MRC CORE COMPETENCIES TRAINING

(A hands-on resource manual for MRC volunteers and coordinators)

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The Medical Reserve Corps is part of the Office of the U.S. Surgeon General. Medical Reserve Corps volunteers play a vitally important role in the preparation, mitigation, recovery, and follow-up in an emergency situation. In addition, MRC volunteers can assist their communities in other ongoing public health initiatives as the need arises.

Volunteers with personal emergency plans for themselves, their families, and their workplace, combined with ongoing comprehensive training are important to the effectiveness and satisfaction of every MRC volunteer. Grateful appreciation is extended to each volunteer who has committed their time and expertise to the Medical Reserve Corps.

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TABLE OF CONTENTS

MRC CORE COMPETENCIES TRAINING HANDBOOK

I. Introduction to the MRC Handbook

"MRC Core Competencies Training"

This handbook is a resource manual for the Florida Medical Reserve Corps (MRC) Core Competencies Training Program (available online or on DVD). This training program and handbook provides MRC volunteers with an orientation to the national MRC Core Competencies mandated by the U.S Surgeon General.

MRC Core Competencies — The competencies listed at the beginning of each module detail the competencies that are contained in the course. This content demonstrates the level of expertise necessary to function as a volunteer in times of public emergencies in the State of Florida.

Activities and Discussion Questions — Throughout the six modules are activities and discussion questions for each MRC unit coordinator to use with their volunteers.

Textboxes — Additionally, textboxes and references are located within the guide to highlight special areas and to assist the volunteers on better understanding the topic areas and the material presented.

Bibliography — The references at the end of each section provide the participants with resources they can use to obtain the latest revisions and information available on the topics included in each module.

Assessment — An assessment of the course material is provided within the online course or following the viewing of the DVD (paper copies provided by each MRC Unit Coordinator). The questions measure the understanding of the competencies listed at the beginning of each module and the outcome of the training that has been provided online or using the DVD. It will be important for all MRC volunteers to complete the pre and post-assessments, the *IS-100.b Incident Command System* and *IS-700.a National Incident Management*

System in order to fulfill the State's basic requirements for all MRC volunteers.

A) MRC Introduction:

Medical Reserve Corps volunteers are an important resource in our public health system, and developing partnerships between the MRC and law enforcement, public health, and public safety agencies at all levels of government is an important step for every community to be better able to respond to emergencies. MRC units are community-based and function as a way to locally organize and utilize volunteers who want to donate their time and expertise to prepare for and respond to emergencies and promote healthy living throughout the year. MRC volunteers supplement existing emergency and public health resources.

In April 2007, the Office of the U.S. Surgeon General presented the Medical Reserve Corps (MRC) Core Competencies Matrix as a guide for training MRC volunteers at the local level. MRC Core Competencies represent the baseline of knowledge and skills that all MRC volunteers should have, regardless of their role within the MRC unit. Utilizing the competencies makes interoperations between MRC units more efficient by providing a "common language" in which units can communicate their volunteers' capacities to each other and to partner organizations.

- Based on this recommendation and the need for a comprehensive and customized training that could fulfill this important task, the MRC units of Broward, Miami-Dade, and Palm Beach counties in partnership with the Institute for Disaster and Emergency Preparedness (IDEP) at NOVA Southeastern University, College of Osteopathic Medicine developed the MRC Core Competencies Training.

- MRC volunteers include medical and public health professionals such as physicians, nurses, pharmacists, dentists, veterinarians, and epidemiologists. Many community members—interpreters, chaplains, office workers, legal advisors, and others—can fill key support positions.

For more information about the MRC, please refer to:

http://www.medicalreservecorps.gov/QuestionsAnswers

http://naccho.org/topics/emergency/mrc/corecompetencies.cfm

a. Mission of the Medical Reserve Corps:

The mission of the Medical Reserve Corps (MRC) is to improve the health and safety of communities across the country by organizing and utilizing public health, medical and other volunteers. The MRC Core Competency Training program presented in this handbook is designed to meet the national MRC core competencies and the State Guidelines for the Florida Medical Reserve Corps Network, as developed in October 2007.

The Office of the U.S. Surgeon General provides MRC units with specific areas to target that strengthen the public health infrastructure of their communities. The overarching goal of the MRC is to improve health literacy and to work towards **increasing disease prevention, eliminating health disparities, and improving public health preparedness.**

MRC volunteers can choose to support communities in need nationwide. When the U.S. southeast was battered by hurricanes, MRC volunteers in the affected areas and beyond helped communities by filling in at local hospitals, assisting their neighbors at local shelters, and providing first aid to those injured by the storms.

b. Objectives of the Training:

Module 1: Health, Safety, and Personal Preparedness
Objectives:

- Understand the role of public health and who has authority to activate a unit
- Describe the procedures and the steps necessary for the MRC member to protect health, safety, and overall well-being of themselves, their families, the team, and the community
- Identify and prepare a personal and family preparedness plan

Module 2: Vulnerable and Hard to Reach Populations
Objectives:

- Identify vulnerable and special needs populations and the unique measures necessary to be able to assist these groups with health services in the event of a public health emergency
- Assist individuals with special needs during the recovery phase of a disaster

Module 3: Psychological First Aid
Objectives:

- Identify the range of anticipated stress reactions experienced by disaster survivors, MRC members, responders and others in the early aftermath of a disaster
- Identify when, how and where to refer disaster survivors, MRC team members, responders and others for additional mental health support and care
- Identify and offer psychological first aid to disaster survivors, MRC team members, and others

Module 4: Incident and Unified Command System
Objectives:

- Understand the role of the Public Information Officer (PIO) or other authorized agent
- Understand an individual MRC member's role and responsibilities in communicating with response partners, media, general public and others
- Understand legislative requirements related to the sharing of protected information (HIPAA, etc.)

Module 5: Mass Prophylaxis Local Point of Dispensing (POD) Training
Objectives:

- Identify the roles and responsibilities of POD managers and staff
- Identify and address issues affecting POD set-up
- List the activities and resources needed to open a POD
- Identify and address issues affecting the operation of a POD
- Identify and address issues affecting the closing of a POD

Module 6: Roles and Responsibilities of Individual Volunteers
Objectives:

- Understand an individual MRC member's role and responsibilities
- Identify personal and professional liability
- List the MRC's guidelines for activation, reporting, assignment and deactivation
- Identify the limitations of volunteer's individual skills while serving in the MRC

B) MRC Core Competencies:

The office of the U.S. Surgeon General has identified the following core competencies for all MRC volunteers:

1. Describe the procedure and steps necessary for the MRC member to protect the health, safety, and overall well-being of themselves, their families, the team, and the community.
2. Document that the MRC member has a personal and family preparedness plan in place.
3. Describe the chain of command (e.g., National Incident Management System – NIMS and Incident Command System - ICS), the integration of the MRC, and its application to a given incident.
4. Describe the role of the local MRC unit in public health and/or emergency response and its application to a given incident.
5. Describe the MRC member's communication role(s) and processes with response partners, media, general public, and others.
6. Describe the impact of an event on the mental health of the MRC member, responders, and others.
7. Demonstrate the MRC member's ability to follow procedures for assignment, activation, reporting, and deactivation.
8. Identify limits to own skills, knowledge, and abilities as they pertain to MRC.

See the MRC Core Competency Fact Sheet for more information:

http://www.medicalreservecorps.gov/File/MRC%20TRAIN/Core%20Competency%20Resources/MRC_Core_Competency_Fact_Sheet.pdf

C) Introduction to the MRC Core Competency Training

A major disaster can happen at anytime and at any place in the world. No matter where we are, disasters natural or manmade are an everyday part of our global society. It is not a question of *if* a disaster will occur, but rather, *when and where* it will occur!

Disasters are defined as emergencies of such severity and magnitude that the resultant combination of deaths, injuries, illness, and property damage cannot be effectively managed with routine procedures or resources. Disasters disrupt hundreds of thousands of lives every year. Each disaster has lasting effects: people are seriously injured, some are killed, and property damage runs into the billions of dollars.

Disasters can be natural or man-made. It is important to determine the vulnerability of your region and to identify the types of disasters with which you may be involved. We live in a different world than we did before September 11, 2001. We are more aware of our vulnerabilities, more appreciative of our freedoms, and more understanding of our personal responsibility for the safety of our families, our neighbors and our nation.

In the event of a disaster of catastrophic proportions, such as an influenza pandemic or the detonation of improvised nuclear devices, the resulting tens of thousands of victims will likely overwhelm the resources of a community's health care system. The need for volunteers is then obvious, but during a large-scale medical or public health disaster, those volunteers involved must have a well-grounded understanding of the public health consequences of disaster and human response to disaster on the part of both victims and responders. Finally, volunteers must be trained and credentialed to respond to such events. Volunteers are often the link to survival in a major disaster.

The Medical Reserve Corps (MRC) is a federally sponsored program of the Office of the U.S. Surgeon General. The MRC represents medical, public health and support personnel that volunteer their time, skills and expertise during local emergencies. The organization is a partner program of Citizen Corps, a national network of volunteers dedicated to ensuring hometown security. Community-based groups of volunteers make up an MRC unit that include medical and public health professionals such as physicians, nurses, pharmacists, dentists, veterinarians, and epidemiologists. Other community members such as interpreters, chaplains, office workers, and legal advisors can fill other vital

support positions. MRC volunteers do not need to have medical or public health backgrounds, as there are numerous job roles to fill in an emergency.

The MRC can also be activated for non-emergency public health services such as immunization or to support the priorities of the U.S. Surgeon General which include:

1) **Promoting disease prevention**
2) **Improving health literacy**
3) **Eliminating health disparities, and**
4) **Enhancing overall public health preparedness**

MRC volunteers assist local hospitals and health departments with surge personnel needs, participate in mass prophylaxis and vaccination exercises, community disaster drills, and train with local emergency response partners.

MRC CORE COMPETENCIES MATRIX

The MRC Core Competencies Matrix represents the baseline level of knowledge and skills that all MRC volunteers should have, regardless of their roles within the MRC unit. Utilizing the competencies makes interoperations between MRC units more efficient by providing a "common language" in which units can communicate their volunteers' capacities to each other and to partner organizations. Furthermore, the Core Competencies describe what the role of an MRC volunteer is and define what communities can expect from them.

The MRC Core Competencies Training included in the online training program or DVD is based on the MRC Core Competencies Matrix. This training handbook is a compliment to the online training programs and DVD. As a new MRC volunteer member or as a seasoned one, this training should be used as a tool to accrue or refresh the basic MRC Core Competencies.

The MRC Core Competencies training has been developed with efficiency and effectiveness in mind. Within the six training modules, there are three overarching and interrelated domains:

1) **Health Safety, & Personal Preparedness**
2) **Roles and Responsibilities of Individual Volunteers**
3) **Public Health Activities and Incident Management**

The first domain is *Health Safety, & Personal Preparedness*, which includes principles of personal, family preparedness, and work-life. Psychological First Aid is also part of this first domain. As an MRC volunteer it is important for you to identify the need for emotional care and comfort to yourself, disaster survivors

and others in the early aftermath of disaster. Also included in this domain is a training module focused on preparedness for vulnerable populations.

The second domain is *Roles & Responsibilities of Individual Volunteers*. This includes the broad roles and responsibilities that pertain to MRC volunteers during assignment, activation, reporting, and deactivation, so you will be able to perform your roles and responsibilities in the position you are assigned. Communication during an emergency is vital; MRC volunteers need to know the roles and responsibilities in the emergency communication process and the role of the Public Information Officer (PIO) and other authorized agents in the emergency planning and response processes.

The third domain, entitled *Public Health Activities and Incident Management,* includes an introduction to the Emergency Management System. An overview of the *IS-100.b Introduction to the Incident Command System (ICS)* and the *IS-700.a Introduction to the National Incident Management System (NIMS)* are discussed. All MRC volunteers are required to complete the online IS-100.a and IS-700.a. These courses available at:

References:

http://training.fema.gov/EMIweb/IS/IS100A.asp

http://training.fema.gov/EMIweb/IS/IS700a.asp

The journey of the MRC volunteer is a challenging and rewarding one. Thank you for your service!

II. MODULE ONE: HEALTH, SAFETY, AND PERSONAL PREPAREDNESS

MRC Core Competency # 1 Describe the procedures and steps necessary for the MRC member to protect the health, safety and overall well-being of themselves, their family, their team, and the community.
MRC Core Competency # 2 Document that the MRC member has a personal and family preparedness plan in place.

PERSONAL AND FAMILY SAFETY

Disaster can strike quickly and without warning. Therefore, it is imperative to be prepared. **As an MRC volunteer, it is critically important to have your personal, family and professional emergency plans written down and in place. It is also important that you review these plans, at a minimum, on an annual basis. You also need to put together an emergency pack that you can take with you at a moment's notice.** This module provides you with the components of family, workplace and community emergency planning. "The efforts begin with a plan!"

PERSONAL RESOURCES

As an MRC member, you must protect yourself, your family and the community in case of a public emergency. You need also to recognize the emotional impact that emergency situations can have on you as an MRC responder.

Activities:

1. Assess your readiness and availability before your deployment and verify that your family and employer support this decision.
2. Develop a written family emergency plan and share it with family in your immediate area and family or friends outside your immediate area.

When deciding if you are ready to become a responder, you may want to conduct a PERSONAL AND FAMILY INVENTORY and prepare a family plan that will enable you to respond within 24-48 hours of being contacted and last for up to two weeks in duration. This most likely will be in a local deployment.

Personal Inventory

- Are you ready to work in a non-traditional setting?
- Are you emotionally prepared?
- Are you ready to work in unpredictable environments and events?
- Are you flexible?
- Are you willing to put yourself at risk?
- Can you work with culturally diverse populations?
- Are you physically and mentally healthy?
- Have you had a recent significant life change that might impact your ability to respond?

Family Inventory

- Is your family prepared for your absence?
- Do you have a support system in place while you are away?
- Do you have unresolved family issues that will distract you?

Remember to:

- Talk to your children's schools and to your employer about emergency plans.

- Stay together in an emergency. Tell your family to stay together.
- Make pet arrangements ahead of time
- Choose several destinations in different directions as meeting points, and practice meeting there so that you have options in a real emergency.

Planning for family communication is extremely important. Family readiness also includes discussions with your neighbors, your immediate family in the area, and those living out of state.

Activities:

1. Discuss your plan at home.
2. Practice using your plan at home in the event of a natural or man made disaster.
3. Make a list of the important items to include in your emergency pack?
4. Do you have a list of all you and your family's medications and their dosages available?
5. Conduct a vulnerability assessment of the types of disasters that could occur in the area in which you live.

Personal Emergency Communication

- Where are you planning to go?
- Do all family members carry important phone numbers and contacts in writing? (Remember that cell phones may not be working, so stored phone numbers may not be available). Remember also to include out-of-town contacts.
- Who else outside your immediate family should know how to contact you?

Activities:

1. Develop a calling card list with important phone numbers, addresses, and emails.
2. Give each member of your family and those on the list, especially out of state family members and contacts, a copy of the list.
3. Put all information on back up flash drives and give to members of your family.

