HOMELAND SECURITY AND SAFETY

LIISA JACKSON
ROBERT IRVING DESOURDIS

OUR MEDICAL RESERVE CORPS

The Power of Volunteers and Inspired Leadership

NOVA

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Homeland Security and Safety

The Homeland Security and Safety Series is focused on developing books that address the prevention, protection, detection, response, and recovery from manmade and natural threats to people and their economy. The series includes not only the civilian public safety and emergency response domain, but also the needs and solutions of its warfighters, that is, its military forces whatever their mission. Our hope in either domain is to publish critical, but lesser known, content leading to innovative holistic solutions to homeland security and safety problems. Our books therefore to date address the critical historic role of human collaboration in all aspects of homeland security and safety. This perspective was taken recently in a two-book series on the COVID-19 disaster, with Volume I focused on understanding the pandemic in 2019-2021 and Volume II providing the methodology needed to prevent, if possible, and if not, protect people and their means from the inevitable next pandemic.

In addition to the traditional domains of human innovation for security and safety, including introspection and recommendation to improve human collaboration, we also address public safety and warfighting commemoration. In other words, we provide books that address the life and times of specific noteworthy individuals in the form of their memoirs. To this end, we published a three-book memoir series on a celebrity in American history, namely Edwin Cole Bearss. Mr. Bearss was a wounded Marine in the WWII Pacific theater who rose in the National Park Service to be its Chief Historian, ultimately known to the world in the Ken Burns Civil War documentary series. A second memoir was done for Bernard Nolan, an 8th Air Force pilot and "Mr. Airplanes" for NASA. We also have a trilogy (so far) describing a walking tour of WWII Italian Battlefields, with other battlefield tour books in planning. The commemoration domain is important to understand lessons learned and those who learned them.

Robert Irving Desourdis operates a one-person company called Desourdis Collaboration, LLC, which provides engineering and proposal collaboration and consulting. In addition, it develops a variety of books and other publications. He has developed 17 books to date, including wireless technology, human collaboration and homeland security, and warfighter history, including memoirs. Mr. Desourdis spent 15 years in post-nuclear-attack radio communications, 15 years in public safety communications, and

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more recently, proposal and business development work, and publication development. He has an MS degree in Technology and Policy from MIT and an MSEE and BSMA from the Worcester Polytechnic Institute.

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A Walking Tour of Italy's WWII Battlefields: From Rome to Bologna
Frank de Planta de Wildenberg and Robert Irving Desourdis
2024. ISBN: 979-8-89113-509-3 (Hardcover)
2024. ISBN: 979-8-89113-630-4 (ebook)

The COVID-19 Disaster. Volume II:
Prevention and Response to Pandemics Using Artificial Intelligence
Robert Irving Desourdis (Chief Editor),
Christopher Peter Jacobson and Lee Aaron Angelelli (Editors)
2022. ISBN: 978-1-68507-118-9 (Hardcover)
2022. ISBN: 978-1-68507-485-2 (ebook)

The COVID-19 Disaster. Volume I: The Historic Lessons Learned and Benefits of Human Collaboration
Robert Irving Desourdis (Editor)
2021. ISBN: 978-1-53619-861-4 (Hardcover)
2021. ISBN: 978-1-68507-024-3 (ebook)

A Walking Tour of Italy's WWII Battlefields:
From the Anzio Landings to Rome
Frank de Planta de Wildenberg and Robert Irving Desourdis
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Walking the Ground: The Pied Piper of History.
A Memoir of Edwin Cole Bearss
Edwin Cole Bearss and Robert Irving Desourdis
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2020. ISBN: 978-1-53617-659-9 (eBook)

Walking the Ground: Making American History.
A Memoir of Edwin Cole Bearss
Edwin Cole Bearss and Robert Irving Desourdis
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2020. ISBN: 978-1-53616-936-2 (eBook)

God Was Our Pilot: Surviving 33 Missions in the 8th Air Force.
The Memoir of Bernard Thomas Nolan
Bernard Thomas Nolan and Robert Irving Desourdis
2020. ISBN: 978-1-53617-685-8 (Hardcover)
2020. ISBN: 978-1-53617-686-5 (eBook)

Human Collaboration in Homeland Security
Robert Irving Desourdis and Kuan Hengameh Collins (Editors)
2017. ISBN: 978-1-53611-935-0 (Hardcover)
2017. ISBN: 978-1-53611-956-5 (eBook)

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Liisa Karin Jackson
Robert Irving Desourdis

Our Medical Reserve Corps

The Power of Volunteers and Inspired Leadership

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Liisa dedicates this book to the Medical Reserve Corps volunteers without whom many would have suffered or died. Thank you.

Liisa dedicates this book to her daughter Celia for her unwavering support during deployments and during her cancer treatment.

Liisa also dedicates this work and the tremendous leadership skills behind its words to her cancer care team at Dana-Farber, who she says are "amazing."

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This book is sourced from expertise and history of Medical Reserve Corps units in Massachusetts led by Liisa Karin Jackson and others whose testimonials demonstrate shared experiences. Any textual or photographic content found in error will be corrected if identified in subsequent editions of this work.

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Advance Praise

MRC Relations

27 June 2024
Dear Liisa,

Hearing from you recently about the pending release of your new book along with your request for a testimonial from me was a true surprise. It has been 12 years since I retired from active duty in the US Public Health Service and 22 years since the founding of the Medical Reserve Corps [MRC] in the US. Your request brought back so many wonderful memories of our launch and development meetings in the "early days" of the MRC. Your leadership and zest for making a difference in our communities, state and country cannot be understated. Meeting you and working with you and so many other great public health front line leaders throughout New England and the US was one of the many highlights of my career in uniform.

Liisa, you are a true inspiration to so many who have been privileged to work with you. Your energy, creativeness, personal strength, and drive made you one of the top public health leaders in Region 1 of the US. I cannot recall a time when I reached to you for help or mission support when you did not jump into action and deliver outcomes that far exceeded expectations. Your "never say no attitude" made public health and emergency response leaders at the highest levels of our state and national government pause and take notice. As one of them, along with several former US Surgeon Generals and Assistant Secretaries of Health, I know this fact first hand. When a new request or idea was initiated from my headquarters in DC or brought to my attention as a regional public health leader, I knew just who to reach out to. Your suggestions and creative ideas on how to "make it happen" in the Commonwealth of Massachusetts or throughout New England or sometimes, across the US were always welcome. Your leadership made such a difference in the early days of the MRC and it has continued uninterrupted for the past twenty-two years.

Congratulations on this wonderful undertaking and thank you for your unwavering passion to help those all around you with ongoing challenges or sudden life events that they were not prepared for. I wish you God Speed and great success with this book and continued success in your future endeavors.

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I am humbled and truly honored that you asked me to contribute this small note.

Best Regards for continued success,
Michael R. Milner, DHSc, PA-C
Rear Admiral, US Public Health Service (retired)
Assistant US Surgeon General
Former Regional Health Administrator for US Region 1 New England

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I am a retired RN [Registered Nurse] and an active member of the Massachusetts MRC, the North Shore Cape Ann Emergency Preparedness Coalition. I met Liisa Jackson before I retired in 2014 and expressed interest in volunteering for the organization. Initially, there were some training opportunities and ways to give back to the communities by manning a health station during road races, blood pressure clinics and screenings, and various other events.

The public health nurses tapped into this resource, and we assisted in deploying to the local towns to assist in Flu Vaccination Clinics. They included Lynn, Swampscott, Marblehead, Danvers, Beverly, and Gloucester for me. Communication was via email and everything was clearly explained, I was able to accept or to decline any deployment with no pressure and no judgement. Education programs offered included timely topics such as Narcan administration, “Stop the Bleed,” and Covid. In September 2018, we were deployed to Lawrence to assist with the huge Merrimack Valley gas explosion. I really learned the importance of preparedness and communication during that disaster.

Then, in March 2020, Covid hit the world and the MRC was active in all phases of community help, we worked with First Responders, finding ways to help with food insecurity and learning every day from the CDC through LIIsa; from making masks to proper fit masking, to vaccinations the MRC was on the front lines under the expertise of Liisa Jackson. I was interviewed for TV and an article was written about the MRC and its volunteers in our local newspaper.

I so valued Liisa and her role at MRC that I invited her to be the guest speaker at the Lynn Hospital School of Nursing Alumni Association annual Meeting for which she received rave reviews and positive feedback for the

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talk. Liisa is always professional and kind and although I have been less active this past year I am honored to write this letter in support.
– Mary McCormick-Gendzel, RN

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Documenting historical events is essential for future generations to capture the moment in time. I first heard Liisa Jackson's name at an MRC event in the early 2000s when she was recognized for outstanding efforts on behalf of the MRC. I met her the following year, and it is an honor to work with Liisa. I treasure our mutual collaborative efforts, support, and brainstorming. Our work truly embodies the MRC mission statement: community coming together to build up each other up in times of wellness or disaster. Liisa has provided numerous trainings, administrative/technical support and over twenty years of expertise in public health emergency preparedness to our MRC unit. Sheltering, immunization clinic support, food drives, wellness fairs are amongst the myriad efforts that MRC participates in. Most importantly, she does it with a huge smile and enthusiastic spirit!

– Jacquie O'Brien, RN

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Since the beginning of my Public Health career in 2015, the MRC volunteers lead by Director Liisa Jackson have played an integral role in supporting and advancing public health programs in our communities. The organization has provided the health departments with the necessary resources and capacity to perform activities at a higher quality and service delivery level.

Volunteers represent the communities we are serving, whether it is assisting folks at the Council on Aging to complete their pre-vaccination paperwork or setting up a call bank of volunteers during Covid-19 response to answer concerns in the native languages of our constituents, the MRC step up when help is needed.

The trusting relationship established with Liisa Jackson and MRC volunteers far before the pandemic truly made a difference in saving many lives in our community. As soon as I started receiving Covid-19 positive cases, I immediately knew I needed Liisa's help to establish a call center for Covid related questions and concerns from constituents and assistance with case investigation to mitigate the spread of disease. With the many years of working with MRC volunteers and Liisa's leadership, we were able to quickly

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mobilize dozens of volunteers to assist at our first Covid-19 vaccination clinic for our First Responders and additional priority populations.

Additionally, Liisa and I advocated to establish the first formalized MOU with a FQHC [Federally Qualified Health Center] in our region to engage volunteers in community-based activities such as immunization clinics and food distribution events. We have hosted MRC educational events to provide volunteers with the knowledge and support to support our unhoused neighbors safely and effectively. We have mobilized volunteers to assist at Somerville's first ever overnight Warming Center in 2023 and 2024.

The MRC volunteers and leadership represent the cultures, languages, diversity, and medical expertise of our communities, making them a sustainable and trustworthy organization that truly makes a lasting impact on our communities.

– Kelley Hiland, BSN, Bachelor of Science Nursing, RN, Deputy Director of Public Health, Health and Human Services, City of Somerville, Massachusetts

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It has been my distinct pleasure to have worked with Liisa Jackson as she established the Medical Reserve Corps for the Massachusetts Emergency Preparedness Region 4A.

I have known Liisa since 2004 when I was the Chairman of Region 4A and she first started providing services to the region. During that time working with Liisa I found her to be extremely cooperative and knowledgeable.

Her personal skills, professional knowledge, and qualifications in establishing volunteer medical reserve corps are second to none. She has a genuine interest in connecting with the volunteers of the Corp.

Whether it was a natural disaster, conducting community health outreach, or organizing emergency drills. Liisa's unwavering dedication, transformed mundane tasks into meaningful endeavors.

Her ability to rally volunteers and inspire them to give their best remains unparalleled. With her guidance Region 4A developed countless training sessions, practiced emergency dispensing site protocols, honed communication skills, and simulated crisis scenarios. Liisa's optimism is contagious, even during the most trying times.

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Her positivity uplifts everyone around her. Region 4A would not have been successful without her and for that I will be ever grateful!

– Doug Halley, Retired Acton Health Director and Region 4A Public Health Coalition Chairman

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I hope this letter finds you in good health and high spirits. As I sit down to pen this heartfelt tribute. In the past, I have been requested to provide letters of reference for various individuals many times. On many occasions I am reluctant to do so because I am not willing to make a favorable recommendation / reference if I do not truly believe one is deserved. This, however, is not one of those instances. I can think of no finer a person than Liisa Jackson. I have known Liisa since 2011 for 13 years, through a working relationship at Middleborough Health as well as personally. I have found Liisa to be extremely cooperative and knowledgeable. I feel that Liisa's professional knowledge and qualifications to be superior.

I am filled with gratitude for the remarkable journey we have shared through our friendship and professional collaboration within the MRC. Our bond transcends mere acquaintanceship; it is a testament to the power of shared purpose and unwavering commitment. Our paths first intersected during hiring you to help do training for MRC for the Middleborough Unit. Your genuine interest in connecting with fellow volunteers immediately put me at ease. Little did I know that this chance encounter would blossom into a friendship that would enrich both our lives. We stood side by side whether it was a natural disaster, conducting community health outreach, or organizing emergency drills.

Liisa, with your unwavering dedication, transformed mundane tasks into meaningful endeavors. Your ability to rally volunteers and inspire them to give their best remains unparalleled. The Middleborough MRC allowed us to engage directly with the community. Middleborough MRC and Health Department conducted health fairs, disseminated vital information, and organized vaccination drives. With your help we developed countless training sessions, practiced emergency dispensing site protocols, honed our communication skills, and simulated crisis scenarios. Your attention to detail and ability to keep everyone engaged made these sessions not only informative but also enjoyable. When the opportunity arose to lead a team during a mass

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dispensing exercise, you stepped up without hesitation. Your calm demeanor and strategic thinking ensured the smooth flow of operations.

Liisa, your optimism is contagious, even during the most trying times, you find a silver lining. Whether it is sharing a funny anecdote during a tense situation or offering words of encouragement to a weary volunteer, your positivity uplifts everyone around you. As we continue our journey with the Middleborough MRC, I eagerly anticipate more shared experiences. Perhaps we will pioneer new initiatives, mentor budding volunteers, or collaborate on community resilience projects.

Liisa, thank you for being more than a colleague. Thank you for being a confidante, an inspiration, and a friend. Our friendship transcends the confines of our MRC roles—it is a beacon of hope in a world that often feels chaotic.

Here is to many more adventures, laughter-filled meetings, and impactful moments. May our friendship continue to thrive and may the Middleborough MRC benefit from our unwavering dedication.

– Robert W. Silva, Retired Fire Chief, Middleboro Fire Department

The Medical Reserve Corps is a unique and wonderful thing. It is like a family. Really, more like a family of families. Each Unit has its own identity but is part of the larger network family. Through the network, I have met many interesting people who have become colleagues, and in many cases, good friends. It is easy to make friends with people who share a common mission and are passionate about their work.

One of those people is Liisa Jackson. We met many years ago at an MRC National Conference. Liisa is always quick with a smile and her positive attitude is infectious. Over the years we have shared stories of success, and failure, acted as sounding boards, and sometimes, were just there to listen and help each other through difficult times.

As “seasoned leaders,” we share our experience with new Unit Leaders and help to mentor folks who are often thrown into our chaotic world as part of their “other duties as assigned.”

For close to 20 years, we have been “conference friends” seeing each other only once a year at national conferences, but we communicate regularly both about work and our crazy lives. Liisa is always looking for new and innovative practices, developing new materials and plans, and generously giving of her time to support other units. Liisa and I share these goals and a very mission-driven perspective with many of the successful unit leaders across the network.

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I am proud to be part of this important family that serves so many, and to call Liisa a friend.

– Bill Ray, MEPP [Master Exercise Practitioner Program], Homeland Security Exercise and Evaluation Program (HSEEP), Executive Director, Homeland Preparedness Project National Office Texas

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I had thought my focus might be how Public Health was asked to prepare to dispense prophylaxis within 48 hours of a CBERNE [Chemical, Biological, Radiological, Nuclear, and high yield Explosives] event or provide support services during a natural disaster. At that time there were few paths on how to recruit, train, organize, motivate, partner, or actually deliver services during an event.

Your creative approach to problem solving with a no quit, "can-do" attitude, forged a path through a forest as thick as any Amazon jungle to establish one of the largest MRCs in the country. You forged partnerships with multiple units, cross disciplines, and community leaders to respond successfully to several natural disaster events including a tornado and ice storm event both which required several days/weeks of volunteer deployment. The unit also provided local flu vaccine clinics, trainings and town public health education events which strengthened awareness of family emergency preparedness across the region. You modeled building partnerships across all disciplines, strengthening every aspect of the MRC.

You did all this while engaging volunteers and motivating them into a cohesive dedicated group prepared to deliver service to their communities when the need arose. Many of these volunteers stepped to the front during Covid to provide these critical services to deliver vaccine to their community's First Responders and their most vulnerable seniors.

I have met some outstanding individuals in my life which I can say I was truly honored to have had the opportunity to work with, but none more than you.

– Wendy Diotalevi, Retired Weston Health Director, and Region 4A Medical Reserve Corps Director.

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In 2020 a team of educators and students teamed up with Liisa Jackson and other health officials throughout the US. Liisa was essential in our local efforts to supply First Responders and hospital workers with the proper PPE [Personal Protective Equipment] during COVID.

The team of educators and students designed 3d printed headbands that could be fitted with transparency sheets that were three-hole punched to create a full-face shield.

The headband portion could be reused with the transparency sheet easily replaced as frequently as needed. Liisa Jackson spearheaded the distribution of many of these face shields here in Massachusetts. She offered up her own garage at her residence as a depot. Teams of students and teachers would drop off cardboard boxes full of shields.

Liisa through her work with the Massachusetts Medical Reserve Corps would organize drivers to distribute those shields to those in need. The Shield Team 2020 fielded numerous requests for shields and Liisa with her leadership skills was able to fulfill those needs throughout Massachusetts.

Nationally The Shield Team 2020 manufactured 60,554 units that were distributed to help reduce the spread of COVID during a critical time in our nation's health and care history.

– The Shield Team 2020: https://www.mrscottbot.org/p/covid.html

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Liisa Jackson has been a strong advocate for student involvement in the betterment of the nation's healthcare. Liisa is a frequent mentor and guest during our Inventive Assistive Device project at Hopkinton High School (Massachusetts). She provides feedback to students that identify a disability related problem, then seek out to improve the situation through an inventive device. Liisa is always engaged with students fully and cares about their learning. It has been a fantastic partnership as our students are able to learn from a healthcare leader like Liisa. She then returns to the class to help judge the showcase of assistive devices and to provide feedback to the students. This project and partnership have enhanced the learning of our students through an empathetic process as young inventors.

