

Standard Operating Procedures



**Upper Merrimack Valley
Medical Reserve Corps**

Background

This document is based on information gathered from several MRCs across the U.S. and from plentiful written materials about disaster response, adapted for use by the Upper Merrimack Valley unit. It is hoped that this document serves a practical purpose in guiding the operations of the MRC over the coming year. These guidelines should be reviewed and updated every six months, to ensure that they are relevant based on current understandings of local disaster response.

Audience

This document is primarily intended for UMV MRC use by these entities:

1. **Staff.** This includes the Director, Coordinator, and their designees. The Director and Coordinator must be in agreement about general operations, which must be in writing so designees could carry out these guidelines in their absence. Staff members can also include key committees, such as the UMV MRC Advisory Council and ad hoc groups, as well as possible team leaders who could be asked to make decisions based on these guidelines.
2. **Members.** Each volunteer in the unit is encouraged to learn these guidelines, so they will see how their activities fit in context of the unit as a whole.

A separate version of this document can be provided to **Response Partners and Affiliates**. Any group with whom the MRC interacts should have access to the appropriate sections of these guidelines. The primary reason is to ensure a clear chain of command in planning drills and deployments, identifying the relationships between our various roles in an emergency. Another purpose is to streamline shared operations, fostering positive communications and inter-agency support.

These guidelines will not be placed in a public forum (such as the unit's web site, unless a members-only section is created).

History

During the events of September 11, 2001, it became clear that there was no method for coordinating the services of thousands of well-meaning volunteers, who showed up at disaster scenes wanting to help. There was no mechanism for checking credentials and assigning volunteers where they could do the most good, and no pre-planning to ensure their safety. Nor had these volunteers been trained in methods that would allow them to work effectively as a team, interacting with other agencies at the scene. In fact, the presence of unidentified care providers created numerous problems and potentially put trained rescuers at risk.

Over time, an umbrella organization called Citizen Corps was created to engage potential volunteers in disaster response, as well as to maintain public safety and preparedness. Citizen Corps includes CERT (Community Emergency Response Teams), Fire Services,

an expanded Neighborhood Watch, VIPS (Volunteers in Police Service), and the Medical Reserve Corps. (See www.CitizenCorps.gov for details about Citizen Corps.) The first grants to launch the Medical Reserve Corps were issued in July 2002. (See www.MedicalReserveCorps.gov for information about the national program.)

It was clear that the existing resources in the Upper Merrimack Valley would be insufficient to mitigate the impact if a major disaster were to occur. Therefore, a grant was written through the Westford Health Department to solicit funds for launching an MRC in the local area. The grant included letters of support from boards of health in each of the communities in the region, plus emergency services personnel and government officials.

By March 2004, a coordinator was hired to focus on the development of the Upper Merrimack Valley Medical Reserve Corps. The first 20 members joined the unit in a focus group in June 2005. (See www.umvmrc.org for a description of the unit and its activities to date).

Overview of the UMV MRC

Mission

The mission of the UMV MRC is to provide public health volunteer medical services that supplement existing resources in case of disaster.

Purpose

The Upper Merrimack Valley MRC was formed to promote public health and safety across the region, in three key areas:

1. Public Health Emergencies – events that threaten public health, such as a disease outbreak or toxic chemical release.
2. Mass Casualty Incidents – disasters that cause injury or threats to large numbers of people. These can include a building collapse, fire, storm, flood, or other event that displaces groups of residents that must be moved to emergency shelters.
3. Community Service Activities – opportunities to foster the well-being of local residents; such as health fairs, blood pressure clinics, or training programs.

Service Area

The Upper Merrimack Valley MRC, which is based at the Westford Board of Health, provides medical surge capacity to seven communities.

Residential populations:

Billerica – 40,000
Chelmsford – 34,000
Dracut – 28,600
Lowell – 105,600
Tewksbury – 29,000
Tyngsboro – 11,100
Westford – 21,000

TOTAL: 269,300

The number of people in the coverage area at any given time is subject to fluctuations in the work day, as well as seasonal differences (such as summer vacations).

One of the key challenges for the region involves the diversity of its multiple cultures. Numerous languages are spoken, especially in Lowell – which is the largest and most urban of the seven towns, and has a history of welcoming immigrants. The corresponding range of lifestyles and attitudes toward health require flexible approaches to education and patient care.

Contact Information

Contact information for issues regarding the Upper Merrimack Valley MRC is as follows:

Sandy Collins, Director, scollins@westford.mec.edu, 978-399-2908

Nancy Burns, Coordinator, nburns@westford.mec.edu, 978-399-2549

Mailing address, phone, and web site:

c/o Board of Health
55 Main Street, 2nd Floor
Westford, MA 01886
978-692-5509
www.umvmrc.org

UMV MRC Organizational Structure

Several entities are involved in expanding the capabilities of the unit.

Director – Initiated the formation of the UMV MRC. Ultimately responsible for all aspects of the unit. Determines when the unit will be deployed, and which activities warrant involvement by members. Arranges representation of the unit with the Coordinator.

Coordinator – Handles day-to-day operations of the UMV MRC. Maintains ongoing contact with members, welcomes new applicants, arranges training programs and drills, organizes meetings, and tracks member data.