Resources for a Personal Plan:

http://www.ready.gov/

http://www.fema.gov/areyouready/

EMPLOYMENT ISSUES

- Does your employer know that you are an MRC volunteer?
- Do you have employer support for your activation during MRC deployment?
- Will you be allowed 'leave time' with or without pay?
- Can you respond within 24-48 hours?
- Do you have support of co-workers?
- How will your absence affect your clients or patients?

It is important to establish parameters of your leave time policies at work before becoming an MRC volunteer.

YOUR EMERGENCY PACK

Have an evacuation kit with adequate emergency supplies ready at all times. The first step in preparing for emergency situations is to ensure that the basics of survival are met: fresh water, food, clean air, warmth, and essential medications.

- Don't presume that a disaster will be short-term
- Pack essentials first, then consider comfort items
- Plan for more supplies than you think you may need
- Inspect / renew your supplies each spring and fall

The MRC emergency pack is essential for your home and your car and should include.

- Two (2) kits: one to use if you shelter in place and the other to take with you if you need to evacuate.
- Cell phone and GPS with chargers
- Review and update your car emergency kit, which should include a basic first aid kit as well as:

- Vehicle registration, maps, spare tire that is full of air, jumper cables, flashlight with new batteries, all tools including jack you can operate to change a tire or perform other basic auto tasks, duct tape, and emergency flares.

You need to set aside emergency 'cash' in your emergency packs (a minimum of $300 for each and every person; ideally $500). Remember, banks may be closed. If ATM machines are not working or destroyed in a fire or hurricane, credit or debit cards are of little use.

Include an emergency pack for your pet(s). It is important to have a carrier for each animal labeled with your contact information in the event of an evacuation of you and your family. Always have extra food and water on hand for each pet. See the Humane Society website for more information.

Resources for Pet Preparedness:

http://www.hsus.org

"Vulnerable Populations and Poor and Chronic Disease" include the following:

- Non-English speaking residents
- Rural populations
- Elderly, especially the frail elderly
- Children and infants
- Pregnant or lactating women
- Persons who abuse substances
- Homeless individuals
- Migrant and seasonal farm workers
- Seasonal residents and tourists/visitors

"Individuals with Special Needs" include:

- Cognitive impairments
- Mental illness
- Developmental delays
- Physical disabilities
- Sensory impairments

Vulnerability is increased in those with low income and those with chronic diseases such as diabetes and heart disease. Preparedness planning for vulnerable populations and special needs individuals takes more time.

Activities:

1. List and discuss the needs and challenges for persons with special needs in an emergency.
2. How would an emergency pack differ for a person with special needs?
3. Discuss this in terms of each vulnerable group.

BUSINESS PLAN

Does your business have a plan and a command structure? In the plan, you should consider the following questions:

- Do all of your employees stay or leave?
- Do you have an emergency supply kit?
- Are your services and those of your business critical to disaster response?

Designate an out-of-town phone number where employees can leave an "I'm Okay" message in a catastrophic disaster. It is also important for you as an MRC volunteer to communicate fully to your employer and employees your roles and responsibilities in a disaster as part of an MRC team.

Personal Safety Lessons Learned AFTER Hurricane Katrina

- Public is not prepared, even if repeatedly educated and warned
- Real disasters may be worse than expected
- Response (support) is NOT right around the corner…think 72+ hours
- Concerns over family health and safety affect responders (preplanning is key)
- Communications and logistics are critical
- Impact affects healthcare, infrastructure, and economics
- Computer based information needs to be backed up out of state
- Taking care of families is an extension of caring for your employees

As an MRC volunteer, you are accepting a leadership role in assisting your fellow citizens!

Disaster Preparedness is a continuing exercise for every one. A responsible citizen has to prepare themselves, their families, and their homes for disasters. As an MRC volunteer, you should become familiar with local, state, and national emergency plans and emergency operations systems. You are now part of a network of volunteers who can assist in an emergency working collaboratively in a team to make a real difference.

Activities:

1. Discuss why persons may be complacent in developing personal, family, or business plans.
2. How can you as an MRC volunteer help to educate others about personal emergency preparedness?
3. What innovative ways can you communicate a "preparedness culture" to those around you?

One of the Core Competencies is to complete a personal emergency plan that will include your family and your workplace plans. The websites below can serve as valuable resources to you as you complete your plan:

http://www.floridadisaster.org/

http://www.ready.gov/

http://www.safezonellc.com/library.html

Refer to the Appendix – Section (b) for All-Hazards Preparedness: Emergency Plans for Families developed by the State of Florida.

TAKING CARE OF YOURSELF

Care for yourself so you can care for others! While you are deployed to assist with disaster services, please keep your health and well being in mind. Your health and safety is just as important as those you are trying to help. You can only be of assistance to others if you are strong and healthy. Listed below are some helpful guides for you as an individual MRC member.

1. Be sure your team section knows where you are going, and what time you will return.

2. Make sure you stay hydrated. It is recommended that you drink ½ oz. of water per pound of body weight each day. This means a 150 lb. person should drink approximately 75 oz. of water each day. Make sure the water you drink is safe. Either drink bottled water or water that has been appropriately treated with (treating clear/cloudy water $^{1}/_{8}$ teaspoon per 1 gallon; treating cloudy, very cold, or surface water ¼ teaspoon per 1 gallon) Clorox or Purex.

3. Make sure you eat regularly to keep your energy level up. Avoid excessive intake of sweets, caffeine, or alcohol. Small more frequent meals and snacks are recommended.

4. Continue taking your regular medications at the normal times each day. In stressful situations, it is easy to forget and suffer adverse effects.

5. Try to incorporate short periods of mild exercise into your day. This will help relieve stress increase energy.

6. Communicate your needs to your co-workers. Schedule a break or rest period before you become seriously fatigued.

7. If possible, communicate with family members or friends for support.

8. Share your feelings and frustrations with others before they cause physical or emotional symptoms and inhibit your ability to perform your job.

9. Recognize signs of stress, inability to focus, sleep disturbances, physical symptoms (headache, stomach ache), and physical exhaustion, and discuss them with your team leader.

10. Use stress management techniques, e.g., visualization, deep breathing, taking a break, stretching, or talking with a co-worker, to diffuse stress before is becomes debilitating.

Activities:

1. What are the individual challenges that you may have during deployment?
2. Will it be difficult for you to be deployed if you know that you may not be able to speak to your family for several days?

PRE – DEPLOYMENT CRITERIA

The following pre-deployment criteria and pre-deployment considerations are important guides for the MRC volunteer to review carefully as part of their overall personal preparedness.

During the period following a disaster, you may be asked to volunteer for on-site disaster relief duties. Although everyone wants to do their part to assist, you must evaluate your situation and determine where you can be the most useful to the relief process. Deploying to an area following a disaster where you will encounter limited resources and certain physical hardships may not be appropriate for everyone.

General	Yes	No	N/A
I have made safe, dependable arrangements for my children or adult dependents.			
I have made safe, dependable arrangements for the care of my pets.			
I can easily extend these arrangements for my dependents and/or pets if I am unable to return when expected.			
I have a valid Florida Driver's License.			
I can operate vehicles other than a car or pickup truck. If yes, list all types:			
I have canceled my mail, paper, and paid my bills.			

Medical	Yes	No	N/A
I have had unusual stressors in the past year that may be revisited by stress during this deployment, e.g. death in family, divorce.			

Medical	Yes	No	N/A
I am on prescription medications that would impact my ability to deploy, such as strict administration times, causing drowsiness, etc. If yes, list:			
I am on medications that require refrigeration. If yes, list:			
I have a chronic medical condition that may exacerbate due to deployment conditions; and that may also require electrical equipment. If yes, list condition, and possible electrical equipment needed:			
I need American with Disabilities Act (ADA) accommodations.			
I have dietary restrictions. If yes, explain:			
I have had surgery in the past six months. If yes, explain:			
I have difficulty bending or stooping.			
I can ride in a vehicle for long periods on time.			
I have allergies to certain medications, foods, insects, etc. If yes, list:			
I have difficulty with night vision.			
I am colorblind.			

Work	Yes	No	N/A
I have completed IS-100.a Incident Command System.			
I have completed IS-700.a National Incident Management System.			
I can work in a non air-conditioned environment for more than four hours at a time.			
I can stand for long periods of time.			
I can work in areas with low lighting.			
I can lift over 20 pounds.			
I can work in highly chaotic environments for long periods of time.			

Personal	Yes	No	N/A
I can go several days without a shower.			
I do not mind sharing sleeping quarters with other relief workers, male and female.			
I like camping types of activities.			
I do not have any religious restrictions on bathing or sleeping arrangements.			

_____ _____

Volunteer Signature Date

_____ _____

Supervisor Signature Date

PERSONAL DEPLOYMENT EQUIPMENT CHECKLIST

You are encouraged to have the following equipment available:

• Sufficient amount of cash for food for number of days deployed.
• Drinking water for 48 hours (1 gallon per day per person)
• Snacks and light food
• Multiple channel walkie-talkie with extra batteries, cell phone with a back up battery
• Eight changes of personal clothing **appropriate for weather conditions** (heat and humidity) or location of work (in community, dealing with large debris, etc). It may be necessary to hand wash some of your clothing.
• Two pairs of boots - appropriate foot wear, as nails, debris, mud, and water will be present. Inexpensive shower shoes, plenty of dry socks and undergarments.
• Jacket/wet weather gear/poncho
• Work gloves and hat
• Personal hygiene products: toilet paper, **sunscreen**, shampoo, shaving kit, deodorant, toothbrush, toothpaste, floss, foot powder, tissues, lip balm**,** wet wipes (this may be your bath) alcohol based hand sanitizer, feminine hygiene products
• Towel and wash cloth
• Extra eyeglasses, prescription and over the counter medications for 7 to 9 days (in original prescription bottles), allergy medication, eye drops, aspirin, etc.
• Sunglasses

• Sleeping bag, pillow, bedding, and air mattress
• Copy of professional license, drivers license, DOH identification
• **Insect repellent with DEET**
• Plastic plate and utensils
• Manual can opener, Swiss army knife, multi-purpose tool, bandage scissors
• Fanny Pack, backpack-- **no purses**
• Watch, whistle
• Personal flashlight / headlamp and extra batteries
• Two large trash bags for dirty clothing and to keep sleeping gear and luggage dry.
• Stethoscope and drug reference book if available
• Books, magazines, cards, crossword puzzles, games, leisure activities
• Re-sealable plastic storage bags
• Duffel bag / soft carry-on bag, waterproofed
• Ear plugs and eye mask
• Camphor-based ointment or lotion – will help mask offensive odors

X. MODULE TWO: VULNERABLE AND SPECIAL NEEDS POPULATIONS

MRC Core Competency # 1 Describe the procedures and steps necessary for the MRC member to protect the health, safety and overall well-being of themselves, their family, their team, and the community.
MRC Core Competency # 8 Identify limits to own skills, knowledge, and abilities as they pertain to MRC.

Did You Know?

- Over 40 million Americans are 65 years of age and older. Of these, 1.6 million reside in nursing homes.
- 55 million Americans have at least one sensory disability.
- 31.7 million adults have difficulty functioning physically.
- There are over 72 million children in the United States.
- More than 600,000 men, women, and children are homeless every night in this country, and the number of homeless families increases each year.
- More than 20 million persons visit the United States from overseas each year.
- Nationally, 19 percent of persons speak a language other than English at home.
- Over 3 million migrant farm workers are employed in the United States; almost 80 percent are from Mexico.

*(**Sources:** CDC, National Center for Health Statistics • U.S. Census Bureau, 2001 • U.S. Department of Health and Human Services • U.S. Department of Commerce, Office of Travel and Tourism Industries • New England Journal of Medicine, July 20, 2006 • U.S. Department of Agriculture)*

Vulnerable and *special needs* populations represent major targets for public health in overall efforts related to emergency preparedness, response, and recovery. For vulnerable population groups, communication and service provisions are among the greatest challenges. A September 2004 report developed for the Florida Department of Health by Nova Southeastern University-College of Osteopathic Medicine (NSU-COM) faculty members Leonard Levy, D.P.M., M.P.H. and Jean Malecki, M.D., M.P.H., identified the need for health professionals, in the time of an emergency, to be able to know:

- How to properly recognize and treat special needs groups
- How to work within a team
- How to alert the system to the need for appropriate assistance

In 2005, the National Council on Disability published a paper calling for "immediate changes in emergency planning for people with disabilities." The paper indicated that the legitimate concerns of people with disabilities are often

overlooked or swept aside in emergency situations. Major concerns include accessibility of emergency information in the evacuation plans for high-rise buildings (a very real concern in Florida) and responding to the worries and unique needs of people with disabilities in all planning, preparedness, response, recovery, and mitigation activities. In Florida, these individuals account for approximately 65% percent of the state's total population.

Vulnerable or hard-to-reach populations are identified as the following:

- Non-English speaking residents
- Rural populations
- Frail elderly
- Children
- Pregnant or lactating women
- Persons who abuse substances
- Homeless individuals
- Migrant and seasonal farm workers
- Seasonal residents and tourists/visitors
- Individuals with low income*
- Persons with chronic disease*

* The vulnerabilities can co-exist with others and increase vulnerability overall.

Individuals with special needs include the following:

- Cognitive impairments
- Mental illness
- Developmental delays
- Physical handicaps
- Sensory impairments

In working with special needs populations, one needs to consider these important questions:

- What resources can be used to communicate information to non-English speaking individuals?
- What factors make children more susceptible to disaster?
- How can we better serve the elderly in disaster planning?
- Are there enough special needs shelters in the area?

Activities:

1. Explore the approximate number of vulnerable and special population groups in your MRC unit area?
2. In your individual neighborhood, identify those individuals with special needs and contact them to inquire as to their preparedness plans. How could you assist them?
3. Discuss the challenges of vulnerable and special population groups at your MRC unit meeting.

Activity:

Each MRC member or group of members in a unit can focus on studying the emergency preparedness issues of one specific vulnerable/special needs group and then present a program to the MRC unit.

NON-ENGLISH SPEAKERS

The number of those who speak a language other than English at home is growing in the U.S. English is a second language for one-fourth of all school-aged children in the nation's schools. Non-English speakers have special vulnerabilities related not only to communication challenges and language barriers, but also to cultural differences. It is imperative to address the needs of this group of individuals who do not speak/understand English in order to successfully plan and respond to an all-hazards event. Some of the specific vulnerabilities of such persons at the time of an all-hazards incident include the following:

CHALLENGES

- May have difficulty communicating with public officials, medical personnel, and other service providers before, during, and after an all-hazards event
- May have difficulty understanding the directions needed for successful outcomes during a disaster
- May have difficulty making their own needs known to key personnel directing the disaster response
- May not understand appropriate information provided by media such as magazines, newspapers, and TV
- May lack informational brochures in appropriate languages

In working with non-English speakers, the following should be considered:

- Appropriate translations of materials
- Accurate verbal communication
- Multilingual translators at key locations before and after a disaster
- Broadcast information (radio, TV) in different languages

Translators and persons who speak other languages are valuable MRC volunteers. It is important to recognize and respect different cultural norms. Certain groups may prefer to receive information by radio or at neighborhood stores, while others may read newspapers in their native language.

