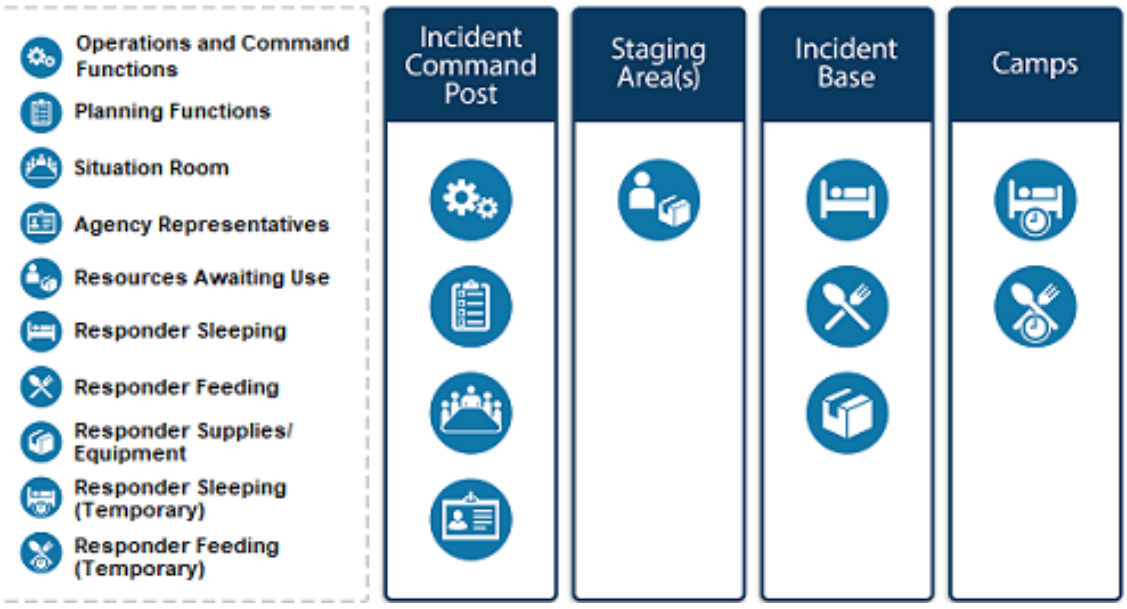
Introduction to the National Incident Management System

The IC/UC establishes a Finance/Administration Section when the incident management activities require on-scene or incident-specific finance and administrative support services.

- Record personnel time
- Negotiate leases
- Maintain vendor contracts
- Administer claims
- Track and analyze incident costs

Common Types of ICS Facilities. The Incident Commander or Unified Command may establish several different kinds of facilities in and around the incident area.

- The Incident Command Post (ICP) - location of the tactical-level, on-scene incident management (Incident Commander or Unified Command and Staff)
- Staging Areas - temporarily position and account for personnel, supplies, and equipment awaiting assignment
- Incident Base - location at which personnel conduct primary support activities (may be co-located with the ICP)
- Camps - satellites to an Incident Base, established where they can best support incident operations by providing food, sleeping areas, sanitation and minor maintenance and servicing of equipment



Training Summary:
Introduction to the National Incident Management System

V. Emergency Operations Centers (EOS)

ICS is used to manage on-scene, tactical-level response; EOCs are off site locations where staff from multiple agencies come together to:

- Address imminent threats and hazards
- Provide coordinated support to incident command, on-scene personnel and/or other EOCs

The purpose, authorities, and composition of EOCs vary widely, but EOCs generally perform the following primary functions:

- Collecting, analyzing and sharing information
- Supporting resource needs and requests, including allocation and tracking
- Coordinating plans and determining current and future needs
- In some cases providing coordination and policy direction

EOCs can be fixed locations, temporary facilities or virtual structures with staff participating remotely.

Emergency Operations Centers are activated for a variety of incidents, threats and events. Some circumstances that might trigger center activation include:

- Multiple jurisdictions or agencies involved in an incident.
- The Incident Commander or Unified Command indicates an incident could expand rapidly, involve cascading effects or require additional resources.
- A similar incident in the past led to EOC activation.
- The EOC Director or an appointed or elected official directs EOC activation.
- An incident is imminent such as predicted hurricane, flooding, hazardous weather, or elevated threat levels.
- Threshold events described in an emergency operations plan occur.
- Significant impacts to the population are anticipated.

Emergency Operations Centers frequently have multiple activation levels to allow for:

- Response scaled to the incident
- Delivery of the exact resources needed
- A level of coordination appropriate to the incident

Training Summary:

Introduction to the National Incident Management System

NIMS Activation Levels Table.

Activation Level	Description
3 Normal Operations/ Steady State	• Activities that are normal for the EOC when no incident or specific risk or hazard has been identified • Routine watch and warning activities if the EOC normally houses this function
2 Enhanced Steady-State/ Partial Activation	• Certain EOC team members/organizations are activated to monitor a credible threat, risk, or hazard and/or to support the response to a new and potentially evolving incident
1 Full Activation	• EOC team is activated, including personnel from all assisting agencies, to support the response to a major incident or credible threat

VI. Other NIMS Structures and Interconnectivity

Multi-agency Coordination Groups (MAC Group). Multi-agency Coordination Groups (MAC Group) are part of the off-site incident management structure of NIMS, also sometimes referred to as policy groups.

During incidents, MAC Groups:

- Act as a policy-level body
- Support resource prioritization and allocation
- Make cooperative multi-agency decisions
- Enable decision making among elected and appointed officials and the Incident Commander responsible for managing the incident.

MAC Group members are typically agency administrators, executives or their designees from stakeholder agencies or organizations impacted by and with resources committed to the incident. The MAC Group may also include representatives from non-governmental organizations such as businesses and volunteer organizations.

The MAC Group does not perform incident command functions, nor does it replace the primary functions of EOCs or other operations, coordination, or dispatch organizations.

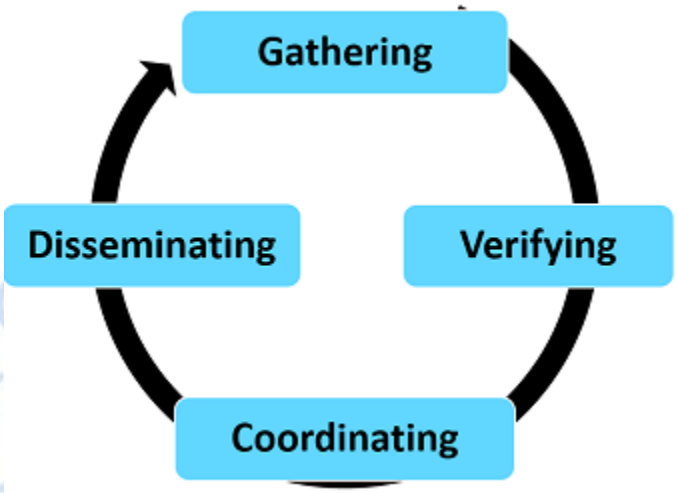
Joint Information System (JIS) Purpose. JIS integrates incident information and public affairs into a unified organization that provides consistent, coordinated, accurate, accessible, timely and complete information to the public and stakeholders during incident operations.