Advisory Council – One Council member per community serves as the liaison between their board of health and Local Emergency Planning Committee, and the MRC. Meets regularly to evaluate ideas and offer suggestions for running the unit. Helps to foster good relations between the MRC and its affiliates. Council members to date:

Billerica – Brian Luttrell, EMT-P
Chelmsford – Sue Rosa, RN
Dracut – Ed Nadolny, CCP
Lowell – Chris Connolly, RN
Tewksbury – Tom Churchill
Tyngsboro – Nanci Dowling-Meehan, RN
Westford – Covered by staff (based in Westford)

Members – Minimally, stay in contact with the coordinator to ensure that their records are up to date, so they can be notified for the appropriate activities. (See *Member Roles* for details.)

Ad-hoc Teams – These entities address issues of special interest. They can include:

- Task force to evaluate and recommend training programs
- Focus group to identify and build community support
- Specialists in communications and networking
- Team leaders for medical initiatives and deployment
- Legal liaisons, to promote policies favorable to medical volunteers

Membership

Anyone who sincerely wants to become a member of the UMV MRC and support its mission is welcome to join at any time. See *Application Procedures* for details.

Upon enlisting, all members become eligible for training programs and basic correspondence. Members are not required to live or work in the service area, as long as they are willing to participate in activities within the region.

There are additional requirements before members are assigned badges, and are allowed to participate in the full range of activities on behalf of the MRC. See *Eligibility for Service* for details.

Recruitment

Recruitment will be ongoing. Methods will include:

- Word of mouth from current members
- Presentations to affiliates and potential response partners
- Information tables at health fairs and community events
- Meetings with municipal agencies and health care organizations
- Presentations at local colleges and universities
- Speaking engagements at conferences
- Focused membership drives within each community
- Mass mailings to health professionals
- Media campaigns (newspapers, cable TV, radio, Internet, posters)
- Links to related web sites
- Joint marketing with affiliated organizations

The unit is open to creative ideas that would continue to draw new members.

Application Procedures

There are three basic ways to join the UMV MRC:

- I. Submitting an Application Form
- II. Sending an e-mail indicating interest
- III. Speaking with the coordinator (by phone or in person)

I. A four-page application form is posted on the web site.

II. *E-mails* can provide the same information as the original Intake Form, used through 2005, including optional fields:

- Name, Address, City/State/Zip
- Home and work e-mail addresses
- Home, business, and cell phones
- Specialty (Physician, EMT/Paramedic, nursing, other licenses and certifications)
- Foreign Language Skills

III. The coordinator welcomes members who join through phone calls, at meetings, and in any other forum in which they ask to sign up with the MRC.

The director/coordinator calls all new members upon receipt of their application. The purpose is to welcome them to the unit and answer any questions they may have. During these calls, members frequently provide additional information and offer specific services, based on their unique training and interest. Similar exchanges are encouraged at any time. The data is promptly entered into the Excel spreadsheet of members.

Eligibility and Readiness for Service

The only requirement to join the UMV MRC is to submit an application, even over the phone. However, *members must meet additional requirements before they are eligible for a full range of deployments.* These requirements include:

- Training – as appropriate for the event, the member’s skill level, and the service(s) they’ll provide. National core competencies and training standards are utilized, which would allow members to be assigned at their highest level of capability.
- Background checks – CORI screening will be conducted to ensure that the member has no criminal record, and that no sanctions exist to prohibit unsupervised patient care. Members whose backgrounds are determined to pose a security risk will be dismissed, to protect other care providers as well as patients. The UMV MRC considers the process a formality for legal protection.
- License and certificate verification – Medical licenses and certificates will be verified through the appropriate agency (Office of Emergency Medical Services for EMTs and paramedics, Board of Registration for nurses), to ensure that their credentials are valid. Members will be asked to provide a photocopy of their license or certificate, to be maintained in the member binder. Copies of CPR cards and training certificates will be kept on file as appropriate. Retired and inactive professionals are welcome to join.

- Identification – All members who meet certain basic criteria will be assigned badges and uniforms, to enable rapid identification as trained members.
- Event-specific preparations – equipment, instructions, and other prerequisites.

Members may also be asked to complete a form to verify their conduct and respect for patient confidentiality. A benefit that other MRCs have experienced in doing so, is that the existence of these signed documents fosters greater trust and a sense of enhanced professionalism for members among response partners.

In the event of a large public health emergency, MRC members will be utilized commensurate with their training and skills. Though there are some tasks that members whose licenses have expired will be prohibited from performing, their expertise and training may be used in other areas .

If an emergency is of sufficient magnitude, the governor may waive licensure requirements and authorize retired and out-of-state medical professionals to perform various procedures. In this case, members whose licenses are inactive may be granted additional capabilities to meet the urgent needs and address the unusual life threats that may be posed by a disaster.

Training

For the coming year, members will be asked to take a three-hour *New Member Orientation* as their minimum training. Content for the Orientation:

- Overview of the national MRC program
- Introduction to the Upper Merrimack Valley unit
 - o Interaction with regional response units
 - o Priorities and typical activities
- Basic concepts of disaster response; *Intro to Disaster* as applied to the MRC

An overall training program is being evaluated to match varying levels of certifications with the range of possible deployments. Courses that the UMV MRC expects to offer:

- Four-module ARC disaster training (Intro, Mass Care, DHS Overview and Simulation)
- Mass Dispensing Clinic (by DPH; contents also known as EDS – Emergency Dispensing Site, or POD – Point of Distribution)
- Smallpox Certification
- START Triage (and JUMPSTART for pediatrics)
- CPR/AED Refreshers
- CPR/AED first-time training, contingent on funding
- Ad hoc courses (including Stress Mgt.), pending member interest

The main goals are to help each member develop top-notch skills in disaster response, and to practice this enhanced knowledge with team members. Core competencies and minimum training requirements are being assessed. Recommended:

1. Incident Command System (ICS) 100 and National Incident Management System (NIMS) 700 – Classes on ICS and NIMS must be tailored for use by rank-and-file members, with additional depth for team leaders. To ensure that the concepts are as clear as possible, scenarios would be offered to show how ICS and NIMS can be applied successfully in a disaster. (Training on these topics is available online @ <http://training.fema.gov/EMIWeb/IS/is700.asp> and <http://training.fema.gov/EMIWeb/IS/is100.asp>, as well as in classroom format.)