Individuals who can speak one or more additional languages or are proficient in sign language are valuable resources within an MRC unit and can serve as interpreters when needed.

Activities:

1. Identify the number of individuals in the MRC unit who speak another language.
2. Discuss the language needs of your area at an MRC meeting and make available lists of those MRC volunteers who are multi-lingual.

RURAL POPULATIONS

Rural populations can sometimes be isolated. A disaster can increase this isolation and delay assistance in the recovery.

CHALLENGES

- A rural area is defined as an area with a population density of less than 100 individuals per square mile.
- Rural communities are generally small and self-sustaining.
- Due to the nature of rural communities and their isolation, they may be overlooked by local, county, regional, state, and federal governments during times of crisis.

It is therefore important that the challenges of these communities are recognized to insure their welfare during an all-hazards event.

Rural groups may experience:

- Housing stress (lack modern amenities, poor quality housing, etc.)
- Reduced access to resources and supplies
- Insufficient policing, fire rescue, and healthcare services
- Reduced access to information and technology
- Persistent poverty*
- Insufficient resources to evacuate if necessary*
- Lack of education *
- Poor transportation issues which could lead to isolation during disasters such as floods and mudslides

*These challenges can also be observed in large underserved urban areas.

Some Basic Responses to Assist Rural Populations

Identify how best to notify residents of an anticipated all-hazards event. Provide preparedness and response information critical to a successful outcome to such an event. This might include:

- Radio, television, and/or other immediately accessible forms of media
- A door-to-door effort through local religious, volunteer, and civic groups (e.g. police and fire rescue departments).

Inform the residents about the available services, where to shelter, and how to plan for their own needs. Provide easily accessible transportation with identification of safe evacuation routes should evacuation be necessary. Design an action plan well in advance to avoid any access or other issues in the last minute.

Remember that urban underserved groups who may not speak English often have many of the same challenges as do rural populations.

Activities:

1. Identify rural or urban inner city groups that should be targeted by your MRC unit for preparedness education, response and recovery.
2. Are there other vulnerabilities within the rural or urban groups that you can also identify?
3. Discuss how your MRC can address these issues.

ELDERLY, INCLUDING FRAIL ELDERLY

Older adults are individuals 65 years of age and over, with a growing majority over 85 years old. Frail elderly pose an additional challenge in preparedness.

- Florida has the highest percentage of those 65 years and older of any state in the nation (18%).
- In Florida, as in the rest of the nation, most of the older adults live in the community, in their own homes. Less than 5% reside in long-term care (e.g., nursing homes, assisted living facilities).
- Over 74% of all elders report a delay in purchasing or foregoing health items, and many report limited or no health insurance Medicare coverage alone is often not adequate. This number is growing annually since 2005.

CHALLENGES

Older adults face a number of challenges that can impede appropriate planning for and response to an all-hazards event. These include:

- Nearly 35% of all elders live alone.
- Nearly 40% of all elders often do not know where to get information concerning emergency preparedness resources and recovery following a disaster.
- Nearly 40% of all elders often do not where to get information about needed services
- 70% of all elders live with some disability or medical condition.
- Even though a majority of older adults report that they are able to perform tasks to manage their household, almost 50% of all elderly live with a disability that impairs sensory function and/or limits daily functioning to some degree.
- 75% of elders are dependent on medications or assistive devices and medical equipment
- Electricity is critical for these individuals to maintain medications, use elevators, operative assistive devices, etc.
- Hearing aids and glasses are most often a necessity
- Pets may effect an elderly persons evacuation arrangements (65% of those over 55 years have a pet).
- 20% of elders and persons with disabilities have a service animals/companion animals, which can be a factor in evacuation.
- Over 50% of all elders are on a special diet or dietary restriction.

Activities:

1. Identify where the older adults are in your community and provide them with resources and information concerning emergency preparedness, particularly those with special needs.
2. Inquiry in your community(ies) if there is an emergency response database which registers individuals with special needs during a disaster. Obtain for your unit a copy of your county's list.
3. Older populations need to be encouraged to have at least a month's worth of prescriptions. Identify and communicate to them a plan for storing medications that need refrigeration.

CHILDREN

Children represent a particularly vulnerable population during an all-hazards event for three basic reasons:

- Children are dependent on their parent(s)/legal guardian(s) for their safety and well-being
- They are physiologically more vulnerable
- They are psychologically more vulnerable

It is important to recognize that a child's perception of an all-hazards event may be dramatically different from the reality of the incident.

CHALLENGES

Unlike other vulnerable or hard-to-reach populations, children have minimal civil rights. It is the responsibility of parents/caregivers to guard the welfare and safety of children; thus children present a number of unique issues. They include:

- Many hospitals and institutions are not prepared for the needs of children during an all-hazards event, particularly a terrorist attack.
- Not all medicines or antidotes to potential hazardous or infectious agents are available for children.
- Comprehension of and response to the situation is age-dependent.
- Children with special needs have compounded vulnerability (i.e., physical and emotional disabilities, mental health problems, and language/cultural issues). Additionally, children can be specific terrorist targets.

Since children are so uniquely vulnerable, knowing how to respond to an all-hazards event begins with preparation.

Activities:

1. Discuss programs that your MRC unit can do in your community, schools, or faith-based community to better prepare children and families. Prepare and deliver a program that your MRC has developed.
2. Discuss how shelters can be better equipped to meet the needs of children.

PERSONS WITH DISABILITIES

Persons with cognitive, mental, physical and sensory impairments also require special assistance before, during, and after emergencies.

Cognitive Impairments:
Alzheimer's disease represents a major proportion of individuals in this category. Adding dementia substantially increases these numbers.

Mental Illness (including Substance Abuse):
Many times a disaster can exacerbate the onset of a mental illness, including increased use of drugs or alcohol.

Physical Challenges:
Of those 65 years and older, over 50% have some sort of physical challenge.

Sensory Impairments:
Sensory impairments can affect all age groups.

Persons with any type of disability are vulnerable in that they may require a caregiver and/or assistance for all transportation needs. Each population has their own specific challenges with potential for overlap with other groups.

CHALLENGES

- Individuals with a cognitive impairment, mental illness (including substance abuse) and those with developmental disabilities each share a set of vulnerabilities.

- Persons with disabilities may have difficulty comprehending verbal/written instructions, as well as not being able to communicate questions/needs to people around them.

- They may not understand what is happening; being in an unfamiliar environment may induce adverse behaviors/emotional deregulations.

- They may have dependency on treatment/medications, limited coping skills, impaired judgment/decision-making/planning skills and limited self-care/advocacy.

- They may have limited or no social support.

- Individuals with physical disabilities may have decreased mobility due to their condition and it may be more difficult for them to access transit. The elderly with a physical disability may be particularly vulnerable if they are frail.

- Individuals with sensory impairments may require assistance communicating and receiving information.

- Service animals will need admission and appropriate accommodations in shelters.

Activities:

1. In your MRC unit's area, make a list of persons with disabilities who:
   A. May require a caregiver and/or other designated person to assist, and make decisions.
   B. May not be able to advocate for themselves (e.g., to make or follow an emergency plan).
   C. May have special transportation needs.
   D. May have special medical needs.
   E. Have access and are registered with a special needs shelter.
   F. May not have any family member or caretaker.
2. Discuss how your volunteers might better work with each group.

In the event of an emergency, there should be an increased number of well-prepared MRC volunteers and others to assist individuals with disabilities. MRC volunteers should be aware of the needs of persons with disabilities. Listed below are some key considerations when planning for persons who have disabilities:

1. Coordinate appropriate transportation and accommodations and identify special needs shelters.
2. Identify a caregiver to check on them and make sure that the caregiver has the entire medical and personal contacts necessary; also remember that the caregiver or neighbor might be an individual who also needs assistance.
3. Create a detailed evacuation plan with all personal information. Have that readily available for volunteers, caretakers, and neighbors.
4. Due to decreased mobility, provisions need to be made for wheelchairs, crutches, or other adaptive equipment for person with physical disabilities. Shelters are always in need of these devices as well.

Activities:

1. Identify emergency preparedness needs that persons with disabilities in your community might have.
2. How could your MRC unit assist these individuals prior to an emergency event?
   (HINT: THE OPPORTUNITIES TO ASSIST ARE ALMOST UNLIMITED.)

HOMELESS INDIVIDUALS

The Annual Report of Homeless Conditions across the U.S. reports that the numbers of homeless are growing in all groups: children, adults and the elderly. This is a very hard to reach population, especially in the case of a natural disaster or terrorist event. Under normal conditions, there is only capacity to house about one-quarter of the homeless in the U.S. at any one time and only on a temporary basis. Under disaster conditions, locating homeless persons and finding safe shelter are critical. The many reasons for homelessness create significant challenges for officials who must account for this population during an all-hazards event. These include:

- Unemployment
- Substance abuse
- Domestic abuse
- Disability

The primary vulnerability of the homeless population is the lack of permanent shelter, which makes it difficult to provide information about all-hazards preparedness and response. Homeless individuals should be identified and brought to safe shelters. Any communication barriers and special needs should be identified as soon as possible.

A second vulnerability is the lack of trust that these individuals often have toward government and perceived government officials, which may impede outreach efforts. Homeless individuals oftentimes prefer living on the streets or hiding out of plain sight.

The major challenges with the homeless population are identification and communication. Because disasters can strike anytime and anyplace, every possible venue should be identified for homeless population to better prepare them for any type of emergency situation.

Outreach programs for the homeless are important. Outreach possibilities include:

- Place posters and or billboards about an anticipated disaster (e.g., hurricanes) at supermarkets, shelters and other locations where homeless may gather.
- Distributing flyers on the street through volunteer groups is also helpful.
- Developing outreach programs and plans for homeless individuals in your community.
- Identify trusted individuals to offer information and support (e.g., faith-based volunteers, social service personnel, and community volunteers).

Activities:

1. Discuss in your MRC unit any experience that MRC volunteers have with homeless populations.
2. Approximately how many homeless individuals live in your MRC unit area? Where are these individuals primarily located?
3. Plan an activity to provide homeless individuals with tools they might use to better prepare for an emergency.

MIGRANT AND SEASONAL WORKERS

Migrant and seasonal farm workers often lack resources for appropriate housing and materials to assist in personal and family preparedness. These workers usually live in rural communities, and many are non-English speaking. These qualities make this group isolated with multi-levels of vulnerability in all-hazards events.

CHALLENGES:

- Poor housing for migrant and seasonal farm workers is a very real problem. Housing is often substandard or non-existent. Overcrowding is common. If a disaster strikes, often times their substandard housing is seriously affected.
- Low literacy and language, cultural, and logistic barriers impede farm workers' access to social services and primary health care.
- Communication may be problematic due to poor understanding of the English language and limited reading abilities.

Important considerations when dealing with migrant and seasonal workers is a:

- Lack of trust (due to undocumented status for many) makes it difficult for officials to approach this population with information regarding access to services before and during an all-hazards event
- Translation may be difficult - Use interpreters to help with providing information and answering questions in a timely, language-appropriate, and culturally sensitive manner. MRC interpreter volunteers are always needed. (REMEMBER: No medical background is necessary).

When working with migrant and seasonal workers, identify the type of media to be used with this population (e.g., radio stations, TV stations, native language newspapers) and provide information through those sources. Other suggestions also include:

- Develop multi-language brochures
- Determine availability of interpreters
- Identify multi-language media outlets
- Integrate preparedness education, mitigation, and recovery with social service agencies

Activities:

1. Identify the locations of migrant and seasonal farm workers in your MRC area.
2. What are the language needs of the seasonal or farm workers in your area?
3. How many MRC members in your unit speak another language? Identify these individuals and make this resource list available.

TOURIST AND SEASONAL RESIDENTS

Tourists are any individuals who are spending time away from their homes for pleasure. The location is usually unfamiliar and more than miles away from home. Seasonal residents are defined as individuals spending not more than six months in an area away from their primary residence. Due to the transient nature of the visit, seasonal residents and tourists have overlapping vulnerabilities during all-hazards incidents.

CHALLENGES:

- Their arrivals and departures cannot be tracked.
- Many live in mobile homes.
- Many are older adults, with the challenges previously described for that populations and do not have a permanent working phone.
- There may not be family or friends for assistance during an all-hazards event.
- English may not be the native language.
- They may move frequently, visiting difference places.

Important considerations for tourists and seasonal residents include:

- Provide all-hazards preparedness brochures that include resource numbers for assistance and websites and make information available at sites frequented by tourists and seasonal residents (e.g., supermarkets, drug stores, airports, boat/bus/train terminals, theme parks, shopping malls).
- Develop an online visitor database with backups out-of-state

- Have readily available ongoing information available for tourists and seasonal residents to avoid confusion.

Activities:

1. Tourists may frequently visit tourist areas in your region; including tourist information centers, chamber offices, etc). Are there any informational resources available for tourists or seasonal visitors in all-hazards emergency preparedness?
2. Identify ways in which your MRC unit can promote preparedness for tourists and seasonal visitors.
3. What are good places to put posters and brochures?
4. Identify the most important preparedness, mitigation, and evacuation information that a tourist or seasonal visitor should have.

SUMMARY

Vulnerable populations present individually unique challenges for the MRC volunteer. The support available to special needs and hard-to-reach persons is often fragmented and varies by population. With an increase in perceived threats from natural disasters, technological hazards, and terrorist attacks, better emergency planning is needed for people with special needs and populations that are traditionally "hard to reach."

ADDITIONAL RESOURCES

Refer to the Appendix – Section (c) more detailed information and a training flyer focused on vulnerable population groups.

Special Populations and Disaster Preparedness
United States National Library of Medicine, National Institutes of Health
http://sis.nlm.nih.gov/outreach/specialpopulationsanddisasters.html

Evacuation Preparedness Guide
Center for Disability Issues and the Health Professions at Western University of Health Sciences
http://www.cdihp.org/evacuation/toc.html

Prepare Yourself: Disaster Readiness Tips for People with Disabilities
National Organization on Disability
http://www.nod.org/resources/PDFs/epips1disability.pdf

Coping with Crisis: Helping Children with Special Needs
http://www.nasponline.org/resources/crisis_safety/specpop_general.aspx

Ready Kids
http://www.ready.gov/kids/home.html

Emergencies: What to do in an Emergency: A Checklist
(Multi-media emergency preparedness information in multiple languages)
Healthy Roads Media
http://www.healthyroadsmedia.org/

Accommodating Individuals With Disabilities In The Provision Of Disaster Mass Care, Housing, And Human Services
http://www.fema.gov/oer/reference/index.shtm

Just in Case: Emergency Readiness for Older Adults and Caregivers
http://www.aoa.gov/AoARoot/AoA_Programs/HCLTC/Caregiver/docs/Just_in_Case030706_links.pdf

IV. MODULE THREE – PSYCHOLOGICAL FIRST AID

MRC Core Competency # 6

Describe the impact of an event on the mental health of an MRC member, responders, and others.