JIS activities include:

- Developing and delivering coordinated interagency messages
- Developing, recommending and executing public information plans and strategies
- Advise on public affairs issues that could affect the incident management effort
- Addressing and managing rumors and inaccurate information that could undermine public confidence

The JIS performs these activities in support of the Incident Commander or Unified Command, the EOC Director, and the MAC Group.

Informing the Public and Stakeholders. Getting information to the public and stakeholders during an incident requires an ongoing information cycle:



- Gathering complete information for the public and other stakeholders
- Verifying information to ensure accuracy
- Coordinating information with other public information personnel who are part of the JIS to ensure consistency
- Disseminating consistent, coordinated, accurate, accessible, timely and complete information to the public and stakeholders

The importance of interconnectivity. Interconnectivity of NIMS structures is important to allow personnel in diverse geographic areas, with differing roles and responsibilities, and operating within various functions of ICS and/or EOCs to integrate their efforts through common organizational structures, terminology, and processes.

Training Summary:

Introduction to the National Incident Management System

Summary of how NIMS structures interact with each other.

- When an incident occurs or threatens, local emergency personnel manage response using NIMS principles and **ICS**.
- If the incident is or becomes large or complex, local **EOCs** activate.
- EOCs receive senior level guidance from **MAC Groups**.
- A Joint Information Center (JIC) manages the Joint Information System **(JIS)** operations to ensure coordinated and accurate public messaging among all levels: ICS, EOC and MAC Group.

If required resources are not available locally, they can be obtained under **mutual aid agreements** from neighboring jurisdictions, or State, tribal, territorial, and interstate sources and assigned to the control of the Incident Commander or Unified Command.

Acknowledgments

The information in this summary was provided by the *Federal Emergency Management Agency.*

Training Summary:

Disaster Health Core Curriculum: Communication

I. Risk communication

Theory. The process of communicating information to public health agencies and their stakeholders via non-media conduits (e.g. hotline, fact-to-face, web-based material).

The goal of risk communication is for stakeholders and the public to be:

- Informed
- Appropriately concerned
- Situationally aware
- Calm

Risk communication theory is based on four models.

1. Risk perception: the perception of risk is often very different than actual risk. When communicating risk, be calm in the approach, show genuine concern about the public's wellbeing, be transparent, and provide actionable, real-time, and consistent information. Align the *perception* of risk with the *actual risk*.
2. Negative dominance: when people process information, negative messages have greater influence. Communicate information that is positive and solution oriented.
3. Mental noise: when people are upset, they have difficulty hearing, understanding, and remembering details. Communication should be clear (no jargon), concise (time sequence, priorities), and repeat information if necessary.

4. Trust determination: stakeholders and the public must trust the information being given. Do not speculate, improvise or discuss hypothetical situations. Do not lie or try to cloud the truth.

Audience. A variety of stakeholders interact with the governmental public health infrastructure. Examples include:

- Communities (MRCs, faith-based organizations)
- Health Care Systems (hospitals, long-term care facilities, local doctors' offices, ambulatory care centers, dialysis centers)
- Homeland Security (FEMA, CDC, local public health departments, Police, Fire)
- Employers and Businesses (American Red Cross, volunteer disaster groups, national retail organizations)
- Academic (universities, schools, after school programs)
- Media (TV, radio, newspapers, social media)

II. Cultural considerations

Perception of information. Some people (and organizations) will react to and understand information differently due to cultural differences. Cultural sensitivities must be considered when disseminating information (choose words intentionally, be cognizant about how the message is being relayed)

III. Authoritative sources of information

Sources. Identify sources most directly connected to emergency management agencies.

Training Summary:

Disaster Health Core Curriculum: Communication

IV. Using a message map

Planning. When communicating with the community after an emergency, it is critical to organize the message so it can provide the public with the most useful information. Follow these steps to help you plan an effective message:

1. Ask yourself and others, "What are people really concerned about?"
2. Start with three key points to address these concerns
3. Back up each key point with one or two facts

Acknowledgments

The information in this summary was provided by the *National Center for Disaster Medicine and Public Health.*

Training Summary:

PODs (Points of Dispensing): Public Health Training for Staff and Volunteers

I. Overview

What are PODs? They are established to rapidly distribute medicine or vaccine to the public in order to prevent illness and death.
Two characteristics make POD operations unique compared to other dispensing clinics, speed and the large number of people served.

II. Setting up and operating a POD

Location. PODs will be set up in large public areas, such as school gymnasiums that are easily accessible to the public and have space to safely accommodate large numbers of people moving through them.

Floor plan. Each POD is unique, and its floor plan will be based on the specific characteristics of the event. The design of the POD needs to allow for efficient patient flow, patient triage, patient screening, medication dispensing, security, and crowd control.

(Typical) Flow of operations.

- Triage: necessary to sort those who need medication from those who don't or from those who may need more emergent health services

Training Summary:

PODs (Points of Dispensing): Public Health Training for Staff and Volunteers

- Form distribution: As people enter this station, staff will hand out forms. In some instances a form will be posted on an organization's website, so people can download, print out and bring the form with them to the POD
- Form Filling: This is the area where people will fill out their forms. The information they provide on the form will be used to determine each person's correct dosage
- Screening and dispensing: Here staff will determine which medication to give and to dispense
- Education: Staff will provide information about medications or illness at this station. Some PODS have plans for video education or printed materials.

How is a POD Staffed? When there is a sustained emergency **both medical and nonmedical personnel** will be needed to meet the demand. Public health staff and volunteers will work side by side in stations to operate the POD.

How are POD staff (MRC volunteers) contacted? You may receive a phone call, email, text message or all three. When you are notified you will receive a description of the POD and the role in which you are served. Your assignment may differ from the kind of work you normally perform. Assignments will be based on the needs of the emergency and the people available to work. You will also learn the location of the POD along with the amount of time you will be asked

to devote to the POD. Volunteers can then accept or decline the assignment.

III. Supplying a POD

Strategic National Stockpile (SNS). SNS is a national repository of medications and supplies and is designed to supplement and resupply a state's own resources. The SNS is stored at various sites around the country. It is packed and ready to be delivered within 12 hours to receiving sites. The inventory of the SNS is extensive and includes antibiotic, vaccines, chemical antidotes and medical and surgical equipment. The US Department of Homeland Security and the Centers for Disease Control and Prevention are responsible for maintaining the SNS.

IV. PODs and Incident Command Structure (ICS)

The use of the Incident Command System in a POD provides roles and responsibilities for all staff and a clear and uniform chain of command. The ICS allows for efficient site management, worker safety, site security, and coordination with external agencies and media. *Please see "Training Summary: ICS-100" for more information about ICS.*

Acknowledgments

The information in this summary was provided by the *University of Minnesota School of Public Health*

Training Summary:
Psychological First Aid (PFA)

I. Background

What is Psychological First Aid? Psychological First Aid (PFA) is an evidence-informed approach that is built on the concept of human resilience. Emotional distress is not always as visible as a physical injury, but is *just as painful and debilitating*. Reactions manifest differently at different periods of time during and after the incident.

