
**MEDICAL RESERVE CORPS
Of SOUTHWESTERN VERMONT**

*medical
reserve
corps*



**OPERATIONS
AND MANAGEMENT PLAN**

April 2005

Version 1.2.1

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Overview of the Medical Reserve Corps

1. The Medical Reserve Corps of Southwestern Vermont (“MRC”) is a locally-based, region-wide medical-personnel resource whose purpose is to augment, assist and support the existing medical and public health systems during disasters and public health emergencies.
2. The MRC was created through a partnership with the American Red Cross Green Mountain Chapter (“ARC”), Southwestern Vermont Health Care (“SVHC”) and the Vermont Department of Health (“VDH”) pursuant to a grant from the U.S. Department of Health and Human Services as part of the USA Freedom Corps and Citizens Corps.
3. The MRC consists of volunteer healthcare professionals from several different disciplines who can be called upon to assist the community in the event of a major disaster or large-scale public health emergency, including natural or man-made disasters or acts of terrorism.
4. As an “all-hazards” resource, the unit’s personnel and resources may be utilized in any type of natural or man-made emergency. Unit personnel will only be used in functional areas or assignments for which they are properly trained and equipped.
5. The Medical Reserve Corps of Southwestern Vermont may be used in large-scale, complex emergencies involving multiple jurisdictions and interagency operations or in smaller incidents involving a single jurisdiction or agency. MRC personnel and resources may be assigned to area hospitals, public health agencies or mass care facilities to augment and assist the staff of these healthcare facilities.
6. The Medical Reserve Corps unit *will not* replace or supplant existing emergency medical response systems or its resources. During emergencies, Medical Reserve Corps volunteers may provide an important "surge" capability to perform some functions usually performed by emergency health staff who have been mobilized. They can also augment medical and support staff shortages at local medical or emergency facilities.
7. The Medical Reserve Corps of Southwestern Vermont is primarily designed to assist and supplement the existing emergency medical response and public health systems in emergencies. However, MRC personnel and resources may be utilized in non-emergency situations (i.e. public health initiatives, community health outreach programs, etc) depending upon on their availability and the approval of the Board of Directors.

Mission Statement

The mission of the Medical Reserve Corps of Southwestern Vermont is to serve as a medical personnel resource for the Southwestern Vermont and surrounding region. The Medical Reserve Corps of Southwestern Vermont will support and assist local governments and area healthcare systems with emergency medical operations and vital public and community health activities.

Purpose:

1. When major disasters have occurred, the American people have been quick to offer aid and assistance to their fellow citizens. However, as evidenced by the Oklahoma City bombing and World Trade Center collapse, an uncoordinated response of civilian volunteers can overwhelm and clog the rescue efforts and result in an increased risk of injury or death to the volunteers.
2. The MRC seeks to attract professionals from various local healthcare disciplines to assist in this essential community service. Throughout the year, the MRC will provide continuing education and training to support its mission and enhance the volunteers' abilities. MRC volunteers may include physicians, nurses, pharmacists, dentists, and other allied health professionals. Additionally, volunteers with administrative or support qualifications may be enrolled to assist the MRC development and implementation.
3. The MRC will maintain volunteers' credentials, contact information, and other relevant information in a database so, during times of critical need, the volunteer may be rapidly deployed to assist the community's response.
4. The MRC has an integral role in community's disaster plans and the Vermont Department of Health's Strategic National stockpile (SNS) and Chempack plans The three main missions (roles) of the MRC of Southwestern Vermont are to:
 - Improve the community's "surge capacity" (influx of ill or injured),
 - Enhance the Vermont Department of Health with Mass Medication Distribution
 - Support the Vermont Department of Health with Mass Immunizations in the event of a public health emergency or bioterrorist event.
 - Provide emergency Mental Health Initiatives: Mass Care for the Worried Well

ROLES OF MEDICAL RESERVE CORPS

1. Increase “Surge Capacity” of Community:

- a) In the event of a natural or man-made disaster, the federal government recommends a hospital of Southwestern Vermont Medical Center’s size and location should be able to be self-sufficient and able to acutely manage 150-200 patients for up to 72 hours. It is estimated that it may take this longer, or longer, for state and/or federal assistance programs (e.g. Disaster Medical Assistance Teams, Metropolitan Medical Response Systems, etc) to arrive and set up.
- b) In the event part or all of Southwestern Vermont Medical Center became disabled or incapacitated, the nearest hospital is over 45 minutes away by ground transfer. EMS agencies within this area are limited in resources and personnel and might not be able to effectively manage both the provisions of community emergency care and transportation to these nearest hospitals.
- c) Southwestern Vermont Medical Center has established cooperative agreements with area businesses to utilize space in emergency situations to create Alternate Care Facilities.
- d) Medical Reserve Corps Volunteers would be trained and able to respond to these facilities and assist in the provision of care, stabilization and transfer of patients.
- e) Lessons learned from the Oklahoma City bombing and 9/11 show that a massive influx of volunteers during disasters is inevitable and can lead to increased confusion, inhibition of rescue efforts and risk of injury and death to these untrained, spontaneous volunteers.
- f) Often spontaneous volunteers with much needed knowledge and skills are not able to assist with disaster operations for lack of an ability to verify the volunteer’s credentials or qualifications.

2) Mass Prophylaxis (Immunizations):

- a) In the event of a Bioterrorist attack or other public health emergency in which mass immunizations will be needed in a timely manner, there are currently not enough qualified and trained healthcare professionals to accomplish this in the Southwestern Vermont area.
- b) Upon the MRC activation, this void can be filled by simultaneously deploying multiple teams of personnel to establish and manage remote immunization sites.

- c) Teams would consist of physicians, nurses, pharmacists, and other allied health professionals specially trained in mass immunization techniques and utilizing specific protocols and policies established.

3) Mass Medication Distribution

- a) Similarly, if mass medication distribution were required due to a public health emergency, the Southwestern Vermont area does not have a process to identify and train additional healthcare providers.
- b) Although there are many pharmacists and pharmacies within this area, there is not a mechanism by which mass medication distribution can be accomplished or accomplished in a manner that does not adversely economically affect these businesses.
- c) Activation of the MRC will fill this void by deploying teams of physicians, nurses, pharmacist, pharmacy techs, etc. to assist with the receipt and distribution of medications and implementation of the National Pharmacy Stockpile (NPS) plan.

4) Emergency Mental Health Initiatives: Mass Care for the Worried Well

- a) Catastrophic events result in an increase in the need to mental health evaluation and care to victims, rescuers and families.
- b) The Medical Reserve Corps of Southwestern Vermont will be able to assist in this matter through the Disaster Mental Health Services in conjunction with the Green Mountain Chapter of the American Red Cross and the United Counseling Service, Inc.
- c) Mental Health professionals, clergy, pastoral counselors, physicians, nurses and other allied health professionals will be able to meet the mental and physical health needs of the community.

Situations

- 1) There are several emergency medical service agencies in the MRC coverage area providing Basic Life Support (BLS) and limited Advanced Life Support (ALS) capabilities. Many of these agencies are volunteer, with limited personnel resources. Physicians and/or nurses do not normally respond to emergencies in the field with these EMS agencies.
- 2) There is only one acute care hospital in the Southwestern Vermont area serving a population of approximately 80,000 in Bennington and Windham Counties. A large-scale emergency or disaster with mass casualties may severely tax the resources of this facility.
- 3) Local public health agencies do not have adequate staffing to execute large-scale mass immunization or prophylaxis operations and will need assistance from volunteer medical and other personnel in these and other public health operations.
- 4) There are not any Disaster Medical Assistance Teams (DMAT) within the state of Vermont. The nearest DMATs are in Springfield and Boston Massachusetts and in Rockland and Westchester Counties, NY. However, out-of-area emergency medical resources may take at least 12- 24 hours (possibly longer, depending upon availability) to arrive in the Southwestern Vermont area.
- 5) In addition, Disaster Medical Assistance Teams (DMATs) can only be activated in three ways:
 - a) By a presidential declaration of a disaster,
 - b) By request for major medical assistance from a state health official under provisions of the Public Health Service Act, or
 - c) In a foreign military conflict involving U.S. Armed Forces, where casualty levels are likely to exceed the capacity of the Department of Defense-Veterans Administration Medical System.
- 6) Historically, medical personnel spontaneously volunteer to assist in emergencies or disasters. Spontaneous volunteers may not be familiar with the organization and structure of the existing local emergency response system and, therefore, may not be as effective and efficient in the provision of emergency medical services as members of organized response groups. Additionally, well-qualified medical professionals may not be put to their best use when they spontaneously volunteer for lack of verification of licensure or qualifications.

Assumptions

- 1) Emergencies, especially those that are large-scale, may require medical response operations in austere environments for extended periods of time. Assistance from federal resources may require greater than 72 hours to arrive or may not be available.
- 2) Medical Reserve Corps of Southwestern Vermont personnel will need to have adequate equipment and supplies to operate for at least 72 hours.
- 3) Mutual aid agreements exist between political subdivisions and agencies across the greater MRC coverage area.
- 4) Adequate supplies of required medical equipment and pharmaceuticals may not be immediately available to medical personnel due to logistical disruptions or other limitations caused by an emergency situation.
- 5) Medical Reserve Corps of Southwestern Vermont volunteers will be well versed in the National Incident Management System (NIMS) and can be readily integrated into the existing emergency medical response system.
- 6) Area hospitals, emergency services organizations and public health agencies are aware of the organization and capabilities of the Medical Reserve Corps of Southwestern Vermont and may request the unit's assistance in emergencies.
- 7) In a large-scale mass casualty event, it is assumed that the area's only acute care hospital will be quickly overwhelmed and the traditional "treat and transport" mechanism may not be sufficient to minimize loss of life. Due to the potential delay in treatment at the hospital, patients may need to be properly triaged, periodically assessed and receive life-saving care at the scene of an emergency event. MRC personnel may be able to assist with field medical operations.

Local Plan Coordination

- 1) The operational procedures in this plan are consistent with, and complementary to:
 - The Bennington County Regional Emergency Operations Plan
 - Local Emergency Planning Committee's (LEPC) Hazardous Materials Plan
 - Vermont Department of Health's Strategic National Stockpile plans
 - Vermont Department of Health's Emergency Operations Plan
 - Vermont EMS Mass Casualty Incident Plan
 - Southwestern Vermont Medical Center's Emergency Management Plans
 - The Green Mountain Chapter American Red Cross Disaster Services
 - State of Vermont Emergency Management response plans.
 - Northern New England Metropolitan Medical Response System

ORGANIZATION AND COMPOSITION

The Medical Reserve Corps of Southwestern Vermont, Inc. encompasses a large geographic area and multiple diverse disciplines, therefore the organizational structure needs to be broad enough to meet the needs of the participating organizations, volunteers and communities served, yet remain manageable and efficient. To accomplish this, a Board of Directors shall govern the MRC. In an effort to ensure the MRC is meeting the needs of the communities served, a larger, Advisory Council shall provide guidance and advice on the scope and operations of the MRC.

Board of Directors:

- 1) The Board of Directors is comprised of stakeholders from various healthcare; organizations, community members, volunteer service agencies, and other key agencies designed to provide services to the community.
- 2) The Board of Directors has the responsibility of representing the interests of the community regardless of their respective organizational affiliation or role. The purpose of the Board is leadership and decision-making for MRC operations and activities, including:
 - Representing the interests of the Advisory Council and affiliated organizations in meeting the needs of the community.
 - Clarify the vision, mission, and roles of the MRC
 - Manage the fiscal operation of the MRC
 - Develop and support policies that facilitate the purpose of the MRC,
 - Identify needs and priorities for the MRC work,
 - Develop plans that respond to needs and maximize resources,
 - Ensure alignment of the MRC work with purpose and mission,
 - Ensure accountability of the MRC work and resources,
- 3) The Board will meet at least quarterly throughout the year with the specific purpose of setting direction, reviewing progress, and making decisions. The Board will empower the MRC Coordinator to carry-out the day-to-day leadership and operation of the program.

Advisory Council:

- 1) The MRC Advisory Council is comprised of stakeholders from various organizations with a vested interest in the community and the healthcare system. The purpose of the Advisory Council is to ensure broad-based input and support for the MRC and its activities. The role of the Advisory Council is to support the work of the MRC by:
 - Providing advisement about the needs of the community,
 - Offering input/feedback that helps shape and assess MRC activities,
 - Contributing resources for funding or facilitating MRC activities as appropriate,
 - Serve as advocates by raising awareness and sharing information about MRC activities.

- 2) The Advisory Council shall meet at least annually with the specific purpose of providing input and feedback to the Board of Directors and MRC Coordinator.

MRC Director/Coordinator:

- 1) The MRC is a complex entity and the Board of Directors is comprised of busy individuals with other employment commitments. Thus, it is prudent that the Council empower a Director and/or Coordinator to act on decisions, lead the work, and facilitate the MRC activities to ensure ongoing progress towards its mission and purpose. The Coordinator will:
 - Provide the day-to-day management of operations for the MRC
 - Develop the policies, protocols and procedures necessary for efficient operation of the MRC.
 - Organize and facilitate meetings, processes, and decisions.
 - Organize and facilitate the Advisory Council meetings, processes, and input.
 - Champion the vision for the MRC.
 - Represent the MRC's interest with the community.
 - Serve as a conduit for internal and external communications regarding the MRC.
 - Document and report to the Board of Directors on the MRC operations and activities.
 - Facilitate the evaluation of MRC operations and activities.