This program addresses the MRC core competency that will enable you to:

- Identify the range of anticipated stress reactions experienced by disaster survivors, MRC members, responders and others in the early aftermath of a disaster.
- Identify when, how and where to refer disaster survivors, MRC team members, responders and others for additional mental health support and care
- Identify and offer psychological first aid.

REMEMBER: STRESS CAN AFFECT ANYONE. THE PERSONAL LOSSES, PHYSICAL INJURY, AND DEATH FOLLOWING A DISASTER CAN TAKE A HEAVY EMOTIONAL TOLL ON BOTH VICTIMS AND RESPONDERS.

Disaster Stress

The term disaster stress relates to an unexpected loss of control and is a normal response to an abnormal situation. Disaster stress responses are age-specific and may evolve over a period of time, so that successive disaster events, such as a series of hurricanes, produce long-term effects. To recover, citizens need to gain a sense of control and should be involved in the public health response and cleanup.

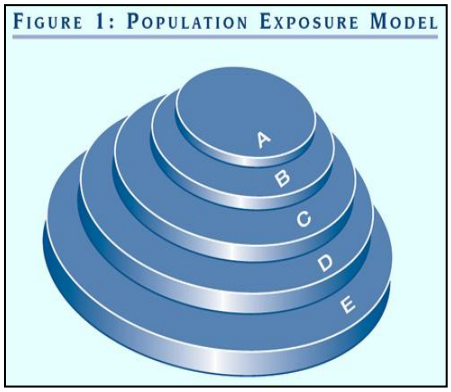
Stressors

- Physical injury/death
- Threat of isolation or quarantine
- Lack of medical care
- Disruption of routine
- Fear of the unknown
- Loss of possessions/home
- Uncertainty about future threats
- Relocation

- Loss of control/independence
- Family disorganization/ separation
- Missing loved ones
- New roles and responsibilities
- Job loss
- Multiple losses or events (retraumatization)
- Media inundation
- Limited resources
- Not having a place to go

The **population exposure model** illustrates that the impact extends out of the psychological reaction to an event impacts more people than just those immediately and personally affected.

FIGURE 1: POPULATION EXPOSURE MODEL



A: Community victims killed and seriously injured

B: Community victims exposed to the incident and disaster scene, but not injured

C: Bereaved extended family members and friends

D: Mental health and crime victim assistance providers

E: Groups that identify with the target-victim group

Victims and responders may exhibit a variety of cognitive, emotional, behavioral, physical and spiritual symptoms at any time during and after a disaster. Research on the psychological effects of disasters on victims has shown that the "psychological casualties" and the "contagion of anxiety" may be far greater than the medical impact. This is illustrated in the model above.

SIGNS OF DISASTER STRESS AND SYMPTOMS

Cognitive

- Inability to concentrate and process new information
- Difficulty solving problems
- Poor memory
- Preoccupation with event
- Confusion
- Inability to understand consequences
- For children, difficulty in school

Emotional

- Fear
- Anxiety
- Depression
- Helplessness
- Feeling of being overwhelmed
- Irritability
- Anger
- Grief
- Mood swings

Behavioral

- Impulsiveness/Risk taking
- Excessive eating
- Compensatory sexuality or spending
- Alcohol/drug use
- Withdrawal
- Family discord (including separation or divorce)
- Hyper vigilance
- Career burnout
- Nightmares that can erupt in loud screams of fear

Physical

- Rapid heart rate
- Headaches
- Hyperventilation
- Muscle aches, spasms
- Sleep/appetite changes
- Fatigue/exhaustion
- Gastrointestinal changes (indigestion, nausea, vomiting)

Spiritual

- Crisis of faith
- Withdrawal from faith-based community
- Religious hallucinations or delusions
- Over reaction to religion and a significant deviation from normal religious practices

Activities:

1. Identify among your MRC unit any psychological stressors that members have experienced. Discuss each of these types of disaster, personal effects, coping skills, who provided assistance to you?
2. Survey your individual MRC unit and your location, identify the resources available to you if referrals for further professional psychological assistance would be needed.
3. If there are large numbers of vulnerable populations in your community, are there adequate mental health professional services to assist you?
4. If members in your unit need more information on psychological first aid (PFA), your MRC unit should arrange a special program on how to most effectively and efficiently meet the PFA needs of your area.

MENTAL HEALTH FOR THE MRC VOLUNTEER

Large-scale disasters place a strain on the community and its residents. Responders may also be coping with their own losses and problems while serving their communities, creating a double burden. Helping those who respond to disasters represents a different challenge than assisting civilian disaster survivors. Listed below are important personal and disaster volunteer stressors that the individual responder may encounter.

PERSONAL STRESSORS	MRC ROLE STRESSORS
• Overwork/fatigue • Change in eating/drinking schedule • Factors adversely impacting health • Interpersonal conflict • Highly emotional experiences • Existential conflict • Denial • Role conflict • Anger • Anxiety • Disappointment • Family reactions • Reassertion of old roles • Balancing family re-entry • Resistance to assistance	• Long hours • Unfamiliar environment • New challenges • Time pressures • Multiple/conflicting priorities • Exposure to traumatic experiences • Unclear duration of response • Fear of death/injury/illness • Bureaucracy/politics • Conflict that can arise post-disaster

Activity:

Identify the stressors that you might experience before, during, and after deployment. Discuss these and possible strategies to reduce these stressors.

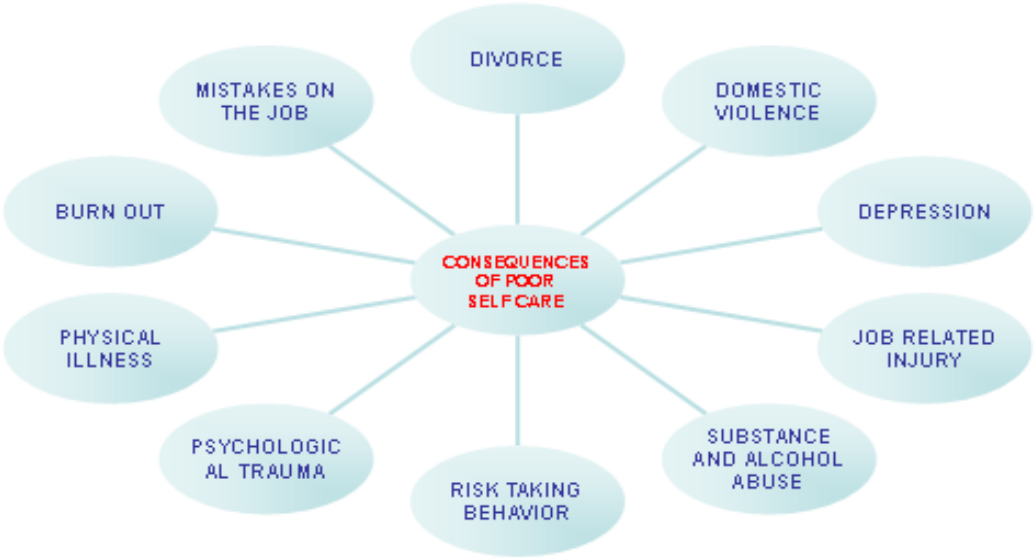
Responders need to know what they can tolerate physically and emotionally, limit their work schedules and not work for more than 12 hours straight, sleep and rest as needed, keep fed and hydrated, and take breaks to refresh mind and body. Responders should check in with their supervisors regularly, and take part in debriefing with their response team.

References:

http://www.deep.med.miami.edu

Psychological First Aid (PFA)

Psychological First Aid (PFA) is an evidence-based method of assisting people in the immediate aftermath of a disaster. Its goals are to reduce initial distress and foster short and long term adaptive functioning. It can be used by trained individuals including health specialists, first responders, crisis teams, and MRC volunteers. Below is a diagram of the consequences of poor self care that can result from a disaster.



Although stress is normal and expected after a disaster, a portion of people will suffer more serious, persistent symptoms. **If a victim's symptoms are severe and/or prolonged, a referral for further mental health care may be in order.** Symptoms that mandate a referral for further evaluation:

- Disorientation
- Anxiety
- Depression
- Dissociation
- Psychosis: (hallucinations)
- Unable to care for themselves
- Is a threat to self or others
- Shows evidence of domestic violence/child abuse/elder abuse
- Substance abuse

An important characteristic of PFA is its versatility. It can be used in a variety of settings, including shelters, healthcare facilities, and homes. PFA is appropriate for people of all ages, includes an understanding of cultural differences, and is flexible in how it can be delivered.

Delivering PFA

- Don't intrude; be respectful in your questioning
- Provide practical assistance
- Be calm
- Use simple, slow speech
- Acknowledge positive strategies and use positive encouragement as much as possible

Activity:

Identify factors that may come into play when delivering PFA to vulnerable population groups (e.g. children, persons with specific developmental disabilities, elderly, etc.)

PFA works, but it is important NOT TO:

- Assume survivor experiences
- Assume everyone will be traumatized
- Label reactions as pathologies
- Talk down/patronize
- Assume everyone will want to talk
- Ask about traumatic details
- Speculate or give inaccurate information

The "7" PFA actions include:

1. **CONTACT AND ENGAGEMENT**.

   Engage victims in a helping relationship. An easy way to begin a conversation is to simply introduce yourself and inquire what immediate needs the victim has. Be genuine and show that you care. Sometimes just being there to listen and hold their hand is all that is needed.

2. SAFETY AND COMFORT

- Help to clean the immediate environment.
- Ensure physical safety. Especially important for children, elderly, and others with special needs.
- Offer information about disaster response activities and services
- Attend to physical comfort and special needs like eyeglasses, medication, walkers, hearing aid, etc.
- Promote social engagement.
- Set up a child-friendly space and attend to separated children parents/caregivers.
- Protect from additional trauma.
- Help survivors who have missing family members.
- Help survivors who had a loved one die or who have received a death notification.
- Attend to grief and spiritual issues.
- Assist survivor in connecting with family or others outside of the area
- Offer information about casket and funeral issues.
- Support survivors involved in body identification.
- Provide current and accurate information.
- As much as possible, keep intrusive media away.

3. STABILIZATION

- Enlist family members and friends to help you with the distressed survivor.
- Have parents help their children stabilize their emotions.
- Help orient those who are overwhelmed.
- Seek assistance from medical and mental health professionals, if you are unable to help calm the person.

4. INFORMATION GATHERING

- Identify needs and concerns and gather information to provide assistance.
- Direct individuals to appropriate resources.
- Talk to survivors about their disaster experiences, concerns, losses, fears.
- Provide information about grief, coping and social support.
- Assist survivors in prioritizing their needs.

5. PRACTICAL ASSISTANCE

- Provide people with needed resources that can help increase their feelings of empowerment.
- Help restore dignity and independence.

6. CONNECTION WITH SOCIAL SUPPORTS

- Work to enhance access to primary support persons like family members and close friends.
- Identify faith-based groups that may assist individuals who have no family or social support.

7. INFORMATION ON COPING

- Talk with survivors about physical and emotional responses.
- Help to provide information for personal and family coping.
- Address negative emotions and anger management.
- Provide resources to assist in sleep problems.
- Refer individuals for assistance on alcohol and substance abuse.

"PFA" Actions Summary

DISASTER STRESS IS NORMAL AND EXPECTED. IT IS KEY TO:

- Recognize the stress and stressors
- Identify individual coping strengths and weaknesses
- Assist others in coping
- Take care of your physical and psychological needs first
- Seek professional help for survivors, including responders, when necessary

Activities:

1. As a MRC volunteer, what are important self-care practices can you work on to prepare yourself better to cope with all of the psychological stressors related to a disaster.
2. Discuss in your MRC unit how different disasters might cause differing psychological stressors
3. How can communities at large better prepare citizens to cope better following a disaster?

References:

http://www.ptsd.va.gov/professional/manuals/psych-first-aid.asp

V. MODULE FOUR – NATIONAL INCIDENT COMMAND SYSTEM (NIMS) AND INCIDENT COMMAND SYSTEM (ICS) OVERVIEW

MRC Core Competency # 3 Describe the chain of command (e.g., National Incident Management System – NIMS and Incident Command System - ICS), the integration of the MRC, and its application to a given incident.
MRC Core Competency # 5 Describe the MRC member's communication role(s) and processes with response partners, media, general public, and others.
MRC Core Competency # 7 Demonstrate the MRC member's ability to follow procedures for assignment, activation, reporting, and deactivation.

It is important for all MRC volunteers to understand the National Incident Management System (NIMS) which includes the Incident Command System (ICS). As part of the requirements to be a MRC volunteer, all members must complete the ICS-100.a and IS-700.a.

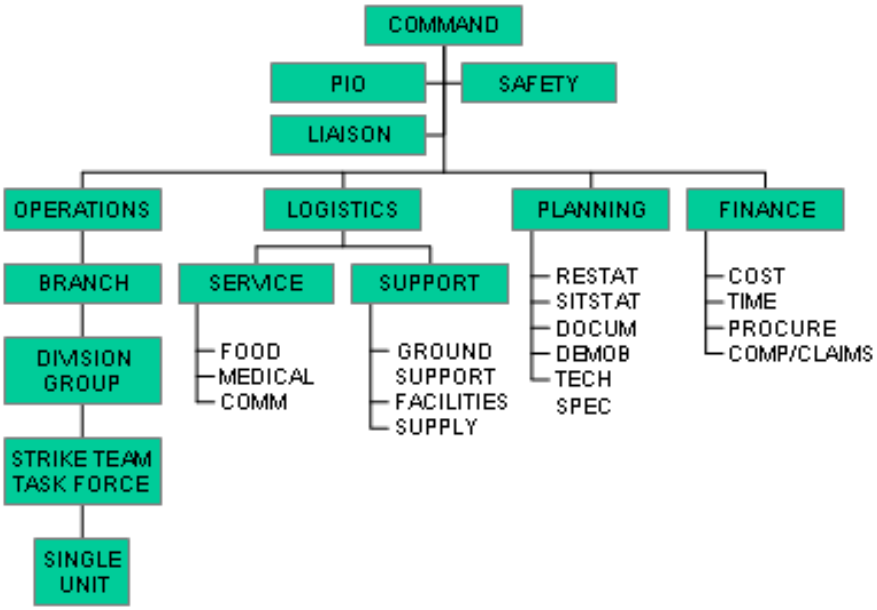
The ICS allows everyone working in a disaster situation to respond as one coordinated and consistently similar team. Think of the ICS as a musical composition being played with a director leading the group. As in a musical composition where there is one conductor (commander) who works with the orchestra members (responders), who know the notes, what section should play, what tempo is needed throughout the selection (which can vary), knows what musical terms and what keys to play, so in an emergency response the "selection" (response) which differs each time must be delivered under the direction of a leader.

All persons have a lead conductor and they respond knowing the same structure, language of response, role in the response, and action to be taken depending on the type of disaster (tempo).