Why use PFA? PFA aims to reduce stress symptoms and assist in healthy recovery following a traumatic event, natural disaster, public health emergency, or even a personal crisis.

II. What does emotional distress look like?

Some common stress reactions include:

- Confusion
- Fear
- Feelings of hopelessness and helplessness
- Sleep problems
- physical pain
- anxiety
- Anger
- Grief
- Shock
- Aggressiveness
- Withdrawal
- Guilt
- Shaken religious faith
- Loss of confidence in self or others

III. How does PFA work?

Addresses basic needs and reduces psychological distress. By understanding an individual's reaction to stress, PFA empowers the individual by supporting strengths and encouraging existing coping skills. It also provides connections to natural support networks, and referrals to professional services when needed.

Is a degree necessary to use PFA? No, Psychological First Aid does not rely on direct services by mental health professionals, but rather on skills that most of

Training Summary:
Psychological First Aid (PFA)

us already have. PFA is not traditional psychiatric or professional mental health treatment, but rather a strategy to reduce stress reactions by providing additional support to those who have been affected by a traumatic or emergency incident.

IV. Audience

Who needs PFA? PFA can help everyone—children, adolescents, adults, elders, families, and communities who have been exposed to a traumatic or emergency incident, including responders and support service providers.

Cultural considerations. PFA encourages the use of "Cultural Leaders" for the provision of PFA services within various cultural groups. While the core strategies remain the same, inter-personal interaction and written communication should be adapted to respect and fit the needs of the impacted culture.

Where do you use PFA? Psychological First Aid is designed to be simple and practical so that it can be used in any setting. Psychological First Aid can be provided anywhere that trauma survivors can be found - in shelters, schools, hospitals, private homes, the workplace, and community settings.

What if someone needs more help than I can give? If you feel that someone needs more help than you are qualified to provide, speak with your supervisor or a mental health professional on how to best assist the individual, or how to refer them to on to professional mental health services.

IV. Overall goal

To create and sustain an environment of: Safety, calm and comfort, connectedness, self-empowerment, and hope.

Acknowledgments

The information in this summary was provided by the *Minnesota Department of Health, Office of Emergency Preparedness*

Training Summary:
Situational Awareness

I. Background

What is situational awareness? A state of calm alertness and consciousness, in which environmental factors and events and their ramifications are considered. By having high levels of situational awareness, you can make better decisions before, during, and after a crisis.

II. What are the key features of situational awareness?

Since real-world situations are dynamic, you must be able to:

1. **Perceive factors accurately and rapidly:** efficiently processing information while minimizing the impact of bias and emotions on our ability to think logically and emotionally.

2. **Comprehend their significance:** Comprehension involves understanding the significance of various factors and how they affect the current situation. Maintain a careful balance between attention to details and big-picture awareness.

3. **Project various outcomes:** Making realistic predictions about the unfolding of events. The closer a prediction is to the final outcome, the better the decisions will be.

III. Situational awareness before an event occurs

Hazard Vulnerability Assessment. Pertinent hazards are explored based on

- The probability of occurrence
- Their level of impact
- The degree to which a community or organization is prepared for that specific threat

Hazard mitigation helps build partnerships for risk reduction by involving the government, organizations, businesses, and the public. It enables stakeholders and the public to identify long-term, broadly supported strategies for risk reduction, which can impact potential sources of funding.

Training Summary:
Situational Awareness

Indications of an upcoming disaster. Being culturally competent means having a broader understanding of what culture is—it is not only ethnicity, nationality, or language. A culturally competent person does not oversimplify or generalize an individual's culture, nor do they stereotype. They recognize cultural factors and adapt their skills accordingly.

IV. What is cultural humility?

It is a willingness to suspend what you know, or what you think you know, about a person based on generalizations about their culture. It means that truly understanding any individual's culture is an ongoing endeavor, because no two people are the same, even from the same culture.

What values align with cultural humility?

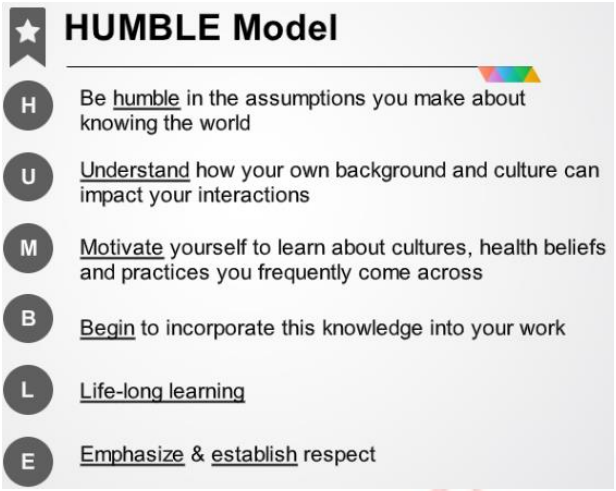
- Openness
- Appreciation
- Acceptance
- Flexibility
- Compassion

How can I practice cultural humility? Being aware of one's personal beliefs and not letting them interfere with engaging with others from a place of learning. Additionally, having an attitude that acknowledges culture is individual and can only be understood individually. An easy way to remember these values and practices is through the HUMBLE model.

Training Summary:

Situational Awareness

What is the HUMBLE model?



IV. Final expectations

- Be able to define cultural awareness, culture, cultural competency, and cultural humility.
- Be able to highlight the skills necessary to work effectively across diverse cultures.

Acknowledgments

The information in this summary was provided by the *Wisconsin Center for Public Health Education and Training, University of Wisconsin—Madison.*

Training Summary:

You Are the Help Until Help Arrives

I. Background

If you act quickly and purposefully, you can save lives. When multiple people witness an emergency, everyone assumes that someone else will help. The first person to step forward often triggers a supportive response from others.

WHEN PEOPLE ACT

TEND TO HELP	TEND NOT TO HELP
• Event is unexpected, sudden • More than one person is injured • Experience the event firsthand • Believe they can help • Recognize an immediate threat to life that appears to be getting worse • Empathize with the injured	• Assume professional medical responders will arrive quickly and take action • Feel they don't know what to do • Are afraid

II. Step 1: Call 9-1-1

It always helps to call – don't assume someone else has already done so.
9-1-1 operators are highly trained and will help you:

- Assess what is going on.
- Take appropriate action.
- Be as safe as possible.

You and the 9-1-1 Operator: The questions they ask help to send the appropriate resources to the right place. Depending on the situation, they will give you specific instructions-follow their lead and let them coach you through the situation.

Common questions:

1. Where: Specific locations, such as floor, room number, landmarks. This helps responders find you easily and quickly.
2. Type and severity of life-threatening situation: This helps to send the appropriate responders and equipment.
3. Safety concerns: Disclose obvious dangers or ongoing threats. This helps to protect and aid everyone on the scene.