MRC UNIT ORGANIZATION AND COMPOSITION

Organizational Structure: The Medical Reserve Corps' Unit organizational structure is composed of the following functional areas:

1) Administrative Division

- a) Unit Commander –
 - i) A physician or healthcare administrator is desirable, although no specific profession is required.
- b) Executive Officers –MRC administrative personnel. Healthcare administrators are desirable, although no specific profession is required. Incident Command System (NIMS) experience required.
- c) Public Information Officer (PIO) – A public or media relations professional is desirable, although no specific profession is required (volunteers serving in this capacity must be trained in emergency public information, however).
- d) Liaison Officer – A healthcare professional is desirable, although no specific profession is required.

2) Medical Operations Division

- a) Chief of Medical Operations – A physician is required for this position, since he/she will oversee clinical operations.
 - 1) Physicians Unit – Physicians and physician assistants. Unit shall consist of a leader and additional physicians. The unit leader shall be a physician.
 - 2) Nursing Unit – Registered nurses, nurse practitioners, licensed practical nurses and nursing assistants. Unit shall consist of a leader and additional nurses.
 - 3) Allied Health Unit –Dentists, Dental Hygienists, Physical Therapists, Retired (unlicensed) medical professionals, Student of Nursing, Medicine, Radiology, etc.
 - 4) Pharmacy Unit – Pharmacists and pharmacy technicians. Unit shall consist of a leader and additional pharmacists or pharmacy technicians. The unit leader shall be a pharmacist.
 - 5) Mental Health Unit – Psychologists, psychiatrists, mental health counselors, grief counselors and related mental health practitioners. Unit shall consist of a leader and additional mental health professionals. *This unit focuses on mental health services for victims and their families.*

- 6) EMS Unit – Consists of Emergency Medical Technician (EMT), Emergency Medical Technician- Intermediate (EMT-I) and EMT-Paramedic (EMT-P). Role is to support medical operations and/or assist with field/transport operations.

3) Support Division

Consist of unlicensed and/or retired healthcare professionals, administrative, clerical, human resource personnel, communications specialists, HAM radio operators, Information Technology specialists, etc.

- (1) Administrative Clerical Personnel
 - (a) Records Unit
- (2) Logistics
 - (a) Supply
 - (b) Communications
 - (c) Transportation
 - (d) Labor (Personnel) Pool
- (3) Security
 - (a) Security
 - (b) Traffic/Pedestrian Flow

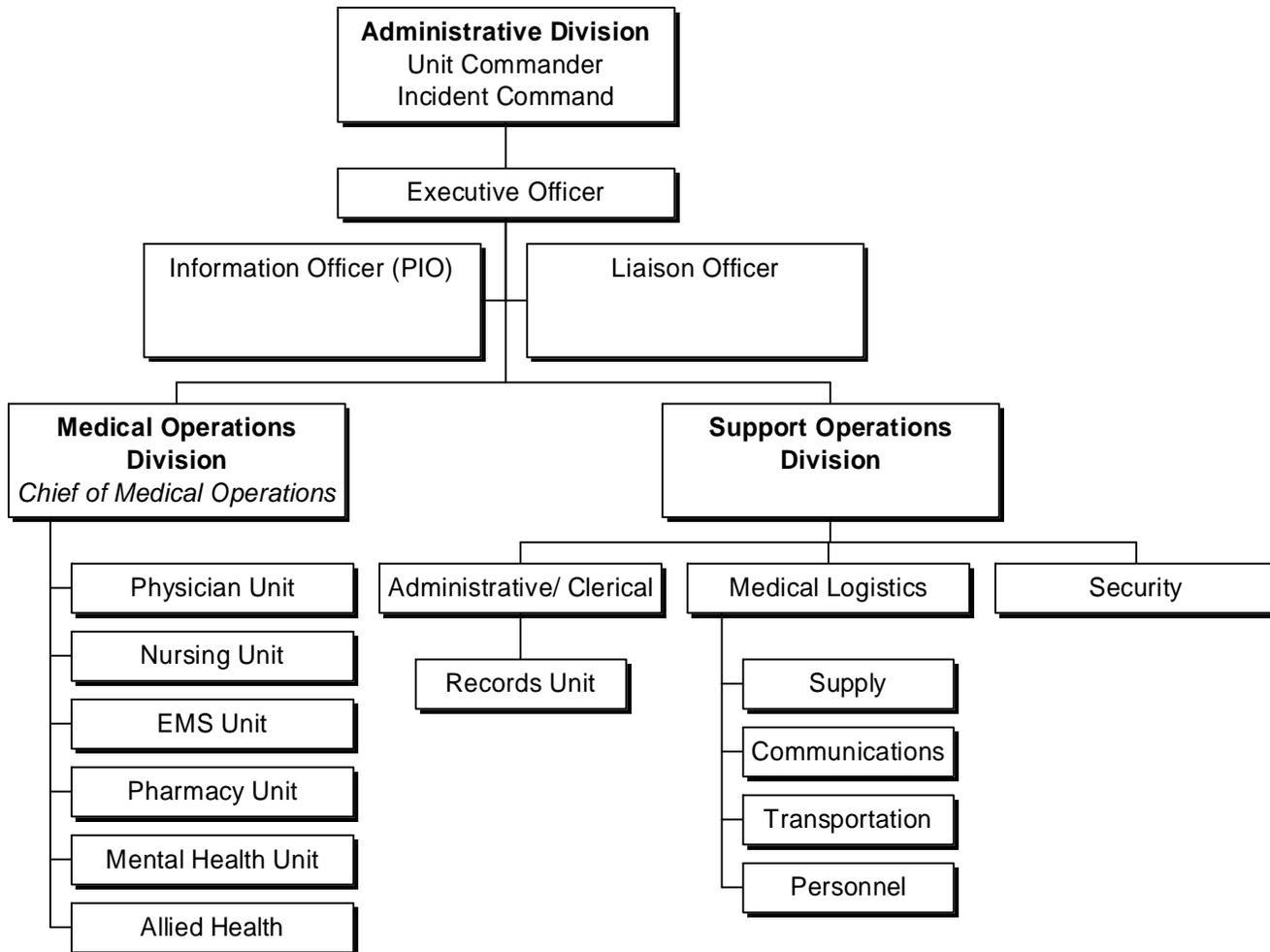


Figure 1: Organizational Structure of MRC

MEDICAL RESERVE CORPS POSITION DESCRIPTIONS

Many Medical Reserve Corps position descriptions are based on the DHHS Health and Medical Response System *Response Teams Description Manual*, May 1999.

Medical Reserve Corps personnel will normally be integrated into an incident management structure in the field or healthcare facility and will assist primary responders or medical personnel with emergency medical and medical support operations. Some Medical Reserve Corps personnel shall be trained in ICS/IMS so that they may assume ICS/IMS positions and duties commensurate with their training, experience, licensure and certifications.

ADMINISTRATIVE DIVISION: COMMAND STAFF

1) Unit Commander

- A) The Unit Commander is responsible for directing all aspects of the organization and operation of the Medical Reserve Corps during both day-to-day and emergency operations. The Unit Commander:
- i) Ensures unit personnel are properly trained and equipped to carry out their assigned duties in support of emergency medical operations in the field and assisting the local medical and public health infrastructure.
 - ii) Manages and ensures proper and timely completion of Medical Reserve Corps functions and activities at an incident.
 - iii) Ensures that supplies and support necessary to accomplish unit assignments and activities are available.
 - iv) During deployments, interacts with the Incident Commander(s) and other officials for the coordination of unit activities and support requirements.
 - v) Resolves any deploy -ability issues of individual unit members.
 - vi) Works closely with the Medical Reserve Corps Steering Committee for the formulation of policies related to unit organization, operations and activities.

2) Executive Officers

- A) The Executive Officer is the second-in-command of the Medical Reserve Corps unit during both day-to-day and emergency operations. The Executive Officer:
- i) Be trained in the National Incident Management System/Incident Command System.
 - ii) Assists the Unit Commander with the overall management and administration of the unit.

- iii) Under the direction of the Unit Commander, manages and ensures proper and timely completion of Medical Reserve Corps functions and activities at an incident.
- iv) Assists the Unit Commander in ensuring supplies and support necessary to accomplish unit assignments and activities are available.
- v) Serves in specialized positions as assigned by the Unit Commander.
- vi) Acts in the absence of the Unit Commander.
- vii) Reports to the Unit Commander.

3) Public Information Officer

- A) The Public Information Officer (PIO) is responsible for the formulation and release of information about the unit or incident to the news media, incident personnel and other appropriate agencies and organizations. he PIO reports to the Unit Commander.
- B) During emergencies, the PIO is responsible for coordinating informational activities with the PIOs of other agencies in a Joint Information Center, if one is established. The PIO:
 - i) Determines any limits on the release of information.
 - ii) Develops materials for use in briefings.
 - iii) Obtains the Incident Commander's approval of media releases.
 - iv) Provides information to the media and conduct media briefings.
 - v) Arranges for tours, interviews or required or requested briefings.
 - vi) Obtains and disseminates information that may be useful to incident planning.
 - vii) Working with an incident's Situation Status Unit, maintains current information summaries and/or displays related to the incident and provide this information to assigned personnel.

4) Liaison Officer (Agency Representative)

- A) The Liaison Officer is responsible for coordinating unit operations with other appropriate agencies as needed, including local, state and federal government agencies or private organizations.
- B) The Liaison Officer serves as an agency representative for the Medical Reserve Corps and has authority to make decisions on matters affecting the unit's participation at an incident.
- C) In an emergency, the Liaison Officer will normally be assigned to an incident command post, host jurisdiction's EOC or healthcare facility EOC as a representative of the Medical Reserve Corps. The Liaison Officer:
 - i) Ensures Medical Reserve Corps resources are properly checked-in at an incident.

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- ii) Provides input on the use of Medical Reserve Corps personnel and resources at an incident.
- iii) Assists the Medical Reserve Corps Unit Commander and Executive Officer to ensure the well-being of unit personnel assigned to an incident.
- iv) Advises the Incident Commander or Liaison Officer of any special Medical Reserve Corps needs or requirements.
- v) Ensures the Medical Reserve Corps Unit Commander is kept informed of incident status and use of unit personnel and resources.
- vi) Assists the Medical Reserve Corps Unit Commander and Executive Officer in ensuring all unit personnel and equipment are properly accounted for and released prior to departure from an incident.

MEDICAL OPERATIONS DIVISION

1) Chief of Medical Operations

- A) The Chief of Medical Operations is responsible for the management of all unit medical and/or medical support operations directly applicable to the primary missions of the unit (i.e., supporting emergency medical operations or assisting the local medical and public health infrastructure).
- B) The Chief of Medical Operations must be a licensed physician. The Chief of Medical Operations reports to the Unit Commander
- C) The Chief of Medical Operations:
 - i) Oversees and directs medical elements of the unit in accordance with the requests for medical assistance.
 - ii) Facilitates the operation of the unit to ensure quality patient care and optimal support to Incident Commanders, public health agencies or healthcare institutions.
 - iii) Determines the unit's medical staffing and logistical needs during an emergency and requests additional resources as necessary.
 - iv) Ensures Universal Precautions for all personnel against exposure to communicable diseases.
 - v) Coordinates operational actions with appropriate medical officials of other agencies and healthcare facilities.
 - vi) Receives briefings and situation reports, and ensures that all Medical Operations Division personnel are kept informed of mission objectives and status changes.
 - vii) Provides situation updates to the Unit Commander and maintains records and reports of unit medical and medical support activities.

2) Physicians Unit

- A) A Physicians Unit Leader manages the operation of the Physicians Unit and provides direct medical care to victims of an emergency or disaster.
- B) The Physicians Unit Leader must be a licensed physician.
- C) The Physicians Unit Leader reports to the Chief of Medical Operations
- D) The Physicians Unit Leader:
 - i) Supervises the overall flow of victims and medical care provided by the unit.
 - ii) Identifies conditions requiring urgent medical intervention and makes referral for patient care.
 - iii) Counsels medical personnel on difficult cases and the resolution of intensive treatment problems.

- iv) Supervises the diagnosis and treatment of victims using disaster care medicine.
- v) Refers patients for further consultation and treatment, when necessary.
- vi) Recommends methods and procedures for coordination of medical services with other medical activities.
- vii) Performs major medical care that requires a licensed physician.
- viii) Supervises medical treatment administered by other unit professional and technical personnel to assure that adequate medical services are provided to patients.

3) Nursing Unit:

- A) A Nursing Unit Leader manages the nursing operations of the Medical Reserve Corps and performs direct nursing services. The Nursing Unit Leader must be a licensed nurse.
- B) The Nursing Unit Leader reports to the Chief of Medical Operations
- C) The Nursing Unit Leader:
 - i) Provides leadership, direction and supervision of unit nursing care operations.
 - ii) Identifies and assesses needs, trends, issues and developments that may impact nursing services.
 - iii) Serves as the focal point for the identification and analysis of problems and issues affecting nursing services and recommends actions to overcome them.
 - iv) Ensures compliance with established procedures and protocols, including maintaining professional nursing standards.
 - v) Provides direct nursing services, if required, including the assessment of injuries and illnesses, performing or assisting in life support procedures and conducting required diagnostic tests.
 - vi) Performs other related duties as required to facilitate efficient nursing care operations.