– Doug Scott, Business/Technology/Engineering Subject Matter Leader, 6-12, Hopkinton Public Schools

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6/19/24
Testimonial to Liisa Jackson

There is no one better to write a book that chronicles the events of the Medical Reserve Corps (MRC) in Massachusetts than Liisa Jackson. Liisa has been involved with the MRC for more than 18 years in different roles and across several cities and towns. During this time, she has inspired many like-minded individuals to volunteer to help their fellow citizens in distressful and trying times.

Liisa's strong leadership along with her ability to motivate and mobilize others has been recognized and honored by many organizations including: the Mass Environmental Health Association, the Safe America Foundation, the Health and Human Services Mentor Award, and the Hopkinton Trails Club. As a nurse and a nurse educator, the one award of which I am very proud is the Excellence in Caring Award she received from the Visiting Nurses' Association. Caring is what nurses do, everywhere and this is at the heart of what Liisa brings to all her endeavors.

I am proud to call Liisa a colleague and friend. Liisa, I am proud that you are telling the world an important story about caring.

Sincerely,
Barbara R. Kelley, EdD, RN, MS, MPH, CPNP
Professor Emerita, Northeastern University, School of Nursing

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As Director of Health and Human Services for the City of Peabody, Massachusetts, I have had the opportunity to partner with Liisa Jackson and the North Shore – Cape Ann Medical Reserve Corps for over 15 years. Liisa is a passionate and tireless public health advocate, and her work in recruiting and training community volunteers for the MRC has truly made a difference in our city. To prepare us for emergencies, Liisa has coordinated several trainings such as emergency dispensing site operations, shelter operations and Stop the Bleed. During non-emergency times, she has recruited volunteers to assist us with necessary preparedness tasks such as inventorying our emergency response trailers and has also helped us staff educational events such as Melanoma Awareness tables at community festivals.

Our local health department relies each year on MRC volunteers to support our flu clinic staffing - as vaccinators, as registration staff and as logistics support. Although we had long appreciated the work of Liisa and the MRC volunteers, it was during the COVID pandemic that we came to depend on their support more fully. In the early days of the pandemic, MRC volunteers

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assisted us providing public information to an anxious public. Once vaccine became available, Liisa coordinated volunteers who were willing to suit up in full PPE to vaccinate, observe, support, and provide some much-needed empathy and laughter to those attending our vaccination clinics. These volunteers provided countless hours of service to our community and were willing to do so because they felt prepared and supported by the systems that Liisa has created.

Liisa Jackson is trusted and respected throughout the local public health community as well as among the MRC volunteers and we are so grateful to have her working alongside us!

– Sharon Cameron, Director of Health, Human and Social Services/City of Peabody, 24 Lowell Street/Peabody, Massachusetts

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The MRC has been a big part of public health response since I started working with them in the early 2000s. Liisa Jackson has been an integral part of the MRC and an important connection between volunteers and municipal programing from the beginning. Emergency response and preparedness must rely on the willing participation of all of us.

Liisa Jackson is a shining star demonstrating her willingness to work together, share resources, coordinate diverse people and entities, and create new connections. The creative thinking and readiness to forge new paths through legislative and municipal challenges is her hallmark.

Liisa and I have been privileged to work with amazing volunteers and passionate about the work we have done alongside each other during the most difficult and life-altering event of our careers. COVID-19 demonstrated, in real, practical, and personal ways, the effective leadership Liisa provides to the MRC Coalitions she directs. I am excited that her experience is available for everyone to read. It is valuable for planning and moving forward into the next actions for the MRC volunteers. I am grateful for her constant enthusiasm and dedication. Liisa Jackson is one of my favorite role models, and this book is an exciting milestone for everyone involved in her work.

– Wendy Hansbury, Registered Environmental Health Specialist /Registered Sanitarian, Massachusetts Registered Sanitarian, A Region 3 Municipality Health Director

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I had been involved in Emergency Management and Volunteer Medical Response for about ten years when I first became aware of The Medical Reserve Corps (MRC). Dr. Fritz Vohr, my chief medical officer, showed me a Request for Proposals (RFP) for interested organizations to apply to the US Surgeon General's initiative to establish a civilian corps of medical and administrative volunteers to be available in times of extraordinary medical needs in in their communities.

With a short window to apply for this grant I forged ahead with a proposal to form such a group. In retrospect, this turned out to be a pivotal point in the management and development of my team. Aside from the modest injection of funding that came with the grant, it opened both opportunities for new directions for the team, but connections with other MRC leaders across the country. My single MRC team in Rhode Island was contrasted with several dozen units in nearby Massachusetts, and literally hundreds across the country. I suddenly had connections in nearly every state.

These connections not only allowed collaboration with other unit leaders and their members but encouraged it. We all had a chance to share and learn from one another. There were regional and national conferences where we could meet and network, explore new ways of doing things and all these things were possible because of these new and exciting people with a shared interest and a chance to explore new things.

One of these new people who stood out from the crowd was a lively young woman with blond hair and tons of enthusiasm. She asked questions, probed deeply for answers, and did not accept quick answers. Her name was Liisa Jackson and over more than 20 years now we have collaborated on many projects, from teaming on presentations at local, regional, and national conferences to actual responses to local and national deployments for these same extraordinary medical needs laid out in the original Request for Proposals. This relationship with Liisa is rewarding in many ways. It is demonstrated to me that we can do anything we want to do. Not only is she an extraordinary volunteer leader, but a great mother to her daughter Celia, a body builder, an expert horsewoman and even a farrier (blacksmith) to her horses.

Liisa Jackson is an inspiration to all who know her, and that includes me of course!

– Tom Lawrence, Founder of Rhode Island DEMAT [Disaster Medical Assistance Teams] and MRC, Nationally Registered Paramedic, the President of Rhode Island Disaster Medical Assistance Team, Inc., and Team Leader.

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When I think of the Massachusetts Medical Reserve Corps (MRC) I think of Liisa Jackson, to me they might as well be synonymous.

I met Liisa Jackson in 2006 when the MRC was just beginning to take a hold across Massachusetts. As part of another position, I was involved in the establishment of two south shore (south of Boston) MRC units; The Brockton Arean MRC and the Duxbury Bay Area Regional MRC.

Liisa was there to help. Her altruism immediately apparent, she, with no strings attached, shared her knowledge, boots on the ground experiences and the foundations of volunteer recruitment, deployment, and management. Liisa's expertise and encouragement were invaluable, helping me to set strong foundations for the MRCs for which I was responsible.

Over the years Liisa and I have collaborated on multiple MRC efforts. Our differing skill sets have allowed us to support each other's strengths and limitations, making all of our shared MRC endeavors that much better. We have been co-facilitators, co-authors, and co-conspirators! Whether they were community-based events, Local and/or Regional MRC trainings, drills and exercises or multiple emergency responses Liisa has always, if needed, been there. She shows up with a sense of purpose and a sense of humor.

Our strong, mutually beneficial professional relationship has led to an adventurous and enduring friendship. In my opinion, there is no one in the Massachusetts MRC community with more volunteer deployment skills, experience, and expertise.

Liisa's work with the MRC is an inspiration and unparalleled. It continues to be my pleasure and privilege to collaborate and conspire with her.

– Lisa C Kaufman, ATR-BC (Nationally Registered, Board-Certified Art Therapist), LADC1 (Massachusetts Licensed Alcohol and Drug Counselor 1)
Assistant Coordinator, Duxbury Bay Area Regional Medical Reserve Corps

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I met Liisa when I became a public health nurse in 2015. We met at a coalition PHEP (Public Health Emergency Prep) meeting at which I heard a little bit about what MRC was. Liisa reached out to me shortly after to give me a little more insight. We met for lunch. My plan was to meet for an hour. That hour turned into about three and could have gone on longer if I did not

Complimentary Copy

have to get back to my office. Since then, we have met and talked often, especially during the pandemic. Liisa's positive and enthusiastic attitude about everything has never stopped/wavered. Regardless of the hours, she always has an incredible smile on her face, a positive comment and a "let's do this" kind of an attitude.

Liisa's enthusiasm surrounding MRC was like a teen getting their first car, so excited to tell me about it and to take me along and see what it is all about. I was so impressed back then and nine years later even more so. Liisa's enthusiasm has not waned. Her MRC group not only assist during pandemics, bombings, or any other disasters, but they also get involved in "happier/uplifting" issues such as reaching out to older adults who may need someone to talk to. The year after I met Liisa, we set up a program (her idea) in Danvers where her volunteers would make calls to these older adults who may not otherwise have had anyone to talk to. Feedback from these individuals was so positive.

She and some of her volunteers has shown up to my trailer and storage area (an hour away from her home) on a Saturday to empty out, put an inventory list together and neatly arrange it back for me.

During the beginning of the pandemic, her group made face shields and masks when they were in hot demand and unavailable elsewhere. I would meet up with Liisa to get various supplies in areas that were at least an hour drive (one way) for her.

MRC was the reason we were able to hold so many vaccination clinics. Without them it would not have worked. My comment to them was "We had to show up day after day. You didn't. But you did," and we got paid. They did not.

An email sent out on a Friday night with no expectation of an answer until Monday morning, would be answered that Friday late or Saturday early. I remember telling Liisa to stop working late hours. With a laugh she answered, "I can't."

An email sent out last minute (meaning the need is for the next day) looking for volunteers never fails to have someone respond within a half hour: "I'm available."

I have never met anyone with the drive and dedication Liisa has, along with her "team." I know there have been things that have come along that most people would raise the white flag and say "done." Not only has she not, Liisa is the person that has and will continue and do it with that huge smile.

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With all that she has to manage, I have never seen aggravation; never seen negativity. Same holds true for all the volunteers. They are an incredible group of people.

I would say Liisa is one of the biggest reasons why our MRC "pool" is so big and those who have joined have stayed for years.

In 2023, our North Shore group held a luncheon for our MRC group in honor of their extreme dedication to helping us run our covid vaccine clinics.

Liisa was trying to help as usual until I finally told her "This is about you as well." But she does not/has not/probably never will see that.

– Judith Ryan, BSN, RN
Public Health Nurse, Danvers/Hamilton, Massachusetts

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It is a pleasure to send you this endorsement of my long-term colleague and friend, Liisa K. Jackson. The fact that she is added "contributions to publications for the Library of Congress" to her many accomplishments is both surprising and very much in character. I did not learn until April 2024 that Liisa had been involved in this type of endeavor. However, because Liisa is one of the smartest and most accomplished people I have ever met, it seems we are always learning about "yet another cool thing" that Liisa is tackling.

It was back in 2005 when our current MRC (Medical Reserve Corps) Director and I first met Liisa. She had just begun her role as an MRC Coordinator. Brimming with her usual enthusiasm, she was seeking out established units to learn as much as possible about running an MRC.

As we shared our insider views of MRC operations, Liisa listened carefully and asked insightful questions. She took everything she learned and ran with it, launching a highly successful series of MRC activities – from recruitment and training to actual responses.

We have since collaborated on a wide range of initiatives, all leading to positive outcomes. (If she has not discussed with you our shared experiences with the Andover/North Andover /Lawrence gas explosions in 2018, please call for details!).

Most of our colleagues and affiliates recognize the importance of being a "Jack of all trades" in leading an MRC unit. This characteristic is fundamental for many reasons that include the following:

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- MRC leaders interact with a wide spectrum of people in nearly unlimited environments. Coordinators may be making a pitch to funders, recruiting volunteers who hail from a range of backgrounds, encouraging members to complete various training courses and drills, and overseeing emergency deployments. The ability to listen with wisdom and empathy, while being relatable to a wide cross-section of humanity, is a major advantage. Liisa's varied background leads naturally to this capability.
- Every deployment is different, evoking skill sets that could not be predicted. Liisa has done everything from training horses ('caring for animals in disaster'), to providing home care for vulnerable patients ('supporting those with access and functional needs'). It is much more effective to direct volunteer response in such areas based on lived experience. Coordinators need to train-and-delegate—instead of rolling up their sleeves and taking over for every task.
- Still, Liisa is no stranger to hands-on efforts when needed, including driving big trucks and affixing trailers with which to haul heavy equipment. (Mercifully, she is also certified as a master personal trainer!)
- Liisa's persuasion and leadership qualities are evident from the numerous awards she has received, and from the accolades that arise whenever she gives a presentation. She generates "magic" whether speaking from a podium or leading an otherwise dry class on incident command.

Though I could write volumes on Liisa's savvy as an MRC Coordinator, hopefully these insights provide a sense of her passion for life in general and MRC activities in particular.

There are many layers to her lifetime of skills and experiences. I wish her the very best in her publications—which of course will be as successful as everything else she puts her mind to and pursues.

– Nancy V. Burns, EMT, CHEP, AFAA, AHA-I
Upper Merrimack Valley MRC Coordinator, Westford, Massachusetts
nburns@westfordma.gov

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How can anyone sum up the passion and commitment that Liisa has for the MRC program and all who volunteer under her leadership?

She has always had an energetic spirit and creative mind when engaging partners in volunteer use.

She looks beyond the limits that open up opportunities for various skills sets of individuals desiring to get involved.

I am so lucky to have Liisa as one of my unit leaders, but more so, my friend!

– Jennifer Frenette
Regional Liaison – New England, DHHS Region I, Office of Emergency Management and Medical Operations, Division of Readiness, Medical Reserve Corps (MRC), Administration for Strategic Preparedness and Response (ASPR), U.S. Department of Health and Human Services, 76 Portland St., Lancaster, New Hampshire

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I have spent my career working closely with Liisa Jackson. I cannot pinpoint the first time that I met Liisa or the first time that she helped my recruit volunteers through the Medical Reserve Corps, but she has made a huge difference in my life and my ability to do Public Health work.

Liisa has been with the MRC for so long that it feels like she has always been there, which is unusual in the field of public health where roles seem to be filled with new people every couple of years.

Liisa the only person that I consistently associate with the MRC, and I have grown to count on her in many ways.

I have been a Public Health Nurse for over 20 years; working for the Boston Public Health Commission, the Gloucester Health Department, and later the Peabody Health Department. In these roles, I quickly learned that the public health budget was small, but great things are expected. A community of 30,000 people with one Public Health Nurse might be expected to hold a mass immunization clinic for 1,000 people. This occurred in 2009 with H1N1. Vaccine might be provided free from the state health department, with no funding to staff a large clinic. Staffing such a large clinic would require at a minimum many greeters, registration staff, vaccinators, and other ancillary staff. Just the thought of recruiting, training, scheduling, and keeping track of staff for a mass immunization clinic is daunting. In the early days, most Public

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Health Nurses would need to rely on a small cadre of dedicated local citizens to volunteer and the staffing resources would be spread thin.

The creation and growth of the Medical Reserve Corps in Massachusetts changed the way public health could reach large groups of people. No longer reliant on a small local group, a Public Health Nurse could put a call out to MRC volunteers across the state to hold a mass vaccination clinic and would not need to worry about having enough staff show up on the day of the clinic. For years, Liisa Jackson has been the face of that staff recruitment operation. She has worked tirelessly day and night to send recruitment emails and hold trainings to keep volunteers up to date on necessary skills. Beyond recruiting staff, Liisa has also acted as a cheerleader for all public health endeavors, suggesting MRC volunteers for post-overdose door knock projects, health fairs, or emergency shelters.

The health departments in the northeast region of Massachusetts routinely collaborate on public health activities and reach out to Liisa Jackson for MRC support. During the COVID-19 pandemic, that collaboration and request for support intensified. On a weekly and sometimes daily basis, Public Health Nurses in our region reached out to Liisa through phone and email requesting assistance with staffing for vaccination efforts. No request was ever denied. Liisa put out the call to volunteers and they consistently responded by showing up for daytime, evening, and weekend clinics and vaccinated thousands of residents when the COVID-19 vaccine was first available. Volunteers have continued to show up, years later for routine influenza vaccination efforts.

The strength of public health in Massachusetts is truly its dedicated MRC volunteers. Liisa Jackson is the person who recruits, trains, organizes, and supports this vital group of individuals.

I am grateful for the amount of dedication and passion she brings to her role. Liisa Jackson is a joy to work with and Massachusetts and the MRC are lucky to have her.

– Chassea Robinson, RN, MSN, MPH
Public Health Nurse, Peabody Health Department

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I was at an age in my life where I was looking for a volunteer opportunity that allowed me to use my professional skills as an occupational therapist. First, I got involved when the tri-town medical reserve corps was looking for volunteers during the H1N1 vaccine clinics at the Topsfield fairgrounds. I am

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not sure when Liisa Jackson took over as coordinator of this MRC, and when she did notifications for a wide variety of trainings, resources, and events to volunteers became available.

The trainings through Liisa were good quality for our MRC volunteers, with well trained and equipped instructors. A few examples where shelter care, shelter care for an animal, "stop the bleed" CPR for humans and animals, Narcan, and set up and breakdown other emergency dispensing sites. Events were held at the MEMA [Massachusetts Emergency Management Agency] bunker, hospitals, fire stations, Topsail Fairgrounds, and schools. Liisa and her collaborators for these trainees always made sure volunteers were well taken care of with shelter, water, and breaks from the elements if held outside. We especially appreciated that she brought Girl Scout cookies as snacks for one of our outdoor events.

I was part of several events that I believe stand out. The first is the COVID pandemic, for which I was one of Liisa volunteers. I helped testing and vaccine clinics in various locations, in all kinds of weather conditions, including high heat and humidity, torrential rain, and in winter cold. Liisa's volunteers we were always appreciated by the organizer of the sites that we served. I may be biased, but I think oftentimes we were more efficient than the paid companies on site. Another event was the Columbia gas explosion in Lawrence and Andover, in North Andover, Massachusetts.

Liisa signed volunteers to provide 24-hour staffing at emergency shelters, working in various capacities at sites helping victims access emergency housing and basic services. These services included prescription replacement, when they lost or were able were unable to get into their homes or access portable appliances to take care of basic needs like heat and cooking. There were two situations where Liisa assigned me as a psychological support helper. This was a good use of my time and professional skills at these sites.

One deployment was helping Columbia gas employees deescalate, and another was an agitated young man who just wanted to get services for his grandmother. Security was trying to escort him away from the site due to his behavior, but we were able to calm him down so he could go back and get his and his grandmother's needs met. Another event was supervising a plan with a developmentally delayed young girl, who had come to the site with her young single mother late in the day after work in preschool. By engaging in her favorite activity of ball play, she was kept safe in the building and her mother and others could work with agents to fill out paperwork.

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During my involvement with the MRC under Liisa Jackson, the volunteers were also provided opportunity to attend conferences. One of the most memorable for me was domestic violence, as I was working professionally in the inner City of Lowell, Massachusetts, at the time. I received good resources for my profession as well as volunteer life. I left the conference with handmade blankets to give to children affected by domestic violence. I also received a checklist for disaster go-bags. Volunteers were also tapped to be victims in disaster drills, which helped First Responders, fire, police, and medical staff at hospitals, get out of there. Drills have been held at a variety of locations, like schools, hospitals, shopping malls, and MBTA train stations. Liisa even dressed me up with bloody fake wounds as a victim when she acted as one of the active shooters at one school drill.