Training Summary:

You Are the Help Until Help Arrives

III. Step 2: Stay Safe

ASSESS THE SITUATION

Briefly pause. Use all your available senses:

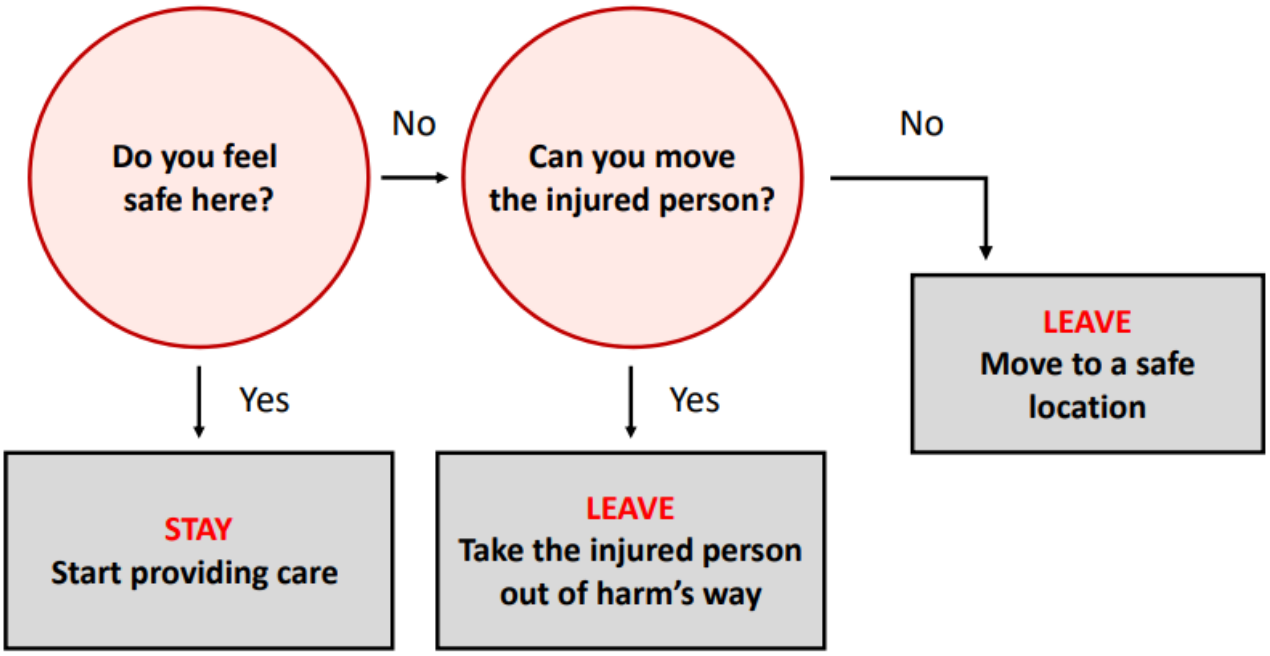
What do you see?
- Downed power lines
- Smoke
- Debris
- Moving vehicles
- People running

What do you hear?
- Voices
- Creaking
- Hissing
- Booms
- Gunshots

What do you smell?
- Gasoline
- Smoke
- Chemicals

BEFORE TAKING ACTION

Use your best judgment…

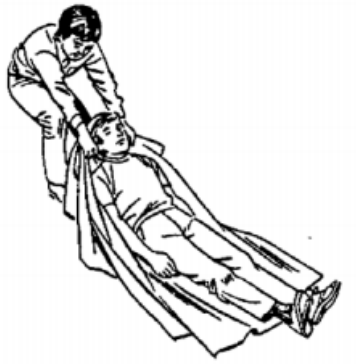


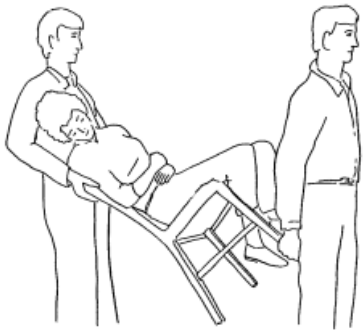
Training Summary:

You Are the Help Until Help Arrives

HOW TO MOVE THE INJURED

- Drags and one-person carries for moving injured short distances
- Two-person carries for longer distances





Move Smartly

- Get help from others around you
- Use things around you, such as blankets, chairs, and carts.

Moving an injured person who is in grave danger **will not** cause more harm than leaving them to die.

Training Summary:

You Are the Help Until Help Arrives

IV. Step 3: Stop the Bleeding

(when there is a training opportunity, please register to take this class in person. This training summary is NOT designed to replace in-person training)

WHY STOP THE BLEEDING

Stop the Clock!

- Every minute with uncontrolled bleeding decreases the chance of survival!
- 35% of pre-hospital trauma deaths are due to blood loss.*

IRREVERSIBLE SHOCK

When your body loses approximately half its blood volume, it cannot survive – **regardless of the quality of medical care you eventually receive.**

You can lose that amount in just **minutes**!

STEPS TO CONTROL BLEEDING

1. Find the source(s) of bleeding.
2. If you have something to put in between the blood and your hands, use it. Examples include gloves, a cloth, or a plastic bag.
3. Apply firm, steady pressure directly on the source of the bleeding. Push hard to stop or slow bleeding – even if it is painful to the injured!
4. Keep applying pressure until EMS arrives.

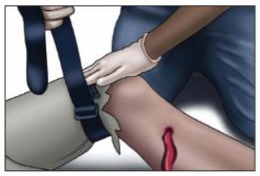
Training Summary:

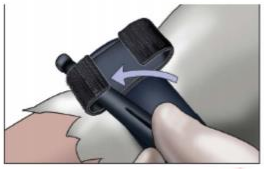
You Are the Help Until Help Arrives

WHEN TO USE A TOURNIQUET

Think of a tourniquet as another way to apply firm, steady pressure when:

- The injury is to an arm or leg.
- The bleeding is so severe it cannot be controlled otherwise.






HOW TO USE A TOURNIQUET (OPTIONAL)

1. Place as high up as possible on the injured limb – closer to the torso. It can be placed over clothing.
2. Pull the strap through the buckle.
3. Twist the rod tightly until bleeding stops/slows significantly. This may be painful!
4. Secure the rod.
5. If bleeding doesn't stop, place a second tourniquet.
6. Leave in place until EMS takes over care.