2. Clinic Support – Classes on **Mass Dispensing Clinics** (also known as PODs, or Points Of Distribution) and **Smallpox Certification** address the deployments for which the MRC is best suited.

3. Bioterrorism, Decontamination, and Scene Safety – Members will receive instruction in general bioterrorism concepts; agents (anthrax) and treatments (cipro); contamination issues, and whether a scene is safe to enter. These courses provide a background on key concepts, followed by checklists on scene safety and Personal Protective Equipment. This course is a key part of risk reduction and ensuring each member's personal safety.

4. Crisis and Stress Management – The local Critical Incident Stress Management team offers pre-event training in concepts to help members recognize and deal with the unique stresses and symptoms that frequently arise during a disaster.

5. Disaster Triage and Treatment – This curriculum explains how members should approach a staging area in which vast numbers of injured people need care. Contents would include standard forms for evaluating patients, the **S.T.A.R.T.** (Simple Triage and Rapid Treatment) system, techniques for performing initial patient assessment, initial treatment for trauma victims, hands-on exercises to simulate response, methods for managing personal stress, mental health aspects, and after-action analysis.

6. Basic Disaster Life Support (BDLS) and Advanced Disaster Life Support (ADLS) and courses offered to a limited number of team leaders and advanced level care providers (physicians, nurse practitioners, other). A brief description of the initial course from the web site, <http://www.lpmh.org/BTLS.html>, is as follows:

BTLS is a nationally recognized course that provides participants with a systematic method for evaluating and treating patients with multiple systems trauma. The BTLS course has become a standard in the prehospital arena for first responders and EMS personnel as a consistent and rapid means of finding, treating and arranging transportation for patients with serious life threatening trauma.

7. Weapons of Mass Destruction (WMD), Emergency Operations Center (EOC) , Strategic National Stockpile (SNS)– Organizations including MEMA, FEMA, and the Red Cross offer training on local implementations of these national concepts.

8. Targeted sessions – Analysis of further applications for the MRC can match interests with a variety of courses: epidemiology; blood borne pathogens; disaster mental health; respiratory care in hazardous environments; isolation and quarantine; infectious disease identification, control and treatments; pediatric issues; stress management; mass trauma response.

These courses may be offered at no cost, and provide continuing education credit, as incentive for keeping our members engaged and active. Classes may be held on an ongoing basis, with a side benefit that members have the chance to mingle and get better acquainted in a stress-free environment.

There is an unlimited spectrum of **online courses** available as well. While these provide useful information and concepts in a flexible system of delivery – entirely at the member’s convenience – they do not include interaction with other members, and do not allow hands-on practice. Therefore, online courses will never be the only method of instruction. One currently recommended, besides the ICS courses previously mentioned, is:

- **Public Health and Bioterrorism**

Specialized trainings suggested for key roles

- **Physicians and Physician Assistants** – High-level training to provide care in disaster response: advanced assessment techniques and treatment, setting priorities with vast numbers of sick patients, issues per isolation and quarantine.
- **Nurses** – Treatments per infectious diseases and toxic agents, mass dispensing, and smallpox certification.
- **Pharmacists** – Overview of the SNS and possible roles for dispensation.
- **Mental Health Professionals** – PFLASH: Practical Front Line Assistance for Supportive Healing. (Developed post 9-11 with support from Project Liberty; for psychiatrists, psychologists, social workers, and counselors.) Mass Department of Public Health Behavioral Health courses.
- **EMTs** – Hands-on drills in mass casualty triage and treatment, post-extrication. (Also applies for paramedics and trauma nurses, and others who would provide care in an initial assessment and treatment area.) Basics of infectious disease: prevention, how these diseases are contracted, major concerns and treatments.

- **Hospital Support** – Orientation and policies for all members who would provide direct patient care (or perhaps administrative support) at local hospitals during a crisis, on behalf of the MRC.
- **Child Care Providers** – Disaster child care services (adapted from **PFLASH: Practical Front Line Assistance for Support and Healing**, a disaster mental health education program, by University of Washington).

The short-term priority is to train as many members as possible in basic disaster response, before developing courses for advanced-level providers. Input is welcome from each specialty group.

Timing of Response

The first 72 hours of an incident demand local response. However, *it is unlikely that many MRC members will be able to respond within the first four hours of an event.* Unlike existing ambulances, hospitals, and municipal services, most MRC volunteers have other commitments (full-time jobs, child care, other) and need to make arrangements for sudden deployments. Furthermore, these volunteers may be physically located far from the scene when the call goes out.

Thus the first line of defense in a disaster would be provided by existing agencies. The MRC would offer surge capacity later into the situation, after Incident Command has completed an initial assessment and identified the immediate services that are required.