4) EMS Unit

- A) A EMS Unit Leader manages the EMS operations of the Medical Reserve Corps and performs a variety of ALS and BLS health care activities.
- B) The EMS Unit Leader must be a Vermont Certified EMT or paramedic.
- C) The EMS Unit Leader reports to the Chief of Medical Operations
- D) The EMS Unit Leader:
 - i) Ensures the application of the full range of ALS and BLS functions for patients.
 - ii) Provides treatment according to established protocols.
 - iii) Recognizes symptoms that require referrals and makes such recommendations to unit physicians.

- iv) Performs medical procedures as allowed by law, including resuscitations, insertion of intravenous lines, insertion of endotracheal tubes and esophageal airways and the treatment of shock victims with volume expanders, as needed.
- v) Ensures unit EMS activities are collaborated with medical personnel in the identification and management of disaster patients in accordance with established protocols.

5) Pharmacy Unit

- A) A Pharmacy Unit Leader is responsible for compounding and dispensing prescriptions requested by physicians and other licensed practitioners at the site of an emergency or disaster.
- B) The Pharmacy Unit Leader carries out the clinical pharmacy functions of drug selection, compounding and dispensing of a variety of pharmaceuticals.
- C) The Pharmacy Unit Leader must be a Vermont licensed pharmacist.
- D) The Pharmacy Unit Leader reports to the Chief of Medical Operations.
- E) The Pharmacy Unit Leader:
 - i) Maintains responsibility for the distribution and accountability of pharmaceuticals utilized by the Medical Reserve Corps at the incident site.
 - ii) Maintains required controls on the dispensation of all pharmaceuticals.
 - iii) Provides information to medical personnel regarding concentration, number of dosages in a solution, etc.
 - iv) Makes judgments concerning drug effects and patient behavior, especially adverse effects. Brings potentially serious situations to the attention of medical personnel.
 - v) Prepares detailed reports and records involving inventories, requisitions and issuance of drugs according to applicable laws and regulations.
 - vi) Develops special formulas, extemporaneous compounding and special preparations as required.
 - vii) Resolves problems in the area of biopharmaceutic effectiveness, including problems concerning solubility, stability, incompatibility, etc.
 - viii) Suggests alternative medications to avoid incompatibilities, alleviate side effects, overcome potentiating drug combinations and prevent antagonistic reactions.
 - ix) Provides clinical pharmacology consultation to medical personnel.
 - x) Develops and implements plan to secure any controlled substances utilized by the unit.

6) Mental Health Unit

- A) A Mental Health Unit Leader manages the mental health operations of the Medical Reserve Corps.
- B) The Mental Health Unit Leader must be a licensed mental health professional, e.g., a clinical psychologist, mental health counselor or related professional. The Mental Health Unit Leader reports to the Chief of Medical Operations
- C) In collaboration with local mental health programs and services, the Mental Health Unit Leader implements and coordinates mental health services for disaster victims, including children and their families. The Mental Health Unit Leader may:
 - i) Assist with the implementation of mental health and crisis counseling services for on-site first responders and medical personnel, including Medical Reserve Corps volunteers.
 - ii) Identify appropriate intervention and prevention techniques and counseling for early identification of victims at risk of mental health and related problems.
 - iii) Consult with unit volunteers, mental health providers and family members to identify needed clinical testing and evaluation procedures for disaster victims.
 - iv) Plan for and arranges professional assistance and consultation regarding treatment planning and other interventions efforts.
 - v) Plans for and arranges professional assistance and consultation regarding treatment planning and other interventions efforts.
 - vi) Initiates efforts to develop mental health resources to serve the special needs of infants and children during disaster situations.
 - vii) Recommend stress reduction measures for unit volunteers, as necessary.

SUPPORT SERVICES DIVISION

1) Chief of Support Services (Logistics Section Chief)

- A) The Chief of Support Services directs the medical logistics, personnel and administrative operations of the Medical Reserve Corps. The Chief of Support Services:
- i) Oversees and directs the operation and administration of unit support elements and functions (i.e., personnel, administration and medical logistics sections and their subordinate units).
 - ii) Ensures unit medical and support personnel receive the training, equipment, supplies, communications, transportation and other support required to conduct emergency medical operations in the field or assist the local medical and public health infrastructure.
 - iii) Determines the unit's support staffing and logistical needs during an emergency and requests additional resources as necessary.
 - iv) Coordinates unit support services with appropriate officials of other agencies and healthcare facilities.
 - v) Receives briefings and situation reports, and ensures that all Support Services Division personnel are kept informed of mission objectives and status changes.
 - vi) Provides situation updates to the Unit Commander and maintains records and reports of unit personnel, administrative and logistical activities.
 - vii) Reviews unit personnel requirements and develops staffing plans.
 - viii) Advises the Unit Commander and staff on volunteer personnel matters.

2) Logistics Officer

- A) The Logistics Officer is responsible for planning, management and coordination of medical equipment and supply, communications and transportation operations for the Medical Reserve Corps.
- B) The Logistics Section:
- i) Implements and manages an efficient supply management program to satisfy the immediate and long-term logistical needs of the unit. Provides procurement oversight in obtaining needed external logistical support.
 - ii) During mobilization, directs loading and transportation of the unit equipment cache.
 - iii) In conjunction with the Incident Commander, Unit Commander and Chief of Support Services, determines an acceptable unit equipment cache storage site upon arrival at an incident and plans the physical layout to facilitate proper unit operations.
 - iv) Manages the set-up of the unit equipment cache and oversees the issuance of supplies and equipment.

- v) Reviews, analyzes and prioritizes requests for unit supplies and equipment.
- vi) Establishes ordering procedures.
- vii) Investigates and submits documentation and reports on lost or destroyed property to the Unit Commander for the purpose of accountability and replacement.
- viii) Maintains an adequate level of supplies and equipment necessary to accomplish the unit mission at all times during a deployment.
- ix) Develops transportation resources and coordinates transportation schedules to ensure a sufficient number of vehicles are available for transport to assigned location(s) as well as while on-site.
- x) Implements and maintains an up-to-date logistical tracking system to maintain an accountability of supplies and equipment expended and distributed from the unit cache.
- xi) Maintains a document control system that facilitates ease of transition from active disaster files to archived files.

C) Communications Section

- i) The Communications section is responsible for the management of unit communications activities and operation and maintenance of unit communications equipment. Duties may include:
 - (1) Manages unit communications activities.
 - (2) Assesses overall communications needs and development of the unit communications plan.
 - (3) Obtains radio frequencies. Sets up, operates and maintains unit communications systems during incident operations.
 - (4) Coordinates communications with appropriate entities, such as local EMS agencies, Amateur Radio Emergency Services (ARES), medical examiner/coroner, hospital communications, etc.
 - (5) Ensures accountability, maintenance and minor repairs of all issued communications equipment.
 - (6) Establishes and posts contact information for incident operations (i.e., telephone numbers, pagers, radio designations, etc.).

D) Transportation Unit

- (1) The Transportation Unit manages transportation operations for the Medical Reserve Corps.
- (2) Provides safe and reliable transportation for unit deployments and operations.
- (3) Maintains an inventory of all modes of transportation available to unit volunteers and other health and medical personnel.
- (4) Prepares time records on rental equipment and contract drivers.
- (5) Prepares the transportation plan for approval by the Medical Logistics Officer.

- (6) Operates, as necessary, medium size trucks and light vehicles, assuming vehicle operator duties and responsibilities when driving.
- (7) Maintains liaison with other agencies relative to transportation matters.

E) Security Unit

- (1) The Security Unit manages on-scene security activities for the Medical Reserve Corps unit.
- (2) Establishes contacts with local law enforcement agencies as required.
- (3) Coordinate incident security activities with appropriate law enforcement and/or security personnel.
- (4) Contacts incident Agency Representatives to discuss any special custodial requirements which may affect unit operations.
- (5) Assists law enforcement or healthcare facility security personnel with security and access control of medical work areas.
- (6) Ensures security of unit equipment and supplies.
- (7) Assists law enforcement personnel and medical examiner/coroner with removal, processing and disposition of victim remains.
- (8) Assists law enforcement and other agency personnel with evidence collection and crime scene preservation, especially related to victims' remains and belongings.

F) Administrative/Clerical Unit

- (1) This unit will consist of non-medical personnel with clerical, administrative skills who can perform a variety of functions necessary to ensure smooth operations of the MRC.

G) Records Unit

- (1) Records Unit – Training, health information, medical records or administrative specialists are desirable, although no specific profession is required. The unit shall consist of a leader and other personnel as needed

Medical Reserve Corps Operations

A. Activation

Activation Criteria: The MRC of Southwestern Vermont may be requested at any time for disasters or public health emergencies. The three main missions (roles) of the MRC of Southwestern Vermont are to:

1. Improve the community's "**surge capacity**" (influx of ill or injured),
2. Enhance the Vermont Department of Health with **Mass Medication Distribution**
3. Support the Vermont Department of Health with **Mass Immunizations** in the event of a public health emergency or bioterrorist event.
4. Provide **emergency Mental Health Initiatives**: Mass Care for the Worried Well

As the MRC is comprised solely of volunteer members, and volunteers will not adhere to a duty schedule, a request for activation *does not guarantee* availability or deployment of the MRC.

B. Activation Authority:

- 1) The Medical Reserve Corps of Southwestern Vermont may only be activated by one of the following "triggers":
 - a) **Vermont Department of Health** officials or their designated representatives.
 - b) **Hospital Chief Executive Officers**, emergency department directors or their designated representatives.
 - c) **The MRC Coordinator**; may activate the MRC for non-emergency, public health outreach services
- 2) The Vermont Emergency Management Office shall be notified of any MRC activation and/or training exercises.
- 3) The MRC may be activated in its entirety or specific units (i.e. Physician unit, Nursing Unit, Pharmacy Unit, etc) may be requested.
- 4) The MRC Coordinator can be contacted 24 hours/day at (802) 440-4236 or toll-free (800) 543-1624 extension 4236 for questions relating to activation/deployment.

C. ACTIVATION PROCESS:

- 1) Activation Authorities requesting the Medical Reserve Corps shall complete the “Activation Request Form” providing the following information:
 - a) The nature and scope of the emergency
 - b) The location of the emergency.
 - c) The estimated number of patients and their injuries.
 - d) The staging area(s) or location(s) to which the MRC unit should deploy.
 - e) Specific medical skills and/or resources needed, i.e., physicians, nurses, etc.
 - f) A contact phone number and/or radio frequency.
- 2) The Notification of MRC Volunteers shall be accomplished by whichever means is possible; depending upon circumstances:
 - a) Primary: Telephone, cell phone, pager
 - b) Secondary: Public notification via broadcast media (radio, TV, Emergency Alert System)
- 3) If telephone systems remain operational, the “Activating Authority” may contact the MRC Activation Hotline at Berkshire Communicators toll-free at **(888-390-1899)**; the call center operators will then contact the individual MRC volunteers; either via phone, pager, etc.

D. Volunteer Response:

- 1) Berkshire Communicators will contact individual MRC Volunteers to notify of activation requests. Volunteers may receive 888-390-1899, a toll-free number on their phone or pager; the MRC Activation Hotline. .
- 2) At the time of activation, ALL Medical Reserve Corps personnel will respond to the staging area specified. Personnel will be deployed from this staging area to field assignments.
- 3) For lengthy, extended operations, multiple shifts may be required. Medical Reserve Corps personnel will be assigned specific shifts of operation and will be assigned to duty stations from the staging area.

E. Staging Area:

- 1) The Staging area will serve as a central location for all MRC volunteers to:
 - a) Assemble and sign in
 - b) Be briefed on incident/deployment activities
 - c) Receive assignments
 - d) Provided “just in time” training related to incident/deployment.
 - e) Receive equipment, supplies, security badges, etc.
 - f) Provided additional instructions regarding mobilization/demobilization procedures.
 - g) Assemble post-event or post-shift to sign out (important for volunteer accountability and safety)
- 2) The Exact location of the staging area will be dependent upon the incident and areas impacted by the events; the staging area should be large enough to accommodate the needs of the MRC in processing MRC volunteers.
- 3) To avoid traffic and congestion at the incident site, all MRC volunteers shall meet at the staging area where transportation to their field assignments will be coordinated.
- 4) It may be necessary for elements of the Medical Reserve Corps volunteers with specialized skills to deploy in support of medical response efforts, rather than the entire unit.
- 5) In emergency medical operations, Medical Reserve Corps personnel may be deployed to a hospital or other healthcare facility, or to any other location where their services are needed.
- 6) Once on scene, Medical Reserve Corps volunteers will check in with the appropriate officials (usually at a staging area) and unit personnel will be integrated into the emergency medical response effort

F. Medical Operations

- 1) The Medical Reserve Corps normally will not act as a free-standing medical resource at incident scenes. Rather, unit personnel shall be integrated into the existing healthcare response system and, to the extent of their training and capabilities, provide medical assistance as needed.
- 2) The Medical Reserve Corps may support and assist local hospitals and other healthcare institutions in emergency medical operations, consistent with the training and availability of unit personnel.
- 3) If assigned to a local hospital, Medical Reserve Corps personnel shall be integrated into the facility's emergency medical organization. Unit personnel, depending on their specialty, could be used in a variety of assignments, from triaging patients in an emergency department to crisis counseling of victims and their families.
- 4) Southwestern Vermont Medical Center has adopted the Hospital Emergency Incident Command System (HEICS) for use during emergencies and disasters. Consequently, Medical Reserve Corps personnel assigned to a hospital shall be prepared to operate within a hospital's HEICS organizational framework.
- 5) In a hazardous materials or related incident with casualties, Medical Reserve Corps personnel may be utilized for post-decontamination triage, stabilization and patient care prior to transfer to hospital emergency departments. Such activities shall be confined to the "cold zone" of a hazardous materials incident and shall generally be in support of EMS resources at the scene.