MAKESHIFT TOURNIQUETS (OPTIONAL)

If you don't have a commercially available tourniquet, you can attempt to improvise one using material that is:

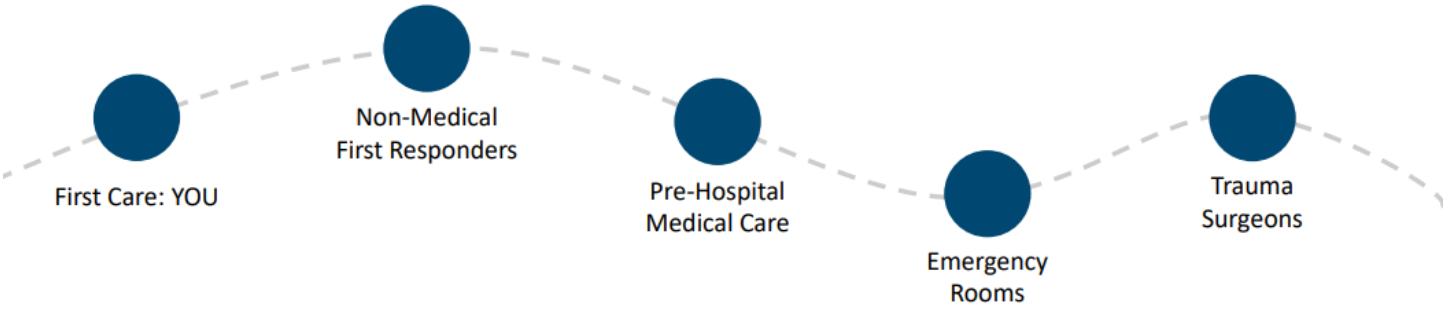
- Broad
- Flexible
- Strong
- Able to be twisted, tightened, and secured.

Training Summary:

You Are the Help Until Help Arrives

CHAIN OF SURVIVAL

How the emergency medical system keeps people with serious injuries alive:



V. Step 4: Position the Injured

ALLOW SELF-MANAGEMENT

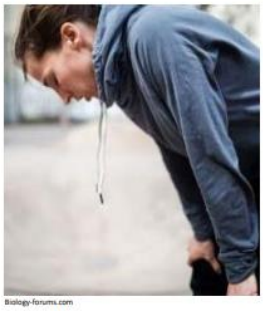
When a person is conscious and breathing, **allow them to position themselves**; if they are struggling to do so, assist them.

Do not force them to lie down or sit up!

TRIPOD POSITION

Allows the lungs and ribcage to expand as fully as possible.

When sitting on a chair or bench: Legs shoulder width apart, elbows or hands on knees, leaning slightly forward.

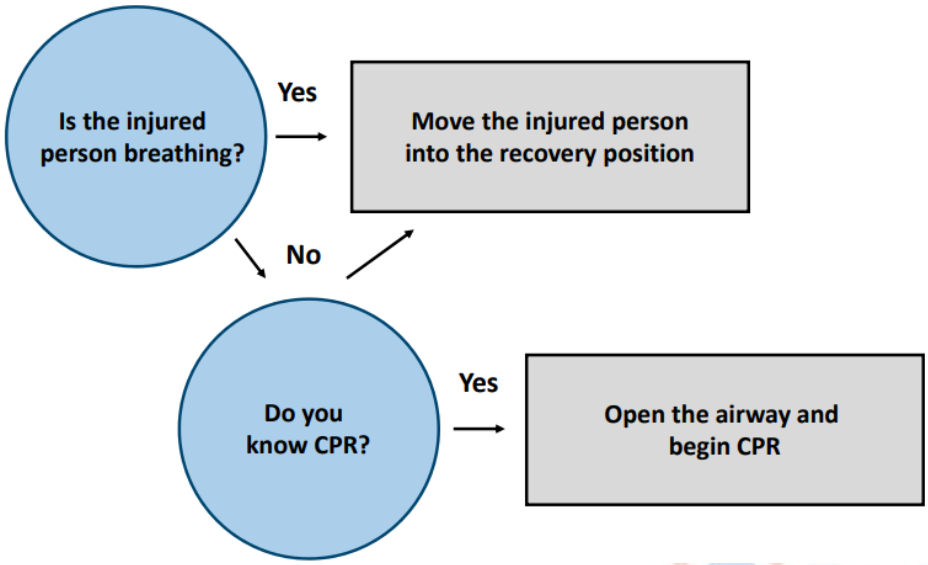


When standing: Legs shoulder width apart, hands on knees arms straight, leaning forward with flat back.

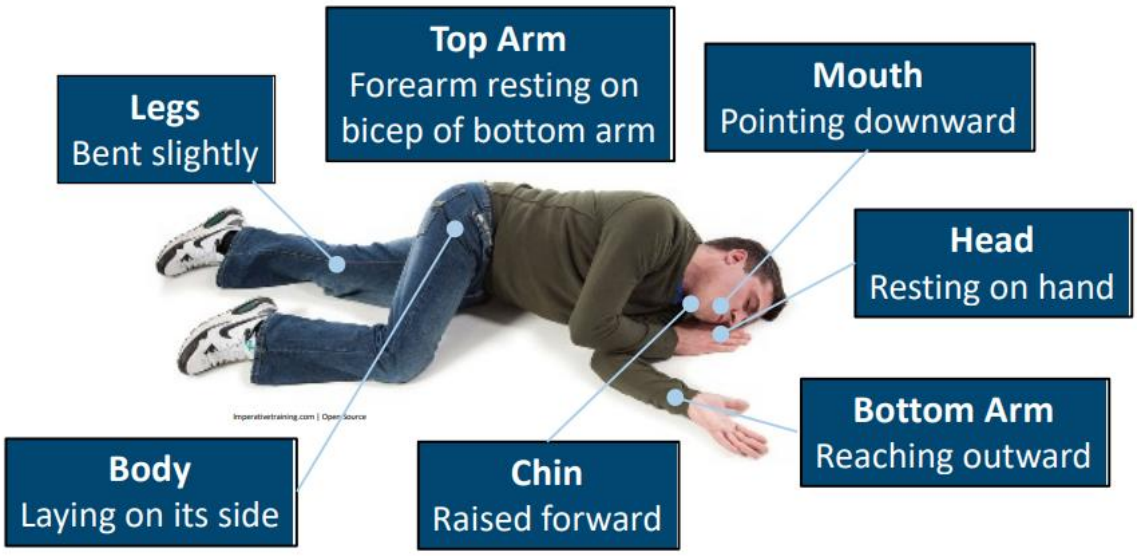
Training Summary:

You Are the Help Until Help Arrives

ASSESS THE UNCONSCIOUS



RECOVERY POSITION SETUP



Training Summary:

You Are the Help Until Help Arrives

MOVE WITH PURPOSE

Although the risk is very small, it is possible that moving someone into the recovery position could cause harm to their spine.

- Try to support the head and neck when rolling them onto their side.
- Continue supporting their head if possible.
- Don't move the individual more than necessary.

VI. Step 5: Provide Comfort

SIMPLE ACTIONS

What can you do?

- **Keep them warm.**
- Offer a hand to hold.
- Maintain eye contact.
- Be patient and understanding.
- If you have to move on to provide aid to another person, let them know.

Keeping the injured person warm will:

- Improve blood clotting.
- Reduce stress on the body.
- Provide a level of comfort.

Training Summary:

You Are the Help Until Help Arrives

WORKING WITH CHILDREN

- Sit or crouch at eye level.
- Shield them as much as possible from the scene; create a barrier between them and the injured.
- Use simple words.
- Listen carefully and ask questions to make sure they understand.