Incident commanders and authorized agencies are urged to contact the MRC director immediately after an event occurs, in case there MIGHT be a need for additional medical help. This allows the director to make arrangements for a possible response.

Uses for the UMW MRC

The purpose of the MRC is not limited to medical emergencies. This valuable resource can also be mobilized to support a range of public health initiatives and emergencies.

- Supplement existing medical services at emergencies such as fires, plane crashes, chemical spills, terrorist incidents, and explosions.
- Unusual disease outbreaks or suspected bioterrorism events, which may require massive immunization within a region or distribution of preventative medicine
- Health education, including nutrition and fitness classes, awareness programs for health and safety, programs offered to vulnerable populations.
- Support to existing community service organizations.

These potential roles can be revisited through periodic needs assessments within the region, as well as by member surveys.

Member Roles

The range of possible activities is as diverse as the membership itself. This section offers a partial list of potential member roles.

I. Levels of Involvement

a. **Local** – The primary focus of the unit is on local response. Members are first invited to provide service in their own towns.

b. **Regional** – If the need arises, members may be asked to respond to other towns within the Upper Merrimack Valley.

c. **State and National** – During a statewide or national disaster, MRC units across Massachusetts and also throughout the U.S. may be asked to respond. The choice of whether to call members rests with the Director.

Members can have varying levels of potential response capabilities, depending on their levels of commitment, training, and availability:

- New member. These people are on the roster and planning to participate more fully as time goes on – undergoing background checks and attending training sessions and drills.
- Full member. These volunteers have passed CORI and license checks, attended an orientation and basic training, have been assigned badges and uniform shirts, and are ready for drills and deployments.
- Team leader. Members who have demonstrated leadership qualities and expressed interest in guiding others will be designated as team leaders. They may be asked to coach other members and guide teams during drills and deployments.

Deployment assignments can be practiced during training and drills, and refined as necessary.

Members have already been invited to deploy outside of their proscribed service areas. These opportunities are evaluated at the staff level on a case-by-case basis, to:

- Avoid siphoning members to a degree that would leave the UMV area more vulnerable in case of disaster.
- Determine whether the call is appropriate in terms of the unit's capabilities
- Minimize unnecessary risks to members: legally, physically, other
- Ensure that the appropriate channels are respected (other emergency response agencies, authorities per proclamation of State of Emergency, municipal agencies)

II. Types of Service

Roles and responsibilities depend on the member's physical ability, interest, training, and expertise. All service is voluntary. Responsibilities can include the following.

a. Medical

- Inoculation (immunization and prophylaxis)
- Clinic prep (fill syringes, measure meds, other)
- Interviews for patient history
- First responder (initial assessment and vital signs)
- Triage (START or otherwise)
- Treatment (basic first aid)
- Phone screening and consulting
- Local distribution of medications from SNS (Strategic National Stockpile)
- Communicable disease control measures
- Supporting health needs of vulnerable populations
 - o Integration with local, regional, and statewide initiatives
- Shelter care

b. Non-medical

- Patient intake (basic data forms)
- People movers
- Translators
- Ham radio operators
- Administrative tasks
- Record keeping
- Comforting and consoling

c. Non-emergency

- Coordinate and evaluate training programs
- Assist in community health programs
- Support public awareness campaigns
- Advocate for liability protections
- Promotion and public relations
- Organize drills and exercises
- Focus group involvement (for issues of special interest)

III. Service Environments

Members could find themselves serving the MRC in the following kinds of environments.

- Mass Dispensing Clinics (public health outbreaks, counteract toxic agents)
- Mass Casualty Sites (often austere environments)
 - o Staging areas
 - o Triage and treatment

- Alternate care locations (school auditoriums, other)
 - Field hospitals
- Emergency Shelters (residents displaced due to fires, floods, storms)
- Shift Relief and Backfill at Hospitals

Principles of Operation

The Upper Merrimack Valley MRC will operate according to the following principles.

- We treat all people, volunteers, clients, and co-workers with respect and dignity in all situations.
- We honor the fact that volunteers are donating their time and expertise, for the overall health and well being of their communities, as well as training to be of service in emergencies.
- We will communicate clearly and consistently with MRC volunteers.
- Input from members is encouraged and valued.
- No member will be asked to perform beyond the scope of his or her licensure, credentials, training, or comfort level.
- No member will knowingly be placed at risk, during training or deployment.
- Members have the option to refuse assignments for any reason.
- Response to disasters outside of their community and region are at the member's discretion, whenever they are invited to participate by the MRC staff.
- No member will self-deploy. Rather, involvement in any event that represents the MRC is strictly upon agreement with an authorized staff member.
- The MRC will consistently seek inclusion of UMV residents across all demographics, thereby truly representing all of the (adult) citizens in the region.

Integrity and Privacy of Member Data

Policies are in place to ensure the integrity and privacy of member data.

Storage: Member data will be kept in an Excel spreadsheet. Hard copy printouts are created as needed, for easier record-keeping in discussions and invitations to activities.

Security: All member records will be treated as confidential, and protected from unauthorized use.

Sharing: Health directors and representatives of the UMV MRC Advisory Council can be given the names and specialties of members in their community upon request, with contact information as needed, if events of interest to a specific sub-group have been authorized by the Directors.

Backup: The coordinator will make copies of the master database, to be shared with the director, at regular intervals and when a significant number of changes have been made.