As a volunteer, I always appreciate that Liisa was always making sure her volunteers had what they needed even, if she could not physically be there for some or all of them every time. We were sent out to an event in one incident in which she had contracted a road race coordinator, got two RNs and myself, needed for setup and approved purchasing of First Aid supplies. When the First Aid provided were found without most of the basic supplies needed, she made sure I was reimbursed. As I am writing this testimonial, I keep remembering more and more things Liisa and the MRC volunteers have been providing. Information, such as weather alerts in anticipation for storms, foot care for homeless individuals at a Community Center, substance abuse resources, and more.

Finally, on a personal level, Liisa's Facebook page has become an important part of my life. First and foremost, she is a single mother who is raising a remarkable young daughter. Any parent or grandparent would be proud of what she has shared, including both major and minor life events as well as some heartwarming comic relief and an amazing cross-country trip.

Liisa is basically an outdoor person who has a menagerie of animals, like horses a pony and a cat. Her animals, like my own, are truly her tribe. I have not ridden a horse in years, but with her helmet camera videos, I feel like I have been a part of the action. My own bucket list has always included going cross country. Due to life circumstances, I do not expect to ever be able to do so. Liisa and her own incredible journeys, mostly on horseback, enable me to enjoy the pictures of the memories that show up from her cross-country trips.

Finally, I must praise her infectious laugh. It is hardy, distinct, and full of life and heartfelt feelings, usually of amusement and joy, even when you hear that laugh but do not physically see her. My dad had a philosophy of life that if you bring a smile to a face of at least one person on any given day, no matter

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the kind of day, they will have a good day. This laugh, in the background of her postings, gives me good days. Although we are colleagues through the MRC, and mainly share similar values—including loving nature and the love of animals. It spawns strong personal connections with the humans with whom we share our lives.

Liisa is a combined kind of person you know will have your back and help whenever she can.

It is truly an honor and a pleasure to work with her and to be included in her life and as her friend's friend.

Presently, Liisa is probably in the biggest fight of her life battling cancer. She reached out to family and friends to ask for advice and resources. She has received excellent care.

She has embraced her family and friends in their journey and has kept us informed. Research has shown that maintaining a positive attitude is a major part of cancer treatment, so my recommendation to her was to embrace her resources, and I still hear laughter in her postings.

– Elizabeth Cameron
Occupational Therapist, MRC Volunteer

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In 2005 when my then Board of Health Chair approached me about establishing a unit for our community, I wondered what the MRC was and why we needed it. Nineteen years later, that unit now covers 14 communities and in partnership with two other units in Public Health Region 2 supports 74 communities with volunteer rosters well over 1000! Surprisingly, that first conversation also provided for me an unexpected and fulfilling career that has enriched and motivated me and for which I will be forever grateful.

– Lois Luniewcz
Medical Reserve Corps Coordinator, Western Massachusetts

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I first met Liisa Jackson around 10 years ago. Over the years, I have had the privilege of witnessing her remarkable abilities firsthand. Whether as a friend, personal trainer, or supporter throughout my journey with myasthenia

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gravis (MG), Liisa's talents have consistently shined brightly. MG, an autoimmune condition causing communication breakdown between nerves and muscles, brought mobility challenges. With treatment and Liisa's guidance, I regained strength lost due to the illness. Balancing exercise with MG requires patience to avoid overtaxing muscles, and Liisa's attentive approach to my progress was both crucial and impressive.

Recognizing her expertise, I invited Liisa to speak at a New England Myasthenia Gravis Support Group meeting, where she shared invaluable insights on exercise for chronic illness management. Attendees found her knowledge extensive and eagerly sought further advice. As a leader in the Medical Reserve Corps, Liisa prioritizes community preparedness for disasters. During my MG journey, she partnered with me to educate individuals on how to access treatment during disaster emergencies and leveraging resources from the Medical Reserve Corps for local MG community health events.

Liisa's unwavering support transcends personal and professional challenges, embodying the qualities of a true friend and a dedicated individual. She exemplifies the characteristics of an individual committed to the leadership of an honorable organization like the Medical Reserve Corp and they are evident in all of community, professional and personal endeavors. I am deeply honored to pen this tribute to Liisa Jackson's accomplishments, celebrating her recent book publication and the impact she continues to make.

– Glenda Thomas
nceptive-DMM,617-803-5016, www.nceptive-DMM.com

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As Director of Health and Human Services for the City of Peabody, Massachusetts, I have had the opportunity to partner with Liisa Jackson and the North Shore—Cape Ann Medical Reserve Corps for over 15 years. Liisa is a passionate and tireless public health advocate, and her work in recruiting and training community volunteers for the MRC has truly made a difference in our city. To prepare us for emergencies, Liisa has coordinated a number of trainings such as emergency dispensing site operations, shelter operations and Stop the Bleed.

During non-emergency times, she has recruited volunteers to assist us with necessary preparedness tasks such as inventorying our emergency response trailers and has also helped us staff educational events such as

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Melanoma Awareness tables at community festivals. Our local health department relies each year on MRC volunteers to support our flu clinic staff—as vaccinators, as registration staff and as logistics support.

Although we had long appreciated the work of Liisa and the MRC volunteers, it was during the COVID pandemic that we came to more fully depend on their support. In the early days of the pandemic, MRC volunteers assisted us providing public information to an anxious public.

Once vaccine became available, Liisa coordinated volunteers who were willing to suit up in full PPE to vaccinate, observe, support, and provide some much-needed empathy and laughter to those attending our vaccination clinics.

These volunteers provided countless hours of service to our community and were willing to do so because they felt prepared and supported by the systems that Liisa has created.

Liisa Jackson is trusted and respected throughout the local public health community as well as among the MRC volunteers and we are so grateful to have her working alongside us!

– Sharon Cameron/Director of Health, Human and Social Services, City of Peabody, 24 Lowell Street/Peabody, Massachusetts 01960

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Testimonial for Liisa Jackson

I have known Liisa since the inception of the MRC Region 4A in Massachusetts, where Lisa was the unit coordinator and I served as the MRC town chair in Ashland, Massachusetts. We worked together to help build the town MRC and the regional MRC presence.

When I became the chair of the MRC advisory group house, NACCHO [National Association of County and City Health Officials] mini-tools were added to the MRC skill set, including factors for success and core competencies. Liisa always amazed me with her forward thinking and volunteer management, and supporting the MRC completely.

This book is “hands down” a must read for all new aspiring MRC leaders, regardless of the level of their responsibility. Moreover, it is a complete resource on many topics involving any MRC management roles.

Having retired as a Boston fire officer after some 33 years, I am extremely versed in Emergency Management and crisis intervention. Some commonalities in this for a successful practitioner are confidence in one’s role

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ability to lead; utilizing available resources appropriate to the need; having foresight to anticipate future needs; and evaluating how improvements might be warranted; and, by the way, a healthy sense of humor, only can help!

I can more than safely say Liisa has the best of these qualities, "and then some." Her coauthoring this book provides a great summation of the MRC mission. Overall, I wish I had this when I was first involved with the MRC. It should, no doubt, generate further discussion, especially as best practices are concerned and how volunteers are managed, which lies at the heart of the MRC mission.

– Micheal Gurnick, Retired Boston Fire Lieutenant, training officer for the Massachusetts firefighter's academy and Chair of the MRC NACCHO Advisory Committee.

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For Liisa Jackson and the Medical Reserve Corps
6-10-24

This is a wonderful book, just chock full of useful information, but there is only one place to begin. Please read Forward A. In this summary tribute to Liisa's ad a mom, you will see a reflection of the same grit that makes Liisa who she is as a leader, and as a person.

This is all you need to know to read this book and move forward as a volunteer for the Medical Reserve Corps!

Richard Fitzpatrick, PhD. MRC Volunteer

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Testimonial for Liisa Jackson

One cannot speak of Liisa Jackson without making reference to a soon-to-be published book, *Our Medical Reserve Corps: The Power of Volunteers and Inspired Leadership*. It is a thorough, invaluable, information filled, highly readable reference. Anyone who has worked with her can see the role she played in writing this resource book.

I have had the opportunity to work with Liisa over the years on different projects and endeavors. To say she is knowledgeable, dependable, trustworthy and an invaluable partner is only partially describing her.

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Her enthusiasm and energy inspire those who work with her; anyone who has met Liisa can almost instantly appreciate her passion for the MRC.

Her ability to interact with people of diverse backgrounds and keep them all working together is something few people have mastered as well as she has. Liisa is the person that one would want to be working with them when a well-planned, detailed, and comprehensive response to a public health emergency is needed.

Our Medical Reserve Corps: The Power of Volunteers and Inspired Leadership is an amazing resource and tool. It should be required reading and on the shelf of anyone involved or interested in Local Public Health or Emergency Response and Planning. Its thoroughness and depth of detail gives a comprehensive understanding and appreciation for the role of the MRC. Although it details the activities of the MRC in Massachusetts, its discussions and examples are germane to any region of the country.

It is less of a dissertation and more of a complete guidebook on how to set up, manage and provide all the services an engaged and reliable MRC is capable of. The sharing of the nuances and lessons learned in engaging and working with community partners; the obstacles and means of financing and sustaining operations; the creative ways of maintaining the commitment of volunteers; the frank discussions of after-action evaluations; the importance of balancing politics and maneuvering through governmental bureaucracies are all incredible pieces of information that can make an organization's journey in emergency response so much easier.

Any health department leader who reads this book would most likely clamor to have a local MRC if they have none or insist that they be a partner at their table when planning for any type of event.

– Henry R. Vaillancourt MD MPH FAAFP, Retired Health and Community Services Director, City of Fall River, Massachusetts

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The first thing I learned about Liisa was that she has made helping others her life's work. One only needs to spend minutes with Liisa to observe this quality in her, whether it is a sharing of expertise for a health ailment, offering up resources for a need in the community, or simply giving emotional support for a challenging personal situation.

Liisa thrives on the opportunity to serve others.

Complimentary Copy

Liisa is the mother of my stepdaughter Celia and effectively an "aunt" to my sons. We are a close-knit, blended family who have prioritized our three combined children over all else.

Having come into Celia's life at a young age, I have known Liisa long enough to witness up close how passionate and dedicated she is to the Medical Reserve Corps.

Throughout Celia's childhood, she attended many trainings with Liisa and came home with an impressive medical response knowledge and skill set. I am certain that even as a child, Celia was better equipped to handle a medical disaster than my husband or I would have been. In the two times I have run the Boston Marathon, I have watched the preparation work Liisa does to keep runners, volunteers, and spectators safe during this deeply important event to the town of Hopkinton.

During the early days of COVID, I saw Liisa on the front lines right along with essential workers and First Responders, learning as much as she could about this new virus and how to best keep our local community safe and healthy in the midst of it.

At any given visit to her house, I might hear her on the phone to colleagues, coordinating medical teams, or stumble upon her, neck-deep in medical supplies in her garage, sorting and packaging them for shipment.

My husband and I got to see the work of the Medical Reserve Corps firsthand when we, along with Celia, volunteered at a COVID vaccination clinic in 2021.

How grateful we felt to be able to give back, and how inspiring it was to see the MRC in action in such a meaningful way that will protect our communities for years to come.

It is thrilling to see the culmination of Liisa's work in this new book. We know it will be a valuable resource for anyone in the medical field looking for expertise in medical disaster response, coordination, and collaboration.

– Katharine Brummett (Celis's stepmom) and Randy Jenkins (Celia's dad)

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It is with great pleasure that I contribute to this book for Liisa Jackson, I have been associated with the Medical Reserve Corps for over 30+ years, long before it became the MRC. I have enjoyed volunteering under the leadership of Liisa many of those years.

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I am a nurse by profession. I have participated in numerous events and fairs in many towns and cities in the Commonwealth. I have also participated in many drills and simulations preparing for disasters we hoped never happened.

Because of my volunteering to do flu clinic vaccinations in surrounding communities, I was asked to work with a nearby city as COVID. This resulted in working seven days a week for two years.

Liisa's energy, knowledge and dedication to the MRC is unequaled. She keeps us informed of all events, trainings, and educational opportunities.

Liisa comes to an event prepared, willing to "roll her sleeves up" to lend a hand and ALWAYS with a smile.

I look forward to participating in future events with Liisa at the Helm.

– Sally Ann Rich, Essex, Massachusetts 01929
June 12, 2024

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Family Relations

Liisa Jackson is a gem of a human being whose driving force stems from having one of the biggest hearts on the planet.

It has been my great fortune to count her among the members of my extended family for nearly 30 years and to engage with her in a range of settings and circumstances.

Over this time, she has become more perceptive and motivated about the inherent value of helping others and increasingly passionate about guiding others to discover its benefits for themselves.

While traveling among widely differing communities and cultures in parts of Africa, Asia, and South America, she had the opportunity to witness and participate in cultures and lifestyles and practices beyond the scope of what one is typically exposed to within the US. It is these collective experiences, including one on one personal encounters with others unlike herself, that have enriched her profound respect and appreciation for all of humanity.

For Liisa, who approaches all aspects of her life with gusto, her leap to embrace volunteerism as a way of life was a natural next step.

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With boldness and skill, always saturated with kindness and a sense of humor, she has forged a comprehensive model for making a meaningful difference in the lives of others.

Her multifaceted work with the Medical Reserve Corp has nourished her and led to her adeptly modeling and mentoring others as volunteers. In sharing her practical techniques, as well as her personal gratification as a volunteer, it is her hope that readers will gain sensitivity in their attitudes toward others and honor this approach to living that embraces our interdependence on one another.

Sometimes, the plight of today's world can feel overwhelming. The methods and stories outlined herein remind us that change is possible on many levels and progress begins with building trust and relationships between individuals like yourself and others.

Let us continue such meaningful efforts and celebrate the generosity of many remarkable volunteers and their accomplishments.

– Claudia Kopkowski and Steve Jenkins
Celia's grandparents on her dad's side and my family

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Horse Relations

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We raised and trained thoroughbred racehorses, and our best ever, nickname Macho, was retiring. He came back to the farm and relaxed, and then a person at a nearby barn asked if we would lease him. He was big and handsome, but feisty. We liked the facility and the girl, so we agreed. Well, she returned him in two days! Even though she was an experienced rider, he was too much for her. Oh, well… then a few weeks later another girl contacted us and heard we had a horse to lease. I told her she was welcome to come see him but warned her that he could be feisty.

So, one day, she drove up, and I brought him from the barn to see her. She looked at him; he looked at her, and I could tell right away this would work! She took him home with her, went to shows, rode on trails ... and when she had a baby, got a saddle with a back seat, he was part of her family. I would show people who knew him at the track pictures of her little girl sitting on him

Complimentary Copy

while he grazed, and they could not believe it. They say horses can "read" people, and can tell those with true hearts. He surely "read" Liisa: he was one horse who lived happily ever after! He knew a good heart when he saw it!

– Susan K. Walsh, Thoroughbred Breeder, one of the original founders of the MTBA [Massachusetts Thoroughbred Breeders' Association], and Chairman for many years until I became a steward at Suffolk Downs Race Track.

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Dear Liisa Jackson,

I am humbled and honored that you requested I write a letter of reference for you Liisa, I only hope that I can articulate what an amazing person you are, and the reader can get a glimpse of what we all experience in knowing you. I first meet Liisa through a mutual horse crazy friend, about seven years ago. My first impression was, what an interesting person, I would love to get to know her better. Through our love of horses, and spending time on many adventures with our horses I did get to know Liisa, and my life has been enriched through our friendship.

Now being a person that is a bit queasy around blood and horrific injuries, I cannot even fathom how she does what she does. I would have fainted and become one of the patients, because I would have hit my head on the way down, and she would chuckle, bandage me up, and move on to the next person in need, and then love retelling that story to our friends around the campfire. When she talks about the variety of disasters, both professionally and of a personal nature, I sit in awe of all that she has accomplished, but not surprised.

Just being around Liisa for a few minutes, you get the feeling you have meet someone special. She is so caring, thoughtful, funny, and happy, she can light up a room with her smile and personality, if you need anything, she is always there with a helping hand. If you ever meet the love of her life, her daughter Celia, she also embodies those same qualities. She is an amazing young woman, and I cannot wait to see what she accomplishes in *her* life.

When Liisa first told us that she was diagnosed with cancer, I just didn't believe it, I thought to myself, how can this happen to a person that gives so much of herself to everyone else?

In true Liisa spirit, she was trying to make us feel better, trying to help us cope with the devasting news. She looked at all of us and proclaimed that she

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would beat this, and it would not even slow her down. Once again, we are inspired by Liisa's tenacity to beat cancer and to continue to do the things she loved.

After chemo, she did not go home and sleep, she came to the barn and rode, smiling and happy. She is an inspiration to all that meet her, and I cannot wait to experience more adventures, laughing so hard we cannot breathe, and planning the next practical joke on an unwitting friend.

Thank you for all you do, and for all the lives you have touched with your glowing smile and personality.

– Carolyn Assad Horse Crazy Friend

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Subject: A Heartfelt Tribute to Liisa Jackson: Medical Reserve Coordinator, Best Friend, Mentor, and Horse Whisperer

Today, I wish to take a moment to express my utmost admiration and gratitude for someone who holds a very special place in my heart – Liisa Jackson. As a dear friend, dedicated MRC coordinator, and passionate equestrian, Liisa embodies a rare blend of compassion, skill, and unwavering dedication that inspires all who are fortunate enough to know her.

Liisa's commitment to her profession as a coordinator of medical volunteers is truly remarkable. Her unwavering dedication to caring for others, coupled with her genuine empathy and kindness, make her a beacon of hope and comfort in times of need.

Whether she is inspiring professionals to volunteer, tending to people in their most vulnerable moments or offering a listening ear and words of encouragement, Liisa's selflessness and compassion know no bounds.

Beyond that role, Liisa's love for horses and equestrian pursuits is nothing short of infectious. Her passion for these magnificent animals is evident in every aspect of her life, from the gentle skilled way she handles them to the joy she radiates whenever she is in their presence. It is truly inspiring to witness the bond she shares with her beloved horses, a bond built on mutual trust, respect, and a deep understanding of these majestic creatures.

I will forever be grateful to Liisa for the invaluable role she has played in my life and the lives of my children. From a simple friendship based on having children of the same age came a family bond between all of us. She has changed the trajectory of our lives with love, caring and education about the amazing world of the horse.