G. Public Health Operations

- 1) For mass immunization or prophylaxis operations conducted by the Vermont Department of Health, volunteer medical personnel will be needed to augment the public health staff in administering vaccines, handling patient education, screening patients, maintaining medical records, emergency medical response to potential vaccine reactions and other activities that must be conducted in support of direct medical activities. Medical Reserve Corps personnel may assist with these kinds of operations.
- 2) In operations involving the deployment of the Strategic National Stockpile (SNS), Medical Reserve Corps pharmacists, pharmacy technicians and other volunteers may augment and/or assist the Vermont Department of Health, Centers for Disease Control and Prevention (CDC) and other personnel responsible for reformulations and breakdown of bulk packages to smaller, patient-specific prescriptions. In the event of an SNS deployment, Medical Reserve Corps personnel will operate in

accordance with procedures set forth in the Vermont Department of Health's emergency plans.

- 3) Medical Reserve Corps personnel may assist in staffing quarantine or isolation facilities, consistent with CDC and/or public health agency protocols and local plans.
- 4) Medical Reserve Corps personnel may assist public health agencies in response to food- or water-borne disease outbreaks, based on local plans and protocols.
- 5) Depending on their availability, Medical Reserve Corps personnel may support and assist local public health agencies in other emergency operations for which they are properly trained and equipped.

H. COMMUNICATIONS

- 1) As a new organization without its own communications equipment, the Medical Reserve Corps must rely on the communications resources of other organizations during emergency operations.
- 2) Medical Reserve Corps personnel may be assigned portable radios from a cache at the scene of an emergency. Unit personnel may also use wireless telephones or the communications resources of amateur radio organizations in an emergency (i.e., Amateur Radio Emergency Services, or ARES).
- 3) The Communications Unit shall be responsible for the procurement, operation and maintenance of the Medical Reserve Corps' communications equipment.

I. DEMOBILIZATION

- 1) Medical Reserve Corps personnel will support emergency medical, public health or hospital operations for the duration of an incident or as long as their assistance is required. It is possible that some unit personnel and resources are demobilized before others as their assignments are completed.
- 2) The Unit Commander should confer with the Incident Commander (or similar official if operating within a hospital or public health agency setting) to determine whether additional Medical Reserve Corps assistance is required.
- 3) Unit personnel will demobilize along with resources, in accordance with the Incident Action Plan and/or the Incident Commander's instructions.
- 4) When demobilizing, unit personnel should ensure all assigned activities are completed, account for unit equipment and clean up any debris or trash associated with unit assignments.

TRAINING AND EDUCATION

1. **INITIAL TRAINING FOR MEDICAL RESERVE CORPS VOLUNTEERS**

Medical Reserve Corps volunteers shall be required to successfully complete the following required initial training course before being eligible to participate in actual unit deployments:

- a. ***Medical Reserve Corps Orientation Course*** - This course provides students with an overview of the Medical Reserve Corps. This course shall cover topics such as:
 - Background and history of the Medical Reserve Corps program
 - Purpose and mission of the Medical Reserve Corps
 - Medical Reserve Corps organization and composition
 - Expected roles, tasks and duties of Medical Reserve Corps volunteers in an emergency; Familiarization with roles, procedures, responsibilities and personalities in an organization's or jurisdiction's emergency management system.
 - National Incident Management System/Incident Command System
 - Unit concept of operations, including field medical operations, public health operations, hospital operations and IMS
 - Overview of local and regional emergency services organizations and operations
 - Unit training and exercise program

- b. ***First Aid*** – For unlicensed/uncertified medical volunteers. This course combines lectures, demonstrations and video with hands-on training and practice. Participants in this course learn to recognize and respond to emergencies including shock, cardiac and breathing emergencies for adults, children and infants, heat and cold emergencies, sudden illnesses and poisonings. Additionally, participants will learn first aid for everything from cuts and scrapes to muscle, bone and joint injuries. This course is available from the American Red Cross.

- c. ***Adult, Child and Infant CPR*** - This hands-on skills training prepares students to respond to breathing and cardiac emergencies in victims. These courses are available from the American Red Cross, SVMC and other organizations.

Optional Continuing Education

- A) Optional, advanced training programs will also be developed and offered throughout the year.
- B) Specialized courses may be developed specific to each unit's (e.g. Physician unit, Pharmacy unit, Nursing unit, Support unit, etc.)
- C) The Medical Reserve Corps of Southwestern Vermont provides links to online, current, evidence-based continuing education programs. Visit the MRC website at WWW.VTMRC.ORG
- D) Additional sources of education and training are included in the Appendix.

EXERCISES

- A) Exercises are methods of evaluating local and regional responses to emergency incidents. Exercises should be designed to assess the readiness and training level of responding personnel and organizations.
- B) Exercises should include organizations potentially affected by the type of scenario or response being exercised, i.e., agencies at all levels of government, businesses and charitable and community organizations.
- C) The Medical Reserve Corps shall periodically participate in various types of exercises:
 - i) Full-Scale Exercises: These exercises are the most complex and are centered on a realistic scenario designed to evaluate response plans, methods and procedures.
 - ii) Functional Exercises: Functional exercises are designed to evaluate specific components of an emergency response. These exercises involve a simulated incident with agency personnel performing and managing various components of the event, and may occur in an classroom setting or in the field.
 - iii) Tabletop Exercises - Tabletop exercises involve a discussion and problem-solving session with agency personnel to determine if adequate policies, procedures and resources exist to manage an emergency.
 - iv) Drills – Drills are usually “practice sessions” for specific skills, functions or procedures. An example of a drill would be nurses or paramedics practicing intubations.

UNIFORMS AND EQUIPMENT

1) Uniforms

- A) The Medical Reserve Corps does not require or provide a special uniform for MRC volunteers.
- B) Volunteers should dress appropriately for the event and climate; dressing in layers is recommended especially during cooler months. In cold weather, Medical Reserve Corps personnel should carry or have available the following clothing:
 - a. Long underwear
 - b. Wool sweater
 - c. Parka or heavy coat
 - d. Watch cap or balaclava
 - e. Winter scarf
 - f. Heavy gloves or mittens
- C) During deployments, MRC volunteers may be provided with unique MRC work vest which clearly identifies volunteers as official members of the Medical Reserve Corps, provides volunteers with durable work garments necessary for medical operations in the field. Only members of the Medical Reserve Corps are authorized to wear the uniform of the unit.

2) Identification Cards

- A) Medical Reserve Corps volunteers will be issued official, photo-identification cards for use at the scene of an emergency. These identification cards will:
 - (1) Identify unit volunteers as members of a recognized emergency medical response organization.
 - (2) Provide unit volunteers with access to the scene of an emergency as part of the region's emergency medical response system.
 - (3) Document the licenses, credentials and of unit volunteers, thereby facilitating their deployment and identification in an emergency.
- B) Identification cards will be issued to unit volunteers upon their completion of requirements for active membership in the Medical Reserve Corps.
- C) Identification cards remain the sole property of the Medical Reserve Corps of Southwestern Vermont and shall be immediately returned to the MRC Coordinator upon the volunteer's resignation or termination

3) Individual Equipment

- A) The Medical Reserve Corps does not accept any responsibility for personal equipment of valuables. It is recommended that Medical Reserve Corps members refrain from bringing valuables when deploying to the field hospitals or local public health agencies.
- B) Medical Reserve Corps volunteers occupying medical positions should consider carrying the following items (if necessary to accomplish their medical duties):
 - a. Stethoscope
 - b. Hemostat
 - c. Sphygmomanometer (blood pressure cuff)
 - d. Bandage scissors
 - e. HEPA filter mask

4) Medical Equipment

- A) The Medical Reserve Corps maintains a small cache of medical equipment and supplies and an enclosed cargo trailer for rapid deployment.
- B) In addition,, organizations requesting assistance from the Medical Reserve Corps should be prepared to provide the unit necessary medical equipment and supplies.

5) Pharmaceuticals

- A) The Medical Reserve Corps does not maintain its own cache of pharmaceuticals. Consequently, organizations requesting assistance from the Medical Reserve Corps should be prepared to provide the unit with necessary pharmaceuticals.
- B) The Pharmacy Unit will be responsible for coordinating and obtaining pharmaceuticals for use by the Medical Reserve Corps.
- C) If used, pharmaceuticals will be stored, managed and accessed **ONLY** by a licensed pharmacist in accordance with state and federal laws and regulations pertaining to controlled substances.

Volunteer Recruitment and Selection

1) Recruitment

- a) Membership in the Medical Reserve Corps is open to anyone with a desire to serve their community.
- b) Although the focus of the Medical Reserve Corps is on medical operations and public health activities, healthcare experience is not a prerequisite for service with the unit. For example, while doctors and nurses may provide direct care during an emergency, persons with no healthcare experience can assist with administrative and other essential support functions.
- c) Applicants will be screened by a committee appointed by the Medical Reserve Corps Board or their designees.

2) Selection:

- a) Criteria for selection of applicants shall include:
 - 1) Possession of specialized skills, experience, licenses and/or certifications, if required by a unit position.
 - 2) Satisfactory verification of an applicant's professional credentials and/or character references, if applicable.
 - 3) Medical Reserve Corps members who (1) are physicians, nurses, pharmacists, EMTs/paramedics or other licensed and/or certified healthcare professionals and who (2) fill unit positions utilizing their specialized medical skills must ensure their medical training, licenses and/or certifications are current for the duration of their Medical Reserve Corps appointments.

APPENDIX A: SOURCES OF ADDITIONAL TRAINING/EDUCATION

The following is a preliminary listing of educational and training sites (facilities and websites) and documents which may be helpful to Medical Reserve Corps volunteers in considering training opportunities. This information is from the *Medical Reserve Corps: A Guide for Local Leaders*, published by the U.S. Department of Health and Human Services and available at the Medical Reserve Corps website, www.medicalreservecorps.gov.

MRC of Southwestern Vermont Website: www.vtmrc.org

The Training section of the MRC website offers a variety of educational programs; including web-casts and videos which can be viewed at the convenience of the MRC volunteer. In addition, announcements of special educational programs will be posted on this site periodically.

TRAINING CENTERS

Clara Barton Center for Domestic Preparedness – Pine Bluff, Arkansas

A center of the American Red Cross.

Public Health Service Noble Training Center – Anniston, Alabama

Trains doctors, nurses, paramedics and emergency medical technicians to recognize and treat patients with chemical exposures and other public health emergencies. A training program has been developed for pharmacists working with distribution of the National Pharmaceutical Stockpile. Expansion of the bioterrorism component of the Noble Training Center curriculum is a high priority for the U.S. Department of Health and Human Services (DHHS).

Federal Emergency Management Agency National Emergency Training Center – Emmitsburg, Maryland

FEMA's national training center.

BROADCAST TRAINING-LIVE RESPONSE PROGRAMS

The Office for Domestic Preparedness (ODP) and the Technical Support Working Group (TSWG), in cooperation with the Federal Emergency Management Agency (FEMA) Education Network (EENET), sponsor "**Live Response**." "**Live Response**" is an hour-long training broadcast in which a panel of experts explores topics related to WMD consequence management and engages in question and answer sessions with the program audience. "**Live Response**" is produced by the National Terrorism Preparedness Institute (NTPI) of St. Petersburg College and is a recurring satellite and internet training broadcast offering WMD related awareness information to the nation's

civilian and military emergency response communities. **"Live Response"** experts welcome phone calls concerning these and other issues and invite viewers to network during the program on the program's interactive message board.

For more information visit the following website:

<http://terrorism.spjc.edu/NTPTliveresponse.htm>

INTERNET-BASED EDUCATION AND TRAINING

FEMA Training

Federal Emergency Management Agency

<http://www.fema.gov>

IS700 NIMS

IS700 NIMS: An Introduction is a Web-based awareness level course that explains NIMS components, concepts and principles. Although it is designed to be taken online as an interactive Web-course, course materials may be downloaded and used in a group or classroom setting. Answer sheets may be obtained from the Emergency Management Institute by calling the EMI Independent Study Office at 301-447-1256. To obtain the IS700 course materials or take the course online go to <http://training.fema.gov/emiweb/IS/is700.asp>.

National Library of Medicine (NLM)

NLM has rapidly accessible information on the transmission, diagnosis and treatment of possible agents of biological and chemical warfare.

<http://www.sis.nlm.nih.gov/Tox/bioloicalwarfare.htm>

<http://www.sis.nlm.nih.gov/Tox/ChemWar.html>

<http://www.nlm.nih.gov/medlineplus/anthrax.html>

NDMS Response Team Training Program

The goal of this program is to ensure that all National Disaster Medical System team members have appropriate orientation and training for optimal in-field performance. This on-line training program allows team members to receive training as their schedule permits from any computer that has Internet access. Content has been developed by a functional working group of response team members under the guidance of the DHHS Office of Emergency Response. On-line assessment tools verify competency and completion of each module. Individual progress is tracked by both OEP and response team administrators. At this time, this training is available only to NDMS team members. Information about becoming an NDMS member is available at:

<http://www.ndms.dhhs.gov>.