Master Binder: The master binder is maintained in a locked location, to include hard copies of all relevant member data. These records include training courses, member participation in events, "face sheets" that associate names and basic data with photos, and miscellaneous notes and correspondence (awards, special capabilities, etc). The binder serves these purposes:

- Precaution in case of power failures, so data is always available
- Thorough documentation about the unit and its members
- Rapid access to information in case of a sudden need for deployment

Communications with Members

This issue has become increasingly complex with the expanding number of members and their range of capabilities. Current and planned methods of communication are as follows. These methods will vary depending on the situation (ongoing interactions versus a call-out).

1. **Direct phone calls.**
2. **Phone trees.** Trusted entities such as Advisory Council members and team leaders may be asked to make calls on behalf of the MRC, purely to streamline member contacts – such as applying an emergency call-down list. Phone numbers would never be shared for non-MRC purposes.
3. **E-mail.** The use of individual messages, and through a ListServ, has proven to be a very efficient method of reaching members who have ongoing access to PCs.
4. **Web site.** Members are strongly encouraged to check the web site on a regular basis. ListServ reminders can notify members of new postings.
5. **Printed mail.**
6. **Two-way radio.** These items will allow members to communicate with each other during a deployment, especially when cell phone contact is jeopardized.
7. **Meetings and Training Sessions.** Every time members congregate, there is an opportunity to strengthen communications. Any scheduled session can include kickoff announcements, follow-up socializing, and informal sharing of ideas.

The unit will continue to examine its methods of contacting its volunteers, and is open to creative ideas (such as the HHAN) – especially as our numbers continue to grow.

Communications with the Press and Outside Agencies

During a disaster, only the Public Information Officer – as specified through Incident Command – is authorized to speak with the media. Members of the MRC are instructed to refer the press to their supervisor (who would reference the PIO), rather than providing any opinions or information for the public.

Uniforms

The uniform to be worn for deployments, community service events, training exercises, and any other opportunities where members are identified as part of the UMV MRC, includes a polo shirt with the MRC logo.

Whenever members are in uniform, they must always be mindful that they are representing the national MRC system, as well as their unit and their own capabilities.

Blue vests with reflective strips and clear ID pockets are also available, to be worn during drills and deployments.

Badges

All members who successfully pass CORI and license checks, and complete some basic training, will be provided with a photo ID badge. These items have a vertical (“portrait”) orientation, with specific layout for the photo, logo and text. Badges are to be worn on a lanyard, in a clear plastic pouch, as provided by the UMV MRC.

Equipment

Depending on the activity, members should have access to the following items.

General – UMV MRC badge and logo polo shirt, for instant identification as a member. These items should be on hand for community service events, meetings, presentations, training sessions, and other non-emergency situations. These are also prerequisites for drills, simulations, and deployments.

On-site deployments – Members should have the following items ready for rapid response, especially at mass casualty scenes, depending on the situation.

Go-kits (to be provided):

- Back-pack
- Safety scissors
- Nitrile gloves
- Face masks for PPE (including N95, if possible)
- Pocket mask or face shield for resuscitation
- Eye protection
- Gown
- First Aid supplies (bandages, sterile wipes, other)
- Generic salve (Neosporin/bacitracin)
- Small bottle of sterile water
- Pen lights
- Notebook and pen

BP Cuff and Stethoscope (members bring their own, if they have these)

Personal items (brought by members as needed)

- Sweater or sweat shirt
- Bottled drinking water (16-oz)
- Snack bars
- Extra socks
- Leather or canvas work gloves
- Work boots
- Personal medical supplies (such as diabetic meds and snacks)

Triage forms

START assessment tags

Response Partners and Affiliates

A key strength of any entity that responds effectively to deployments is the ability to work well with other groups. Thus the MRC strives to foster optimal relationships with many partner organizations and affiliates.

All MRC activities will factor in the role of existing or potential affiliates: health departments, police, fire, ambulance companies, emergency service agencies, the Red Cross, and other key groups. Affiliates will be considered when planning tabletop drills and training, as well as deployment, and will be kept informed of MRC initiatives as appropriate.

Any organization that might request the services of the MRC should have a copy of these guidelines (or at least activation instructions), and be contacted to ensure that the methods for activating the MRC are clear.

The UMV MRC strives to maintain positive relationships with the relevant organizations, continually building and strengthening its network of contacts.

Networking with potential partners and affiliates must be an ongoing activity for the staff. Presentations and communications with certain contributors can also provide an avenue for recruitment, as well as additional involvement by members.

Organizations authorized to request the UMV MRC

Any of the following entities is authorized to contact the UMV MRC Director for multi-agency training exercises or deployments.

Other key organizations (school departments, churches, other) would request emergency help through their primary channels; typically by calling 9-1-1. In addition, agencies are welcome to contact the Director for non-emergency requests, such as civic events.

Notes:

- (1) These names are provided to help members recognize the leaders of key organizations, and are offered strictly for informational purposes. Only MRC staff would contact any of these people directly for UMV MRC issues.
- (2) The Board of Health director or health agent is the most likely source of designees for emergency deployment, in case the MRC Director is unavailable.
- (3) Other departments in each town, including the town manager or selectmen, should work through their own board of health to request MRC activation.