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From teaching us the fundamentals of riding to nurturing our love for horses, Liisa has been a source of guidance, support, and inspiration every step of the way. Her patience, expertise, and unwavering encouragement invited us into this world, and has also enriched our lives in countless ways.

As I reflect on the many memories we have shared together—from the joyous moments spent riding through the woods to the quiet conversations shared over a cup of tea—I am reminded of the profound impact Liisa has had on all of us. Her warmth, generosity, and boundless love have touched the lives of so many, leaving a lasting legacy of kindness and compassion in her wake.

In closing, I want to extend my heartfelt thanks to Liisa for being the incredible person that she is. Her unwavering kindness, boundless compassion, and zest for life serve as a constant reminder of the beauty and goodness that exist in the world.

I feel truly blessed to have her as a friend, mentor, and role model, and I look forward to many more cherished moments together in the years to come.

With deepest gratitude, love and admiration,

– Pamela Bathen with my daughters: Olivia White and Alexandra White

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Foreword A

As I am sure you will soon understand, I can declare with confidence that my mother is one of the most genuine, hardworking, and caring people you will ever encounter. I grew up with her radiance, not just through all the shelters, drills, and conferences I tagged along to, but at home and behind closed doors as well.

Growing up in Idaho, losing a kidney to illness at two years old and being left with a father who was horribly neglectful at best, my fiery toe-headed mom fended for herself from age 11.

In doing so, she became an independent person younger than most - working to pay for her own (crappy) food and showing horses to keep afloat. I think growing up in disaster makes this work come much more easily to her, although it shatters me to know the reasoning behind her calm.

At 17 she fled Idaho, trekking all the way to Massachusetts despite the vigorous protestation of her father.

Here she trained horses for a while. Horses have always been one of her most considerable salvations and loves. However, the barn she worked at did not treat her fairly, prompting her to head towards Boston to work for the visiting nurses.

She then forged the path that led her to the Medical Reserve Corps, until I came into her life (meeting my dad roller blading along the way), and eventually going into public health.

Before returning fully to work after I was born, my mom got involved in town politics and goings-on. I would act as her wing-woman in a child-carrying backpack as she flamed through the town, convincing landowners to allow walking paths, getting her hands dirty making such paths herself, and cleverly navigating the best ways to preserve and use the open land and forests surrounding my home. She never let an entitled man or sour town committee stop her from doing what was right for the people residing there.

Outside of (and during) these endeavors, she spoke to me like an adult, with respect and love.

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Even in light of my snotty-two-year-old status, I always felt as if I was an equal in her eyes. Starting from these days, people in town still come up to me and ask, “Do you know Liisa Jackson? You look just like her!” I wear her features proudly as I speak to them about how vibrant she is.

Work in town led her to region 4A in the MRC, where she began a tumultuous journey in public health. In defiance of my memory lacking some detail during these years, I know that the work she did was astonishing. She organized countless drills, even making me a (Incident Commander) at one of them (I got a yellow vest! Or maybe it was orange?), got shelters set up, and led teams at the end of the Boston Marathon. Her team was the one that responded to the catastrophe after the bombing, triaging people based on injuries and distributing emergency medical help.

The trauma of this and the reactions of higher-ups is one reason why she took a break from public health.

When I was in elementary school, after being forced to put space between herself and the MRC, there was a period when my mom worked as a personal trainer, needing a break from testy co-workers and bureaucratic nonsense.

While I could not necessarily see it then, I realize now that a basis for why she was able to make personal training work was her aforementioned radiance.

Of all the words in my vocabulary, that one feels the closest to capturing her personhood.

I certainly could never survive off a self-made personal training business, but the connections she is able to foster with anyone and everyone carried her to success. I remember sitting on the couch in different and mysterious adults’ houses, listening in to the conversations she would have with them. I normally would not associate working out at 5 am with laughter, but she was somehow able to make the secessions joyous, filling the room with light and support, which even I could feel as a grumpy nine-year-old awake before the birds.

She had a slow return to the MRC but made it back in due time. This iteration of public health work came with exploding houses, pandemic, and 60-hour work weeks, on top of serious personal strife, mostly in the form of illness.

There were times when my mom would get so sick that I, at 14 or 15, would cook for her for months, helpless as she remained bedridden and unable to even drive.

Not to mention the fact that she continued to show up for the people who needed her and for the volunteers even through such severe sickness.

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I can't imagine living through the pain she has endured. I knew she was resilient long before that, but watching someone you love so much suffer so terribly for so long teaches you what resilience really means in a devastating capacity.

My mother taught me more about living than most young kids are ever exposed to and did so in an amazingly natural and authentic way.

I saw what it looked like to lose your life to disaster, saturated with havoc and upheaval, and how vital it is to have a level-headed, intelligent, and most of all kind person to lean on in the aftermath.

I witnessed her acute ability to focus and be calm when so many other people would crumble. I watch her delegate critically and have a profound trust and admiration for the volunteers, yet I often find her to be humble to a fault, brushing off compliments with a casual wave of the hand.

I saw cooperation, skill, organization, and focus firsthand. She taught me what it means to be a leader, and a great one at that.

I am approaching 21 now as I write this, and I remain in awe of the person who raised me. Every year I age I learn more about her and realize her radiance to a fuller degree.

In my own struggles with mental health and hardship, she has been the guiding hand, and I continue to gather more about what she has faced throughout her life.

Her recent cancer diagnosis was the pinnacle of bad things happening to good people.

Although logically I understand that lymphoma does not know who it is affecting, it is overwhelming to rationalize someone like her developing a disease like that.

We were both blindsided. I will never forget the feeling I got when she first told me, and the look on her face. It felt like I had the floor cave in under my feet, sending me into freefall.

Yet she has continued to work just as hard as she always did, facing new disasters with adaptability and positivity.

Although she certainly would never have gotten this disease if life was just, she is unconditionally uplifted by the good she has done and the bonds she has made.

The radiance she spreads as she storms through life comes to support her in her times of need. I have yet to meet a stronger person.

Although this is a grossly simplified illustration of a life so complex and full, it holds the major pillars of her trajectory.

I will not say too much more since I do not want to spoil the book.

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If you are looking to understand the inner workings of the Medical Reserve Corps and what it is like to be a leader in such a hectic field, I cannot think of a better person to tell you.

Celia Jenkins Hopkinton
Massachusetts, USA
April 2024

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Foreword B

Massachusetts Medical Reserve Corps a Brief History, the Challenges and the Triumphs

Beginning in 2006, working as a Behavioral Health, Emergency Planning Consultant, I was involved in the start-up of two Medical Reserve Corps units on the South Shore of Massachusetts. The Medical Reserve Corps (MRC) is a national network of more than 300,000 volunteers, organized locally to improve the health and safety of their communities. MRC volunteers step up to keep their family, friends, and neighbors safe and healthy."[1]

MRC units in Massachusetts respond to medical, man-made and natural disasters, and support community events. The South Shore is a region of Massachusetts stretching south and east from Boston toward Cape Cod, it spans the shores of Massachusetts and Cape Cod Bays and encompasses communities in both eastern Norfolk and Plymouth counties.[2]

The Massachusetts MRC is currently supported by the Massachusetts Department of Public Health (MDPH), Office of Preparedness and Emergency Management (OPEM); the monies are part of the Center for Disease Control (CDC) Public Health Emergency Preparedness (PHEP) funding. Presently, there are 32 active and two inactive MRC units across the Commonwealth; a few communities are not currently part of an MRC.

When the MRC was starting up in Massachusetts, one of the deliverables for Local Public Health (LPH), set out by OPEM, was to make sure that every community in Massachusetts was included in the coverage area of a Federally recognized MRC Unit. This deliverable became part of my job as a consultant, and began my involvement in the MRC. The push for MRC units in

[1] Administration for Strategic Preparedness & Response, Medical Reserve Corps: https://aspr.hhs.gov/MRC/Pages/index.aspx.

[2] Wikipedia, South Shore, Massachusetts: https://en.wikipedia.org/wiki/South_Shore_(Massachusetts).

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Massachusetts was born out of the need to have trained volunteers who could man an Emergency Dispensing Site (EDS). EDS are more commonly known outside of Massachusetts as Points of Dispensing (PODs).

As consultants, in addition to the overall responsibility of working with local public health and their partners in the establishment, design, and drilling of local EDS sites, we were tasked with helping to establish local MRC units. We worked with LPH to find and train volunteers who would be able to staff an EDS. At the time there was no MRC specific funding.

The funding for the consultants was paid out of the Public Health Emergency Preparedness (PHEP) funding for each MDPH Region, and the MRC became part of our job responsibilities.

Massachusetts is a home-rule Commonwealth. There are 351 individual communities in Massachusetts each with their own governance, including Local Public Health (LPH) and/or Boards of Health (BOH). How MRC units came about, mostly hosted by LPH/BOH, varied from region to region, for example, MRC units on the South Shore versus Central or Western Massachusetts. However, in general, the idea that MRC units would be individually/locally managed with some oversight "strings" from DPH/OPEM, did not sit well with the locals with whom I worked.

An inordinate amount of work went into standing up the two MRC units with which I was initially involved. One, the Brockton Arean MRC (BAMRC), encompassed the largest urban city in Plymouth County and two adjacent suburban communities.

The other, the Duxbury Bay Area Regional MRC (DBAR MRC) coverage communities, includes five suburban communities, two of which are coastal communities. "Threats to coastal communities include extreme natural events such as hurricanes and coastal storms"[3] which, in Massachusetts, can include severe "nor'easters."[4]

The demographics, including total population, median household income, percentages of poverty, and disability within each of the above-noted MRC units, were wide-ranging. This variation added to the type of work necessary to make these units functional. While there were, across the Commonwealth,

[3] National Oceanic and Atmospheric Administration, National Ocean Service: https://oceanservice.noaa.gov/facts/coastalthreat.html.

[4] Online: https://www.weather.gov/safety/winter-noreaster#:~:text=A%20Nor'easter%20is%20a,violent%20between%20September%20and%20April.. Accessed 8 June 2024.

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a multitude of challenges facing the "new" MRC units, many had similar experiences to those of the BAMRC and the DBAR MRC.

I must emphasize here that this is my experience working with the MRC in Massachusetts. The following is a listing of some of the obstacles the MRC units initially faced, specifically on the South Shore, but I believe they can be generalized across the state, and included:

- At the outset, LPH was responsible for starting up, managing, and finding a host agent to administer the MRC and any associated finances. There are 351 individual communities in Massachusetts, each with their own LPH/BOH manpower, responsibilities, and budgets. Management of an MRC unit was "not on their radar," nor was it in any of the Health Director/Agents' job descriptions. There was also the matter of mandatory mutual aid concurrence, which became a legal quagmire for many in LPH and local governance.
- Initial buy-in to the MRC as a service organization was extremely difficult. Most people were familiar with the Red Cross and Salvation Army but, while a Federally backed entity, almost no one knew anything about the MRC. This lack of awareness was true for public "partners" and the public
- Brand recognition continues to be a barrier for the MRC units in Massachusetts. Much education is needed to enlighten the public about the MRC and to dispel the misunderstanding that the MRC is an organization that is *just* for medical volunteers.
- At the time of the MRC startup on the South Shore, there was little to no collaboration between what would become our emergency preparedness partners. LPH/BOH were often not seen or acknowledged as part of emergency preparedness planning or response. This lack of acknowledgement made integration of the MRC into the community difficult.
- The consultants who were promoting and organizing the MRC units were hired by each community's LPH organization. They were not necessarily a part of the communities they were serving, and they too had difficulty being accepted as collaborators with the "locals."
- Funding: It is extremely difficult to promote an entity, recruit, train, and retain volunteers with little to no money. As noted earlier, and as part of their jobs, local consultants were paid with PHEP monies to

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help establish the MRC units. There was a need for training and fundamental equipment for the EDSs: vests, signage for clinics, privacy screens, basic PPE, and the like. Most communities did not have funding for—and/or did not want to use their extremely limited local budgets—to pay for training and equipment. This resource limitation therefore became part of the initial MRC "mission." Eventually, some of the PHEP funding was designated specifically for the MRC and allocated to the MDPH Regions for distribution to each regions' MRC units. While the MRC units determined how they wanted to spend their monies, MDPH/OPEM set forth "guidelines" and "processes" to do so, having the final determination on expenditures.

- Note that Massachusetts is one of the few states that provides any direct funding to MRC units. There are, however, in addition to annual budget period deliverables, considerable time-consuming requirements attached to the funding. There was significant grant funding available through the National Association of County and City Health Officials' (NACCHO) Operational Readiness Awards (ORA). However, the MRC units needed someone to write the grant applications. Most of the units who completed applications were awarded monies. These funds proved to be of considerable advantage in getting the MRCs up and running. In the very early years, part of my job was also to apply for those grants. Both the BAMRC and the DBAR MRC were beneficiaries of the NACCHO awards for multiple years running.
- Over the years, NACCHO has been a champion of the MRC. They continue to provide invaluable guidance, and when possible, the ORA and other awards. Most recently, in addition to the ORA awards in 2022, NACCHO was able to offer the Respond, Innovate, Sustain and Equip (RISE) Awards. The RISE award offered three tiers of grant-funded monies intended providing resources to the MRC network in support of the on-going COVID-19 response.
- Recruitment and retention of volunteers are two additional obstacles that initially impeded the overall success of the MRC units in Massachusetts. Each Massachusetts MRC unit addresses these items individually, with minimal support from MDPH/OPEM. Initially, MRC unit coordinators gathered trusted partners to create what

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would, in some cases, become the MRC Unit Advisory or Executive Boards. These teams made many of the early decisions regarding the directions the MRC unit would take in these and other areas.

- Volunteer Recruitment: MRC volunteer recruitment is dependent on several ideas and was achieved in a variety of fashions. First and foremost, support from LPH/BOH and local emergency preparedness partners proved essential. It was extremely difficult to recruit volunteers for an organization whose mission includes supporting the community and local response partners, when the "partners" would not engage with the MRC or their own LPH/BOH.
    - In many cases, initial outreach for volunteers was done through mailings to local medical professionals. Additionally, to reach and educate the public, local units developed their own brochures and left them in town halls, religious buildings, libraries, and other community gathering places. On the South Shore, some of the consultants prepared and facilitated MRC presentations for BOH members, emergency preparedness partners, local clubs, and other organizations.
    - There were some MRC units who were supplementally funded through local governance, which allowed for expanded outreach. An example of this was the Boston Public Health Commission's support of the Boston MRC; advertisements for the Boston MRC appeared on Massachusetts Bay Transportation Authority (MBTA) buses. Recruitment also depends on demographics, existing volunteer infrastructure, and knowing the appropriate type of outreach to spark community interest. All of these approaches to recruitment depend on local acceptance and community partnerships.
    - Furthermore, the lack of liability coverage specific to Massachusetts volunteers has been, and continues to be, a hindrance when trying to recruit and retain volunteers. There are Federal protections, and some provisions for both healthcare

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professionals[5] and non-healthcare volunteers[6] in Massachusetts, but they are not enough for many prospective volunteers. Some Massachusetts MRC units, working with local governance, have been able to provide coverage for their volunteers during an emergency (they become temporary town employees), but in general, liability coverage specifically for MRC volunteers in Massachusetts, does not exist.

- Volunteer Retention: As with recruitment, methods and approaches to volunteer retention vary by individual MRC Unit. Through the years many have employed ever-changing techniques. I can only speak to the methods chosen by the BA and DBAR MRCs. While as noted, the BAMRC and the DBAR MRC had wildly different demographics, they addressed volunteer retention in similar ways. Both made the decision to provide monthly meetings/trainings for their volunteers. Being a monthly presence for the volunteers would create multiple advantages:
  - Monthly meetings, set on a predictable day, would afford some routine and structure to the MRC units.
  - The meetings would provide needed training for volunteer education and response. Specific trainings have, through the years been included in the annual MRC deliverables. An annual calendar of monthly trainings was created to both educate the volunteers and meet the deliverables.
  - Regular meetings would promote a connection to the MRC and build relationships among the MRC volunteers, which could effectively make the volunteers themselves an avenue for recruitment.
  - Another method that was employed and proved to be successful for recruitment and retention, was to provide trainings that also offered free continuing education credits for some of the monthly meetings.

[5] Massachusetts Department of Public Health Liability for MRC and other Healthcare Volunteers, online: https://www.framinghamma.gov/DocumentCenter/View/34741/Liability-Handout-health-care-profs-Oct-2013?bidId=.

[6] Massachusetts Department of Public Health Liability for MRC and Non-healthcare Volunteers: online https://www.mass.gov/files/documents/2016/07/th/eds-liability-protections-handout.pdf.

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Despite the barriers that existed, MRC units across the Commonwealth began to take hold in many communities. Through all the struggles in the early days, the one thing that stands out to me is the collaborative nature of the Massachusetts MRC Coordinators. Once several of the MRC units were up and running, the MDPH/OPEM sponsored quarterly MRC meetings. This support gave the coordinators and other partners an opportunity to meet in person and share both our frustrations and our achievements. While "guided" under the deliverables and reporting requirements set out annually by OPEM, each individual unit was able to establish themselves in a way that suited and served the communities in their coverage areas. OPEM now holds bi-annual statewide MRC meetings. These meetings became virtual during the COVID-19 pandemic and, as of this writing, remain so.

The BAMRC and the DBAR MRC would not have come into being with strong foundations; without the support of multiple MRC coordinators and partners. In the beginning, one MRC coordinator stood out, Liisa Jackson.

When we met, she was the coordinator for the MDPH Region 4AN MRC, which served 34 communities at the time. The localities were spread out over a large geographic area in central Massachusetts. Each community had its own distinct size, demographics, and LPH rules and regulations. Liisa had recently been recognized for her contributions and outstanding efforts on behalf of the MRC. Her willingness to share her skills, knowledge, and her existing materials, significantly decreased my MRC learning curve. Her assistance allowed me to provide the BA & DBAR MRC partners with guidance and information that I might otherwise have spent years trying to accumulate.

Many others, both from LPH and Massachusetts MRC units, were there to provide support and guidance. A few that stand out are: AnneMarie Fleming MSN-RN and Jacquie O'Brien, RN, both from the Bristol-Norfolk MRC, Tracy Mayo, RS from the Duxbury Bay Area Regional MRC, Joanne Belanger, RN, formerly from the Greater River Valley MRC, now from the Central Middlesex MRC, and Nancy Burns (EMT), and Sandy Collins, RN (ret.), from the Upper Merrimack Valley MRC. Over the years, we have formed strong professional and personal relationships. To this day, many of the MRC unit coordinators continue to champion one another in everyday matters as well as during emergencies. They work together to train and support the MRC volunteers, helping to make them "response ready." I know that the MRC unit with which I continue to work is the beneficiary of these partnerships.