American Medical Association - Bioterrorism and other Disaster Resources for the Physician

This educational resource currently includes information on anthrax, antibiotic misuse, bioterrorism, botulinum toxin, chlordane during time of disaster, organized medicine's

role in the national response to terrorism, diagnosis and treatment related to disaster medicine problems, hospital preparedness, post-traumatic stress disorder, smallpox, tularemia and responding to the growing threat of biological weapons.

<http://www.ama-assn.org/ama/pub/category/6671.html>

Bioterrorism Practical Readiness Network (Bio-PRN)

This free educational and informational program serves as a quick reference and intervention guide for physicians and healthcare administrators in studying, recognizing and treating diseases associated with bioterrorism. This network was established through a partnership of three businesses (AdvancePCS, the Medical Group Management Association and the Medical Learning Co.). Bio-PRN can be accessed through each of the partners' Web sites:

www.AdvancePCSMdnet.com/phys_bioterror.html; www.mgma.com/bioprn.cfm, or www.familypractice.com. The site is recommended for physicians and healthcare administrators. Physicians can examine virtual hypothetical patients exposed to agents used in bioterrorism. The site provides comprehensive references on biological agents; disease management flash cards with information on history, signs, symptoms, diagnosis, testing, treatment and prevention.

Medical Response to Weapons of Mass Destruction

This course is collaboration among Lippincott Williams & Wilkins, the Uniformed Services University of the Health Sciences (USUHS) and Medantic Technology. It is a course on nuclear, biological and chemical warfare for healthcare providers. This interactive online course is designed to provide medical professionals with information and rapid decision-making skills for response environments. The web-based format allows for easy access. The content is from experts at the U.S. Uniformed University of Health Sciences (USUHS). It includes ten interactive modules that address the most likely agents connected with terrorist attacks, including anthrax, smallpox and agent 15. The modules include lectures, cases and tests. Additional lecture modules are available, including psychological/psychiatric aspects, decontamination and logistics. A certificate of completion is issued by USUHS. For more information go to <http://www.wmddemo.com>. To order call: 1-(800) 326-1685 or email halexand@Lww.com

Primary Care Physicians-Diagnosis of smallpox, anthrax and other Bioterrorism-Related Infections

This website is sponsored by the Agency for Health Research and Quality (AHRQ) of DHHS. It is directed toward the estimated 265,000 primary care physicians across the country to enhance their ability to diagnose and treat rare infections and exposures to bioterrorism agents, such as smallpox and anthrax. The site was prepared by the University of Alabama at Birmingham under a contract from AHRQ. It offers five online courses for hospital emergency department physicians, nurses, radiologists,

pathologists and infection control practitioners. Courses cover identification of potential bioterrorism agents, including smallpox and anthrax and commonly associated syndromes.

<http://www.bioterrorism.uab.edu>

American Academy of Pediatrics

This website provides information about the special vulnerabilities and the unique treatment needs of children during disasters. For example, children need different dosages of medicine than adults, different sized equipment than adults, as well as special consideration during decontamination efforts. Children also have unique mental health needs. It is critical that all community preparedness efforts involve pediatric health experts as well as key facilities, institutions and agencies that care for children.

<http://www.aap.org>

An Orientation to Community Disaster Exercises (FEMA)

This study course includes a videocassette and a student manual that provides an orientation to the types of exercises used to test and evaluate a community's emergency plan. The content illustrates the eight basic steps to exercise design and emphasizes the use of a design team to ensure the success of a community's exercise program. The training is web-based with a video available. Target audience: administrators/managers, community leaders, planners. No cost.

<http://www.fema.gov/emi/is120.htm>

HANDS-ON TRAINING/COURSES

American Heart Association (AHA)

The AHA and its local chapters provide training for basic life support (BLS), cardiopulmonary resuscitation (CPR), automated external defibrillator (AED) use and other "Heartsaver" training. Courses are posted on the AHA website at:

www.gmcarc.org .

National Association of School Nurses (NASN)

NASN offers "Managing School Emergencies" training, a three-part course. Part III addresses responding to multiple trauma and mass casualty incidents. Information is available at: www.nasn.org

Society of Critical Care Medicine

Fundamental Critical Care Support (FCCS) Program. Provider and instructor courses are held throughout the year at both domestic and international sites. The Society's FCCS course provides instruction on the initial management of the critically ill or injured patient while awaiting critical care expertise. This includes care related to mechanical ventilation, monitoring, organ hypoperfusion and neurological support. The FCCS course consists of: interactive standardized lectures, interactive skill stations, and the Third Edition Textbook. The FCC covers principles required for the first 24 hours of critical care and complements ACLS and ATLS instruction. The FCCS program is most

beneficial to healthcare providers without formal critical care training, including: primary care physicians, emergency medicine physicians, nurses, critical care fellows beginning their training, residents in training, physician assistants and pre-hospital providers with lengthy patient transfer. For additional information e-mail: fccs@sccm.org or go to www.sccm.org.

VERMONT PROGRAMS

Vermont Department of Health:
<http://www.healthyvermonters.info/>

Vermont Emergency Management Office:

This site is designed to provide emergency service personnel with a single source Internet location for Vermont emergency training. Central to our success is the ability to access the many training opportunities that occur within our state. The Training Source gives Vermont's emergency responders simple access to all areas of response training, enhances our statewide training network, and encourages interagency participation. In addition to state opportunities, educational programs from out of state sources may be posted from time to time. <http://www.vtemergencytraining.org/>

Southern Vermont College's Center for Rural Preparedness & Emergency Services: <http://time2act.org/svc/>

Southern Vermont College realizes that many of the rural emergency responders are volunteers who cannot take time off from their jobs to attend education and/or training courses nor is there adequate funding for such programs. The Center will take these opportunities to them. The College will use a variety of delivery methods—Internet, at the Center, and at remote locations—to provide a blended learning experience focusing on first responders in the public safety sector. That includes but is not limited to sheriffs and local law enforcement, paramedics and EMTs, fire and HazMat, community hospitals (volunteers, nurses, doctors, and the Emergency Room personnel), public health departments, and community social service agencies. The blended learning experience allows for instruction to occur at times that are convenient for program participants.

CURRICULA AND LITERATURE

New Disaster Curriculum for Schools of Public Health. This new book can be ordered from the Public Health Foundation: <http://bookstore.phf.org/prod170.htm>. This book highlights the curriculum which is described below.

Disaster Preparedness in Schools of Public Health: A Curriculum for the New Century. This document contains a model curriculum for schools of public health and others involved in training programs for emergency preparedness. Materials include transparencies and 13 tabbed modules in a 3-ring binder.

Health Management of Natural Disasters, Scientific Publication No. 407, Pan American Health Organization, Washington, D.C. 20037. This publication provides information on structuring health disaster management, disaster preparedness, disaster mitigation in the health sector, coordination of disaster response activities and assessment of health needs, mass casualty management, epidemiological surveillance and disease control, environmental health management, food and nutrition, communications and transport, management of humanitarian relief supplies, management of international humanitarian assistance, and reestablishment of normal health programs. Website: <http://www.paho.org/disasters>

The Public Health Consequences of Disasters, edited by Dr. Eric Noji, Oxford University Press, USA Dictionaries Program, 263 Main, Suite 301, Old Saybrook, CT 06475, Phone: (860) 388-6664. This book summarizes recent and useful information about the public health impact of natural disasters, illustrated by examples from recent research in the field. The author starts with a section on the concepts and role of surveillance and epidemiology, highlighting general environmental health and health concerns. The other chapters cover discrete types of natural and technological hazards, covering their history, origin, nature, observation, prevention, and control. Throughout the book the focus is on the level of epidemiological knowledge on each aspect of natural disasters. Noji emphasizes the need for better epidemiological awareness as the basis for better understanding and control of the different types of disasters. Each chapter is based on a variety of experiences and literature drawn from both developing and industrialized countries. Target Audience: academicians, community leaders, environmental health professionals, health planners, infection control professionals, program managers, public health program staff.

Emergency Medical Services, June 2001, Volume 37, Number 6. “Core Competencies for Medical First Responders to Chemical, Biological, Radiological, and Nuclear Energy Events.” This is the report of a study by an expert task force which assessed the needs, demands, feasibility and content of training for U.S. civilian emergency medical responders (paramedics, nurses, and physicians) for nuclear, biological and chemical (NBC) terrorism. The task force recommends training programs and materials that need to be developed to overcome the identified barriers and challenges to learning for these groups.

APPENDIX B:

Sample of Volunteer Roles Matrix

Discipline		Surge Capacity / Alternate Care Facilities	Mass Immunization Mass /Medication Distribution	Mental Health
Physician (MD or DO)	Licensed	<ul style="list-style-type: none"> Staff Alternate Care Facilities Provide on-site Medical Direction. Provide BLS and ALS care. Perform physical assessments, diagnose and treat patients. 	<ul style="list-style-type: none"> Provide on-site Medical Direction to Immunization clinics Perform physical assessments, diagnose, treat and prescribe medications 	American Red Cross' Disaster Mental Health Services and United Counseling Service cover mental Health Services.
	Non-Licensed	<ul style="list-style-type: none"> Provide BLS care. 	<ul style="list-style-type: none"> Assist VDH with epidemiological surveys, interviews 	
Registered Nurse	Licensed	<ul style="list-style-type: none"> Staff Alternate Care Facilities Provide BLS and ALS care (if trained) Perform physical assessments Administer medications. 	<ul style="list-style-type: none"> Assist VDH with staffing for clinic Provide BLS care Perform physical assessments Administer medications/ vaccinations. 	
	Non-Licensed	<ul style="list-style-type: none"> Assist with delegated nursing tasks (Obtaining vital signs, bathing, dressing changes, education.) 	<ul style="list-style-type: none"> Assist with delegated nursing tasks (Obtaining vital signs, education.) 	

MEDICAL RESERVE CORPS OF SOUTHWESTERN VERMONT

Discipline		Surge Capacity / Alternate Care Facilities	Mass Immunization Mass /Medication Distribution	Mental Health
Nurse Practitioner	Licensed	<ul style="list-style-type: none"> • Staff Alternate Care Facilities • Provide BLS and ALS care (if applicable). • Perform physical assessments, • Diagnose and treat patients. 	<ul style="list-style-type: none"> • Perform physical assessments • Diagnose • Prescribe medications/ Vaccinations • Administer medications/ Vaccinations 	
	Non-Licensed	<ul style="list-style-type: none"> • Assist with delegated nursing tasks (Obtaining vital signs, bathing, dressing changes, education.)	<ul style="list-style-type: none"> • Assist with delegated nursing tasks (Obtaining vital signs, education.)	
Physician Assistants	Licensed	<ul style="list-style-type: none"> • Staff Alternate Care Facilities • Provide BLS and ALS care (if applicable). • Perform physical assessments, • Diagnose and treat patients. 	<ul style="list-style-type: none"> • Perform physical assessments • Diagnose • Prescribe medications/ Vaccinations • Administer medications/ Vaccinations 	
	Non-Licensed	<ul style="list-style-type: none"> • Assist with delegated nursing tasks (Obtaining vital signs, bathing, dressing changes, education.)	<ul style="list-style-type: none"> • Assist with delegated nursing tasks (Obtaining vital signs, education.)	
Pharmacist	Licensed	<ul style="list-style-type: none"> • Prepare & dispense medications • Consult on medications • Provide pt education 	<ul style="list-style-type: none"> • Prepare and dispense vaccinations • Consult on vaccinations • Provide pt education 	

MEDICAL RESERVE CORPS OF SOUTHWESTERN VERMONT

Discipline		Surge Capacity / Alternate Care Facilities	Mass Immunization Mass /Medication Distribution	Mental Health
	Non-Licensed	<ul style="list-style-type: none"> • Assist with non-licensed required tasks • Assist w medication distribution • Provide pt pharmacologic education 	<ul style="list-style-type: none"> • Assist with non-licensed required tasks • Assist w medication distribution • Provide pt pharmacologic education 	
Licensed Practical Nurse	Licensed	<ul style="list-style-type: none"> • Staff Alternate Care Facilities • Provide BLS care • Perform physical assessments • Administer medications within scope of practice. 	<ul style="list-style-type: none"> • Assist VDH with staffing for clinic • Provide BLS care • Perform physical assessments • Administer medications/ vaccinations within scope of practice. 	
	Non-Licensed	<ul style="list-style-type: none"> • Assist with delegated nursing tasks • (Obtaining vital signs, bathing, dressing changes, education.) 	<ul style="list-style-type: none"> • Assist with delegated nursing tasks • (Obtaining vital signs, education.) 	
Licensed Nursing Assistants	Licensed	<ul style="list-style-type: none"> • Assist with delegated nursing tasks • (Obtaining vital signs, bathing, dressing changes, education.) 	<ul style="list-style-type: none"> • Assist with delegated nursing tasks • (Obtaining vital signs, education.) 	

Appendix C

The Strategic National Stockpile

(<http://www.bt.cdc.gov/stockpile/#means>)

CDC's Strategic National Stockpile (SNS) has large quantities of medicine and medical supplies to protect the American public if there is a public health emergency (terrorist attack, flu outbreak, earthquake) severe enough to cause local supplies to run out. Once Federal and local authorities agree that the SNS is needed, medicines will be delivered to any state in the U.S. within 12 hours. Each state has plans to receive and distribute SNS medicine and medical supplies to local communities as quickly as possible.