Billerica

BOH Director: Rich Berube
Public Health Nurse: Christine West
Emergency Management: William Laurendeau
Police Chief: Daniel Rosa
Fire Chief: Anthony Capaldo
Town Manager: Rocco Longo

Chelmsford

BOH Director: Richard Day
Public Health Nurse: Sue Rosa
Emergency Management: Walter Hedlund
Police Chief: James Murphy
Fire Chief: Jack Parow
Town Manager: Bernard Lynch

Dracut

BOH Director: Thomas Bomil
Public Health Nurse: Ron Mote
Emergency Management: Rich Patterson
Police Chief: Kevin Richardson
Fire Chief: Leo Gaudette
Town Manager's Office: 978-452-1227

Lowell

BOH Director: Frank Singleton
Public Health Nurse: Donna Brooks
Emergency Management: Mark Boldrighini
Police Chief: Ed Davis
Fire Chief: William Desrosiers
City Manager: John Cox
Mayor: Armand Mercier

Tewksbury

BOH Director: LouAnn Clements
Public Health Nurse: Virginia Desmond
Emergency Management: Mike Sitar

Police Chief: Alfred Donovan
Fire Chief: Rick Mackey
Town Manager: David Cressman

Tyngsboro

BOH Director: Joan Ferrara
Public Health Nurse: Nanci Dowling-Meehan
Emergency Management: Wes Russell
Police Chief: John Miceli
Fire Chief: Tim Madden
Selectman's Office: 978-649-2300

Westford

BOH Director: Sandy Collins
Environmental Director: Darren McCaughey
Public Health Nurse: Patricia Newell/Lisa Slattery
Emergency Management: Tim Whitcomb (PD) and Joe Targ (FD)
Police Chief: Robert Welch
Fire Chief: Richard Rochon
Town Manager: Steve Ledoux

Other potential sources of requests

The UMV MRC may be invited to training exercises and deployments from several additional sources. Connections must be established for interactions with agencies outside of the region, with clear protocols for engaging help from the MRC.

American Red Cross – This national disaster organization has already requested support from the MRC system, during the 2004 hurricane season. Additional deployments may be requested for staffing Red Cross emergency shelters. The Red Cross is already an affiliate through joint training programs and agreements with the MRC. Merrimack Valley N.E. Chapter: 177 Ward Hill Avenue, Ward Hill, MA, 01835.

Citizen Corps – As the MRC and its sister agencies (CERT, VIPS, other) report to their local Citizen Corps, this entity may play a role in requesting volunteers for deployments.

EMACS (Emergency Medical Assistance Compact) – This network of resources exists in 49 states, and policies are being formed per inter-state sharing of resources, both materiel and manpower..

Emergency Management Agency, Area 1 Operations – This is one of the closest major disaster agencies, which could be a response partner in a disaster. 365 East St, Tewksbury, MA 01876.

MSAR (Massachusetts System of Advance Registration, for volunteer health professionals) – This emerging statewide initiative is expected to play a major role in the

deployment of volunteers, potentially including requests for MRC members, within Massachusetts.

FEMA – The Federal Emergency Management Agency interacts through MEMA. Regional area contact for FEMA is in Waltham.

Governor’s Office of MA – If a state of emergency is declared, UMV MRC may be called for deployment through the director or coordinator or through the designee. Contact Information: State House, Office of the Governor, Room 360, Boston, MA 02133.

MEMA –MEMA is a source of training and guidelines for disaster response in MA. They may recommend through the Emergency Management or Health Directors that the MRC need to be activated. Regional director’s office is at 400 Worcester Road, Framingham, MA.

N.E.M.L.E.C. – The North Eastern Massachusetts Law Enforcement Council is a consortium of 35 police chiefs representing law enforcement agencies from communities in Middlesex and Essex Counties. (See <http://www.nemlec.com/main.asp> for a complete description; including response teams, investigations, and communications.)

Each of the seven UMV MRC police departments are members. While it is unlikely that representatives from NEMLEC would ask to dispatch the MRC directly, MRC volunteers may interact with their personnel on various assignments.

VOAD –National Voluntary Organizations Active in Disasters www.nvoad.org. NVOAD coordinates planning efforts by many voluntary organizations responding to disaster. Member organizations provide more effective service and less duplication by getting together before disasters strike. Once disasters occur, NVOAD or an affiliated state VOAD encourages members and other voluntary agencies to convene on site. This cooperative effort has proven to be the most effective way for a wide variety of volunteers and organizations to work together in a crisis.

Hospitals and Health Care Facilities

The MRC may be called to provide “backfill” or surge capacity in a disaster or other event:

- *Deaconess Nashoba Medical Center, Ayer
Contact: Emergency Preparedness Coordinator
- *Emerson, Concord
Contact: Emergency Preparedness Coordinator

*Note: Although these hospitals are located outside of the seven UMC communities, many of the patients who work or live in the region are transported to this neighboring facility.

Lowell General, Lowell
Contact: Sukie Connolly
295 Varnum Ave.
Lowell, MA 01854

Saints Memorial Medical Center
1 Hospital Drive, Lowell 01852
Emergency Room
Greater Lowell EMS Paramedics

Mutual Aid Agreements

Health Departments are developing mutual aid agreements with these types of facilities, as appropriate:

- Emergency Medical Service (EMS) organizations
- Hospitals and clinics
- Laboratories
- Nursing homes and assisted living facilities
- Home health care agencies
- Psychiatric, mental and behavioral health providers
- Social service agencies
- Local, regional, and state medical societies
- Liaisons to special populations
- Other medical entities

Cultivating relationships prior to an event assures that the MRC is incorporated into the planning and will be utilized as a viable asset for surge.

Community Service Groups

These include civic and fraternal organizations (Lions, Elks, Veterans, other), schools, and other entities.