FIVE MAJOR FUNCTIONS OF COMMAND

- COMMAND
- OPERATIONS
- LOGISTICS
- PLANNING
- FINANCE

LARGE SCALE SYSTEM



The Incident Command System allows for a unified response in the management of a disaster, emergency or non-emergency public event. The definition of a system is many component parts put together to form one functional unit.

The Incident Command System (ICS) and National Incident Management System (NIMS)

The Incident Command System (ICS), is only a small portion of the National Incident Management System (NIMS). NIMS relates to the entire system, including personnel, equipment, and certification to start the system in an emergency situation as soon as possible.

The five major functions of command were developed from a military command model in the 1970s, used in response to fighting forest fires in California. This model was adapted to disaster planning and response. The Incident Command System clearly delineates lines of responsibility, communication, and authority. The command system becomes a detailed flowchart (composition). Each emergency situation utilizes a chart similar to this one.

The Incident Planning Process takes place regardless of the size and complexity of an event. There are six (6) essential steps:

- Understanding policy and direction of the Incident Command organization
- Assessing the situation
- Establishing incident objectives
- Determining appropriate strategies to achieve the objectives
- Giving tactical direction and ensuring that it is followed (e.g., correct resources assigned to complete a task and performance monitored)
- Providing necessary back-up (assigning more or fewer resources, changing tactics, etc.)

Activities:

1. Go to http://www.fema.gov/emergency/nims and check on the training link to review the courses available online and the training options available if you should decide to go into advanced NIMS study beyond the ICS-100.a and IS-700.a.
2. Discuss the ICS in your MRC unit. Do you know all of the players on the organizational chart?

References:

HICS: http://www.emsa.ca.gov/HICS/default.asp

ROLES ANS RESPONSIBILITIES IN THE ICS

Role of the Incident Commander: The incident commander is the conductor. He/she is the person who is in charge.

INCIDENT COMMANDER

- Starts up the organization that will be responding in an emergency
- Determines strategic goals and tactical objectives
- Formulates an Incident Action Plan (the musical score)
- Develops the ICS Organizational Structure
- Determines what is going to be done and how it will be done
- Determines resources needs
- Coordinates all emergency activities
- Coordinates the use of outside agency resources
- Authorizes the release of information
- Serves as the ultimate Incident Safety Officer
- Divides work equally among those responding

Important to note: Incident Commanders know that their plans have to be flexible because of the dynamic nature of disasters (like a musical selection – tempos may have to be increased, changed, or even slowed down).

SAFETY OFFICER

The Safety Officer will:

- Assess hazardous and unsafe situations
- Develop measures to assure safety
- Has authority to stop/prevent unsafe acts
- May have assistants

The Safety Officer, Public Information Officer (PIO), and Liaison Officer can be compared to the "first chair" in the orchestra. They help the Incident Commander in "leading" the coordinated response. They play a major leadership role.

Examples of safety issues include:

- Safety of food and water
- Safety of the fuel supply
- Safety of a location

PUBLIC INFORMATION OFFICER (PIO)

The PIO is the official spokesperson in a disaster. Volunteers and other assisting should NOT speak to the media. **The PIO may have assistants in a large disaster.**

The PIO will:

- Develop accurate and complete information regarding incident
- Serve as a point of contact for media, governmental agencies and Agency Administrators
- Communicate information concerning the event for release to the media; all released information must be authorized by the Incident Commander (IC)

"It is important to recognize that the PIO is the official media spokesperson not the IC."

LIAISON OFFICER (LO)

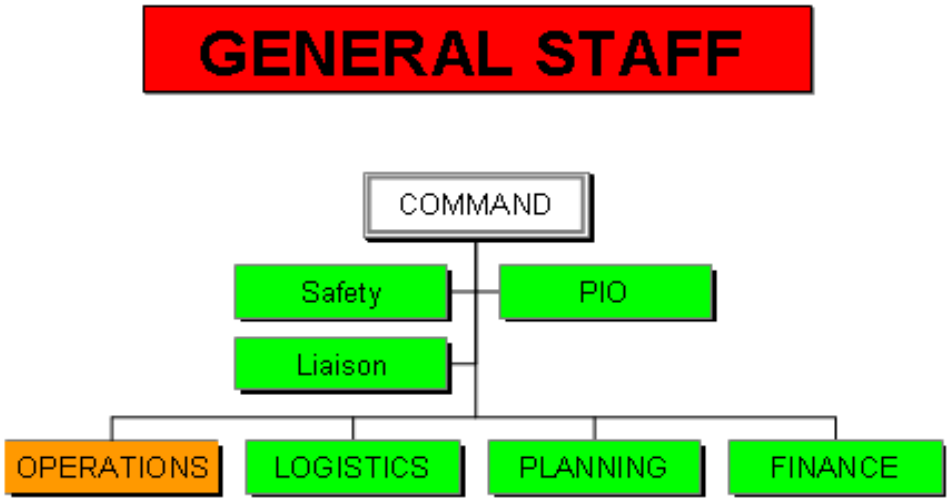
The Liaison officer is the point of contact for representatives of other agencies.

The LI will:

- Serve as a conduit of information between the Incident Commander and the other agencies involved
- Can be point of contact for victims and families
- Works to maintain a coordinated “system” in all response activities

GENERAL STAFF

The **General Staff** is where the work (response to the emergency) is being done. As part of a MRC operations unit, you are most often organized under the MRC umbrella.



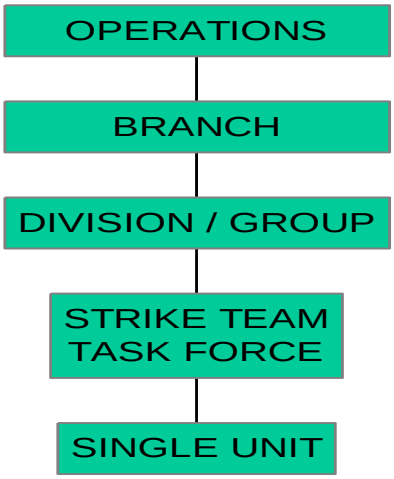
Operations Section

This area is responsible for the direct management of all tactical functions in any emergency response. The head of the Operations Section is led by an Operations Section Chief. There may be deputies in specialized areas as needed to assist the Section Chief. Primary functions of the operations section include:

- Assist in the formulation of the Incident Action Plan
- Supervises the Staging Areas

Structural Models

The Incident Command System is built on a structural model of working in 5 areas. If there are more than 5 units branches are usually created. There is no right or wrong way to organize, as long as you stay within the span of control and maintain the hierarchy using the standard NIMS terminology.



Branch

A branch is usually led by a Branch Director. The Branch can be:

- A tool to organize individuals
- An optional tool for the IC when the number of divisions/groups exceed the span of control
- Can be organized as geographical, functional or jurisdictional

Task Force

Task force is led by a Task Force Leader. Task Force is:

- Any combination of kind and type of less than five individuals assigned for a task
- Has a leader in a separate vehicle
- Has common communications
- Led by a Task Force Leader (e.g. 2 Nurses/1 Doctor/1 Tech)
- Always has a specific name connected to the specific nature of the taskforce (e.g., Southeast Taskforce, Children's Taskforce, etc.)

Activity:
Discuss in your MRC unit how branches might be developed in an emergency response and what specific functions these branches might have.

Other units in the Operation Section are Divisions.

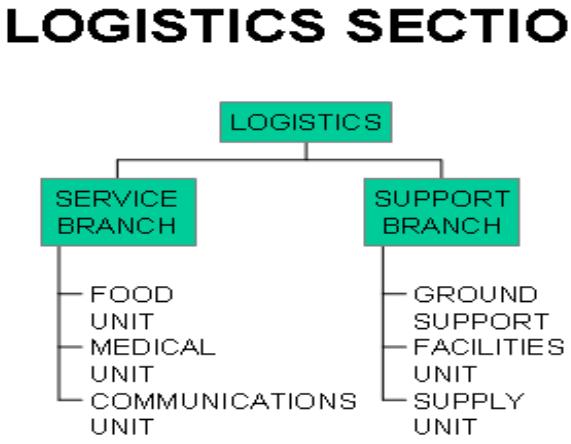
DIVISION

- An organizational level responsible for a specific GEOGRAPHICAL area
- Led by a DIVISION SUPERVISOR
- Responsible for all tactical activities in that area (e.g. West Division, ER Division, Division 3, etc.)

GROUP

- An organizational level responsible for a specific FUNCTION
- Led by a GROUP SUPERVISOR
- Responsible for specific tactical activities in that area (i.e.: Triage Group, Treatment Group, Inoculation Group, etc.)

Individuals in Task Forces, Branches, Divisions, and Groups are supported through Logistics that takes care of all those working/volunteering in an emergency situation, this including food, lodging, transportation, supplies, resources, and equipment.



Logistics is like the supply sergeant of an incident. Logistics is broken into two branches automatically: Service Branch and Support Branch. Logistics is concerned with special feeding requirements of both victims and responders. It also addresses the short and long term impacts of the disaster and if feeding, housing, and health care needs can be met in both the short and long term future.

I. Logistics Section: Service Branch

A. FOOD UNIT

- Determines food and water requirements for incident personnel
- Able to anticipate incident needs
- Handles any special feeding requirements/diets
- Registered dietitians who serve as a MRC volunteers can have an active leadership role in the Food Unit
- Led by a FOOD UNIT LEADER

Activities:

1. Identify any special dietary and/or medical conditions that MRC members in your area might have.
2. How are you preparing to deal with these individual needs in a disaster situation?

B. MEDICAL UNIT

- Develops procedures for handling any major medical emergency involving personnel
- Provides medical aid
- Coordinates transport to proper facilities
- Led by a MEDICAL UNIT LEADER

C. COMMUNICATIONS UNIT

It is important to differentiate from what is normally implied with communications in this unit. This unit deals with the technical aspects of communication such as radio frequencies, computers, cell phones, and fax machines. Responsibilities include:

- Plans for the most effective use of radios and frequencies on an incident which includes use of computers, cell phones and faxes.
- Provides testing and repairing of radios
- Supervises the Incident Communications Center
- Led by a COMMUNICATIONS UNIT LEADER

II. Logistics Section: Support Branch

The Support Branch under Logistics provides ground support, facilities support, and supplies.

A. GROUND SUPPORT UNIT

- Responsible for the maintenance and repair of primary tactical equipment including oil change, tire repair, car re-fueling, etc.
- Provides transportation services
- Provides for fueling of vehicles
- Led by a GROUND SUPPORT UNIT LEADER

B. FACILITIES UNIT

- Responsible for establishing setting up, maintaining and demobilizing all facilities
- Lodging (which may encompass of tents, hospitals, churches, office buildings or mall areas)
- Led by a FACILITIES UNIT LEADER

C. SUPPLY UNIT

- Responsible for developing procedures for ordering of supplies
- Responsible for the coordination and delivery of supplies
- Responsible for maintaining incoming and outgoing supplies and records of all supplies used and stored
- Led by a SUPPLY UNIT LEADER

Activity:

Discuss challenges that each Branch Support Leader might have in various types of disaster:

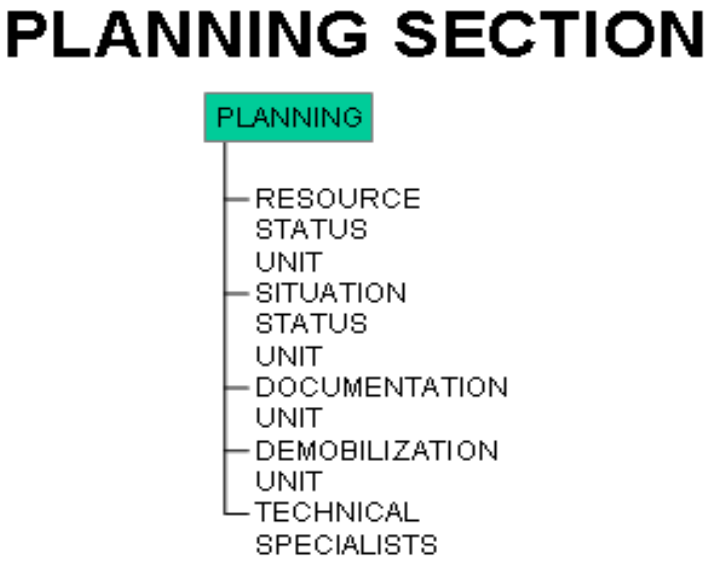
A. Ground Support
B. Facilities Support
C. Supply Support

III. Planning Section

Planning is key in any emergency operation. No one can or should work 24 hours a day, 7 days a week. Staff and volunteers are assigned to operational periods better known as shifts. Day shift and night shift make up what is known as an Operational Period.

Activity:

Discuss the challenges that a situation unit leader might have in the aftermath of a disaster, such as a hurricane, a tornado, an explosion, etc.



RESOURCE STATUS UNIT includes present and future need (short and long term). The Planning Section head is constantly monitoring the need for resources at all levels.

SITUATION STATUS UNIT
As an MRC volunteer, it is imperative for you to be aware of the situation you are in at all times! Situational awareness analysis is the primary response of the situation unit. Responsibilities of this unit include:

- Collection, processing, and organizing of all incident information
- Preparation of projections of future incident growth
- Maintenance of maps and intelligence information
- Led by a SITUATION UNIT LEADER

DOCUMENTATION UNIT
MRC volunteers with management, administrative, and secretarial skills are needed for this unit. The documentation unit has major responsibilities that include:

- Funding issues and monitoring reimbursements
- Paperwork
- Maintenance of records for all expenditures
- Filing of federal paperwork
- Maintenance of federal reimbursements
- Responsibility for the up-to-date incident files
- Provision of duplication & related services
- Storing files for legal, analytical and historical purposes
- Led by a DOCUMENTATION UNIT LEADER

DEMOBILIZATION UNIT
This unit is responsible in planning for all the “extra” people who come to assist in an emergency, and also plan for sending people back home once the incident is stabilized. Functions include:

- Developing an incident demobilization plan
- Sending “extra” persons not needed back home
- Identifying who goes home first
- Assisting volunteers in returning to home following an emergency
- Coordinating with agency representatives
- Developing an incident check-out procedure for the incident
- Led by a DEMOBILIZATION UNIT LEADER

TECHNICAL SPECIALIST

Like a fine musical composition that varies the composer, so the technical specialists vary with the type of emergency.

The technical specialist provides specialized, technical information to the Planning Section (technical specialist will change according to the type of the emergency event). These specialists can include: hazardous materials, diagnostic specialists, other medical specialists, engineers, forensic specialists, etc.

Activity:

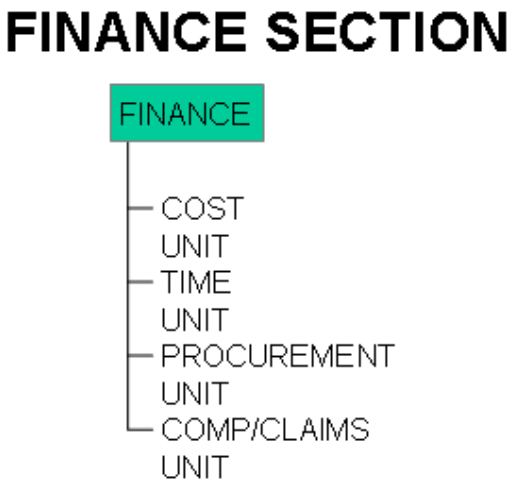
Identify the types of specialists that might be needed in specific emergencies.