The volunteers are the heart of the MRC and the coordinators and advisory committees/boards are the backbone. The MRC coordinators are always

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willing to exchange ideas and aid each other for the volunteers. During the COVID-19 pandemic, immediate local 'focus' differed, but many of the coordinators leaned heavily on one another. They sustained each other, and when possible, deployed volunteers to support each other's communities on a more regular basis. To make the units and volunteers the best they can be for the communities they serve, ideas continue to be exchanged, knowledge, documents and trainings were and are shared. From each other, we learn about and employ new or differing recruitment, retention, and funding opportunities. We impart both frustrations, and lessons learned from drills and exercises, as well as community and emergency deployments.

Individual MRC units' involvement in public health events, such as flu clinics, health fairs and the like, vary by area, but most are involved, at a minimum, with their LPH/BOH in some manner. Sometimes, it takes a disaster or tragedy for people to come together and recognize resources that may be available to them, this was the BA and DBAR MRC's initial experience with local emergency preparedness organizations.

As stated earlier, LPH/BOH and the MRC were not always invited to the planning table or asked to be part of a response. Events that seemed to solidify the MRC in the minds of local Massachusetts emergency preparedness partners were varied in focus and scale. Included in these disasters were several major events, such as the H1N1 pandemic (2009-2010); the Tornado in Monson, Massachusetts (2011); numerous ice storms, nor-easters, severe flooding events; and the Blizzard of 2013 (winter storm NEMO) in which disaster emergency sheltering was needed; the Boston Marathon bombing (2013); the Merrimack Valley gas explosion (2018); and of course, the COVID-19 pandemic (2020). MRC volunteers were included in many of these deployments and played significant roles in the response and community support for these emergencies and disasters.

Once people have seen the MRC-trained non-medical and medical volunteers in action, the value of the organization and volunteers becomes readily apparent. The MRC continues to play a part with LPH/BOH and has begun to be integrated into some communities' local Comprehensive Emergency Management Plans (CEMP). They are integrated not just into a public health response, but also into disaster emergency sheltering, warming and cooling locations, and other areas of community emergency planning.

Local organizations also reach out to their covering MRC units to support non-emergent events. A few that immediately come to mind are the Boston Marathon, the Best Buddies Challenge: Boston to the Cape, and The Big "E."

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The DBAR MRC is asked annually to support the Duxbury Triathlon, local stops for the Best Buddies Challenge, parades, events, and celebrations in many of their coverage communities and the Duxbury Half Marathon. The DBAR MRC is written into the emergency plans for the Town of Duxbury and continues to work with the emergency preparedness partners in their coverage communities to do the same.

There was a noticeable upswing in recognition of the Massachusetts MRC during the COVID-19 pandemic. MRC volunteers manned call centers providing information and education to the public. They staffed testing sites, including drive through sites, and when the mRNA COVID-19 vaccines became available, MRC volunteers were included in local plans for vaccination of First Responders and citizens across the Commonwealth. Volunteer opportunities supporting COVID-19 deployments were shared widely among the MRC coordinators. An example of MRC collaboration with local emergency preparedness partners was very apparent when, in late 2020, the DBAR MRC was asked by Duxbury Emergency Management Agency (DEMA), Duxbury Fire Department (DXFD), and the Duxbury BOH to assist in the planning and staffing of vaccination clinics that would serve First Responders from seven local communities. "The inclusion of the DBAR MRC in planning, management and staffing the five Duxbury First Responder COVID-19 Vaccination Clinics supported and benefitted operations both materially and financially. Additionally, it brought renewed awareness of the MRC, and the capabilities of their trained volunteers to First Responders, local emergency management, and governance in all of the seven communities who took part in the vaccination clinics."[7]

Volunteer organizations tend to see an increase in interest directly after a disaster, which poses a significant challenge. The COVID-19 vaccine distribution in Massachusetts had an enormous effect on the public's interest in becoming a Massachusetts MRC volunteer. When the COVID-19 vaccines became available, it was reported that, in many communities, MRC volunteers supporting vaccination clinics would be offered vaccinations as part of the front-line workforce. Many MRC units were inundated with "new" volunteers.

When the DBAR MRC was asked to support both the Duxbury First Responder vaccination clinics and provide volunteers for the Marshfield (another community in their catchment area) drive-thru vaccination clinics,

[7] Collaboration with the Medical Reserve Corps Ensured a Professional, Efficient and Economical Rollout of COVID-19 Vaccine to Local Massachusetts First Responders: A Case Study.

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over 400+ volunteer applications were submitted in just over a month. This meant 400+ applications needed to be reviewed, people credentialed, and trained, to prepare for deployment. To put this statistic into perspective, the DBAR MRC unit is small. The volunteer membership has fluctuated over the years, but is steadily between 150 and 200 volunteers. Similar upticks in those wanting to volunteer with the MRC were apparent across the Commonwealth.

It is unfortunate, but we found that many who applied did so to have early access to vaccinations. Of those 400+ applicants to the DBAR MRC, about a third registered and of those, maybe 5% to 7% remain on their active rolls. Each unit addressed the influx of interest in volunteering in different ways, always with safety in mind. However, the rapid increase in interest and the associated work put significant pressure and stretched the limits of volunteer manpower for many of the Massachusetts MRC units.

Today, challenges remain. Recognition, recruitment, and retention are enduring issues that affect many of the Massachusetts MRC units. While local acknowledgment and collaboration has vastly improved over the years, the public's lack of recognition of the MRC brand remains a complication for recruitment, especially that of new and younger would-be volunteers. There are hundreds of organizations with which one may volunteer, but if someone is not familiar with the MRC and the work they do, many will pass by the MRC. As noted earlier, the lack of liability protections remains a deterrent to many who may initially be interested in joining a Massachusetts MRC unit. Additionally, as mentioned above, a vast majority of people, when they see "Medical Reserve Corps" believe that they must have a medical background to join. Education about and promotion of the MRC for both response partners and the public is an ongoing undertaking.

In many MRC units, the volunteer population is aging. Volunteers stop driving at night, or altogether, and some do not feel that they are up to the task at hand and/or can only volunteer for short shifts. Recruiting younger volunteers has also proven to be a challenge. Lastly, but equally as important as the issues noted above, is the issue of funding. As with most things, there is never enough money or time. While some units have obtained 501(c)(3) status and can solicit tax exempt funds, this has not been possible for all MRC units.

The MDPH/OPEM continues to provide monies to the Massachusetts MRC units; however, many do not feel that the small amount of money is in line with the "conditions of funding" that include considerable and time-consuming requirements and extensive mandatory documentation. Lack of

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long-term funding remains a constraint. With it all, the Massachusetts MRC units do the best they can to serve the public and provide support for our emergency preparedness partners.

There has been tremendous growth and positive change in the Massachusetts MRC since the early days. We have all learned from both the dilemmas we face and the triumphs we celebrate. There are no more dedicated, well trained, flexible, and caring volunteers than the ones who volunteer with in Massachusetts MRC units. The tireless MRC unit coordinators continue to rely on each other's strengths and experience, sharing information and humor among themselves and with newer MRC unit leaders who join the ranks. The Massachusetts MRC is a thriving community unto itself.

I would like to thank Liisa Jackson for asking me to be a part of this book, *Our Medical Reserve Corps: The Power of Volunteers and Inspired Leadership.* I hope I have shown that since I began working with the Massachusetts MRC, the changes and improvements, challenges and achievements have been many.

My experience with the Massachusetts MRC has been very positive. Experiencing the growth in the Massachusetts MRC, building relationships with our emergency preparedness partners, locally and statewide, and enjoying the long-term relationships with coordinators and volunteers alike continues to bring me joy.

Lisa C. Kaufman
Boston, Massachusetts, USA
April 2024

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Prologue

This book represents the evolutionary development of a portion of the Medical Reserve Corps (MRC) in the Commonwealth of Massachusetts of the US. It presents the evolving expertise and natural collaborative efforts of Liisa Jackson, RN, and her inspired leadership. Her MRC units provide support to their local communities when emergencies or disasters exceed the capacity of local, regional, and statewide capabilities of the established medical facilities. Moreover, they provide full-service shelters for individuals, families, and people with special needs to shelter from any threat (e.g., major winter storms, hurricanes, heat or cold, power outages, etc.) to their wellbeing for which they cannot "shelter in place." During pandemic, they provide a major testing and inoculation capability as well as contact tracing.

I became aware of Liisa's work in the early 2000's and have invited her to contribute her work to the following NOVA Science Publication books:

- Robert I. Desourdis et al. *The COVID-19 Disaster Volume I: The Historic Lessons Learned and Human Collaboration Failures*. Robert I Desourdis (ed.). New York: NOVA Science Publishers, 2022.
- R. I. Desourdis and K. H. Collins, *Human Collaboration in Homeland Security*, Nova Science Publishers, 2017.

Both books emphasize the importance of human collaboration in homeland security and that it cannot be "taken for granted." In 2023, I realized that the importance and extent of essential human collaboration inherent in Liisa's work deserved its own literary treatment and proposed this book. The importance of human collaboration in homeland security was first envisioned in earlier works:

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- R. Desourdis, "Why We Fail - and How to Succeed: The 25 Pearl Harbor Deficiencies of Leadership and Planning: Their Pervasive Impact on Day-to-day Operations, Emergency and Disaster Preparedness," Chapter 12 of *McGraw-Hill Homeland Security Handbook, 2012: Strategic Guidance for a Coordinated Approach to Effective Security and Emergency Management*, McGraw-Hill, New York, 2012.
- R. Desourdis, P Rosamilia, C. Jacobson, J. McClure, and J. Sinclair, *Achieving Interoperability in Critical IT and Communication Systems*, Artech House, Boston, 2009.

I understood that in editing her writings, I would not only learn a great deal about the MRC in Massachusetts, but also the evolution and improvement of the services they have offered over time. In this regard, I have developed an even greater respect for her and her excellent volunteers vital work in this world of terrorism (e.g., the Boston Marathon Bombing), climate-change amplified weather events (snowstorms, hurricanes, etc., and their consequences, such as flooding and power outages), and unforeseen manmade disasters (e.g., train derailments, aircraft accidents, gas explosions), and pandemic (e.g., H1N1 and COVID-19). We have tried to capture that work in what follows. Here testimonials are further proof of her great value to Massachusetts and our country.

Liisa provided initial book input as a personal narrative, and I have replaced it with a third-person perspective by referencing the "MRC leadership," but this expression generally refers to Liisa herself. As other leaders emerge in her MRC units, the text can then take on a broader applicability to them as well as the leadership in other Massachusetts or MRC units nationwide. Lisa Kaufman, who wrote the second foreword, Foreword B, is one example. It is for this reason I edited her work into a general MRC leadership context. It must be understood, however, that the work reported by the "MRC leadership" is, for the most part, referencing Liisa herself.

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Biographies

Liisa Karin Jackson

Lead author: Liisa is the principal author of this book, drawing from the demonstrated collaboration she has inspired in all her healthcare work.

Bio: Currently, Liisa is the Medical Reserve Corps (MRC) Coordinator/Director for eight MRC units in the Commonwealth of Massachusetts. She is a founding partner of Preparedness Specialty Services and has contracts across the state to develop and facilitate Homeland Security Exercise and Evaluation Program (HSEEP) Compliant drills, including disaster sheltering, emergency dispensing site, active shooter, Decontamination (DECON), mass casualty, and supports many other drills. She believes such drills are an ideal environment to build human collaboration prior to a real disaster.

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Liisa has more than 19 years of advocacy and program management experience in a non-profit environment. She is a “big picture” thinker with a visionary, out-of-the-box approach to problem solving that avoids stagnation. She has interacted effectively at all levels with flexible communication skills, building cooperative relationships with community leaders or citizens and constructively resolving issues. She focuses on building a solid leadership structure, planning strategically, standardizing policy and procedure and providing volunteers the tools necessary for success. Tenacious and loyal with a dedication to public service. In her MRC leadership role, Lisa has:

- Coordinated shelter management and medical staffing for the June 2011 tornado response
- Founded and built the Massachusetts Region 4A Medical Reserve Corps organization to almost 5,000 volunteers
- Coordinated shelter staffing during the 2010 spring floods in Massachusetts in partnership with the American Red Cross
- Coordinated staffing for the water distribution centers during the Massachusetts Water Resources Authority (MWRA) water contamination
- Helped coordinate H1N1 clinics across Region dispensing over 100,000 vaccines to the at-risk populations

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- Coordinated the 2008 ice storm MRC deployment to staff special needs shelters
- Served on the Surgeon General's Focus group
- Served on the Surgeon General's Medical Reserve Corps committee
- Chaired the statewide MRC committee and the state training committee
- Partnered with the Boston Marathon to staff for the medical sweep teams at the finish line
- Presented at the State Best Practices Conference and the National Leadership Conferences
- Chosen (her MRC unit) to be one of eight Pilot Core Competencies sites in the country
- Served on the National MRC Advisory Group and focus groups for NACCHO
- Presented at 10 National Leadership conferences sponsored by the Surgeon Generals HHS
- Developed leadership training that was taught at the Integrated Training Summit in Texas in 2011.
- Worked 14 years in long term care and hospice care for the Visiting Nurses
- Member of the Quality Improvement Committee for the Visiting Nurses

Beyond the Medical Field

For her Town of Hopkinton, Liisa has served as:

- Parks and Recreation Commissioner
- Trails management committee
- Trails club founder

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- Center trail building manager (phase 1)
- Marathon Committee member
- Land Use Study committee

Recognition

Liisa has received awards such as:

- Mentor Award from the Surgeon General's office and the National Medical Reserve Corps Program Office
- In recognition of the outstanding contribution to and support of the practice of Environmental Health in the Commonwealth of Massachusetts presented the Vartkes "Vic" Karaian Award from Massachusetts Environmental Health Association
- Medical Reserve Corps Challenge Coin Service from Captain Rob Tosatto: U.S. Public Health Service (USPHS) Director of the Medical Reserve Corps for the U.S and Indian Health Service as a Clinical Pharmacist, USPHS (retired).
- Coin of Service from RADM Michael R. Milner, PA-C Retired Assistant Surgeon General US Public Health Services.
- Top Driller Award from Safe America and USA Today presented by Norman Minteta, Member of US House of Representatives for the State of California and Secretary of Commerce for President Bill Clinton.
- 2011 OCB Spirit of America Body Building Championship 1st Place Figure and 1st Place in the Master's Figure division. And 2nd place in Overall Figure.
- American Secretary for Preparedness and Response Office of Emergency Management award for sharing my Knowledge with the Medical Reserve Corps Network.
- Department of Health and Human Services National Disaster Medical System (NDMS), Office of the Civilian Volunteer Medical Reserve

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Corps (OCVMRC), Office of Force Readiness and Deployment (OFRD) and Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP). For sharing expertise, resources, and presentation at the National Preparedness Summits over the years, from Robert C. Williams, RADM USPHS, Acting Deputy Surgeon General and Kevin Yeskey, MD Assistant Secretary Director of Preparedness and Emergency Operations.

- "Thank you" letter for organizing the Let's Move for Boston from the 18th U.S. Surgeon General, Doctor Regina Bengamin, and former Vice Admiral of the U.S. Public Health Service Commissioned Corps.
- Received the Excellence in Caring Award from the Visiting Nurses Association.
- Hopkinton Trails Club In recognition of your outstanding contribution to the trails and to our community.
- Reserve Champion at the Mendon Horse Show on Macho
- 2nd Hunter Pace in Connecticut on Steve

She is grateful for her recognition but realizes that she would not be able to accomplish what she has without strong support from colleagues, family, and friends, saying, "we all work as a team for the greater good." Liisa has received many other recognitions for her community work, figure modeling, and horsemanship.

Liisa serves on many leadership and advisory committees and working groups. She believes it is important for people to come together and collaborate to accomplish important things. By serving on many committees and working groups, she has been able to learn from others, gather information that can be applied to her professional and personal life, and truly believes in human collaboration through leadership.

She has been asked to present at ten National Leadership and Preparedness conferences about many different subjects, including:

- How to develop and sustain a volunteer origination
- How to build leadership within your organization

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- How to develop strong partnerships
- Communications during a disaster using multiple formats
- Disaster shelter operations
- Psychological First Aid
- Behavioral health response teams
- Emergency Dispensing Site Operations
- Served on several panel discussions talking about disaster operations.
- Training and Exercise Development for Medical Reserve Corps for all Regional Leaders across the U.S.

Governor Baker recognizes the Medical Reserve Corps!

Great to meet Congressman Joe Kennedy at the volunteer Expo!

Liisa worked for the Visiting Nurses in long term care and Hospice for 14 years. During those years, she learned so much from her patients during her visits and how they had survived war, the Great Depression, and many economic and cultural hardships. She was inspired by their strength and she learned so much from hearing their experiences. She was always interested in what this population had to do during a disaster and helped them prepare.

She enjoyed working during snowstorms and server weather to make sure her patients received the care they needed and realized how much they appreciated her help.

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Evolution of Leadership

Liisa Jackson grew up modestly in Idaho with her father from ages 11-17, who was a nuclear engineer after her parents split.

Her mother was an orthodontist assistant and artist.

Liisa also has two older brothers and one sister that are much older than her.

Her brother Jim, who is now a nuclear scientist as well, was a huge influence on her. He took her hunting, camping and taught her survival techniques. Also, her family spent summers camping with their horses, which gave her much directly relevant knowledge of what it takes to live without shelter. She camped in the winter and took a survival course in high school, camping alone in the woods for seven days.

At 17, she moved from Idaho to the east coast right after high school to work on a horse farm training German Warmblood horse. She had no family or friends in New England and had to develop friendships and build a life for herself. She welcomed the challenge and grew to love New England over the years for its many offerings.

She traveled worldwide with her in-laws, taking her to Botswana, Zimbabwe, Zambia, South Africa, India, Nepal, Bhutan, Singapore, Chile, Europe, Mexico, Dominican Republic, Bermuda and Costa Rica. This gave her opportunities to interact with many different cultures and helped her understand how to communicate effectively and respectfully with many different people. Her traveling experiences would help build her awareness of cultural competence, how to interact with people from different parts of the world and to be accepting of different customs.

She has always loved sports; her favorite is horseback riding. She currently owns four horses on her farm in Massachusetts and has always been prepared to take care of her animals during a disaster. She also loves biking, rip sticking, snowboarding, swimming, paddle boarding, hiking, white water rafting, trapeze, and many other sports. She is also a professional figure model in body building.

Today, Liisa absolutely loves being a single mother. That deep experience has made her a better, stronger, person. It has inspired her to give back to her community and state.

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She started her first preparedness job when her daughter Celia was only one year old. Throughout the years her daughter has learned so much about life and human interactions by going to work with her mother. Celia has attended many trainings, meetings, drills, flu clinics, and has done disaster shelter site visits during deployments.