Local chambers of commerce can also provide useful connections and networking, and offer community service programs:

Greater Lowell Chamber of Commerce
144 Merrimack Street
Lowell, MA 01852
978-459-8154
info@greaterlowellchamber.org.

Merrimack Valley Chamber of Commerce
264 Essex Street, Lawrence, Ma. 01840-1496
(978) 686-0900
thechamber@merrimackvalleychamber.com

Middlesex West Chamber of Commerce
77 Great Road, Suite 214
Acton, MA 01720
(978) 263-0010
info@mwcoc.com

As time goes on, the roster of partners and affiliates is expected to grow.

Deployment Procedures

Rules for Deployment

There are three cardinal rules for deploying the UMV MRC.

1. The *only* way to request deployment is by contacting the Director.
2. Members should *never* self-deploy. Doing so could be grounds for dismissal.
3. No unauthorized person should *ever* try to deploy individual members directly.

It is crucial to work strictly through the Director for deployment requests, for several reasons. This method of having a single point of contact ensures that:

- The call-out request is appropriate for the unit.
- Notifications are made through the most effective channels.
- Responses from members are tracked efficiently, with no duplication.
- The appropriate number and type of volunteers are dispatched.
- Members can be assigned at their optimum skill level and preferences.
- Teams of various specialties can be allocated as needed.
- Groups of members who trained together can offer maximum effectiveness.
- Resources are allocated wisely in case of multiple requests.
- Members are provided with the relevant background and directions.
- Responders will arrive with the appropriate training and equipment.
- Member safety is ensured to the greatest degree possible.
- Activities of responders can be monitored, across multiple events.
- After-action reporting and feedback mechanisms are maintained.
- Follow-ups are initiated as appropriate.

Self-deployment, and the contacting of individual members apart from established channels, interferes with these desired outcomes.

If the Director confirms that the assignment is appropriate, the information will be provided to the Coordinator (or a designee) to carry out the deployment procedures.

Any health director of one of the seven communities within the Upper Merrimack Valley who requests MRC response will be provided names of individual members of the unit who are based in their town. Deployment protocols outlined in this SOP will be followed if the unit is activated.

Overview of Activities

The type of disaster determines the specifics of each deployment.

- Whether members are needed for one site or many depends on the scope of the emergency. For example, members could be assigned to:
 - o A single staging area, if there is a localized mass-casualty incident (such as an apartment fire or building collapse).
 - o To various emergency shelters, if a flood or snowstorm displaces people from their homes; or regionally, to assist in more than one community;
 - o Clinics in several towns across the UMV, to prevent the spread of an infectious disease outbreak that has put the region at risk

- The type of event impacts the methods of activation to be used in each case.
 - o A phone tree is the most appropriate means of contacting members to serve in organized teams at public health emergencies. In these instances, land lines and cell phone coverage is unlikely to be affected.
 - o Automated systems (such as Reverse 9-1-1) would be considered for large-scale activations, particularly when multiple communities and services are involved.
 - o Alternate notification (HAM operations, radio and text-message contact, NexTel communications, personal visits, other) must be tested in case the usual methods of contact (phone and e-mail) are disrupted.
 - o Media outlets (cable TV, major news stations, radio) will be tapped depending on the scope and urgency of notifying volunteers.

- The chain of contact for the unit always begins with the MRC director.
 - o Designees would be pre-appointed to serve as alternate contacts, in case the director is unavailable or absent during an emergency.
 - o The coordinator (with team leaders as back-up) would carry out notifications and other disaster activities, as instructed by the director or designee.

- Reporting and coordination with other agencies is part of any response.
 - o The requesting agency would be responsible for ensuring that all appropriate parties are called as needed (building inspectors, highway department, police, fire, Red Cross, MRC, other).

- Incident Command must assess the scope of the disaster, identify necessary resources, and address safety issues before dispatching responders.
- The MRC director would request that the appropriate number and type of volunteer response takes place, on behalf of the unit.
- If the disaster occurs outside of the UMV region, the director would determine whether response outside this area is appropriate. She will ask whether members are willing to respond beyond their usual service area, factoring in any reciprocity issues.
- MRC members would arrive at a specified location, with the appropriate ID and equipment. They would interact with other participants as specified by NIMS and local protocols, and operate within the scope of their training.
- Procedures for checking in and out, completing forms and reports, and other mechanisms for accountability would be specified by the requesting agency, and adhered to by MRC responders.
- The situation must be monitored so staffing can scale up or down as needed, and shift assignments can be adjusted.
- The MRC director would ensure that deactivation of the unit as a whole is carried out effectively, and that after-action reports and recognition of members takes place in a timely manner.

Sources of requests for MRC response can include local, regional, state, and federal agencies.

The Incident Commander for the event– would assess the scope of the disaster and activate or place a request for the necessary responders, according to their town’s LEPC procedures.

The MRC would be available as one of the responding entities, working closely with public health police, fire, Red Cross and other agencies as needed. Collectively, these responding agencies would take direction from the Incident commander or through a Unified Command, as specified in NIMS and ICS.

Types of Deployment

Members can be deployed in local, regional, statewide, or national disasters; both in small-scale and large-scale incidents.

A. Local Activation

As soon as a possible crisis is suspected, the town’s authority is advised to contact the UMV MRC director for a “heads-up” notification. This allows the director to prepare initial response mechanisms: contacting the coordinator and team leaders, gathering paperwork and arranging for contingencies, and issuing “standby” requests.