SNS has four main components:

1. **“12 Hour Push Packs”**
 - Mainly consists of pharmaceuticals
 - Focus on Biologic events (i.e. antibiotics)
 - Sent from CDC to each state’s Health Dept for distribution at state sites
2. **“Vendor Managed Inventory”**
 - A request of specific items from the SNS when a specific chemical/agent or incident has occurred. (i.e. antibiotics, airway equipment, etc)
3. **“ChemPacks”**
 - Cache of pharmaceuticals (i.e. diazepam, autoinjectors, mark IV kits,) used specifically against Chemicals or Nerve Agents-- Events that require a rapid (1 hour) response for best efficacy
4. **Full Strategic National Stockpile**
 - A national repository of antibiotics, chemical antidotes, antitoxins, life-support medications, IV administration, airway maintenance supplies, and medical/surgical items.

What should you know about the medicines in the SNS?

- The medicine in the SNS is FREE for everyone.
- The SNS has stockpiled enough medicine to protect people in several large cities at the same time.

- Federal, state and local community planners are working together to ensure that the SNS medicines will be delivered to the affected area to protect you and your family if there is a terrorist attack.

How will you get your medicine if the SNS is delivered to your area?

- Local communities are prepared to receive SNS medicine and medical supplies from the state to provide to everyone in the community who needs them.
- Find out about how to get medicine to protect you and your family by watching TV, listening to the radio, reading the newspaper, checking the community Web site on the Internet or learning from trusted community leaders.

More Detailed Information about the Stockpile



Helping State and Local Jurisdictions Prepare for a National Emergency

An act of terrorism (or a large scale natural disaster) targeting the U.S. civilian population will require rapid access to large quantities of pharmaceuticals and medical supplies. Such quantities may not be readily available unless special stockpiles are created. No one can anticipate exactly where a terrorist will strike and few state or local governments have the

resources to create sufficient stockpiles on their own. Therefore, a national stockpile has been created as a resource for all.

In 1999 Congress charged the Department of Health and Human Services (HHS) and the Centers for Disease Control and Prevention (CDC) with the establishment of the National Pharmaceutical Stockpile (NPS). The mission was to provide a re-supply of large quantities of essential medical materiel to states and communities during an emergency within twelve hours of the federal decision to deploy.

The Homeland Security Act of 2002 tasked the Department of Homeland Security (DHS) with defining the goals and performance requirements of the SNS Program, as well as managing the actual deployment of assets. Effective on 1 March 2003, the NPS became the Strategic National Stockpile (SNS) Program managed jointly by DHS and HHS. With the signing of the BioShield legislation, the SNS Program was returned to HHS for oversight and guidance. The SNS Program works with governmental and non-governmental partners to upgrade the nation's public health capacity to respond to a national emergency. Critical to the success of this initiative is ensuring capacity is developed at federal, state, and local levels to receive, stage, and dispense SNS assets.

A National Repository of Life-Saving Pharmaceuticals and Medical Material

The SNS is a national repository of antibiotics, chemical antidotes, antitoxins, life-support medications, IV administration, airway maintenance supplies, and medical/surgical items. The SNS is designed to supplement and re-supply state and local public health agencies in the event of a national emergency anywhere and at anytime within the U.S. or its territories.



The SNS is organized for flexible response. The first line of support lies within the immediate response 12-hour Push Packages. These are caches of pharmaceuticals, antidotes, and medical supplies designed to provide rapid delivery of a broad spectrum of assets for an ill defined threat in the early hours of an event. These Push Packages are positioned in strategically located, secure warehouses ready for immediate deployment to a designated site within 12 hours of the federal decision to deploy SNS assets.

If the incident requires additional pharmaceuticals and/or medical supplies, follow-on vendor managed inventory (VMI) supplies will be shipped to arrive within 24 to 36 hours. If the agent is well defined, VMI can be tailored to provide pharmaceuticals, supplies and/or products specific to the suspected or confirmed agent(s). In this case, the VMI could act as the first option for immediate response from the SNS Program.

Determining and Maintaining SNS Assets

To determine and review the composition of the SNS Program assets, HHS and CDC consider many factors, such as current biological and/or chemical threats, the availability of medical materiel, and the ease of dissemination of pharmaceuticals. One of the most significant factors in determining SNS composition, however, is the medical vulnerability of the U.S. civilian population.



The SNS Program ensures that the medical materiel stock is rotated and kept within potency shelf-life limits. This involves quarterly quality assurance/quality control checks (QA/QC's) on all 12-hour Push Packages, annual 100% inventory of all 12-hour Push Package items, and inspections of environmental conditions, security, and overall package maintenance.

Supplementing State and Local Resources

During a national emergency, state, local, and private stocks of medical materiel will be depleted quickly. State and local first responders and health officials can use the SNS to bolster their response to a national emergency, with a 12-hour Push Package, VMI, or a combination of both, depending on the situation. The SNS is not a first response tool.



Rapid Coordination & Transport

The SNS Program is committed to have 12-hour Push Packages delivered anywhere in the U.S. or its territories within 12 hours of a federal decision to deploy. The 12-hour Push Packages have been configured to be immediately loaded onto either trucks or commercial cargo aircraft for the most rapid transportation. Concurrent to SNS transport, the SNS Program will deploy its Technical Advisory Response Unit (TARU). The TARU staff will coordinate with state and local officials so that the SNS assets can be efficiently received and distributed upon arrival at the site.

Transfer of SNS Assets to State and/or Local Authorities

HHS will transfer authority for the SNS materiel to the state and local authorities once it arrives at the designated receiving and storage site. State and local authorities will then begin the breakdown of the 12-hour Push Package for distribution. SNS TARU members will remain on site in order to assist and advise state and local officials in putting the SNS assets to prompt and effective use.

When and How is the SNS Deployed?

The decision to deploy SNS assets may be based on evidence showing the overt release of an agent that might adversely affect public health. It is more likely, however, that subtle indicators, such as unusual morbidity and/or mortality identified through the nation's disease outbreak surveillance and epidemiology network, will alert health officials to the possibility (and confirmation) of a biological or chemical incident or a national emergency. To receive SNS assets, the affected state's governor's office will directly request the deployment of the SNS assets from CDC or HHS. HHS, CDC, and other federal officials will evaluate the situation and determine a prompt course of action.



Training and Education

The SNS Program is part of a nationwide preparedness training and education program for state and local health care providers, first responders, and governments (to include federal officials, governors' offices, state and local health departments, and emergency management agencies). This training not only explains the SNS Program's mission and operations, it alerts state and local emergency response

officials to the important issues they must plan for in order to receive, secure, and distribute SNS assets.

To conduct this outreach and training, CDC and SNS Program staff are currently working with HHS, Regional Emergency Response Coordinators at all of the U.S. Public Health Service regional offices, state and local health departments, state emergency management offices, the Metropolitan Medical Response System cities, the Department of Veterans' Affairs, and the Department of Defense

Appendix D

Summary of
Vermont Statutes

APPENDIX E:

**National Incident Management System
Summary**

What is the National Incident Management System?

On February 28, 2003, President Bush issued Homeland Security Presidential Directive–5. HSPD–5 directed the Secretary of Homeland Security to develop and administer a National Incident Management System. NIMS provides a consistent nationwide template to enable all government, private-sector, and nongovernmental organizations to work together during domestic incidents.

This lesson will describe the key concepts and principles of NIMS, and the benefits of using the system for domestic incident response. At the end of this lesson, you should be able to describe these key concepts, principles, and benefits.

What is that National Incident Management System?

NIMS is a comprehensive, national approach to incident management that is applicable at all jurisdictional levels and across functional disciplines. The intent of NIMS is to:

§ Be applicable across a full spectrum of potential incidents and hazard scenarios, regardless of size or complexity.

§ Improve coordination and cooperation between public and private entities in a variety of domestic incident management activities.

NIMS Compliance

HSPD-5 requires Federal departments and agencies to make the adoption of NIMS by State and local organizations a condition for Federal preparedness assistance (grants, contracts, and other activities) by FY 2005.

Jurisdictions can comply in the short term by adopting the Incident Command System. Other aspects of NIMS require additional development and refinement to enable compliance at a future date.

Why Do We Need a National Incident System

Emergencies occur every day somewhere in the United States. These emergencies are large and small and range from fires to hazardous materials incidents to natural and technological disasters.

Each incident requires a response. Whether from different departments within the same jurisdiction, from mutual aid partners, or from State and Federal agencies, responders need to be able to work together, communicate with each other, and depend on each other.

Until now, there have been no standards for domestic incident response that reach across all levels of government and all emergency response agencies.

The events of September 11 have underscored the need for and importance of national

standards for incident operations, incident communications, personnel qualifications, resource management, and information management and supporting technology. To provide standards for domestic incident response, President Bush signed Homeland Security Presidential Directive –5. HSPD-5 authorized the Secretary of Homeland Security to develop the National Incident Management System, or NIMS. NIMS provides for interoperability and compatibility among all responders.

NIMS Concepts and Principles

NIMS provides a framework for interoperability and compatibility by balancing flexibility and standardization.

- NIMS provides a **flexible** framework that facilitates government and private entities at all levels working together to manage domestic incidents. This flexibility applies to all phases of incident management, regardless of cause, size, location, or complexity.
- NIMS provides a set of **standardized** organizational structures, as well as requirements for processes, procedures, and systems designed to improve interoperability.

NIMS Components

NIMS is comprised of several components that work together as a system to provide a national framework for preparing for, preventing, responding to, and recovering from domestic incidents. These components include:

- Command and management.
- Preparedness.
- Resource management.
- Communications and information management.
- Supporting technologies.
- Ongoing management and maintenance.

Although these systems are evolving, much is in place now.

Command and Management

NIMS standard incident management structures are based on three key organizational systems:

- The **Incident Command System (ICS)**, which defines the operating characteristics, management components, and structure of incident management organizations throughout the life cycle of an incident
 - **Multiagency Coordination Systems**, which define the operating characteristics, management components, and organizational structure of supporting entities
 - **Public Information Systems**, which include the processes, procedures, and systems for communicating timely and accurate information to the public during emergency situations

Preparedness

Effective incident management begins with a host of preparedness activities. These activities are conducted on a “steady-state” basis, well in advance of any potential incident. Preparedness involves a combination of:

- Planning, training, and exercises.
- Personnel qualification and certification standards.
- Equipment acquisition and certification standards.
- Publication management processes and activities.
- Mutual aid agreements and Emergency Management Assistance Compacts.

Resource Management

When fully implemented, NIMS will define standardized mechanisms and establish requirements for describing, inventorying, mobilizing, dispatching, tracking, and recovering resources over the life cycle of an incident.

Communications and Information Management

NIMS identifies the requirements for a standardized framework for communications, information management, and information-sharing support at all levels of incident management.

- Incident management organizations must ensure that effective, interoperable communications processes, procedures, and systems exist across all agencies and jurisdictions.
- Information management systems help ensure that information flows efficiently through a commonly accepted architecture. Effective information management enhances incident management and response by helping to ensure that decision-making is better informed.

Supporting Technologies

Technology and technological systems provide supporting capabilities essential to implementing and refining NIMS. Examples include:

- Voice and data communication systems.
- Information management systems, such as recordkeeping and resource tracking.
- Data display systems.

Supporting technologies also include specialized technologies that facilitate ongoing operations and incident management activities in situations that call for unique technology-based capabilities.

Ongoing Management and Maintenance

DHS established the NIMS Integration Center to provide strategic direction and oversight in support of routine review and continual refinement of both the system and its components over the long term.

Command and Management under NIMS

Incident Command and Management

NIMS employs two levels of incident management structures, depending on the nature of the incident.

- The **Incident Command System (ICS)** is a standard, on-scene, all-hazard incident management system. ICS allows users to adopt an integrated organizational structure to match the needs of single or multiple incidents.
- **Multiagency Coordination Systems** are a combination of facilities, equipment, personnel, procedures, and communications integrated into a common framework for coordinating and supporting incident management.

NIMS requires that responses to all domestic incidents utilize a common management structure. The Incident Command System—or ICS—is a standard, on-scene, all-hazard incident management concept. ICS is a proven system that is used widely for incident management by firefighters, rescuers, emergency medical teams, and hazardous materials teams. ICS represents organizational “best practices” and has become the standard for incident management across the country.

ICS is interdisciplinary and organizationally flexible to meet the needs of incidents of any kind, size, or level of complexity. Using ICS, personnel from a variety of agencies can meld rapidly into a common management structure. ICS has been tested for more than 30 years and used for:

- Planned events
- Fires, hazardous materials spills, and multicasualty incidents.
- Multijurisdictional and multiagency disasters, such as earthquakes and winter storms.
- Search and Rescue missions.
- Biological outbreaks and disease containment.
- Acts of terrorism.

ICS helps all responders communicate and get what they need when they need it. ICS provides a safe, efficient, and cost-effective recovery strategy.

ICS Features

ICS has several features that make it well suited to managing incidents. These features include:

- Common terminology.
- Organizational resources.
- Manageable span of control.
- Organizational facilities.
- Use of position titles.
- Reliance on an Incident Action Plan.
- Integrated communications.
- Accountability.

Common Terminology

The ability to communicate within ICS is absolutely critical. Using standard or common terminology is essential to ensuring efficient, clear communications. ICS requires the use of common terminology, including standard titles for facilities and positions within the organization.

Common terminology also includes the use of “clear text”—that is, communication without the use of agency-specific codes or jargon. **In other words, use plain English.**

Organizational Resources

Resources, including all personnel, facilities, and major equipment and supply items used to support incident management activities, are assigned common designations.