These experiences enabled my daughter to develop strong communication skills and taught her the importance of human collaboration. She gets good reviews from her teachers about how helpful she is in class, and they always comment on her communication skills. She was the 2022 Hopkinton High School Class Valedictorian and is a Math Honors student at Northeastern University in Boston, Massachusetts. Her Co-op was for City Year teaching 6th graders in Hyde Park (Boston) Massachusetts, she loves teaching, and it has become her passion!

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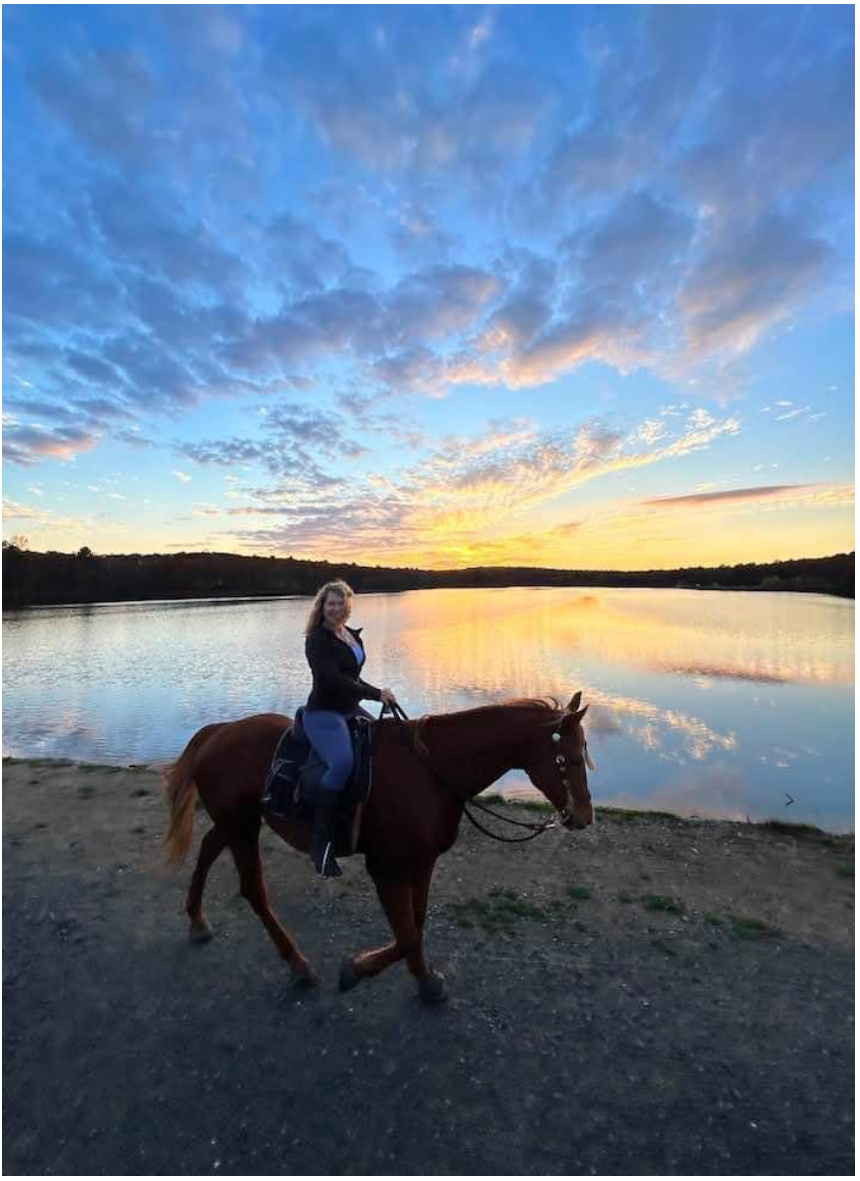

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Liisa and Celia.

Liisa has given back to her community: she served on the town sponsored Land Use Study Committee, Parks and Rec Commissioner, Marathon Committee, and Trails Committee. She founded the Hopkinton Trails Club and the Hopkinton Organized to Preserve and Enhance (HOPE) and received Community Preservation Funding to build the Hopkinton Center Trail. She learned so much about human collaboration needs serving on these committees, working in the community, and interacting with local government. She feels grateful for the opportunity to work in her MRC role and knows she is continuing to learn and apply those lessons from all the human interactions and collaborations she experiences every day.

Liisa Jackson may be contacted at:
Email: liisajackson@mrcvolunteer.org
Phone: +1 (774) 278-0059
Website: http://www.mrcvolunteer.org/

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Robert Irving Desourdis

Editor: Book Editor and NOVA Homeland Security and Safety Series Editor.

Bio. Bob Desourdis is a Master Solution Architect in radio communications and IT, working in Massachusetts and the National Capital Region for over 40 years in post nuclear-attack and public safety communication systems. He began as a radio-systems engineer in 1980, developing software models for hypothetical post-nuclear-attack strategic communications systems. In 2007, he brought his emergency communications background to public safety interoperability issues. In 2015, he became a Solution Architect in heterogeneous IT and communication systems of all types. He started as a communication scientist, then became a division and operations manager and Vice President for Technology before launching his own consulting LLC called Desourdis Collaboration. In 2020, he was awarded and performed a project for the Department of Homeland Security (DHS) Science and Technology Directorate (S&T) in the dual use of digital television for First Responder communications, in which television stations would provide

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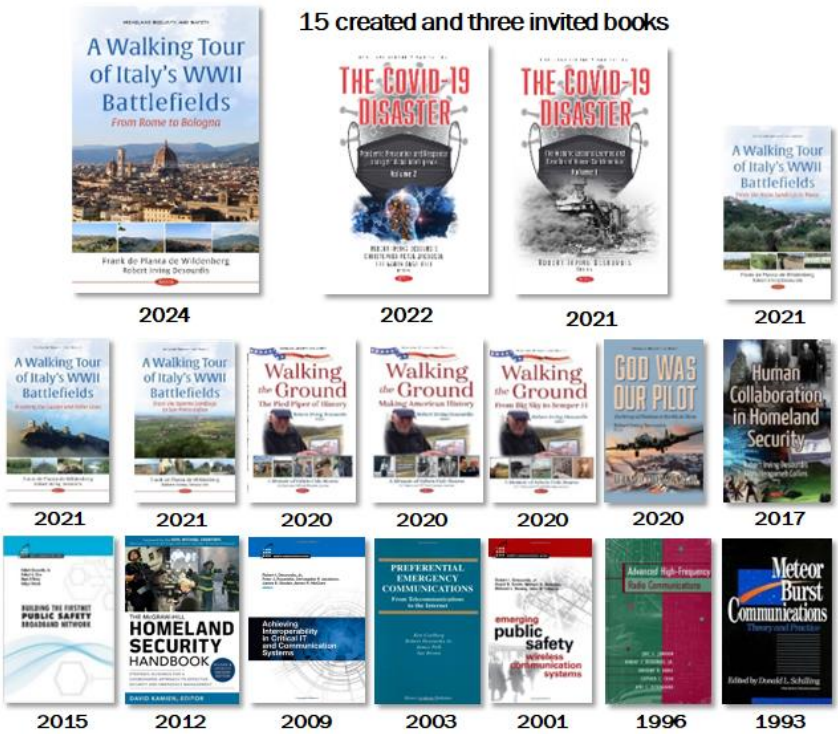
resilient broadband datacasting.[8] He was selected for the 2023/24 edition[9] of Marquis *Who's Who in America*.[10]



Desourdis's technical, homeland security and warfighter memoir books through 2024.

He most enjoys working in small creative teams that envision and develop, often through "trial-and-error," innovative long-lasting solutions through human collaboration. In recent years, he has supported company engagements with the DoD and done extensive proposal writing/reviewing. He is currently working on projects to further public media's support for

[8] Online: https://www.dhs.gov/publication/st-datacasting-fact-sheet. Accessed 19 October 2023.

[9] Online: https://marquistopscientists.com/2023/09/21/robert-desourdis/. Accessed 19 October 2023.

[10] Online: https://marquiswhoswho.com/. Accessed 19 October 2023.

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public safety agencies. His company's work efforts focus on getting people to collaborate in developing cross-organizational information-sharing and workflow requirements.

An International Quest

Currently, Bob is the Chairman of an Executive Council whose goal is to create a world-leading WWII memorialization system for Italy. This system will include international economic an educational integration with memorialization of "Freedom for Italy" as the common theme. This initiative includes Assoknowledge[11] as the Promoting organization and many Italian and international supporting individuals and organizations. His collaborative approach in the "Freedom for Italy" initiative contributed to a July 2023 conference[12] in Catania, Sicily, commemorating the 80th anniversary of the Allied landings at Gela and other sites in southeastern Sicily.

Building Snapshots of History for Veterans

Bob is a long-time model and historic diorama builder as well as a writer. Recently, Bob built two dioramas and an Italian WWI motor torpedo boat. One diorama was of a Tuskegee Airmen's P-51D sitting on the Marston Mat at Campomarino, Italy, now in the museum devoted to their memory there. He also built a German Flak 37 antitank gun mounted in the assumed wreckage of a building in St. Pietro Infine, a town destroyed in the Italian Campaign, which was moved given the level of destruction before being rebuilt. The boat was the MAS-15, famous for sinking the Austrian battleship St. Stefan in WWI.

[11] Online: https://www.assoknowledge.org/. Accessed 18 October 2023.
[12] Online: https://www.instre.org/news/8411/. Accessed 18 October 2023.

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Tuskegee P-51D diorama, 88-mm diorama, and MAS-15.

B-25J “Strafer” diorama.

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In 2023, he completed a B-25J Strafer for his friend Jack Ottaway, representing the aircraft he would have flown in if he had not been killed in an air-to-air crash over Honolulu in 1944.

In 2021, he built and delivered a diorama depicting the completion of the Amazon Bridge. The diorama shows a Sherman M4A2 tank commanded by Lt. Michael H. M. Wayne (the "Death or Glory" 17/21 Lancers) pushing a Bailey Bridge the remaining 20 feet into its final position. It was needed to get armor to the other side of the Gari River during the WWII Italian Campaign attack on the German's Gustav Line. He donated it to Frank de Planta de Wildenberg in the UK, the lead author for our WWII Italian Campaign book series, an expert tour guide and historian on the Italian Campaign, who is retired from the 1st Battalion Royal Anglian Regiment (see the NOVA series *A Walking Tour of Italy's WWII Battlefields* series). The diorama is derived from a period diagram and the famous painting by Terence Cuneo painting permanently at the Royal Engineer Corps Officers' Mess. Frank had the diorama transported and set up in the museum lobby of the Rocca Best Western Hotel in Cassino, Italy. Images are also provided in the Addendum to Chapter 4.

(1) Bob Desourdis with Michael O'Reilly, who transported "The Amazon Crossing" to Frank de Planta; (2-3) Original Cuneo painting in the Officer's Mess; (4-10) Amazon Crossing diorama in the Rocca Hotel, Cassino, Italy.

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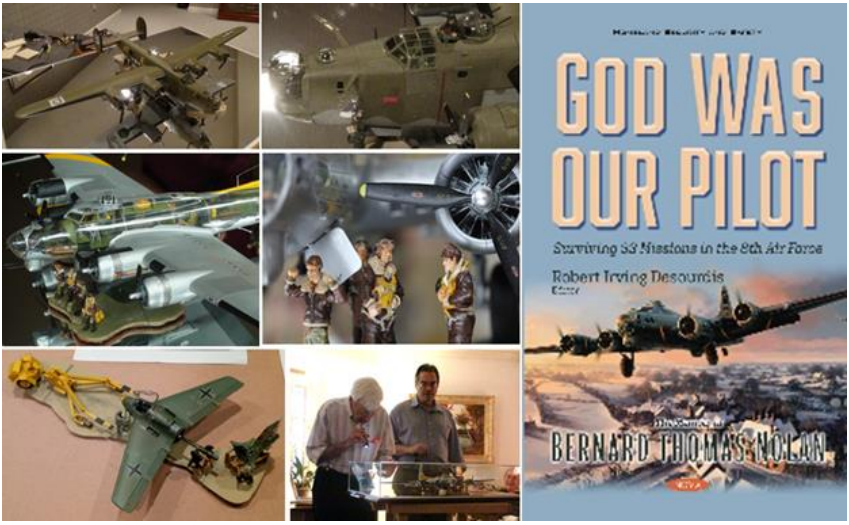
In 2011, Bob met the late Barney Nolan while showing some of his model work at an SAIC-sponsored Eighth Air Force event at the Warrenton-Fauquier airport in Northern Virginia. Barney was a speaker at the event because of his time in the 8th Air Force during WWII. After learning Barney did not have models of the bombers which he had flown, Bob spent a few years of modeling time building Barney's B-17G, his earlier B-24H "Krazy Kat" and the Me-163 Komet that dove past the port side of his B-17 during a mission. The Me-163 Komet is pictured on the cover of Barney's first book. Then, from 2018 to 2020, Bob worked to develop Barney's memoir entitled *God Was Our Pilot: Surviving 33 Missions in the Eighth Air Force – The Memoir of Bernard Thomas Nolan*, also available from NOVA Science Publishers.



The Editor with Barney Nolan after presentation of Barney's WWII B-17G and the 163 Komet that dove past his aircraft.

In 2016, Bob built a USS *Cairo* diorama for the late Edwin Cole Bearss, who found and restored the Union Civil War ironclad from the sediment along the Yazoo River in Mississippi. While developing the late Ed Bearss memoir trilogy available from NOVA, he built a diorama depicting actions at Ed's wounding site at "Suicide Creek" (a Marine name) near Cape Gloucester on the island of New Britain in January 1944.

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The Editor with the late Edwin Cole Bearss after presentation of the Cairo diorama.

Ed Bearss points at his depiction in Desourdis' "Suicide Creek" diorama – now displayed at the Grand Gulf Military Park,[13] depicting the action in which he was wounded four times in WWII covered in the first of three books from NOVA on Ed Bearss's life.

[13] Online: https://www.grandgulfpark.ms.gov/. Accessed 7 February 2021.

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B-25B diorama built for family of a Doolittle Raider, Eugene McGurl, the Navigator on Plane No. 5. Eugene, who was KIA in October of 1942 well after the raid, is on the far left.

"Bud" Quick, crew chief on the C-47 Dakota "Texas Gal," that towed an 82nd airborne glider into France D-Day afternoon and his buddies.

Bob now lives with his wife Betty in Olympia, Washington, and was formerly a resident of Fairfax, Virginia, and earlier, of several cities in Massachusetts. He has three adult daughters Danielle Marie, Nicole Elizabeth, and Amanda Michelle. His grandchildren Declan Robert and Reagan Louise

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were born to Danielle and her husband Jason Reese, an Army cardiologist now in private practice. Theo Nathan Childs, his third grandchild, is from my daughter Amanda Michelle and her husband Nathan Childs, who reside in Rochester, United Kingdom.

Danielle, Nicole, Amanda, Amanda, Elizabeth, Bob, Declan, Theo, and Reagan.

Celia Jenkins

Foreword author: Celia is the author of the Foreword A.

Bio: Celia is an Honors Program, Dean's List, and Merit Scholar student at Northeastern University and is a candidate for Bachelor of Science in Mathematics and Master of Arts in Teaching, with minors in Data Science and Sociology.

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Before college, she graduated from Hopkinton High School, Hopkinton, Massachusetts, as her class Valedictorian with High Honors and served as the STEM Club President. As a teacher's assistant in Hopkinton, she (i) tutored eighth grade students; (ii) constructed and planned full lessons for 10 classes including homework and in-class assignments, and (iii) graded assignments and exams, and created worksheets, tests, and study guides.

She has supported local business, in which she (i) filed, recorded, and organized paperwork, especially invoices, for the company; (ii) completed online office work, such as working with spreadsheets and documenting company spending and profits; and (iii) adapted to new online formats and software systems, such as Excel.

Celia, who is fluent English and Intermediate Conversational Spanish, currently advises and tutors English language learners in a variety of secondary school subjects. And, when needed, serves food, sorts through donations, and forms personal relationships with patrons of a warming shelter.

As a camp counselor, she has (i) planned daily nature-themed lessons and activities while coordinating with co-counselors, (ii) led multiple hikes, crafts, and games daily, and (iii) formed meaningful relationships with 10 to 15 campers.

Lisa C. Kaufman

Foreword author: Lisa is the author of the Foreword B.

Bio: Lisa C. Kaufman, received a Bachelor of Fine Arts, Honors degree from York University in Toronto, Ontario, Canada, and a Masters of Arts in Art

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Therapy from Vermont College of Norwich University in Montpelier, Vermont. She is a Nationally Registered, Board-Certified Art Therapist (ATR-BC), and a Massachusetts Licensed Alcohol and Drug Counselor (LADC1). Lisa has lectured on Art Therapy at both Caldwell College and Montclair State University in New Jersey and was a contributing clinician/artist for a Caldwell College juried art exhibit; *Healing losses: Artwork of therapists and clients* in Caldwell, New Jersey, in February 2000.

Lisa is a contributing clinician in the New York University publication and the associated traveling art exhibit *Childhood Revealed: Art Expressing Pain, Discovery and Hope* (Abrams, 1999). Additionally, Lisa is a contributing author to *Word Pictures: The Poetry and Art of Art Therapists* (Moon, B. L. & Schoenholtz B.), Charles C Thomas Publisher Ltd., 2004, and the cover and graphics illustrator for *My Body, Their Baby* (Miller, L. B.), The Reginald van Fenwick Press, September 2008.

While working at Hackensack University Medical Center in New Jersey, Lisa developed, implemented, and expanded art therapy programming, training and facilities in the adult, geriatric, and adolescent Partial Hospital Programs (PHP). Working with the Massachusetts Department of Youth Services (DYS), as the Statewide HIV Counseling and Testing Specialist, she designed, and as part of a team, implemented services that educated juveniles and provided DYS staff training. The team was awarded the EDCO Outstanding Achievement award in the area of Health/HIV/AIDS Education & Prevention. She was a coauthor of the poster: *Increasing Knowledge of HIV Status Among Juvenile Detention Center Residents: A Case Study from the Massachusetts Transitional Intervention Project* (Logan, JA; Barker, TA; Kaufman, LC; Zafft, W.) which was presented at the XV International AIDS Conference, Bangkok, Thailand (2004).

With a long history and experience in grief and trauma counseling, Lisa was both a lead responder and volunteer for the Boston with The Children's Trauma Recovery Foundation, and Project Joy. In 2005, under the Direction of the Massachusetts Department of Mental Health (MDMH), Lisa was part of the Children's Trauma Recovery Foundation lead response team for *Project Helping Hand.* The project served the families and children who, in the aftermath of Hurricane Katrina, were evacuated and flown from Louisiana to Edwards Air Force Base on Cape Cod to provide a safe haven.