Although this is a regional unit, members will be contacted for activation in their own town first.

- If it is determined that the MRC is not required, the members are not activated. *Note:* It is *never* a problem if we are contacted but not activated! Rather, it is better to provide advance notice and discover we're not needed, than to hold off until the last possible moment and then call us when a catastrophe is clear, giving us minimal lead-time in which to prepare.
- If the MRC is requested, the next step is to determine the appropriate response from within our ranks. (Depending on the emergency, some of our members may have "first call" to another entity, so we'd factor in those circumstances early.)
- If the crisis is confined to one community, then members who work or reside in that community would be called first.
- If specialists are required (such as trauma nurses and paramedics, or physicians with expertise in infectious disease agents), they would be called immediately.
- If only a limited number of MRC members are needed, the notifications would cease as soon as that number is reached.
- If additional staffing is required, or if an insufficient number of members are available from within the affected community, then the next members to be contacted would be those who live at increasing distances from the emergency

B. Large-Scale Activation

An incident that results in vast numbers of victims, causes many critical injuries, or encompasses more than one town, constitutes a large-scale activation.

Regional emergencies impact multiple communities within the UMV.

Requests will be funneled through the MRC director. When requests are processed through the leading MRC authority, personnel can be allocated at the appropriate skill levels and numbers, to the locations where they can do the greatest good for the greatest number.

No UMV community should EVER attempt to dispatch MRC members directly! Doing so could jeopardize the unit's ability to set priorities and send trained members where they are most needed, also limiting the required coverage for surrounding communities.

To request support from the unit, anywhere in the region, ALWAYS work through the MRC director or designee. This is the best way to ensure that members are dispatched in the most effective manner – for their protection, as well as to provide optimum service.

State and federal disasters can generate requests from elsewhere in the state (MEMA) or the nation (FEMA). Typically, a “state of emergency” would be declared through government officials. These situations could result in requests for the activation of several MRC units across the state.

It is entirely at the discretion of each member of the UMV unit whether they choose to be eligible for response outside of their town or region. Such response also raises issues of greater complexity, such as recognition of licenses and intra-state procedures.

It is imperative that the MRC director determines whether to contact members for deployment outside of the region. Having this single point of decision ensures coverage in the local area, should the emergency put UMV communities at risk. Also, the director would have records indicating each member’s abilities, interests, and preferences per responding to disasters at a given location.

MRC Staff Responsibilities in a Deployment

The Incident Commander(s) or designee would determine whether MRC responders would report to a labor pool, staging area, hospital, or other location. The ICS role includes tracking and monitoring response from all entities, including the MRC.

Director responsibilities during activation of the MRC

When a call is received for MRC assistance, the MRC Director is responsible for the following, with assistance from the Coordinator:

- Initiating procedures to ensure that the appropriate number and type of members are activated, at the necessary skill levels.
- Ensuring that members respond to the appropriate locations (such as a predefined staging area) with the appropriate gear and instructions.
- Maximizing each member’s personal safety: decon, hazmat, and other threats on scene are identified and planned for; members are trained to operate safely in that environment; recognizing and avoiding undue risk.
- Monitoring responses and staffing levels with direction from the Incident Commander.
- Maintaining contact with members, or monitoring their involvement, as needed.
- Verifying that reporting and de-activation procedures are followed.

The completion of specific tasks may be delegated as appropriate, such as assigning the coordinator or team leaders to activate a phone tree.

Coordinator responsibilities during activation of the MRC

- Engage team members as appropriate
- Verify transportation of MRC volunteers to and from the correct sites

- Issue badges and distribute uniforms for ID
- Ensure that supplemental equipment (two-way radios) is provided
- Keep tabs on changes in the situation
- Check on safety issues as needed
- Verify that members are dispatched with the appropriate ID (badge, driver's license, CPR card, other)
- Schedule members in shifts, for events of long-term duration
- Maintain communication with the Director

It is crucial for members to sign in and out from their responsibilities at the scene, according to protocols established with the town – for safety reasons as well as accountability.

Member Responsibilities in a Deployment

According to ICS procedures, members should respond according to the following checklist.

1. Receive your incident assignment from the MRC; probably through the coordinator or team leader. This should include, at a minimum: reporting location and time, expected length of assignment, brief description of your role, route information, and a designated communications link if necessary. (Depending on the situation, alternate transportation methods may be advised. Never self-deploy!)
2. Bring any specialized supplies or equipment required for the job. Be sure you have adequate personal supplies to last for the duration of the assignment.
3. Sign in upon arrival, at the check-in location for the given assignment.
4. Use clear text (no codes) during any radio communications. Refer to incident facilities by incident names. Refer to personnel by ICS title, not by numeric code or name.
5. Obtain a briefing from your immediate supervisor. Be sure you understand your assignment.
6. Acquire necessary work materials, then locate and set up your work station.
7. Organize and brief any subordinates assigned to you.
8. Brief your relief at the end of your shift, and at the time you are demobilized from the incident.
9. Complete required forms and reports, delivering them to your supervisor or the Documentation Unit before you leave.
10. Demobilize according to the plan.

Demobilization and Debriefing

Each incident should include assurance that members have signed out from the scene and have the chance to share their observations afterwards. These comments can be included in an after-action report for the UMW MRC, and can be shared as needed (with the

volunteer's name removed for confidentiality, if appropriate) in overall post-event reviews with other agencies.

Opportunities will be made available to meet with mental health professionals, if deployments warrant the need.