References:

Technical specialist examples:
http://www.osha.gov/SLTC/etools/ics/tech_special.html

IV. Finance Section

The finance section handles the money. They provide incident cost analysis and examine efficiency in the overall system. The finance section has four major units as noted below. Each of them operates specifically as described in the unit name.



The Incident Command System really works when implemented with a strong Incident Commander and well trained team. One Incident Command System can handle thousands of responders. As an MRC volunteer, you will be working under the ICS. An ICS team works in a unified fashion using the same terminology, communications, and has the same goals. The ICS is a management system that can handle hundreds of responders. This ICS is your organizational chart and you are an important person in that organization chart. (see chart below)

Potential number of people in ICS structure:

Operations Chief	1
Branch Directors	5
Division/Group Supervisors	25
Strike Team Leaders Task Force Leaders	125
People	625

Hospital Incident Command System (HICS)

The Hospital Incident Command System (HICS) provides the framework for hospitals to respond to emergencies within the parameters of other networks. Under this system, Medical Reserve Corps (MRC) members will be able to respond to a request for assistance and to function within designated parameters regardless of where or when an event occurs. The *HICS Guidebook* is designed to provide immediate understanding of vitally important tenets of response planning, incident command, and effective response. The guide explains the National Incident Management System and the Hospital Incident Command System within the NIMS framework. HICS is useful in managing response, moving a facility to another location, dispensing medications to hospital staff or the community, or planning for a large community event.

The Incident Planning Process takes place regardless of the size and complexity of an event. There are six (6) essential steps:

- Understanding policy and direction of the Incident Command organization
- Assessing the situation
- Establishing incident objectives
- Determining appropriate strategies to achieve the objectives
- Giving tactical direction and ensuring that it is followed (e.g., correct resources assigned to complete a task and their performance monitored)
- Providing necessary back-up (assigning more or fewer resources, changing tactics, etc.)

The size and structure of the Incident Command organization reflects only what is needed to meet and support the incident objectives.

HICS, like NIMS, allows for the deployment and supervision of *single resources, task forces,* and *strike teams*. A *single resource* is an asset such as a stretcher or medicine cart. A *task force* is a combination of like resources such as four ICU trained doctors, four ICU trained nurses and an ICU trained station secretary. A *strike team* is an assembly of the same kind and type of resources (eight Medical Reserve Corps volunteers) who work together to complete an objective. Once an objective is met, a new objective may be assigned or the resource(s) may be deactivated. MRC volunteers always work in pairs or larger units. Individual and team health and safety are paramount.

This *Hospital Incident Command System Guidebook* is designed to be a resource for all MRC volunteers. The information may be generalized to any event that calls for the establishment of a systematic planning or response scenario.

Here is the website link for you to use to complete your IS-100.a and IS-700.a courses.

References:

ICS website: http://training.fema.gov/IS

Activity:

REMINDER: As a MRC volunteer, you will be completing the IS-100.a and IS-700.a course as part of your required core training.

Additional Resources:

http://www.medicalreservecorps.gov/HomePage

http://www.medicalreservecorps.gov/QuestionsAnswers/Volunteering

http://www.nova.edu/idep/

http://www.fema.gov/emergency/nims/

http://www.phe.gov/preparedness/pages/default.aspx

http://training.fema.gov/

VI. MODULE FIVE – POINTS OF DISTRIBUTION (POD)

MRC Core Competency # 3 Describe the chain of command (e.g., National Incident Management System – NIMS and Incident Command System - ICS), the integration of the MRC, and its application to a given incident.
MRC Core Competency # 4 Describe the role of the local MRC unit in public health and/or emergency response and its application to a given incident.
MRC Core Competency # 7 Demonstrate the MRC member's ability to follow procedures for assignment, activation, reporting, and deactivation.

In the event of a disaster or emergency, resources may be activated by local authorities to provide information, emergency relief, or medical dispensation (including vaccines) to an area. In order to reach the entire population in the least amount of time, **points of dispensation or distribution (PODs)** allow for efficiency in the local response and recovery effort.

PODs are generally staffed with volunteers, some of which may be medical or non-medical, and some of which may also be involved in local health or emergency management departments. As an MRC volunteer, learning to work in a POD is part of the 'Public Health Activities and Incident Management' section within the MRC Core Competencies Matrix. POD staff can be internal (within the POD) and external (serving outside of the POD).

Following hurricanes, tornadoes and other natural disasters, PODs may be set up to dispense food, water, ice, or direct those who seek assistance. These PODs may require substantial organization and volunteers to fill necessary roles and responsibilities, which may exceed the capabilities of your area. Depending on the event, manpower to run such PODs may span several days or weeks (or more). Depending on the severity and number of cycles in a pandemic, manpower to run such a POD may span several days or weeks (or more).

A pandemic influenza may require a more advanced POD, with a primary goal of prophylaxis.

Activities:

1. Identify and list the unique challenges that a POD may have during a pandemic.
2. Discuss the staffing challenges in a POD during a pandemic.
3. Discuss in your MRC unit individual family plans that MRC volunteers have for themselves and families during a worldwide pandemic.

The POD team is comprised of the POD Manager and his or her core team and utilizes the Incident Command System (ICS). The POD Manager may serve as the Incident Commander. PODs are staffed with both medical and non-medical volunteers.

The goal of a POD team is to:

- Provide prophylaxis to all people in an area who have been exposed or could have been exposed to an infectious agent in order to save lives and prevent illness.
- Set-up and operate a clinic that runs at maximum efficiency and effectiveness.
- Make maximum use of all resources including human resources, both medical and non-medical.

POD STAFFING

Role of the POD Manager

- Overall responsibility for the set-up and operation of the POD according to the state/regional or local plan
- Forms necessary internal and external partnerships
- Coordinates the activities of the management staff
- Delegates assignments
- Directs information flow and reporting requirements
- Establishes performance standards for all staff
- Appoints or acts as POD spokesperson or can appoint someone on his/her behalf
- Authorizes changes in planning

"It is important and highly recommended that all MRCs have to have POD training, before working in a POD."

Role of the POD Medical Staff

- Medical volunteers such as nurses should be involved in screening, initial assessment, and triage of individuals that arrive at the POD
- Physicians and other providers (ARNP's, PA's) should be involved in evaluations
- Pharmacists should be responsible for repackaging, compounding, and verifying special needs
- Other medical and health professions staff will assume roles as needed by the incident and as assigned by the POD manager.

Role of the POD non-medical staff

- Greet, direct, and help to move people waiting in line
- Translators for non-English speakers or those that are hearing-impaired
- Direct traffic flow and parking
- Serve as runners, helping with errands, supply checks, or copying
- Serve as multi-purpose "float" staff
- Assist in security issues and disruptions that might occur when stressful situation arise in a POD.
- Assist in clerical functions

I. Opening a POD: PODs are open when normal resources are overwhelmed and "a surge situation" arises.

The major tasks and activities in opening a POD are:

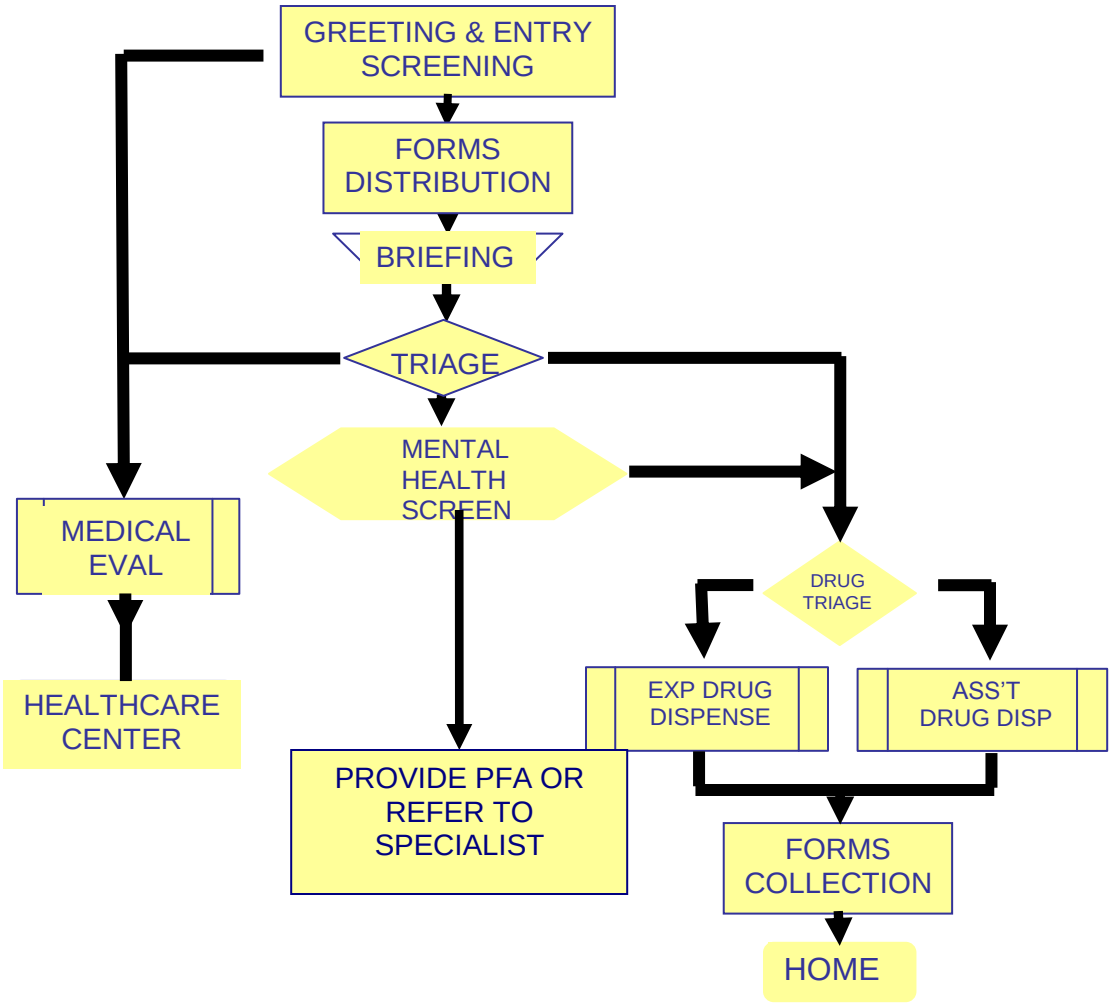
- Notify and assemble POD staff
- Set up the POD stations
- Brief staff and prepare as needed
- Store and issue medicine, vaccines
- Unlock the door
- Open for business
- Review traffic patterns to the POD
- Identify potential security and safety issues.

Activities:

1. Familiarize yourself with the PODs location sites in your MRC area.
2. Discuss possible challenges that might occur during a PODs set-up.

II. Running a POD

Below is a diagram that illustrates a POD's operation:



III. Closing the POD

The closing of a POD should be incremental and is dependent on the situation at hand. Staff should be released intelligibly and safely over a period of time, not all at once. Aside from POD staff, external POD staff will need to be released similarly as well, to include bus drivers, law enforcement, and emergency management. This may be decided by the Incident Commander or Safety Officer and is dependent on POD resources and support. It is critical to pay attention to your POD staff and their needs before closing a POD. Before closing, a final assessment of the remaining inventory should be performed (e.g., pharmaceuticals, medical supplies, dispensing mechanisms, etc.). It will also be important to have volunteers available to close the POD and to break the facility down, cleaning it and turning it back to its original condition.

Activities:

1. Discuss possible roles each person in your MRC unit might have in a POD. Work with your MRC coordinator to plan a tabletop exercise or drill around the opening and closing of a POD.
2. Discuss with your MRC coordinator how any remaining inventory is dealt with when closing a POD.
3. Discuss how volunteerism for a POD will be affected if a large pandemic influenza affects whereby up to 40% of the U.S. population will be affected.

References

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Websites

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References:

Pharmacist's role in MRC:

http://www.ashp.org/DocLibrary/BestPractices/SpecificStPubHlth.aspx

VI. MODULE SIX: ROLES AND RESPONSIBILITIES OF THE MRC VOLUNTEER

MRC Core Competency # 4 Describe the role of the local MRC unit in public health and/or emergency response and its application to a given incident.
MRC Core Competency # 7 Demonstrate the MRC member's ability to follow procedures for assignment, activation, reporting, and deactivation.
MRC Core Competency # 8 Identify limits to skills, knowledge, and abilities as they pertain to MRC role(s).

The primary roles and responsibilities of the MRC volunteer include:

- Identifying an individual MRC member's role and responsibilities on the team.
- Listing the legislative requirements related to the sharing of protected health information (e.g., HIPAA).
- Identifying personal and professional liability.
- Identifying the MRC guidelines for activation, reporting, assignment, and deactivation.
- Identifying the limitations of volunteers' individual skills while serving in the MRC.

The vision of the MRC is a nationwide network of organized volunteers strengthening the health and safety of their communities. As noted by former acting U.S. Surgeon General Kenneth Moritsugu, **"Through the work and service provided in towns, cities, and counties across the United States, MRC volunteers have made an immediate and lasting effect on the health and safety of their neighbors."**

MRC's will differ based upon community characteristics, such as:

- Surge capacities
- Population base
- Geography
- Differing health needs

The concept is to organize groups of volunteers with interest in strengthening the local public health system and providing help in emergencies. MRC volunteers include medical and public health professionals such as physicians, nurses, psychologists, pharmacists, dentists, veterinarians, and epidemiologists. Many community members – interpreters, clergy, office workers, legal advisors, and others – can fill key support positions.

The MRC Concept:

- Organize groups of volunteers strengthening the local public health system
- Integrate with existing resources and other programs
- Identify, credential, train and prepare in advance
- Provide training on an ongoing basis
- Include types and numbers of volunteers based on local needs
- Provide MRC opportunities for those in active practice or work and those who are retired

Activities:

1. Discuss each of the primary MRC goals and responsibilities. Which of these responsibilities is most easily carried out and which is most difficult?
2. Identify possible volunteers in your community who could serve in a MRC role (colleges, universities, retirement communities, professional organization at the local or county level and others). Discuss at a unit meeting.

MRC Team Concept

As a MRC volunteer, you will work in the MRC team concept integrating yourself with other groups and programs also responding during an emergency. Other volunteer programs and resources that you may be working with include the Citizen Emergency Response Teams (CERTS) and the Disaster Medical Assistance team (DMATS). In order for this to function, it is important to identify the volunteers, and then to credential, train, and prepare everyone in advance.

The ultimate goal is to be prepared for the Mission and Mobilization of the MRC units.

Always remember that **Mission and Mobilization** are key to all that an MRC member does. The MRC function takes a role under the Emergency Support Function 8, "Health and Medical Response", which is guided by the State Department of Health.