A founding partner of Preparedness Specialty Services, Lisa is a Behavioral Health, Emergency, Planning Consultant who worked with the MDMH in conjunction with the Massachusetts Department of Public Health

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(MDPH) to develop emergency response planning exercises, and co-author a multifaceted disaster behavioral health training program: *Building Emotional Resilience for Massachusetts Disaster Response Workers*. The training program includes PFA 101: *Massachusetts Psychological First Aid, a foundations course and PFA 202: Developing Your Psychological First Aid Skills.* While working with MDMH, Lisa was part of a team that authored and facilitated the statewide Homeland Security Exercise and Evaluation Plan (HSEEP) Table Top Exercise: *Behavioral Health Response 2011: Mega Marathon*. The exercise focused on behavioral health, *MassSupport Network* response to the bombing of a major marathon (as a note, this was a full year before the Boston Marathon bombing).

For five years, Lisa was an Emergency Operations Center (EOC) Drill & Exercise team member for the Marshfield, Massachusetts, EOC. In that position she was an active participant in EOC trainings, drills and exercises related to all hazards and nuclear emergency preparedness. At that time Lisa was also a trainee in the Massachusetts Emergency Management Agency (MEMA) Nuclear training program.

For over 18 years, Lisa has worked with local Massachusetts Health Departments, Boards of Health and emergency preparedness partners in MDPH Regions 3, 4A/B and 5. She developed, expanded, trained and exercised local emergency preparedness plans; Using her experience and background, she was instrumental in including behavioral health components and child and adolescent advocacy, as appropriate, in emergency preparedness planning. Partnering with local Emergency Management Agencies and adhering to best practices, Lisa has developed templates, guidance and exercises for local emergency sheltering preparedness and deployment. This guidance incorporates emergency/disaster sheltering for animals, as well as safety and wellness components for responders.

As an adjunct faculty member at Massachusetts College of Pharmacy and Health Sciences (MCPHS) University Lisa worked with the Master of Public Health (MPH) program developing and providing workforce training for Local Public Health and their partners.

Integral in the initial development and expansion of multiple Massachusetts, Southeast Region 5, Medical Reserve Corps (MRC) Units, some of Lisa's work with the Massachusetts MRC includes: writing Standard Operating Guidance, Volunteer Handbooks and grants; Developing, implementing and facilitating trainings for medical and non-medical volunteers, as well as regional and local emergency preparedness groups. Lisa

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has boots on the ground experience deploying volunteers and responding to local and regional emergencies.

She has been a strong voice and advocate for the Massachusetts MRC Units and volunteers, and a promoter of collaboration, partnerships, and interagency interoperability. As the assistant coordinator of the Duxbury Bay Area Regional MRC on the south shore of Massachusetts, Lisa continues to serve emergency preparedness partners, and regional and statewide MRCs in multiple capacities across the Commonwealth. In all her work, Lisa brings her awareness of disaster planning, preparedness and response, emotional resilience, Psychological First Aid and self-care techniques for professional and volunteer emergency preparedness partners.

In her spare time, Lisa volunteers and is a Playmaker with the Life is Good® Playmaker Project. She is a mixed media artist, graphic designer, and avid kayaker. She also has a passion for baking and cake decorating. And of course, she always willing to accept commissions for her artwork, and orders for baked goods.

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Acknowledgments

This book is the result of inspired leadership from Liisa Jackson and thousands of volunteers caring for their local citizens across Massachusetts. She deserves majority of gratitude for this commitment and for the content of this book. We also thank the many volunteers and Medical Reserve Corps that deliver the critical life services to these citizens in times of need. Their devotion and commitment to their fellow men and women was and is existential to this work. The Editor fully recognizes and appreciates this selfless work.

MRC Collaborators

Liisa Jackson wishes to personally thank the following people that made—and make—her MRC leadership possible and successful in the Commonwealth of Massachusetts:

- Celia Jenkins - my amazing daughter and Foreword A author

Celia is the light of my life, and I am so proud of what she has accomplished both academically and as a human being. She is one of the most kind and compassionate people I know, I am so proud of the passion she has for teaching children. She was a teacher assistant for AmeriCorps in Hyde Park, Massachusetts. She has been my "wing girl," as she says in her Foreword, through everything. She has never complained about all the hours I work and has taken care of me when I have had health issues.

The cancer diagnosis and treatment has been very challenging, and she has been with me every step of the way. I cannot thank her enough for her support and caring during this and other difficult times. I love her more than I can ever express, and I can't wait to see all the good things she is going to do

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in this world. I am proud to say she is an amazing human being and her kindness and passion for helping others is apparent in everything she does.

She has helped so many people over the years including supporting her friends, helping with her little brothers who are much younger than her. She loves Auggie and Otto very much. In high school, she loved helping her teachers, friends, and students at school. She continues to volunteer at the Malden Warming Center for homeless individuals during winter months and has volunteered at COVID-19 clinics on her own without me.

While this only "scrapes the surface" of what she has done, she is an amazing sister, daughter, granddaughter, and teacher for all the students and others with whom she has worked. They will learn from her patients and ability to teach others. What she loves most is teaching math, spawned from her amazing teachers, professors and stepmother who have inspired her to share her knowledge with others as well as her natural ability to understand and teach math.

- Lisa C Kaufman, ATR-BC, LADC, and Foreword B author

Lisa and I have been friends and colleagues for so many years and have collaborated on many projects involving the medical reserve corps and other public health programs in the Commonwealth of Massachusetts. We always work together to get through the political issues that come up within our program and support each other in any way that is needed to make the program better and to adapt to the ever-changing landscape of public health. I am so grateful for her partnership and friendship. I look forward to many more projects in the future.

- Wendy Diotalevi, retired Weston Health Director and Massachusetts Region 4AN MRC Director:

When I came onto my job as an MRC Coordinator, Wendy helped guide me through the political pitfalls that went on during my tenure there. She always supported the work I was doing, even "taking some hits" to save me from difficult political situations that arose at her own expense.

I am a person of action, and sometimes there is collateral damage. In this regard, she helped me get through my early years as an MRC Coordinator. She

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helped me understand and grow into my role. Her advice and guidance have supported me through my career!

She is a mentor and an incredible friend. She has been there for me "through the thick and thin" of the work I did with region 4AN MRC and always "went to bat" for me when I was working on different projects with which not everyone agreed. She understood my intentions were always for the greater good of the MRC and to support and grow the organization.

I am forever grateful for all the support she has given me over the years as Director of the 4AN MRC. Now that she is retired, I am so grateful for the support she gives to me as a friend. Thank you, Wendy.

- Jennifer Frenette Regional Coordinator, USDHHS Region I (New England), Division of the Civilian Volunteer Medical Reserve Corps:

Jen and I started with the MRC almost at the same time.

When she was hired as the Region 1 Coordinator, I met her at the first Massachusetts MRC meeting and, of course, I picked her brain about what she knew about the MRC. Over the years, we have worked on many projects together and she has always supported the units that I have covered.

I have learned so much from her over the years and her support of my endeavors to grow the MRC has been invaluable. She has supported me at all levels of the work I have been doing. She has always given trustworthy guidance during all the years as MRC coordinator for my units.

We have also developed a strong friendship and had a lot of fun times along the way at conferences and outside of work. She has been incredibly supportive during my cancer journey and her support has reminded me of the love I have for the MRC program. It has helped me heal.

I am forever grateful for her support and friendship. I look forward to many MRC collaborations and adventures in the future.

- Karen Carrol, former Gloucester Health Director and current Somerville Health Director:

Karen is responsible for bringing me back into the MRC when I took a short hiatus, she asked me if I wanted to come work for the North Shore Cape Ann public health coalition to be the MRC coordinator and I was ready to get

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back into the game. We have worked on many projects together including a hoarding program and a Well Check project Gloucester and many other programs that support Gloucester.

She then moved on to Lynn community health. We worked together with clinics and other public health incentives for the people that are in the catchment of the Lynn Community Health Center. After that stint, she became the director of public health in Somerville, Massachusetts, and we have worked on projects together in her city.

She is an inspiration to me and always has been supportive of the Medical Reserve Corps. She values the MRC volunteers and their support of public health programs, pandemics, and disaster response.

She always comes to the table with a forward-thinking attitude with the education and ability to implement these amazing programs. She is an incredible asset to public health and has made her mark. I am happy to call her a friend and a colleague and look forward to our next good work in this world.

I look forward to many more projects ahead.

- Chris Farrand, Director Emergency Disaster Services Greater Boston Social Services Coordinator, The Salvation Army Massachusetts Division:

Chris and I met several years ago working on the behavioral health response team for the Commonwealth of Massachusetts. We worked with a team of other agencies that support mental health during a disaster. With that we developed Psychological First Aid Training 101 and filmed tutorials on how to manage mental health situations during a disaster. Over the years we worked together during disasters and shelter operations. He is always a phone call away to help support with chaplain services, food services and managing donations during the shelter operations during the tornados in Western Massachusetts.

We are both high energy and very likeminded in disaster response. We want to help as many people as we can and optimize use of our assets to support disaster response and recovery.

Chris is an amazing colleague and friend and we always “have each other’s back” whenever needed. These partnerships are what makes disaster response effective. It is so important to develop these relationships, and this is

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done through hard work to support the greater good in public health of our communities we serve. It is all about trust.

- Michael Gurnick, Chair, Ashland Branch, MRC Region 4A Assistant Coordinator Department of Fire Services Flammable Gas Training Program Deputy Fire Chief Boston, Chair of the NACCHO MRC focus group and helped develop Mission Ready Resources for MRCs across the country

When I first started my job as the MRC Coordinator for Region 4A, I was recruiting volunteers and developing leadership locally in each of the communities that I worked in. When I met Mike, I knew he would be an incredible local leader. Due to his engaging personality, professional skills, and willingness to serve his community.

We have become friends over the years and partnered on many projects. I always joke with him telling him I wish that I could clone him and put him in every one of the communities in which I work. His leadership and dedication to the MRC as a volunteer has been invaluable. He has given so much at the local, state, and national levels.

Even though he is retired, he still "gives back" and provides incredible guidance at the national level for MRC programs. He is a wonderful neighbor, friend, and colleague. He has been part of the MRC since I started, I am looking forward to seeing all the upcoming projects he does.

He is a true asset to our country and the represents the epitome of what an MRC volunteer can do. He has made a great difference in the MRC program he has supported.

- Mary McCormick-Gendzel, RN and an amazing MRC volunteer.

Mary has been an incredible volunteer over the years at pretty much any clinic on the North Shore and beyond if she can serve, she will be there. Her kindness and impeccable nursing skill have been such an asset to the MRC.

She continues to serve anytime she can. Mary and I have worked together for many years and anytime she volunteers I know that her work will be professional and appreciated by those she serves. She is an incredible nurse and has brought many other nurses to the MRC. Mary, thank you for all you do. Please know that many communities are grateful for all your help.

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- Doug Scott, Business/Technology/Engineering Subject Matter Leader, 6-12 Hopkinton Public Schools.

During COVID Doug reached out to me to see if I could support their team shield project. This was a very interesting project. They were using 3D printers to make face shields for healthcare workers using plastic from old projector film. He and his team made thousands of them and dropped them off in my garage. I had volunteers pick them up and deliver them to health care facilities that needed them across the state.

This operation became seamless and was needed during the start of the pandemic. It helped protect many healthcare workers that were not able to access PPE during the shortages early in the COVID pandemic. Honestly, I was amazed that many people had 3D printers who donated their time and supplies to make face shields.

I have also worked with Doug and his students on adaptive equipment for people in the healthcare setting. It has been so inspiring to work with the kids in his classroom and see the amazing things they have invented to help make life easier for those that use adaptive devices. One of my favorite things is to work with the kids in his classroom. It has been incredible to many children use their talents and ingenuity to invent assistive devices.

These kids are our future and will certainly make a mark on this world in a positive way.

- Sharon Cameron, Director of Health, Human and Social Services/City of Peabody/24 Lowell Street/Peabody, Massachusetts

Sharon is an incredible asset to public health. She has always been a strong advocate for public health incentives and programs, both inside and outside of her community. She has given so much support and expertise to move forward public health programs for the greater good of our citizens.

She and I have worked on several projects together to provide support both inside and outside of her community, she always uses MRC volunteers when needed and appreciates their help. They love working with her and the City of Peabody to give back and provide their expertise.

Sharon is a mentor and a partner in public health and working with her is an honor. Her ideas and programs are ahead of most. I look forward to working on future projects together and utilizing the MRC.

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- Tom Lawrence, Rhode Island DMAT and MRC Director

When I first met Tom, I went to one of his presentations at the national leadership conference. I was so inspired by the work that he's done across Rhode Island, including his innovative approach in using the MRC to promote public health, support public health during day-to-day operations as well as pandemics and disaster response.

Tom, Cheryl (his wife) and Brooke (his son) have been long time colleagues and friends over the years. At every conference that we have attended together, we have always come together, shared "war stories," and come up with some great ideas.

Tom has been such a huge asset to the medical reserve corps from the beginning. All the programs he developed helped build and expand the capabilities of the medical reserve corps. He is a mentor and a dear friend and I am forever grateful for the work he has done as well as all the resources he has shared over the years. That is what the MRC is all about. He truly embodies the essence of the MRC family.

My Many Collaborators

I also thank many more collaborators and friends, including Robert W. Silva, Retired Fire Chief Middleborough Fire Department, Wendy Hansbury, REHS/RS, Massachusetts RS Region 3 Municipality Health Director, Glenda Thomas of Framingham, Susan K. Walsh Owner/trainer/breeder and then Chief State Steward (sadly, I will go down in history as the "last" Chief State Steward of Suffolk); Chassea Robinson, RN, MSN, MPH Public Health Nurse Peabody Health Department; Kelley Hiland, BSN RN Deputy Director of Public Health and Human Services City of Somerville; Elizabeth Cameron, Occupational Therapist MRC Volunteer; Judith Ryan, BSN, RN Public Health Nurse Danvers/Hamilton; and Andrew Petty, John Coulon, Neia Illingworth, Rachel Lee, Jacquie O'Brien (RN Bristol Norfolk MRC), Donna Palmer, Anne Marie Fleming, Rick Ferrera, Henery Lipe, Elain Lacoursiere, Mike Milner, Rob Tossato, Skip Paine, Kathy Deffer, Tracy Mayo, Gerard Cody, Peggy Motoulous, Mike Nelson, Jim White, Doug Haley, Mike Salvidor, Chris Michaud, Connie Rocha-Mimosa, Rev. David Lima, Carl Alves, Sally Ann Rich, Derek Fullerton, Bill Ray, MEPP, MEPP is designed for

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experienced exercise professionals with significant responsibility for progressive, all-hazard exercise program consistent with the principles of the Homeland Security Exercise and Evaluation Program (HSEEP). Executive Director, Homeland Preparedness Project National Office Texas. Dr. Henry R. Vaillancourt (MD MPH FAAFP, Retired Health and Community Services Director, City of Fall River Massachusetts), Richard Fitzpatrick, PhD (MRC Volunteer), Sally Ann Rich (MRC volunteer, Nurse, Board of Health Member).

My Family

- Joel Jackson, Emergency Room RN

My brother, who lives in Idaho with his wife Erin and my two nephews Vance and Theo. Every year in the summer we would go home for two to three weeks to have adventures with our family. Joel has been such an amazing brother. I am so appreciative of all of the beautiful places he has taken us and all the fun adventures he has shared with us and I'm looking forward to many more. I feel so blessed to have Joel, Erin, Theo, and Vance in my life and I love them all so much!

- Jim Jackson, nuclear scientist

My brother Jim has always been a big influence in my life. He has taught me so much about survival and outdoor sports, which has helped me truly understand what it means to manage yourself and others without all of the comforts to which we are accustomed. From a very young age, my brother taught me how to shoot guns, and that was something we did every time I came home to Idaho. It is one of my favorite activities that we shared together. He always dug out his coolest and most powerful guns that we would use to do target practice. We also spent a lot of time at the family cabin in Island Park, ID.

I chuckle when I think of all the shenanigans we got into when we were up there, mostly teasing my older brother Jack and harassing him. We were a rough and tumble type of family which included play and real fighting and making fun of each other all the time.

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I lost my brother a few years ago and I miss him to this day, but I am always inspired and motivated by the lessons he taught me. He was an amazing brother, and I was so lucky to have him in my life!

- Carol Polacek, my mother: My mother and I have had so much fun and have travelled to so many places. During my trips to Idaho to visit the family every summer.

I am so lucky to have a healthy mother that can do as much as somebody half her age. She has inspired me in so many ways, first and foremost it is about being healthy and taking care of my body so I can do all the things I want to enjoy in life. I learned this by watching her example.

She has been an incredible role model in self-care. We also share the love for horses and that transcends everything we do in life. Both of us have had horses for a very long time, including all of my childhood and adult life. We have ridden hundreds of miles on our horses through beautiful country in Idaho and other places we traveled! I'm looking forward to many more fun times and so glad she is so healthy (in her 80's) so we can have many more adventures together!

- Steve Jenkins and Claudia Kopkowski (Celia's grandparents on her dad's side and my family).

Steve and Claudia have been an amazing influence on my life. They have taken me on trips all over the world and through these travels it has enabled me to understand different cultures and different ways of life. Even though Randy and I are not together anymore (we separated when Celia was very young), they continue to be part of my family and a big influence on me and my daughter. I am so lucky to have them in my life and grateful for all the things they shared with me and my daughter over the years!

- Randy Jenkins (Celia's dad) and Katharine Brummett (Celia's wonderful stepmom).

Randy and Katharine are also a huge part of my life. We have become a blended family as Katharine says in the testimonial! We meet up often to

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watch Randy's bands (Boat Yard Resin and The Grateful Teds). I love their two boys Auggie and Otto and have such a blast with them. I am sort of like the crazy aunt that comes over and gets them into trouble and feeds them a bunch of sugar then leaves to go home to peace and quiet. Usually driving home chuckling about all the fun we had together on that visit. They are so energetic and clever, and I had a blast playing with them and hanging out with Katharine and Randy.

We spend most holidays together as they are my family in Massachusetts. We support each other and always have each other's back when it is needed. During health problems and other situations, we have been there for each other and provided support both mentally and physically during difficult times. I know this is an unusual situation, but we have all worked hard to make our family strong, supportive, and loving. I am so lucky to have them and the boys in my life and look forward to many more years of good times!

Dear Friends

- Pam Bathen, dear friend

Pam and I became friends when our girls were very little, we switched off babysitting while each of us were going to work or our meetings. "Takes a village," right! We have traveled all over Massachusetts and New England to have fun with our kids.