WORKING WITH THOSE WITH DISABILITIES AND ACCESS AND FUNCTIONAL NEEDS

- Ask what you can do to help, don't assume.
- If the person has a caregiver or family member with them, keep them together.
- If the person has medical equipment or a service animal with them, keep them together.
- Confusion, difficulty hearing, loss of memory, and other similar issues may be the result of injuries.

Training Summary:

You Are the Help Until Help Arrives

VII. Prepare at Home

EMERGENCY AID KIT

For life-threatening events, have one kit for home, work, and vehicles:

- Emergency trauma dressing(s) – 6-inch
- S-rolled gauze
- An effective tourniquet with instructions
- Trauma shears
- Gloves
- Emergency blanket
- Bag/Container to hold the equipment and dressings

ENHANCE YOUR SKILLS

American Red Cross

CERT COMMUNITY EMERGENCY RESPONSE TEAM

American Heart Association

Learn and Live

medical reserve corps

Training Summary:

You Are the Help Until Help Arrives

ENHANCE YOUR SKILLS

American Red Cross

www.redcross.org/take-a-class

Training Programs

- First Aid
- Heartsaver CPR/AED
- Babysitting and Child Care
- Lifeguard
- Swimming/Water Safety

ENHANCE YOUR SKILLS

American Heart Association

Learn and Live

www.cpr.heart.org

Training Programs

- CPR/AED & First Aid
- CPR in Schools
- Hands-Only CPR
- Workforce Training

ENHANCE YOUR SKILLS

CERT COMMUNITY EMERGENCY RESPONSE TEAM

www.ready.gov/CERT

Community Emergency Response Teams (CERT)

- Respond to emergencies in your neighborhood.
- Learn basic disaster preparedness and response skills.
- Improve the resilience of your community.

Training Summary:

You Are the Help Until Help Arrives

ENHANCE YOUR SKILLS

Medical Reserve Corps (MRC)

- As a member of an MRC unit, you can be part of an organized and trained team.
- You will be ready and able to bolster local emergency planning and response capabilities.
- Many MRC volunteers assist with activities to improve public health in their community.

https://mrc.hhs.gov

Acknowledgments

The information in this summary was provided by the *Federal Emergency Management Agency (FEMA).*

Training Summary:

Cultural Awareness: Cultural Competency and Humility

I. Background

What is cultural awareness? To ensure that one is cognizant, observant, and conscious of similarities and differences among and between cultural groups. This includes recognition of one's own cultural influences upon values, beliefs, and judgement.

Why is cultural awareness important? We live in a diverse world where different cultures inform the beliefs and behaviors of others. Cultural awareness if the first step in becoming proficient in working well with people for a variety of backgrounds.

II. What is culture?

It is a system of learned beliefs, traditions, principles, and guides for individual and collective behaviors that members of a particular group commonly share with each other. It affects how we work, parent, interact with other and understand health, wellness, illness, and disability. Culture is fluid, not static.

How is culture influenced? The historical and social context of population can influence culture, including migration, resettlement, colonization, religious influences, and territorial shifts. Other cultural influences include values, mental processes, learning, beliefs, attitude, and communication and language.

III. What is cultural competence?

The ability to understand and respect values, attitudes, beliefs and customs that differ across cultures. This includes having self-awareness. What is your background? What are your values? What do you believe? Also being aware of the culture that the community member receiving services comes from and of the person administering services.

Cultures are not homogenous and static. Being culturally competent means having a broader understanding of what culture is—it is not only ethnicity,

Training Summary:

Cultural Awareness: Cultural Competency and Humility

nationality, or language. A culturally competent person does not oversimplify or generalize an individual's culture, nor do they stereotype. They recognize cultural factors and adapt their skills accordingly.

IV. What is cultural humility?

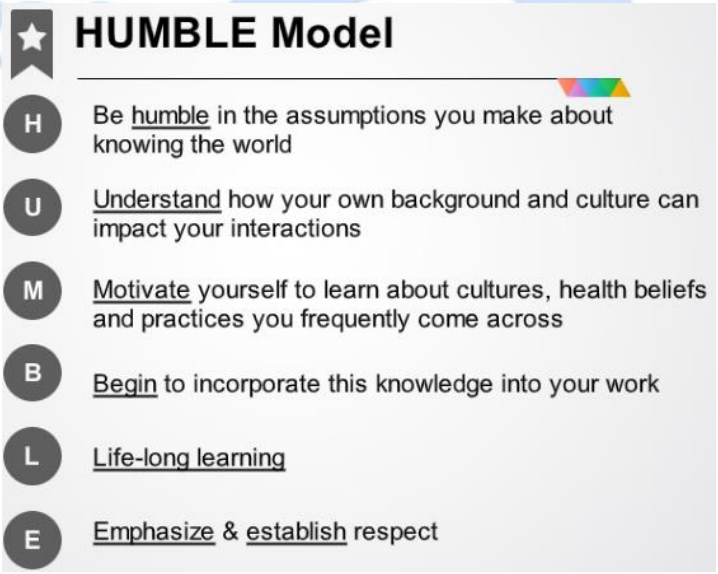
It is a willingness to suspend what you know, or what you think you know, about a person based on generalizations about their culture. It means that truly understanding any individual's culture is an ongoing endeavor, because no two people are the same, even from the same culture.

What values align with cultural humility?

- Openness
- Appreciation
- Acceptance
- Flexibility
- Compassion

How can I practice cultural humility? Being aware of one's personal beliefs and not letting them interfere with engaging with others from a place of learning. Additionally, having an attitude that acknowledges culture is individual and can only be understood individually. An easy way to remember these values and practices is through the HUMBLE model.

What is the HUMBLE model?



Training Summary:

Cultural Awareness: Cultural Competency and Humility

IV. Final expectations

- Be able to define cultural awareness, culture, cultural competency, and cultural humility.
- Be able to highlight the skills necessary to work effectively across diverse cultures.

Acknowledgments

The information in this summary was provided by the *Wisconsin Center for Public Health Education and Training, University of Wisconsin—Madison.*

Training Summary:
Public Health and the Law

I. Scope and Breadth of Public Health Legal Authority in Emergencies

Role of Law. The law authorizes declarations of emergencies and provides practitioners and officials with the authority to respond.

***Emergency Declarations*.** Declarations of emergency, disaster, or public health emergency alter the legal environment during a public health crisis. The type of declaration and level of government issuing the declaration affects local, state, and federal practitioners' authorities.

Interjurisdictional Issues. Relationships between federal, tribal, state, and local governments and laws can facilitate interjurisdictional collaboration to provide effective responses to an emergency. Although federal, state, and local laws may at times work cohesively, they may also overlap or conflict. Interjurisdictional legal issues include the sharing of resources and personnel between localities or states. Mutual aid and interjurisdictional agreements clarify responsibilities and can reduce interjurisdictional conflicts during a declared emergency.

II. Emergency Public Health Powers and Duties

Individual Rights, Constitutional Protections and Communal Interests. Individual and constitutional protections must be balanced with communal interests (e.g., controlling the spread of a highly-communicable and potentially dangerous disease). Individual rights and protections may require that public health practitioners adhere to procedural requirements, which may be altered during an emergency to expedite the implementation of public health police powers.