Resources are “typed” with respect to capability to help avoid confusion and enhance interoperability.

Manageable Span of Control

Maintaining adequate span of control throughout the ICS organization is critical. Effective span of control may vary from three to seven, and a ratio of one supervisor to five reporting elements is recommended. If the number of reporting elements falls outside of this range, expansion or consolidation of the organization may be necessary. There may be exceptions, usually in lower-risk assignments or where resources work in close proximity to each other.

Organizational Facilities

Common terminology is also used to define incident facilities, help clarify the activities that take place at a specific facility, and identify what members of the organization can be found there. For example, you find the Incident Commander at the Incident Command Post. Incident facilities include:

- The Incident Command Post.
- One or more staging areas.
- A base.
- One or more camps (when needed).
- A helibase
- One or more helispots.

Incident facilities will be established depending on the kind and complexity of the incident. Only those facilities needed for any given incident may be activated. Some incidents may require facilities not included on the standard list.

Use of Position Titles

ICS positions have distinct titles.

- Only the Incident Commander is called Commander—and there is only one Incident Commander per incident.
- Only the heads of Sections are called Chiefs.

Learning and using standard terminology helps reduce confusion between the day-to-day position occupied by an individual and his or her position at the incident.

The titles for all supervisory levels of the organization are shown in the table below.

Organizational Level	Title
Incident Command	Incident Commander
Command Staff	Officer
General Staff (Section)	Chief
Branch	Director
Division/Group	Supervisor
Unit	Leader
Strike Team/Task Force	Leader

Reliance on an Incident Action Plan

Incident Action Plans (IAPs) provide a coherent means to communicate the overall incident objectives in the context of both operational and support activities. IAPs are developed for operational periods that are usually 12 hours long. IAPs depend on management by objectives to accomplish response tactics. These objectives are communicated throughout the organization and are used to:

- Develop and issue assignments, plans, procedures, and protocols.
- Direct efforts to attain the objectives in support of defined strategic objectives.

Results are always documented and fed back into planning for the next operational period.

Integrated Communications

Integrated communications include:

- The “hardware” systems that transfer information.
- Planning for the use of all available communications frequencies and resources.
- The procedures and processes for transferring information internally and externally.

Communications needs for large incidents may exceed available radio frequencies. Some incidents may be conducted entirely without radio support. In such situations, other communications resources (e.g., cell phones or secure phone lines) may be the only communications methods used to coordinate communications and to transfer large amounts of data effectively.

Accountability

Effective accountability at all jurisdictional levels and within individual functional areas during an incident is essential. To that end, ICS requires:

- An orderly chain of command—the line of authority within the ranks of the incident organization.
- Check-in for all responders, regardless of agency affiliation.
- Each individual involved in incident operations to be assigned only one supervisor (also called “unity of command”).

Command and Management Under NIMS

While ICS has proven itself to be effective for all types of incidents, other levels of coordination may be required to facilitate management of:

- Multiple concurrent incidents.
- Incidents that are nonsite specific, such as biological terrorist incidents.
- Incidents that are geographically dispersed.
- Incidents that evolve over time.

Unified and Area Command

In some situations, NIMS recommends variations in incident management. The two most common variations involve the use of Unified Command and Area Command.



What Is Unified Command

Unified Command is an application of ICS used when:

- There is more than one responding agency with responsibility for the incident.
- Incidents cross political jurisdictions.

For example, a Unified Command may be used for:

- A hazardous materials spill that contaminates a nearby reservoir. In this incident, the fire department, the water authority, and the local environmental authority may each participate in a Unified Command.
- A flood that devastates multiple communities. In this incident, incident management personnel from key response agencies from each community may participate in a Unified Command.

How Does Unified Command Work?

Under a Unified Command, agencies work together through the designated members of the Unified Command to:

- Analyze intelligence information.
- Establish a common set of objectives and strategies for a single Incident Action Plan.

Unified Command does not change any of the other features of ICS. It merely allows all agencies with responsibility for the incident to participate in the decision-making process.

What Is an Area Command?

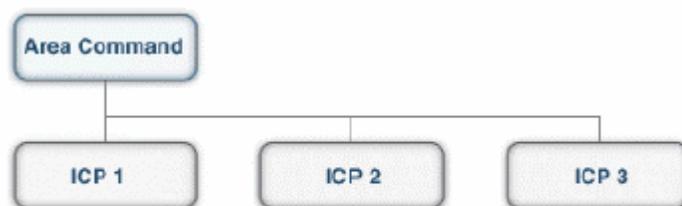
An Area Command is an organization established to:

- Oversee the management of multiple incidents that are each being managed by an ICS organization.
- Oversee the management of large incidents that cross jurisdictional boundaries.

Area Commands are particularly relevant to public health emergencies because these incidents are typically:

- Not site specific.
- Not immediately identifiable.
- Geographically dispersed and evolve over time.

These types of incidents call for a coordinated response, with large-scale coordination typically found at a higher jurisdictional level.



What Does an Area Command Do?

The Area Command has the responsibility for:

- Setting overall strategy and priorities.
- Allocating critical resources according to the priorities.
- Ensuring that incidents are properly managed.
- Ensuring that objectives are met.
- Ensuring that strategies are followed.
-

An Area Command may become a Unified Area Command when incidents are Multi-jurisdictional or involve multiple agencies.

How Is a Area Command Organized?

An Area Command is organized similarly to an ICS structure but, because operations are conducted on-scene, there is no Operations Section in an Area Command. Other Sections and functions are represented in an Area Command structure.

Multi-agency Coordination Systems

On large or wide-scale emergencies that require higher-level resource management or information management, a Multiagency Coordination System may be required.

What Are Multi-agency Coordination Systems?

Multi-agency Coordination Systems are a combination of resources that are integrated into a common framework for coordinating and supporting domestic incident management activities. These resources may include:

- Facilities.
- Equipment.

- Personnel.
- Procedures.
- Communications.

What Do Multi-agency Coordination Systems Do?

The primary functions of Multi-agency Coordination Systems are to:

- Support incident management policies and priorities.
- Facilitate logistics support and resource tracking.
- Make resource allocation decisions based on incident management priorities.
- Coordinate incident-related information.
- Coordinate interagency and intergovernmental issues regarding incident management policies, priorities, and strategies.
- Direct tactical and operational responsibility for the conduct of incident management activities rests with the on-scene Incident Commander.

Multi-agency Coordination System Elements

Multiagency Coordination Systems include Emergency Operations Centers (EOCs) and, in certain multijurisdictional or complex incidents, Multiagency Coordination Entities.

- **EOCs** are the locations from which the coordination of information and resources to support incident activities takes place. EOCs are typically established by the emergency management agency at the local and State levels.
- **Multiagency Coordination Entities** typically consist of principals from organizations with direct incident management responsibilities or with significant incident management support or resource responsibilities. These entities may be used to facilitate incident management and policy coordination.

Emergency Operations Centers

EOC organization and staffing is flexible, but should include:

- Coordination.
- Communications.
- Resource dispatching and tracking.
- Information collection, analysis, and dissemination.



EOCs may also support multiagency coordination and joint information activities. EOCs may be staffed by personnel representing multiple jurisdictions and functional disciplines. The size, staffing, and equipment at an EOC will depend on the size of the jurisdiction, the resources available, and the anticipated incident needs.

Multiagency Coordination Entity Incident Responsibilities

Regardless of their form or structure, Multiagency Coordination Entities are responsible for Ensuring that each involved agency is providing situation and resource status information.

- Establishing priorities between incidents and/or Area Commands in concert with the Incident Command or Unified Command.
- Acquiring and allocating resources required by incident management personnel.
- Coordinating and identifying future resource requirements.
- Coordinating and resolving policy issues.
- Providing strategic coordination.

Multiagency Coordination Entity Postincident Responsibilities

Following incidents, Multiagency Coordination Entities are typically responsible for ensuring that revisions are acted upon. Revisions may be made to:

- Plans.
- Procedures.
- Communications.
- Staffing.
- Other capabilities necessary for improved incident management.

These revisions are based on lessons learned from the incident. They should be coordinated with the emergency planning team in the jurisdiction and with mutual aid partners.

Public Information

Because public information is critical to domestic incident management, it is imperative to establish Public Information Systems and protocols for communicating timely and accurate information to the public during emergency situations. This lesson describes the principles needed to support effective emergency Public Information Systems. The Public Information lesson introduces you to the Public Information Systems required by NIMS.

Public Information During Domestic Incidents

Under ICS, the PIO is a key member of the command staff. The PIO advises the Incident Command on all public information matters related to the management of the incident, including media and public inquiries, emergency public information and warnings, rumor monitoring and control, media monitoring, and other functions required to coordinate, clear with proper authorities, and disseminate accurate and timely information related to the incident.

- The PIO establishes and operates within the parameters established for the Joint Information System—or JIS.
- The JIS provides an organized, integrated, and coordinated mechanism for providing information to the public during an emergency.
- The JIS includes plans, protocols, and structures used to provide information to the public. It encompasses all public information related to the incident.

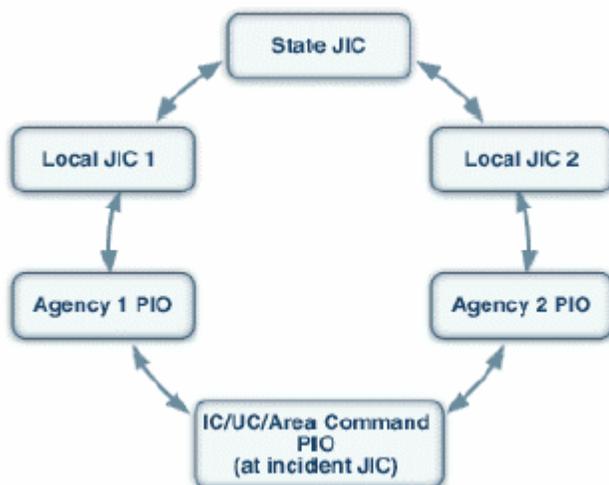
Key elements of a JIS include interagency coordination and integration, developing and delivering coordinated messages, and support for decisionmakers. The PIO, using the JIS, ensures that decisionmakers—and the public—are fully informed throughout a domestic incident response.

Coordination of Public Information

During emergencies, the public may receive information from a variety of sources. Part of the PIO’s job is ensuring that the information that the public receives is accurate, coordinated, timely, and easy to understand. One way to ensure the coordination of public information is by establishing a Joint Information Center (JIC). Using the JIC as a central location, information can be coordinated and integrated across jurisdictions and agencies, and among all government partners, the private sector, and nongovernmental agencies.

The JIC

A JIC is the physical location where public information staff involved in incident management activities can collocate to perform critical emergency information, crisis communications, and public affairs functions. JICs provide the organizational structure for coordinating and disseminating official information.



Organizations Retain Their Independence

Incident Commanders and Multiagency Coordination Entities are responsible for establishing and overseeing JICs, including processes for coordinating and clearing public communications. In the case of a Unified Command, those contributing to joint public information management do not lose their individual identities or responsibilities. Rather, each entity contributes to the overall unified message.

Levels of JICs

JICs may be established at various levels of government. All JICs must communicate and coordinate with each other on an ongoing basis using established JIS protocols. When multiple JICs are established, information must be coordinated among them to ensure that a consistent message is disseminated to the public.

JIC Characteristics

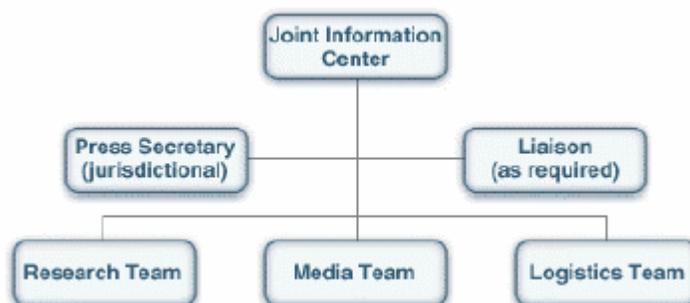
JICs have several characteristics in common:

- The JIC includes representatives of all players in managing the response. This may include jurisdictions, agencies, private entities, and nongovernmental organizations.
- Each JIC must have procedures and protocols for communicating and coordinating effectively with other JICs, and with the appropriate components of the ICS organization.

A single JIC location is preferable, but the JIS should be flexible enough to accommodate multiple JICs when the circumstances of the incident require.

JIC Organization

A typical JIC organization is shown below.



Additional functions may be added as necessary to meet the public information needs of the incident.

Preparedness

Preparedness is a key phase of the emergency management cycle. Through preparedness, jurisdictions take actions to prevent, mitigate, respond to, and recover from emergencies.

What Is Preparedness?

Preparedness is critical to emergency management. Preparedness involves all of the actions required to establish and sustain the level of capability necessary to execute a wide range of incident management operations. Preparedness is implemented through a continual cycle of planning, training and equipping, exercising, and evaluating and taking action to correct and mitigate.

A major objective of preparedness is to ensure mission integration and interoperability in response to emergent crises across functional and jurisdictional lines. Preparedness also includes efforts to coordinate between public and private organizations. Preparedness is the responsibility of individual jurisdictions, which coordinate their activities among all preparedness stakeholders. Each level of government is responsible for its preparedness. NIMS provides tools to help ensure and enhance preparedness. These tools include:

- Preparedness organizations and programs that provide or establish processes for planning, training, and exercising

- Personnel qualification and certification
- Equipment certification
- Mutual aid
- Publication management

National-level preparedness standards related to NIMS will be maintained and managed through a multijurisdictional, multidiscipline center, using a collaborative process at the NIMS Integration Center. Using NIMS as a basis, all preparedness stakeholders will be able to attain and sustain the level of readiness necessary to respond to the range of domestic incidents facing America today.