Mission and mobilization approach (M&M approach)

- MRC takes role to coordinate with other response systems should they be available
- MRC volunteers will work with an interdisciplinary group of volunteers
- Deployment can be local, state, regional or national in focus if more resources are requested

MRC volunteers can serve in many different roles. These roles can be grouped into two broad categories:

- Front-line and direct-service
- Supportive/administrative

Roles will depend on the individual volunteer's background and education.

The U.S. Surgeon General, with a goal to improve overall health encourages MRC volunteers to:

- Improve health literacy
- Work toward increasing disease and injury prevention
- Eliminate health disparities
- Improve public health preparedness.

Roles of a MRC volunteer can include any of the following:

- Provide health education as part of a local public health initiative
- Promote preparedness
- Participate in mass prophylaxis and vaccination exercises and community disaster drills
- Supplement shelter and special needs care
- Assist local hospitals and health departments with surge personnel needs
- Recognize systems and/or mental health issues and offer counseling for victims, families and responders
- Visit homebound patients
- Assist ambulatory services in community health centers and clinics
- Assist Emergency Response teams, FEMA and Red Cross
- Those MRC volunteers with a health background will assist in addressing chronic diseases such as asthma, cancer, dialysis, and diabetes during an emergency, as well as special health/medical procedures, such as dialysis.

Activities:

1. Discuss the other MRC roles you could have in your community other than responding in a disaster situation (based on the U.S. Surgeon General's MRC goal).
2. Identify post disaster roles you could have in your community.

Preparing to be an MRC Volunteer

As a volunteer, you will receive an orientation from your unit. This training is also part of your overall orientation.

You will be required to provide the following:

- An application which will include certifications and experience
- Skills assessment
- Verification of licensure and credentials (when applicable)

Once recruited, as part of your training, all volunteers will receive specific policies of their MRC unit and an orientation to each specific mission.

MRC Education, Training and Experience

Once recruited, and in completing the core training, all volunteers will receive specific policies of their MRC unit and an orientation to each specific mission. Each volunteer will receive a written job description of their position to include:

Key Responsibilities

- Sample tasks/activities
- Qualifications (including required training)
- Support
- Purpose of the position
- Supervisor who they report to

Skills Assessment

Each volunteer comes to the MRC with a preexisting skill set. These qualifications will represent the volunteer's baseline of skills that can be utilized during an emergency or other public health incident. An MRC volunteer's qualifications will be determined by your unit's mission, local laws and professional standards, and the requirements of your response partners.

It is important to note that there are limitations. Volunteers will be permitted or qualified to perform only certain types of activities compatible with the individuals training and education. Additional training may be indicated relevant to emergency response and/or public health activities.

Dress and Equipment

Volunteers will be given information regarding appropriate clothing, and equipment needed, or provided, for each mission. Personal protective equipment will be provided to each MRC participant.

HIPAA

It is important that each volunteer recognizes the importance of laws and regulations. One of these is the **Health Insurance Portability and Accountability Act (HIPAA) of 1996**, Public law 104-191.

HIPAA Includes:

- Access to medical records- patients may gain access
- Notice of Privacy Practices
- Limits on use of Personal Medical Information privacy rules
- Confidential Communications

Volunteer Benefits

These benefits will vary from state to state but usually include:

- State liability protection in accordance with the definition of a volunteer and the provisions and coverage and defined by each state
- Worker's compensation
- Meals
- Temporary lodging: (if necessary and if available)
- Transportation reimbursement (in some cases)

Activities:

1. What could your MRC unit do to attract more young adults?
2. Plan a program around HIPAA and invite a guest speaker to discuss HIPAA and answer questions.

FOR MORE INFORMATION ON HIPAA:

HIPAA: http://www.hhs.gov/ocr/privacy/hipaa/understanding/index.html

LIABILITY PROTECTION

Volunteers can be covered by state liability protection in accordance with certain state provisions. It is important that each volunteer of an MRC understand the protections available to their particular unit and state. These may vary, and it is up to the volunteer to ask questions that relate to their personal liability and protections afforded by state law. If states have volunteer protection programs, it is usually up to each volunteer to sign up for this protection through the health department in order to qualify for many of these protections and benefits.

Activity:

Discuss the state's liability protection at a local MRC meeting.

I. GOOD SAMARITAN LAW

Applies to documented participants of non-profit organizations. Removes volunteers from liability for negligent acts or omissions committed while acting within the scope of their duties as volunteers.

Good Samaritan Law immunizes uncompensated volunteers acting in a good faith, in specific emergency situations. The law can protect volunteer from civil liability who render spontaneous care. The law may NOT be valid on an organized volunteer situation.

II. CHAPTER 110 PROGRAM

The Department of Health encourages maximum participation in the Chapter 110 Volunteer Program. This program is the only method to ensure sovereign immunity to volunteers as agents within a state.

Activities:

1. Identify situation when an MRC volunteer might utilize the Good Samaritan Law?
2. As a health care professional, identify how are you protected in your role as a MRC volunteer?
3. Invite an attorney to speak on the liability protection laws within the state for MRC volunteers responding to an emergency situation, including the recovery phase.

Liability coverage's can vary widely and it is important, as stated earlier, that each volunteer be aware of their situation. Each MRC volunteer should know and understand their state's volunteer protection acts. Here is one example of a state's volunteer protection:

Florida Volunteer Protection Act Chapter 768.1355

A volunteer is an individual performing services for a non-profit organization or governmental entity who does not receive compensation.

- Applies to documented participants of non-profit organizations.
- Removes volunteers from liability for negligent acts or omissions committed while acting within the scope of their duties as volunteers.

Each volunteer is personally responsible to get information regarding their MRC unit, their professional license provisions and restrictions and their responsibilities! The goal of MRC recruitment and training is to educate volunteers in the fact that the best opportunity to volunteer is with an organized team approach. In that situation, you are protected and given an opportunity to serve with resources. It's important to understand that you will receive training and safety equipment, as well as an opportunity to work within the system for the benefit of all.

References:

Florida Volunteer Protection Act:
http://www.leg.state.fl.us/Statutes/index.cfm?App_mode=Display_Statute&Search_String=&URL=Ch0768/SEC1355.HTM&Title=-%3E2005-%3ECh0768-%3ESection+1355

Chapter 110 program:
http://www.doh.state.fl.us/tobacco/VHS/archive/Volunteer/default.html

Good Samaritan Law
http://en.wikipedia.org/wiki/Good_Samaritan_law#In_the_United_States

Uniform Emergency Volunteer Health Practice Act: licensed health practitioners
http://www.uevhpa.org/DesktopDefault.aspx?tabindex=1&tabid=55

VII. MRC TRAINING SUMMARY

Thank you for your dedicated participation in this MRC Core Competency Training Program. You now have a set of tools that will enable you to make a real difference in your community, state, and nation in the event of a disaster.

Remember to:

1. Complete your personal and family preparedness plan – an absolute first step.
2. Participate in ongoing MRC training and related meetings to enable you to protect the safety health and overall wellbeing of yourselves, your families, your MRC team and your community.

Complete the IS-100.b and IS-700.a courses to demonstrate your understanding of the incident command structure utilized during a disaster and emergency communication processes with response partners, the media, general public and others in an emergency.

THIS TRAINING IS AVAILABLE ONLINE AT:

http://training.fema.gov/EMIWeb/IS/is/is100b.asp
http://training.fema.gov/EMIWeb/IS/is700.asp

Through your MRC coordinator you will

1. Continue to identify impact a disaster can have on the mental health of everyone involved including yourselves, your families, your MRC team, and those individuals impacted in a disaster.
2. Demonstrate your ability as a MRC volunteer to actively participate in a drill, exercise, tabletop, or actual emergency event.
3. Continue to develop an understanding of the role of the MRC in public health emergency response.
4. Continue to identify your ongoing needs as a volunteer for training and skills development.

Remember always that your role as an MRC volunteer is a critically important one in the time of a disaster.

Your heath safety and personal preparedness is essential!

Your roles and responsibilities as a volunteer are to be taken seriously and with a great sense of pride!

As a volunteer you have important roles and responsibilities to fulfill. I sincerely hope that your involvement with the public health preparedness system as a MRC volunteer will be a long –lasting one. Soon you can make a real difference in public health preparedness.

Once again thank you for your service as a MRC volunteer. Welcome to the enriching MRC world!

IX. APPENDIX

A) GLOSSARY OF TERMS FREQUENTLY USED IN EMERGENCY PREPAREDNESS

A

ACTION PLAN:
(See Incident Action Plan)

AGENCY:
An agency is a division of government with a specific function, or a nongovernmental organization (e.g., private contractor, business, etc.) that offers a particular kind of assistance. In ICS, agencies are defined as jurisdictional (having statutory responsibility for incident mitigation) or assisting and/or cooperating (providing resources and/or assistance). (See Assisting Agency, Cooperating Agency, and Multi-agency.)

AGENCY EXECUTIVE OR ADMINISTRATOR:
Chief executive officer (or designee) of the agency or jurisdiction that has responsibility for the incident.

AGENCY DISPATCH:
The agency or jurisdictional facility from which resources are allocated to incidents.

AGENCY REPRESENTATIVE:
An individual assigned to an incident from an assisting or cooperating agency who has been delegated authority to make decisions on matters affecting that agency's participation at the incident. Agency Representatives report to the Incident Liaison Officer.

AIR OPERATIONS BRANCH DIRECTOR:
The person primarily responsible for preparing and implementing the air operations portion of the Incident Action Plan. Also responsible for providing logistical support to helicopters operating on the incident.

ALLOCATED RESOURCES:
Resources dispatched to an incident.

AREA COMMAND:
An organization established to: 1) oversee the management of multiple incidents that are each being handled by an Incident Command System organization; or 2) to oversee the management of a very large incident that has multiple Incident Management Teams assigned to it. Area Command has the responsibility to set overall strategy and priorities, allocate critical resources based on priorities, ensure that incidents are properly managed, and ensure that objectives are met and strategies followed.

ASSIGNED RESOURCES:
Resources checked in and assigned work tasks on an incident.

ASSIGNMENTS:
Tasks given to resources to perform within a given operational period, based upon tactical objectives in the Incident Action Plan.

ASSISTANT:
Title for subordinates of the Command Staff positions. The title indicates a level of technical capability, qualifications, and responsibility subordinate to the primary positions. Assistants may also be used to supervise unit activities at camps.

ASSISTING AGENCY:
An agency directly contributing tactical or service resources to another agency.

AVAILABLE RESOURCES:
Incident-based resources which are ready for deployment.

B

BASE:
The location at which primary logistics functions for an incident are coordinated and administered. There is only one Base per incident. (Incident name or other designator will be added to the term Base.) The Incident Command Post may be collocated with the Base.

BRANCH:
The organizational level having functional or geographic responsibility for major parts of incident operations. The Branch level is organizationally between Section and Division/Group in the Operations Section, and between Section and Units in the Logistics Section. Branches are identified by the use of Roman Numerals or by functional name (e.g., medical, security, etc.).

C

CACHE:
A pre-determined complement of tools, equipment, and/or supplies stored in a designated location, available for incident use.

CAMP:
A geographical site, within the general incident area, separate from the Incident Base, equipped and staffed to provide sleeping, food, water, and sanitary services to incident personnel.

CHAIN OF COMMAND:
A series of management positions in order of authority.

CHECK-IN:
The process whereby resources first report to an incident. Check-in locations include: Incident Command Post (Resources Unit), Incident Base, Camps, Staging Areas, Helibases, Helispots, and Division Supervisors (for direct line assignments).

CHIEF:
The ICS title for individuals responsible for command of functional sections: Operations, Planning, Logistics, and Finance / Administration.

CLEAR TEXT:
The use of plain English in radio communications transmissions. No Ten Codes or agency-specific codes are used when utilizing Clear Text.

COMMAND:
The act of directing and/or controlling resources by virtue of explicit legal, agency, or delegated authority. May also refer to the Incident Commander.

COMMAND POST:
(See Incident Command Post)

COMMAND STAFF:
The Command Staff consists of the Information Officer, Safety Officer, and Liaison Officer. They report directly to the Incident Commander. They may have an assistant or assistants, as needed.

COMMUNICATIONS UNIT:
An organizational unit in the Logistics Section responsible for providing communication services at an incident. A Communications Unit may also be a

facility (e.g., a trailer or mobile van) used to provide the major part of an Incident Communications Center.

COMPACTS:
Formal working agreements among agencies to obtain mutual aid.

COMPENSATION UNIT/CLAIMS UNIT:
Functional unit within the Finance/Administration Section responsible for financial concerns resulting from property damage, injuries, or fatalities at the incident.
COMPLEX:
Two or more individual incidents located in the same general area which are assigned to a single Incident Commander or to Unified Command.

COOPERATING AGENCY:
An agency supplying assistance other than direct tactical or support functions or resources to the incident control effort (e.g., Red Cross, telephone company, etc.).

COORDINATION:
The process of systematically analyzing a situation, developing relevant information, and informing appropriate command authority of viable alternatives for selection of the most effective combination of available resources to meet specific objectives. The coordination process (which can be either intra- or interagency) does not involve dispatch actions. However, personnel responsible for coordination may perform command or dispatch functions within the limits established by specific agency delegations, procedures, legal authority, etc.

COORDINATION CENTER:
Any facility that is used for the coordination of agency or jurisdictional resources in support of one or more incidents.

COST SHARING AGREEMENTS:
Agreements between agencies or jurisdictions to share designated costs related to incidents. Cost sharing agreements are normally written but may also be oral between authorized agency or jurisdictional representatives at the incident.

COST UNIT:
Functional unit within the Finance/Administration Section responsible for tracking costs, analyzing cost data, making cost estimates, and recommending cost-saving measures.

CREW:
(See Single Resource)

D

DELEGATION OF AUTHORITY:
A statement provided to the Incident Commander by the Agency Executive delegating authority and assigning responsibility. The Delegation of Authority can include objectives, priorities, expectations, constraints, and other considerations or guidelines as needed. Many agencies require written Delegation of Authority to be given to Incident Commanders prior to their assuming command on larger incidents.

DEPUTY:
A fully qualified individual who, in the absence of a superior, could be delegated the authority to manage a functional operation or perform a specific task. In some cases, a Deputy could act as relief for a superior and therefore must be fully qualified in the position. Deputies can be assigned to the Incident Commander, General Staff, and Branch Directors.

DEMOBILIZATION UNIT:
Functional unit within the Planning Section responsible for assuring orderly, safe, and efficient demobilization of incident resources.

DIRECTOR:
The ICS title for individuals responsible for supervision of a Branch.

DISPATCH:
The implementation of a command decision to move a resource or resources from one place to another.

DISPATCH CENTER:
A facility from which resources are assigned to an incident.

DIVISION:
Divisions are used to divide an incident into geographical areas of operation. A Division is located within the ICS organization between the Branch and the Task Force/Strike Team. (See Group.) Divisions are identified by alphabetic characters for horizontal applications and, often, by floor numbers when used in buildings.

DOCUMENTATION UNIT:
Functional unit within the Planning Section responsible for collecting, recording, and safeguarding all documents relevant to the incident.