Enhanced Public Health Powers. While various response measures may be legally authorized prior to and after an emergency declaration, the declaration

may equip public and private sector actors with enhanced powers to effectively respond. These powers may include the ability to take control over private property, procure and allocate resources, and mandate vaccinations, tests, screenings, or medical treatment.

Potential Duties and Related Waivers. During an emergency, public health officials may be required to continue to adhere to various federal laws or regulations, including the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, Medicare/Medicaid reimbursement requirements, and Emergency Medical Treatment and Active Labor Act (EMTALA). During a federally-declared emergency, some of these requirements may be waived to facilitate response efforts.

III. Social Distancing Measures

Types of Social Distancing and Implementation. Social distancing measures may be an appropriate method for reducing the spread of a communicable disease through direct or close contact. However, public health practitioners and their partners should carefully consider whether such measures are legally authorized and factually warranted. This may require consideration of the epidemiology of the disease, the feasibility of the measure's implementation, and the enforceability of the measure

Legal and Constitutional Protections. When implementing social distancing measures, public health officials must consider potential infringements on individual constitutional rights.

Enforcement. Implementation of social distancing measures may require legal enforcement (e.g., court orders or criminal penalties), although officials should seek to enforce such measures through the least restrictive means necessary

Training Summary:
Public Health and the Law

IV. Deployment and Use of Volunteer Health Practitioners

Registration Programs. The Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or the official state equivalent, provides a mechanism to pre-register volunteers for deployment during public health emergencies. ESAR-VHP is a federal program run by HHS and administered by states to verify volunteer health professionals' (VHPs) identification, credentials, license, accreditation, and hospital privileges prior to an emergency situation.

Medical Reserve Corps (MRC) programs are housed under the U.S. Surgeon General's Office, and overseen by the Division of Civilian Volunteer Medical Reserve Corps (DCVMRC). Units are organized and operated locally to provide volunteers for local emergency response and public health activities. MRC units ensure their volunteers are registered, credentialed, and trained to meet their local mission(s).

Medical Licensure Requirements. Medical licensure, credentialing, and privileging requirements may limit a VHP's capacity to provide services, particularly out-of-state, during an emergency. During declared emergencies: 1) laws may allow for the waiver of these requirements; 2) mutual aid compacts (e.g., EMAC) or agreements may pre-arrange waivers for out-of-state volunteers; 3) hospitals may temporarily waive privilege requirements; and 4) specific scope of practice limitations may be lifted.

Delivery of Medical Countermeasures. During a public health emergency, jurisdictions may need to rapidly provide medical countermeasures to the public to limit the effects of their exposure to a disease. Laws may limit this ability by restricting those who can dispense medication or administer vaccines. During a declared emergency, pharmacists and practitioners

licensed out-of-state and other VHPs may be permitted to provide medical countermeasures pursuant to limited waivers.

V. Liability Issues for Individuals, Volunteers, and Entities

Civil Liability Concepts and Risks. Civil liability can result from actions, or inactions, that fall below specified duties owed and which subsequently cause injuries or deaths. Health care practitioners must adhere to a duty owed to their patients established by the standard of care. Generally, this standard requires that a physician provide the same level of care as a "reasonable physician" in like circumstances. During an emergency, this standard may shift to a "crisis standard of care," as recommended by the Institute of Medicine, to allow for implementation of medical triage or to facilitate the delivery of care when resources are scarce.

Liability Protections for Individuals and Entities. Various liability protections for individuals and entities may apply at the state and federal level. These protections include: 1) governmental (sovereign) immunity; 2) Good Samaritan Laws in all 50 states; 3) Volunteer Protection Acts; 4) immunity provisions pursuant to the PREP Act or other emergency laws; and 5) entity liability protections.

Workers Compensation. Workers compensation generally requires that if an employee is injured at work, the employer is liable for the injury regardless of who is at fault. Application of workers compensation laws to VHPs in emergencies is dependent on whether: 1) VHPs are considered "employees" for workers compensation purposes; 2) the "home" institution employing the VHP extends its workers compensation protections while the individual volunteers at a "host" institution; 3) the VHPs' actions are within the scope of duty; and 4) the VHP was injured as a result of emergency response efforts.

Training Summary:
Public Health and the Law

Acknowledgments

This curriculum was developed by the *National Association of County & City Health Officials (NACCHO)* and the Network for Public Health Law.

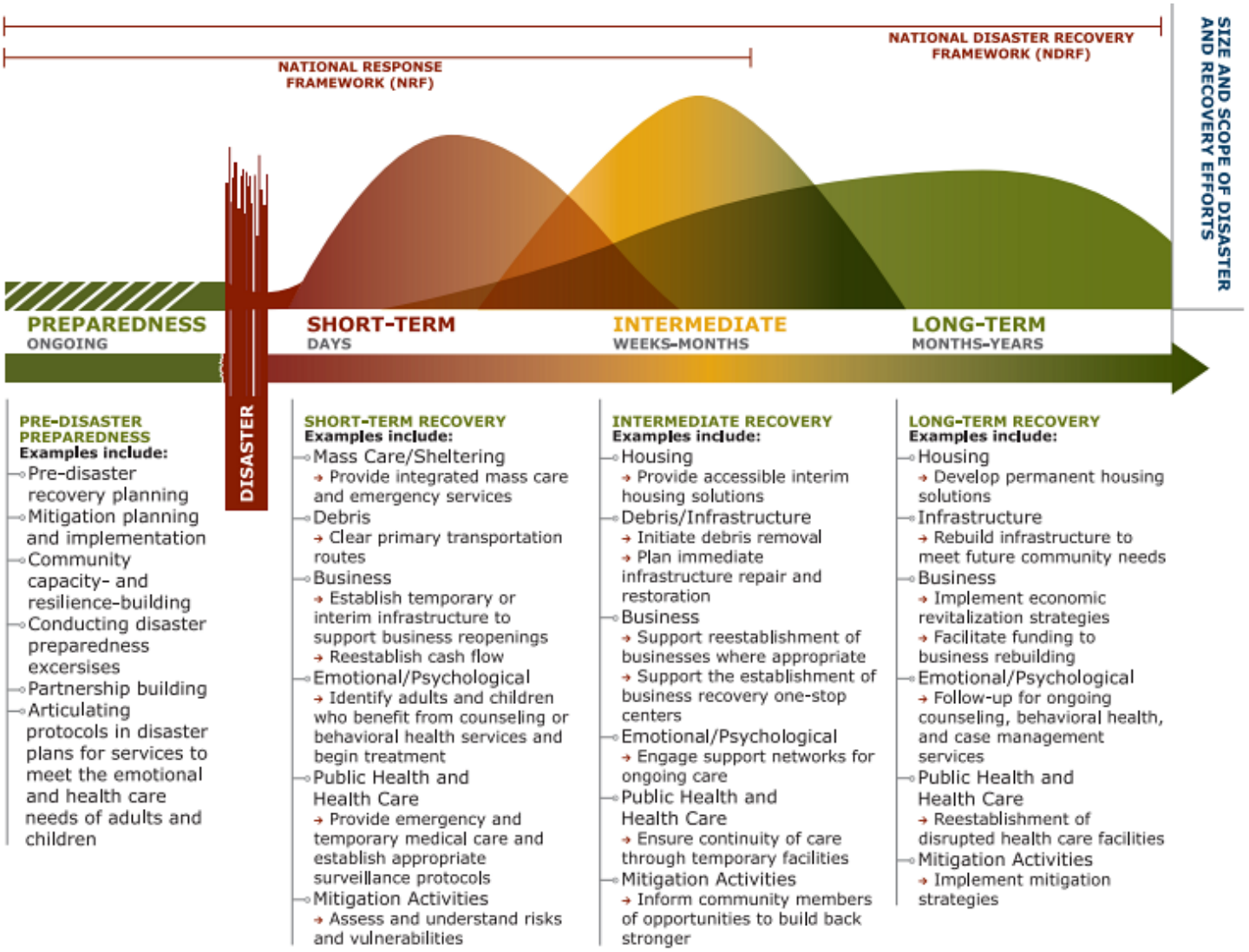
Training Summary:

Short and Long-term Considerations for Recovery

I. Background

Recovery from public health emergencies and disasters is a multi-phase process. It includes short-term (days), intermediate-term (weeks to months), and long-term (months to years). Each of these phases overlap each other, and are integral in sustained recovery progress.

II. Reviewing the model



v

Training Summary:

Short and Long-term Considerations for Recovery

Short-term recovery:

- It is important to provide emergency and temporary medical care, and establish appropriate surveillance protocols. Key mitigation activities include assessing, and understanding risks and vulnerabilities,

Intermediate-term:

- It is important to ensure continuity of care through temporary facilities. Key mitigation activities include: informing community members of opportunities to build back stronger

Long-term:

- It is important to reestablish disrupted healthcare facilities, and continue to implement mitigation strategies.

III. Public Health Considerations in Disaster Recovery

Psychosocial. Socioeconomically disadvantaged populations can be particularly vulnerable. This was the case in Hurricane Katrina and Hurricane Sandy. Clinical examples include, depression, anxiety, and PTSD. Psychological First Aid (PFA, more information in PFA Training Summary) is a great tool for early recognition of disaster mental health impacts.

Physical. Population-health resource challenges. An example is community-level dialysis services for those with chronic underlying renal disease, in disaster recovery contexts. Also important to mitigate spread of disease caused by failing infrastructure.

Public health and healthcare responders are also vulnerable to psychosocial and physical recovery phase impacts following public health emergencies and disasters.

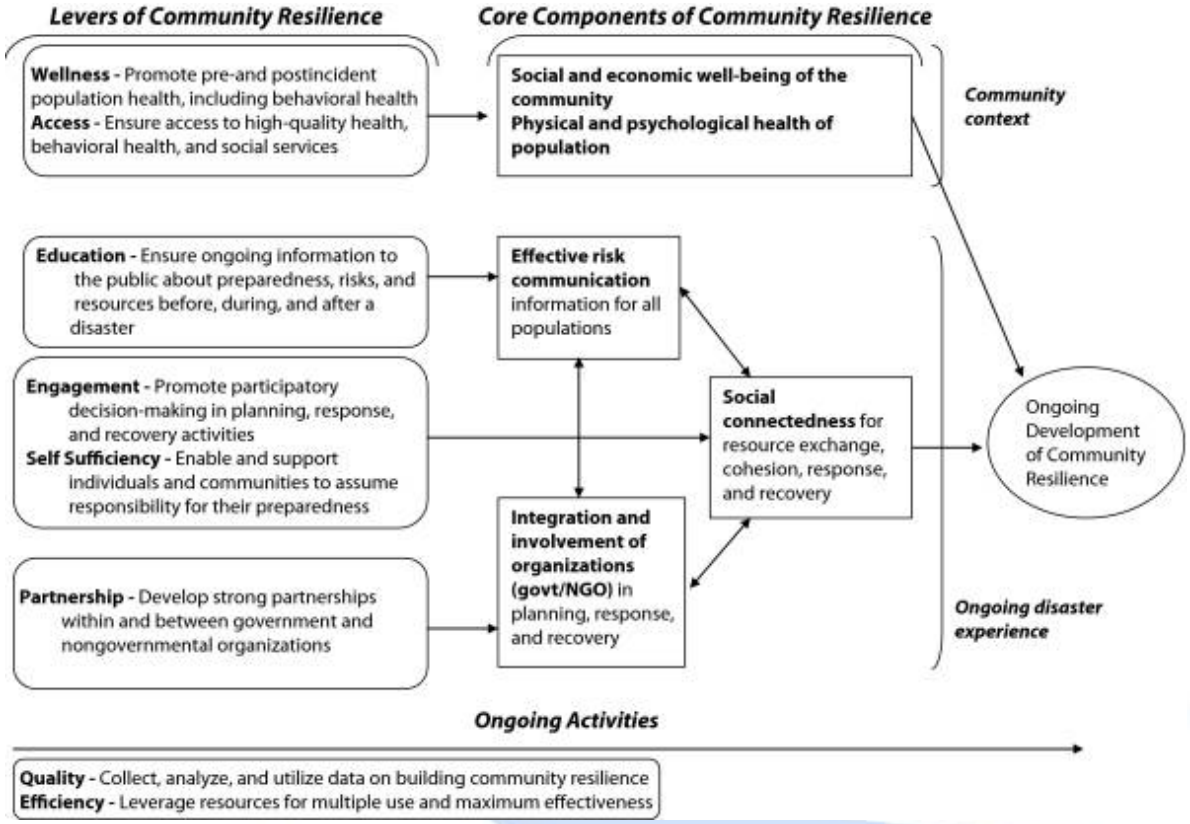
IV. Evidence informed frameworks for recovery and community resilience

The framework on the following page requires utilizing levers of resilience, which include wellness, education, engagement, self-sufficiency, and partnerships. These are all necessary in considerations in order to optimize core components of community resilience. Core components include social and economic well-being, physical, and psychological health. To support these measures, it is also important to include governmental and non-governmental resources.

No two communities are the same. It's important to practice cultural awareness (language, ethnicity, geography, customs) when implementing response and recovery plans.

Training Summary:

Short and Long-term Considerations for Recovery



Other ways to build resiliency.

Disaster Recovery Resilience-Building

There are several practical strategic approaches to enhancing disaster recovery resilience-building efforts. Consider each of the following:

- Leverage existing relationships and networks (e.g., coalitions, collaboratives)
- Identify opportunities for alignment between ongoing public health improvement processes and recovery planning.
- Educate on why health is integral to recovery and how recovery activities impact health outcomes.
- Use and expand health technology infrastructure to facilitate data sharing, evidence-based decision making, and evaluation of progress toward a healthy community.

Acknowledgments

The information in this summary was provided by the *National Center for Disaster Medicine and Public Health.*