Preparedness Organizations

Preparedness organizations represent a wide variety of committees, planning groups, and other organizations. These organizations meet regularly to coordinate and focus preparedness activities. The needs of the jurisdiction will dictate how frequently the organizations must meet and how they are structured.

Responsibilities of Preparedness Organizations

Preparedness organizations at all levels should follow NIMS standards and undertake the following tasks:

- Establishing and coordinating emergency plans and protocols
- Integrating and coordinating the activities and jurisdictions within their purview
- Establishing guidelines and protocols to promote interoperability among jurisdictions and agencies
- Adopting guidelines and protocols for resource management
- Establishing priorities for resources and other response requirements
- Establishing and maintaining multiagency coordination mechanisms

Preparedness Planning

Preparedness plans describe how personnel, equipment, and other governmental and Non-governmental resources will be used to support incident management requirements.

These plans represent the operational core of preparedness and provide mechanisms for:

- Setting priorities.
- Integrating multiple entities and functions.
- Establishing collaborative relationships.
- Ensuring that communications and other systems support the complete spectrum of incident management activities.

Types of Plans

Jurisdictions must develop several types of plans, including:

- **Emergency Operations Plans (EOPs)**, which describe how the jurisdiction will respond to emergencies.

- **Procedures**, which may include overviews, standard operating procedures, field operations guides, job aids, or other critical information needed for a response.
- **Preparedness Plans**, which describe how training needs will be identified and met, how resources will be obtained through mutual aid agreements, and the facilities and equipment required for the hazards faced by the jurisdiction.
- **Corrective Action or Mitigation Plans**, which include activities required to implement procedures based on lessons learned from actual incidents or training and exercises.
- **Recovery Plans**, which describe the actions to be taken to facilitate long-term recovery.

Training and Exercises

Organizations and personnel at all governmental levels and in the private sector must be trained to improve all-hazard incident management capability. These organizations and personnel must also participate in realistic exercises to improve integration and interoperability.

Training and Exercises and the NIMS Integration Center

To assist jurisdictions in meeting these training and exercise needs, the NIMS Integration Center will:

- Facilitate the development of and dissemination of national standards, guidelines, and protocols for incident management training.
- Facilitate the use of modeling and simulation in training and exercise programs.
- Define general training requirements and approved training courses for all NIMS users, including instructor qualifications and course completion documentation.
- Review and approve, with the assistance of key stakeholders, discipline-specific training requirements and courses.

Personnel Qualification and Certification

Under NIMS, preparedness is based on national standards for qualification and certification of emergency response personnel. Managed by the NIMS Integration Center, standards will help ensure that the participating agencies' and organizations' field personnel possess the minimum knowledge, skills, and experience necessary to perform activities safely and effectively.

Standards will include training, experience, credentialing, currency, and physical and medical fitness. Personnel who are certified to support interstate incidents will be required to meet national qualification and certification standards.

Equipment Certification

Incident managers and emergency responders rely on various types of equipment to perform mission-essential tasks. A critical component of operational preparedness is that equipment performs to certain standards, including the capability to be interoperable with equipment used by other jurisdictions. To facilitate national equipment certification, the NIMS Integration Center will:

- Facilitate the development and/or publication of national equipment standards, guidelines, and protocols.
- Review and approve lists of emergency responder equipment that meet national requirements.

Mutual Aid Agreements and Emergency Management Assistance Compacts

Mutual aid agreements and Emergency Management Assistance Compacts (EMACs) provide the means for one jurisdiction to provide resources or other support to another jurisdiction during an incident. To facilitate the timely delivery of assistance during incidents, jurisdictions (including States) are encouraged to enter into agreements with:

- Other jurisdictions.
- Private-sector and nongovernmental organizations.
- Private organizations, such as the American Red Cross.

Publication Management

The NIMS Integration Center will manage publications dealing with domestic incident management and response. Publication management will include:

- The development of naming and numbering conventions.
- Review and certification of publications.
- Methods for publications control.
- Identification of sources and suppliers for publications and related services.
- Management of publication distribution.

The NIMS Integration Center will manage a wide range of publications—from qualification information and training courses to computer programs and best practices.

Resource Management

Resource management involves the coordination and oversight of personnel, tools, processes, and systems that provide incident managers with timely and appropriate resources during an incident. Historically, resource management has been an issue at incidents, both large and small. Resource management is an area of special attention under NIMS.

What Is Resource Management?

Resource management involves four primary tasks:

- Establishing systems for describing, inventorying, requesting, and tracking resources
- Activating those systems prior to, during, and after an incident
- Dispatching resources prior to, during, and after an incident
- Deactivating or recalling resources during or after an incident

The basic concepts and principles that guide resource management and allow these tasks to be conducted effectively are addressed by NIMS. These concepts and principles are described on the following screens.

Resource Management Concepts

Resource management under NIMS is based on:

- Providing a uniform method of identifying, acquiring, allocating, and tracking resources.
- Classifying kinds and types of resources required to support incident management.
- Using a credentialing system tied to uniform training and certification standards.
- Incorporating resources contributed by private sector and nongovernmental organizations.

Resource Management Principles

Five key principles underlie effective resource management:

1. **Advance planning:** Preparedness organizations working together before an incident to develop plans for managing and using resources
2. **Resource identification and ordering:** Using standard processes and methods to identify, order, mobilize, dispatch, and track resources
3. **Resource categorization:** Categorizing by size, capacity, capability, skill, or other characteristics to make resource ordering and dispatch more efficient
4. **Use of agreements:** Developing preincident agreements for providing or requesting resources
5. **Effective management:** Using validated practices to perform key resource management tasks

Managing Resources

Resource management involves the coordination and oversight of tools, processes, and systems that provide Incident Commanders with the resources that they need during an incident. To assist local managers, NIMS includes standard procedures, methods, and functions in its resource management processes. By following the standards established by NIMS, resource managers are able to identify, order, mobilize, dispatch, and track resources more efficiently. Resource “typing” involves categorizing resources by capability based on measurable standards of capability and performance—for example, a 500-kilowatt generator. Resource typing defines more precisely the resource capabilities needed to meet specific requirements—and is designed to be as simple as possible to facilitate frequent use and accuracy in obtaining resources.

Certification and credentialing help ensure that all personnel possess a minimum level of training, experience, physical and medical fitness, or capability for the position they are tasked to fill. NIMS also ensures that training material is current. Resource managers use various resource inventory systems to assess the availability of assets provided by public, private, and volunteer organizations. And resource managers identify, refine, and validate resource requirements throughout the incident using a process to identify:

- What and how much are needed.
- Where and when it is needed.
- Who will be receiving it.

Because resource requirements and availability will change as the incident evolves, all entities must coordinate closely beginning at the earliest possible point in the incident. Requests for items that the Incident Commander cannot obtain locally must be submitted through the EOC or Multiagency Coordination Entity using standardized resource ordering procedures.

Resource managers use established procedures to track resources continuously from mobilization through demobilization. Resource tracking and mobilization are directly linked. When resources arrive on-scene, they must check in to start on-scene in-processing and validate the order requirements. Managers should plan for demobilization at the same time that they begin the mobilization process. Early planning for demobilization facilitates accountability and makes transportation of resources as efficient as possible.

Recovery involves the final disposition of all resources. During recovery, resources are rehabilitated, replenished, disposed of, or retrograded. Reimbursement provides a mechanism for funding critical needs that arise from incident-specific activities. Processes and procedures must be in place to ensure that resource providers are reimbursed in a timely manner. Together, each of these resource management processes create an integrated, efficient resource management system.

Communications, Information Management, and Supporting Technology

Effective communications, information management, and supporting technology are critical aspects of domestic incident management. This lesson will cover the ways in which NIMS supports these areas. At the end of this lesson, you should be able to:

- Describe the advantages of common communication and information management standards.
- Explain how NIMS will influence technology and technological systems required for emergency response.
- Describe the purpose of the NIMS Integration Center.

Concepts and Principles

NIMS standards for communications, information management, and supporting technology are based on several concepts and principles.

Communications and Information Management Principles

Communications and information management under NIMS are based on the following concepts and principles:

- **A common operating picture that is accessible across jurisdictions and agencies is necessary.** A common operating picture helps to ensure consistency at all levels, among all who respond to or manage incident response.
- **Common communications and data standards are fundamental.** Effective communications, both within and outside the incident response structure, are enhanced by adherence to standards.

Principles of Supporting Technologies

NIMS will leverage science and technology to improve capabilities at a lower cost. To accomplish this, NIMS will base its supporting technology standards on five key principles:

- 1. Interoperability and compatibility.** Systems must be able to work together.
- 2. Technology support.** All organizations using NIMS will be able to enhance all aspects of incident management and emergency response.
- 3. Technology standards.** National standards will facilitate interoperability and compatibility of major systems.
- 4. Broad-based requirements.** NIMS provides a mechanism for aggregating and prioritizing new technologies, procedures, protocols, and standards.
- 5. Strategic planning and R&D.** The NIMS Integration Center will coordinate with DHS to create a national R&D agenda.

Managing Communications and Information

NIMS communications and information systems enable the essential functions needed to provide a common operating picture and interoperability for:

- Incident management communications.
- Information management.
- Interoperability standards.

For More Information on NIMS:

1) FEMA IS 700 - National Incident Management System (NIMS), An Introduction. <http://www.fema.gov/nims/>

2) NIMS Online: http://www.nimsonline.com/nims_training/index.htm

APPENDIX F:

**INCIDENT MANAGEMENT SYSTEM
POSITION DESCRIPTIONS**

This appendix describes the IMS positions commonly established for the management of a mass casualty incident or similar emergency requiring field medical operations. During emergency medical operations in the field, Mid-America Medical Reserve Corps volunteers may find themselves supporting individuals assigned to the IMS positions described below. It is also possible that Mid-America Medical Reserve Corps volunteers could be asked to serve in some of these IMS positions. Refer to the MARCER Regional Mass Casualty Incident Plan for detailed information on field medical operations and procedures.

Incident Commander

Responsible for overall incident activities and disaster response. The Incident Commander will designate the Medical Sector Leader.

Medical Sector Leader

Responsible for overall EMS operations at an incident, for appointing all other EMS team members and forwarding all EMS recommendations to the Incident Commander.

Liaison Officer

Responsible for coordinating with other appropriate agencies as needed, including other local agencies, federal, state or private sector agencies. These agencies may or may not be located at the command post.

Public Information Officer

Responsible for formulating and disseminating factual and timely information about the incident to the news media and other appropriate agencies. Other personnel should not give statements to the media unless authorized by the Public Information Officer.

Safety Officer

Responsible for monitoring emergency operations to ensure the safety of all personnel and equipment and reporting directly to Incident Commander.

Planning and Intelligence Section Chief

Responsible for understanding the current situation and predicting the probable course of the incident. Makes recommendations on optional courses of action. Under this section chief's direction, a *Status Unit Leader* will be responsible for collection and display of current situation information, including the current status of resources (personnel, equipment, apparatus, etc.), and *Technical Advisory Unit Leader*, who is responsible for collecting, evaluating and dissemination information concerning specialized technical data.

Logistics Section Chief

Responsible for managing those units that provide personnel, ambulances, equipment, facilities, and personal needs in support of the incident activities. Under this team member's direction, a **Supply Unit Leader** will order, receive, store, distribute and maintain inventory of all supplies, and a **Communications Unit Leader** will be responsible for establishing and supervising the handling of radio and telephone communications. Under this team member, the **Water Unit Leader** will be responsible for the development of adequate water sources in a fire suppression situation.

Sector Leader

Responsible for a specific geographic area or specific function other than those listed (e.g., Hazardous Materials Sector Leader, Cave-In Sector Leader, etc.).

Triage Officer

Responsible for the management of victims where they are found at the incident site, and for sorting and moving victims to the treatment area. This officer shall ensure coordination between extrication teams and patient care personnel to provide appropriate care for entrapped victims. Reports to Medical Sector Leader.

Triage Personnel

Triage Personnel appropriately treat patients on-scene and assign them to treatment areas.

Treatment Officer

Responsible for sorting patients at the treatment area to establish priorities for treatment and transport, and for directing coordination with medical professionals mobilized to the scene. The treatment area should be headed by an individual who routinely functions in pre-hospital EMS, or a previously identified individual who is designated by position, and participates in pre-hospital mass casualty drills. If at all possible, this person should be a physician or the highest ALS available. Reports to the Medical Sector Leader.

Medical Transportation Officer

Responsible for arranging appropriate transport vehicles (ambulances, helicopters, buses, vans, etc.) for those patients that the Treatment Officer has selected for transport.

Morgue Manager

The Morgue Manager is responsible for Morgue Area activities until relieved of that responsibility by the Office of the Coroner.

Hospital Emergency Response Team (HERT)

A Hospital Emergency Response Team is recommended to consist of a minimum of three (3) medical personnel, optimum of five (5) medical personnel, which includes a team leader and any combination of physicians, nurses or physicians' assistants. HERTs will be requested through the Incident Commander. HERTs report to the Treatment Team Leader and assume responsibility for patient assessment and treatment as assigned.

Medical Reserve Corps of Southwestern Vermont
Important Contact Information

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