E

EMERGENCY MANAGEMENT COORDINATOR/DIRECTOR:
The individual within each political subdivision that has coordination responsibility for jurisdictional emergency management.

EMERGENCY MEDICAL TECHNICIAN (EMT):
A health-care specialist with particular skills and knowledge in pre-hospital emergency medicine.

EMERGENCY OPERATIONS CENTER (EOC):
A pre-designated facility established by an agency or jurisdiction to coordinate the overall agency or jurisdictional response and support to an emergency.

EMERGENCY OPERATIONS PLAN:
The plan that each jurisdiction has and maintains for responding to appropriate hazards.

EVENT:
A planned, non-emergency activity. ICS can be used as the management system for a wide range of events, e.g., parades, concerts, or sporting events.

F

FACILITIES UNIT:
Functional unit within the Support Branch of the Logistics Section that provides fixed facilities for the incident. These facilities may include the Incident Base, feeding areas, sleeping areas, sanitary facilities, etc.

FIELD OPERATIONS GUIDE:
A pocket-size manual of instructions on the application of the Incident Command System.

FINANCE/ADMINISTRATION SECTION:
The Section responsible for all incident costs and financial considerations. Includes the Time Unit, Procurement Unit, Compensation/Claims Unit, and Cost Unit.

FOOD UNIT:
Functional unit within the Service Branch of the Logistics Section responsible for providing meals for incident personnel.

FUNCTION:
In ICS, function refers to the five major activities in the ICS, i.e., Command, Operations, Planning, Logistics, and Finance / Administration. The term function is also used when describing the activity involved, e.g., the planning function.

G

GENERAL STAFF:
The group of incident management personnel reporting to the Incident Commander. They may each have a deputy, as needed. The General Staff consists of:

Operations Section Chief
Planning Section Chief
Logistics Section Chief
Finance/Administration Section Chief

GENERIC ICS:
Refers to the description of ICS that is generally applicable to any kind of incident or event.

GROUND SUPPORT UNIT:
Functional unit within the Support Branch of the Logistics Section responsible for the fueling, maintaining, and repairing of vehicles, and the transportation of personnel and supplies.

GROUP:
Groups are established to divide the incident into functional areas of operation. Groups are composed of resources assembled to perform a special function not necessarily within a single geographic division. (See Division.) Groups are located between Branches (when activated) and Resources in the Operations Section.

H

HELIBASE:
The main location for parking, fueling, maintenance, and loading of helicopters operating in support of an incident. It is usually located at or near the incident base.

HELISPOT:
Any designated location where a helicopter can safely take off and land. Some helispots may be used for loading of supplies, equipment, or personnel.

HIERARCHY OF COMMAND:
(See Chain of Command.)

I

ICS NATIONAL TRAINING CURRICULUM:
A series of 17 training modules consisting of instructor guides, visuals, tests, and student materials. The modules cover all aspects of ICS operations. The modules can be intermixed to meet specific training needs.

INCIDENT:
An occurrence either human caused or by natural phenomena, that requires action by emergency service personnel to prevent or minimize loss of life or damage to property and/or natural resources.

INCIDENT ACTION PLAN:
Contains objectives reflecting the overall incident strategy and specific tactical actions and supporting information for the next operational period. The Plan may be oral or written. When written, the Plan may have a number of forms as attachments (e.g., traffic plan, safety plan, communications plan, map, etc.).

INCIDENT BASE:
Location at the incident where the primary logistics functions are coordinated and administered. (Incident name or other designator will be added to the term Base.) The Incident Command Post may be collocated with the Base. There is only one Base per incident.

INCIDENT COMMANDER:
The individual responsible for the management of all incident operations at the incident site.

INCIDENT COMMAND POST (ICP):
The location at which the primary command functions are executed. The ICP may be collocated with the incident base or other incident facilities.

INCIDENT COMMAND SYSTEM (ICS):
A standardized on-scene emergency management concept specifically designed to allow its user(s) to adopt an integrated organizational structure equal to the complexity and demands of single or multiple incidents, without being hindered by jurisdictional boundaries.

INCIDENT COMMUNICATIONS CENTER:
The location of the Communications Unit and the Message Center.

INCIDENT MANAGEMENT TEAM:
The Incident Commander and appropriate Command and General Staff personnel assigned to an incident.

INCIDENT OBJECTIVES:
Statements of guidance and direction necessary for the selection of appropriate strategy(s), and the tactical direction of resources. Incident objectives are based on realistic expectations of what can be accomplished when all allocated resources have been effectively deployed. Incident objectives must be achievable and measurable, yet flexible enough to allow for strategic and tactical alternatives.

INFORMATION OFFICER:
A member of the Command Staff responsible for interfacing with the public and media or with other agencies requiring information directly from the incident. There is only one Information Officer per incident. The Information Officer may have assistants.

INITIAL ACTION:
The actions taken by resources which are the first to arrive at an incident.

INITIAL RESPONSE:
Resources initially committed to an incident.

INCIDENT SUPPORT ORGANIZATION:
Includes any off-incident support provided to an incident. Examples would be Agency Dispatch centers, Airports, Mobilization Centers, etc.

J

JURISDICTION:
The range or sphere of authority. Public agencies have jurisdiction at an incident related to their legal responsibilities and authority for incident mitigation. Jurisdictional authority at an incident can be political/geographical (e.g., city, county, state, or federal boundary lines) or functional (e.g., police department, health department, etc.). (See Multi-jurisdiction.)

JURISDICTIONAL AGENCY:
The agency having jurisdiction and responsibility for a specific geographical area, or a mandated function.

L

LANDING ZONE:
(See Helispot.)

LEADER:
The ICS title for an individual responsible for a Task Force, Strike Team, or functional unit.

LIAISON OFFICER:
A member of the Command Staff responsible for coordinating with representatives from cooperating and assisting agencies.

LOGISTICS SECTION:
The Section responsible for providing facilities, services, and materials for the incident.

LIFE-SAFETY:
Refers to the joint consideration of both the life and physical well being of individuals.

M

MANAGERS:
Individuals within ICS organizational units that are assigned specific managerial responsibilities, e.g., Staging Area Manager or Camp Manager.

MANAGEMENT BY OBJECTIVES:
In ICS, this is a top-down management activity which involves a three-step process to achieve the incident goal. The steps are: establishing the incident objectives, selection of appropriate strategy(s) to achieve the objectives, and the tactical direction associated with the selected strategy. Tactical direction includes: selection of tactics, selection of resources, resource assignments, and performance monitoring.

MEDICAL UNIT:
Functional unit within the Service Branch of the Logistics Section responsible for the development of the Medical Emergency Plan, and for providing emergency medical treatment of incident personnel.

MESSAGE CENTER:
The Message Center is part of the Incident Communications Center and is collocated or placed adjacent to it. It receives, records, and routes information about resources reporting to the incident, resource status, and administrative and tactical traffic.

MOBILIZATION:
The process and procedures used by all organizations federal, state, and local for activating, assembling, and transporting all resources that have been requested to respond to or support an incident.

MOBILIZATION CENTER:
An off-incident location at which emergency service personnel and equipment are temporarily located pending assignment, release, or reassignment.

MULTI-AGENCY COORDINATION (MAC):
A generalized term which describes the functions and activities of representatives of involved agencies and/or jurisdictions who come together to make decisions regarding the prioritizing of incidents, and the sharing and use of critical resources. The MAC organization is not a part of the on-scene ICS and is not involved in developing incident strategy or tactics.

MULTI-AGENCY COORDINATION SYSTEM (MACS):
The combination of personnel, facilities, equipment, procedures, and communications integrated into a common system. When activated, MACS has the responsibility for coordination of assisting agency resources and support in a multi-agency or multi-jurisdictional environment. A MAC Group functions within the MACS.

MULTI-AGENCY INCIDENT:
An incident where one or more agencies assist a jurisdictional agency or agencies. May be single or unified command

MULTIJURISDICTION INCIDENT:
An incident requiring action from multiple agencies that have a statutory responsibility for incident mitigation. In ICS these incidents will be managed under Unified Command.

MUTUAL AID AGREEMENT:
Written agreement between agencies and/or jurisdictions in which they agree to assist one another upon request, by furnishing personnel and equipment.

N

NATIONAL INTERAGENCY INCIDENT MANAGEMENT SYSTEM (NIIMS):
An NWCG-developed program consisting of five major subsystems which collectively provide a total systems approach to all-risk incident management. The subsystems are: The Incident Command System, Training, Qualifications and Certification, Supporting Technologies, and Publications Management.

NATIONAL WILDFIRE COORDINATING GROUP (NWCG):
A group formed under the direction of the Secretaries of the Interior and Agriculture to improve the coordination and effectiveness of wildland fire activities, and provide a forum to discuss, recommend appropriate action, or resolve issues and problems of substantive nature. The NWCG has been a primary supporter of ICS development and training.

O

OFFICER:
The ICS title for the personnel responsible for the Command Staff positions of Safety, Liaison, and Information.

OPERATIONAL PERIOD:
The period of time scheduled for execution of a given set of operation actions as specified in the Incident Action Plan. Operational Periods can be of various lengths, although usually not over 24 hours.

OPERATIONS SECTION:
The Section responsible for all tactical operations at the incident. Includes Branches, Divisions and/or Groups, Task Forces, Strike Teams, Single Resources, and Staging Areas.

OUT-OF-SERVICE RESOURCES:
Resources assigned to an incident but unable to respond for mechanical, rest, or personnel reasons.

OVERHEAD PERSONNEL:
Personnel who are assigned to supervisory positions which include Incident Commander, Command Staff, General Staff, Directors, Supervisors, and Unit Leaders.

P

PLANNING MEETING:
A meeting held as needed throughout the duration of an incident, to select specific strategies and tactics for incident control operations, and for service and support planning. On larger incidents, the planning meeting is a major element in the development of the Incident Action Plan.

PLANNING SECTION:
Responsible for the collection, evaluation, and dissemination of tactical information related to the incident, and for the preparation and documentation of Incident Action Plans. The Section also maintains information on the current and

forecasted situation, and on the status of resources assigned to the incident. Includes the Situation, Resource, Documentation, and Demobilization Units, as well as Technical Specialists.

PROCUREMENT UNIT:
Functional unit within the Finance/Administration Section responsible for financial matters involving vendor contracts.

R

RADIO CACHE:
A supply of radios stored in a pre-determined location for assignment to incidents.

RECORDERS:
Individuals within ICS organizational units who are responsible for recording information. Recorders may be found in Planning, Logistics, and Finance / Administration Units.

REINFORCED RESPONSE:
Those resources requested in addition to the initial response.

REPORTING LOCATIONS:
Location or facilities where incoming resources can check-in at the incident. (See Check-in.)

RESOURCES:
Personnel and equipment available, or potentially available, for assignment to incidents. Resources are described by kind and type, e.g., ground, water, air, etc., and may be used in tactical support or overhead capacities at an incident.

RESOURCES UNIT:
Functional unit within the Planning Section responsible for recording the status of resources committed to the incident. The Unit also evaluates resources currently committed to the incident, the impact that additional responding resources will have on the incident, and anticipated resource needs.

S

SAFETY OFFICER:
A member of the Command Staff responsible for monitoring and assessing safety hazards or unsafe situations, and for developing measures for ensuring personnel safety. The Safety Officer may have assistants.

SECTION:
That organization level with responsibility for a major functional area of the incident, e.g., Operations, Planning, Logistics, Finance / Administration. The Section is organizationally between Branch and Incident Commander.

SECTOR:
Term used in some applications to describe an organizational level similar to an ICS Division or Group. Sector is not a part of ICS terminology.

SEGMENT:
A geographical area in which a task force/strike team leader or supervisor of a single resource is assigned authority and responsibility for the coordination of resources and implementation of planned tactics. A segment may be a portion of a division or an area inside or outside the perimeter of an incident. Segments are identified with Arabic numbers.

SERVICE BRANCH:
A Branch within the Logistics Section responsible for service activities at the incident. Includes the Communications, Medical, and Food Units.

SINGLE RESOURCE:
An individual, a piece of equipment and its personnel complement, or a crew or team of individuals with an identified work supervisor that can be used on an incident.

SITUATION UNIT:
Functional unit within the Planning Section responsible for the collection, organization, and analysis of incident status information, and for analysis of the situation as it progresses. Reports to the Planning Section Chief.

SPAN OF CONTROL:
The supervisory ratio of from three-to-seven individuals, with five-to-one being established as optimum.

STAGING AREA:
Staging Areas are locations set up at an incident where resources can be placed while awaiting a tactical assignment. Staging Areas are managed by the Operations Section.

STRATEGY:
The general plan or direction selected to accomplish incident objectives.

STRIKE TEAM:
Specified combinations of the same kind and type of resources, with common communications and a leader.

SUPERVISOR:
The ICS title for individuals responsible for command of a Division or Group.

SUPPLY UNIT:
Functional unit within the Support Branch of the Logistics Section responsible for ordering equipment and supplies required for incident operations.

SUPPORT BRANCH:
A Branch within the Logistics Section responsible for providing personnel, equipment, and supplies to support incident operations. Includes the Supply, Facilities, and Ground Support Units.

SUPPORTING MATERIALS:
Refers to the several attachments that may be included with an Incident Action Plan, e.g., communications plan, map, safety plan, traffic plan, and medical plan.

SUPPORT RESOURCES:
Non-tactical resources under the supervision of the Logistics, Planning, Finance/Administration Sections, or the Command Staff.

T

TACTICAL DIRECTION:
Direction given by the Operations Section Chief which includes the tactics appropriate for the selected strategy, the selection and assignment of resources, tactics implementation, and performance monitoring for each operational period.

TASK FORCE:
A combination of single resources assembled for a particular tactical need, with common communications and a leader.

TEAM:
(See Single Resource.)

TECHNICAL SPECIALISTS:
Personnel with special skills that can be used anywhere within the ICS organization.

TEMPORARY FLIGHT RESTRICTIONS (TFR):

Temporary airspace restrictions for non-emergency aircraft in the incident area. TFRs are established by the FAA to ensure aircraft safety, and are normally limited to a five-nautical-mile radius and 2000 feet in altitude.

TIME UNIT:
Functional unit within the Finance/Administration Section responsible for recording time for incident personnel and hired equipment.

TYPE:
Refers to resource capability. A Type 1 resource provides a greater overall capability due to power, size, capacity, etc., than would be found in a Type 2 resource. Resource typing provides managers with additional information in selecting the best resource for the task.

U

UNIFIED AREA COMMAND:
A Unified Area Command is established when incidents under an Area Command are multi-jurisdictional. (See Area Command and Unified Command.)

UNIFIED COMMAND:
In ICS, Unified Command is a unified team effort which allows all agencies with responsibility for the incident, either geographical or functional, to manage an incident by establishing a common set of incident objectives and strategies. This is accomplished without losing or abdicating agency authority, responsibility, or accountability.

UNIT:
The organizational element having functional responsibility for a specific incident planning, logistics, or finance/administration activity.

UNITY OF COMMAND:
The concept by which each person within an organization reports to one and only one designated person.