Our girls are like sisters and still have a close bond. As Pam mentioned, we share the love for horses. I "roped her in" when she started hanging out with me, and then I talked her into adopting a racehorse, named "Mark," and he lived here for many years, happy and very spoiled, by a bunch of little and big girls.

Pam is also my family, and we look out for each other, help each other, and support each other through the good and bad. She is a "forever" friend, and I am so blessed to have her in my life. I thank her for all her support when I have been either unable to do chores because of sickness, or when I have been while traveling or deployed responding to disasters.

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- Shari Lavidor, dear friend

Shari is another incredible friend. I met her through Pam Bathen when Shari and her daughter Olivia came over to check out the horses. I found out that Shari also likes to ride and rode in her childhood, so I invited her to ride horses with me.

Since then, we have become great friends. We go riding and hang out with the horses together. Smidge the pony is her noble steed, and they love each other so much it is the cutest thing you have ever seen.

We take them out for walks through the church parking lot often. Smidge is unlike Steve, who loves attention and absolutely loves people! He does not like other human beings and prefers to be left alone. Generally, anybody who meets him wants to pet him, snuggle him and he does not want any part of it. But with Shari she is his special person! I am forever grateful for our friendship, and I am so grateful for all the help she gives me on the farm.

All her support when I have been either unable to do chores because of sickness, or when I have been while traveling or deployed responding to disasters, is a true illustration of friendship is all about.

- Nick Iarussi, dear friend and horse traveling partner

Nick has been an amazing friend through the years. We even took a cross-country trip together with our horses all the way to Idaho then South to West Virginia and Kentucky. In one year during our travels with our horses we visited 32 states and drove close to 20,000 miles riding our horses and camping with them along the way. We have ridden our horses over 1,000 miles on trails, roads and highways and still ride all the time. We also have a pact to talk each other out of doing something dangerous with the horses. Nick has literally talked me off a cliff. I thought this beautiful trail was fine to ride on in Montana, Strawberry Hill, sounds so nice but most of the ride there is a shear cliff that drops hundreds or thousands of feet below, if the horse slipped or spooked, most likely you and the horse would die.

He has become part of my family, and he helps me run the farm. He inherited *Princess*, his beloved horse, from a barter that I had with another friend to take care of her.

Princess loves him so much and they have developed an amazing equine-human partnership. I am forever grateful for all he has done for me, especially

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during my sickness and all the amazing things he has done to improve my horse farm. We will forever be friends and I cannot wait to see what he does in his life. He is a genuine and honest person that loves helping others.

If he is not working or riding a horse, he is helping a friend or a family member with some crazy project like cutting up a tree that has fallen on their barn, he does this to make their lives easier. He can fix whatever needs to be fixed. He is truly a "Jack of all trades" and incredibly talented. He can figure out pretty much anything mechanically and does it with ease and competence.

- Pam Ward, my crazy horse friend:

Pam and I have been friends for almost 30 years. We have had some crazy horse-riding adventures. This includes hunter paces, fox hunts, and trail riding somewhere in the woods defying death. Luckily, we have calmed down with age (sort-of), but not really. We are always laughing along the way. These adventures are always filled with laughter until our cheeks hurt, crazy stories, and shenanigans.

We camp with our horses and have a blast doing that. We love each other's horses like they are our own. On top of that, we have always been there for each other during hard times and helped each other whenever needed. Her support through the cancer journey has been incredible and has brought us much closer. I am forever grateful for our friendship, and I cannot wait to have more adventures with her.

- Carolyn Assad, another crazy horse friend:

Carolyn has done something that is the true embodiment of friendship! While going through cancer treatment, she brought *Levi* (a wonderful horse) to Pam's and Carolyn's barn in Douglas, so I could come out and ride anytime without all the work it takes to trailer a horse 45-50 mins away.

Mike Salvidor, Pam, and Carolyn did this so I could come ride with them anytime I wanted. Pam and Carolyn have taken care of *Levi* at the barn, Carolyn and Mike have paid for his care during this time.

This act of kindness is so incredible, and I believe it has healed me. Kindness and unwavering support have been a big part of why I am surviving cancer! I am honored and blessed to have such an incredible friend. I cannot wait for more adventures and laughter.

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- Donna Aldridge, horse friend

Donna is such a great friend; she hosts us crazy horse girls at her home and farm often. Trust me, this is no small feat. Donna and her husband, Dave, welcome us "with open arms" and provide a wonderful place for us to plan our horse adventures. When it's hot, we just hang out by the pool and laugh, eat, and enjoy adult beverages.

We talk about our crazy horse adventures and of course embellish the stories, adding in other details that make them even more funny. Donna also comes on our camping trips with her horses and has an amazing smile. She has shenanigans of her own, she is known as the "evil queen," coined by her husband. Yet she is the sweetest person you will ever meet, but has a sassy side that we all love.

- Xanadu Caban, horse friend

Xan and I have been friends for almost 30 years. She has been very supportive and always there if needed. She is very helpful and is always giving someone a hand, whether it be building a paddock for horses when we can, sharing the spoils of her garden, or cooking a fabulous meal. She also keeps track of our rides and how many miles we travel. She is an incredible friend and so happy she is in my life.

Books

- Bob Desourdis, Book Editor and NOVA Homeland Security and Safety Series Editor.

He has guided me though the writing of this book. It will valuable information with other healthcare leaders and to inspire volunteers.

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Horses

I would be remiss if I did not talk about the fabulous horses that have been and are in my life.

- *Steve*

Steve is the most incredible horse and companion for which a person could ask. I have had him since he was six years old when a friend gave him to me when *Macho* died. No one had touched him, and he was still a stallion and very green.

I had him fixed and trained him to be the most amazing trail horse, partner and best friend. He is so grounded, but with a side of strong energy that emanates from him. This horse loves people and especially children. Anytime we go to a place where there are children, they come running up and want to pet "the horse," which he thinks is him and him alone.

He stands very tall. He flips his blonde mane and is pictured in thousands of selfies that people have taken with him. I enjoy him so much and I'm grateful to have such a willing and strong equine partner.

- *Levi*

Long story short, I found *Levi* for a friend Mike Salvador so he would have another horse to ride, but it turned out that I started riding him all the time and we have bonded. Mike just recently sold *Levi* to me so we can continue to build upon our partnership. *Levi* is from Montana, and he has been treated roughly. You have to move slowly with him and gain his trust; but once he trusts you, he is in your pocket and with you all the way. He is such an incredible horse and very smart and competent on and off the trail. Thank you, Mike, for letting me keep him. I will find another horse for Mike to ride.

- *Smidge*

Smidge, a cute little pony, thinks he is the size of the other bigger horses. He is probably smarter and more devious than them all. He is in his 20s and is always doing something cute and silly, that makes us all melt. At times I look out and the other horses are sleeping, and I see him biting their legs trying to

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get them to wake up and chase him around the paddock. Eventually one wakes up and tries to catch him, nobody can catch him and of course he loves that.

- *Princess*

Princess, who is now Nick's horse, is such a character; she makes all these goofy faces to get attention. Honestly, I have never seen a horse as athletic as she is. She gallops around the paddock and will do a pirouette on her two hind legs. Then, she will take off bucking while spinning rocks and dirt out the back end of her. She does while doing crazy athletic moves that really a horse shouldn't do. Every time I hang out with her, I laugh and get her to do silly things.

She is one of the sweetest horses I have ever met. She loves people and going out on the trails. I am so glad that she is now Nick's horse. He's been riding her for many years now and their bond is truly incredible, and it wasn't a small task to get her to where she was safe to ride because of her crazy antics. Nick tamed the dragon.

- *Carusa*

Carusa a beautiful mare that was part of the barter that I had with my friend. I would take care of his horses in exchange for yard work and tree work. She is the sweetest and kindest mare and a huge 18 hands, but she thought she was the size of a pony. I gave her up to a breeder to pass on her amazing bloodlines as a Dutch warm blood. I miss her dearly, but I know she's in a happy place with other horses and I know she will make a fabulous mother.

- *Bastille*

Bastille is another horse I inherited from my friend that I bartered for care of horses in return for yard work. He is a beautiful, tall, white, muscley horse and he has a sweet disposition, but he is a bit of a bonehead. He is a blast to ride and he's very athletic and talented. He is very impressive to look at. He can do these crazy dressage moves. I have had many adventures with him and laugh at his shenanigans most of the time.

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- *Macho*

He was my beloved racehorse. As you saw from Susan Walsh's testimony, *Macho* was a very special horse with a very feisty personality, and he was an intimidating size at 18 hands. He and I had so many crazy adventures together. We would ride 10-20 miles, all the time looking for new trails. I did these rides alone with him and we had a blast together. When I bought my house, I finally brought him home with me and that was a dream come true.

I had been boarding horses in Massachusetts until I was 30 years old and it was so nice to have my horse home with me. He turned into a wonderful babysitter for all the little girls that ran around the property, and he was strong and steady He also trained a many of the horses that came along the way. I always felt so safe on him and was always blasting around on him as fast as he could run.

He even knew when I was pregnant before I did, and he became very calm and relaxed. I thought something was wrong with him, but it turned out I was pregnant with beautiful Celia. Celia and he were best friends. She would go out, feed him and sit on him backwards in the yard while reading a book. She would play with him when her friends were over. He was one very happy racehorse that turned into an incredible family horse. He will always be in my heart.

- *Jazz-e*

Jazz-e was my horse in Idaho and my partner in crime, traveling around to shows, cleaning house, and winning championships. He could do all classes, including halter, trail, western pleasure, English pleasure, jumping, dressage, pole bending, barrel racing, and even competitive trail riding. As Celia said, I made a good amount of money showing him, because there were purses attached to winning the classes. They paid for the things I needed for him and myself. He is what I call a "professional" horse; he knew his job and was very good at it, and took his job very seriously. He lived to be 35 years old. He stayed with my mother until he passed after I left for Massachusetts. I would come home every year and ride him in the mountains with my mom and enjoyed every minute that I had with him, he was an amazing horse.

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Introduction: Collaboration as a Profession

I have made the analysis of human collaboration an important element of several chapters of books in the NOVA Science Publisher's homeland security and safety book series. This book presents several key collaboration-based elements of Medical Reserve Corps (MRC) units and their operation and improvement over time. As the Massachusetts MRC units that were Liisa Jackson's responsibility grew in services offered and number of volunteers, their capabilities also increased as well as the diversity in requests for their help. Of course, improvement of MRC capabilities was, and is, inherent in their healthcare operational tempo, as it is in all modern healthcare and operational systems of people and technology.

Thus, there is a pre-disaster "steady state" in which the MRC leadership maintains situational awareness to the modern extent possible, thus enabling greater preparedness for historically apparent events and resulting MRC deployments. This awareness helps to alert her many volunteers that their day-to-day lives may be enhanced by a potential MRC Deployment. This book addresses how Liisa and the MRC volunteers maintain this awareness themselves and prepare to adjust their personal lives if the MRC is "Activated," meaning Liisa is contacted about a local community, regional or Commonwealth need for MRC services.

Once Liisa is asked to activate the MRC to access its capabilities, she uses a variety of electronic mechanisms to contact the geographically and medically appropriate MRC volunteers. This "Notification" not only outlines their likely assignments, but also provides information regarding the specific need and associated assignments of the alerted volunteers. The book describes the tools used by the MRC to perform this notification and its benefits over earlier methods.

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The volunteer Response to the Notification depends on communications connectivity, and redundant technology paths may be used for improved reliability, the travel impact of the disaster or emergency for each volunteer, and other personal factors. Of course, the number of volunteers available offers Liisa a flexibility in MRC Response to the Activation. However, it is rare that assigned volunteers —personally motivated to support the need—is unable to respond positively to the Notification.

The notified volunteers then travel, if necessary, to their "Deployment" site and take up their assigned roles following the predefined protocols and procedures on which they have been trained. The MRC accounts for volunteer safety before, during, and after Deployment, so travel conditions and supporting transportation organizations are available to be engaged as well in this regard. For example, vehicles able to handle heavy snow could be needed to transport volunteers to their Deployment site.

The volunteers work their disciplines at their Deployment site—perhaps living there temporarily themselves, depending on conditions—and working their assigned shift. The shift debriefings during the Deployment let incoming (new shift) volunteers know about specific onsite issues before they start their shifts. Notes documented during and after these shifts provide input for further MRC improvements, including the need to restock onsite supplies.

Once the Deployment (community need) comes to an end and the site is "shut down" (or, demobilized), a "hot wash," or immediate Deployment review, is conducted to capture any Deployment issues experienced as well as recommended improvements to avoid the noted issues in the future. The issues and recommendations are documented in an After-Action Report for the MRC leadership (including Liisa) to plan and execute the necessary improvements. At this point, the MRC stands down and moves back into a preparedness and situational awareness monitoring condition. Of course, Deployments may always be happening in different locations with overlapping time intervals – and the MRC is built to respond effectively to these differing scenarios.

The chapters of this book intended, including any repetition of important concepts for needed emphasis, are the following:

1. *Chapter 1 The Role of the Medical Reserve Corp* – explains the national, state and local organization and types of operations engaged by the MRC, its purpose and objectives.

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2. *Chapter 2 The MRC Operational Response* – explains the steps or stages in MRC operations as described above; they provide the necessary context for the remainder of the book.
3. *Chapter 3 Our Plans, Protocols, and Procedures* – presents an overview of our documented methods for performing our many and varied services. All this material is listed in the books Bibliography.
4. *Chapter 4 The Tools We Use and Relationships We Build* – describes the various physical and depletable material as well as organizational relationships that supplement our deployed volunteers and facilitate their successful activities during Deployment
5. *Chapter 5 Training Our Volunteers* – this chapter we describe the various training methods and materials we use to prepare our volunteers for every aspect of Deployment, including their and their family's personal safety.
6. *Chapter 6 Preparedness* – this chapter describes all the measures our MRC uses to be ready for the full variety of warned or unexpected Deployments we have and will face in the future.
7. *Chapter 7 Historic Deployments* – describes examples of different types of Deployments we have experienced in our MRC, from developing and well-warned snowstorms to sudden disasters, such as the Boston Marathon Bombing.
8. *Chapter 8 Improvements* – summarizes the way our MRC is improved from shift debriefings and After-Action Reports, and presents several important examples.
9. *Chapter 9 Funding the MRC* – presents a description of how Liisa and the MRC leadership seeks and accesses grant funding to provide the materials and other expenses, providing the tools, materials, and services needing to support the unpaid MRC volunteers.

We have assumed the reader is not familiar with the extent of healthcare terms used in the book and have provided footnotes to direct the reader to supporting documentation. In addition, Liisa's MRC website provides a wealth of important information, see:

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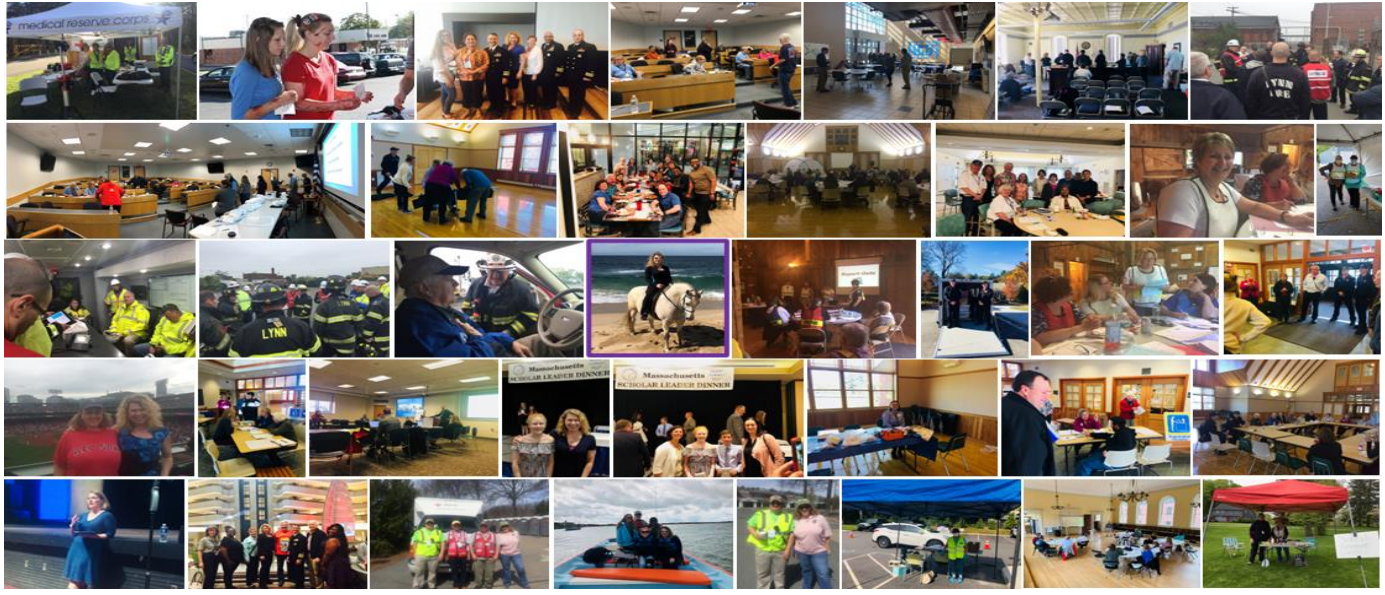

Our Medical Reserve Corps: The Power of Volunteers and Inspired Leadership.

Chapter 1

The Role of the Medical Reserve Corps

Abstract

The Medical Reserve Corps (MRC) is an organization of volunteers from across the US and its protectorates who provide surge capacity in times of need, especially in disasters. Not all are healthcare professionals. Their leadership is organized at the local, state, and national levels. MRC members are trained to support their communities whenever the emergency or public health needs exceed the capabilities or capacity of the local healthcare infrastructure. This chapter provides a high-level view of the MRC as background to appreciate the in-depth review of our activities described in subsequent chapters.

1. Introduction

In this chapter, we explain the MRC, answering the questions "What is it?" "How and when was it started?" "Why is it needed?" and "What has it done?" Subsequent chapters present many more details to further explain the MRC implementations nationwide. The MRC was established in 2002 under the Office of the Surgeon General[14] and is coordinated at the local level by state, local, and tribal health departments.

1.1. The MRC

The MRC is a national community-based volunteer organization[15] that supports public health initiatives and emergency response efforts. Although the MRC is federally coordinated by the Office of the Administration for

[14] Online: https://www.hhs.gov/surgeongeneral/index.html. Accessed 20 October 2023.
[15] Online: https://aspr.hhs.gov/MRC/Pages/index.aspx. Accessed 6 April 2024.

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Strategic Preparedness and Response (ASPR)[16] within the U.S. Department of Health and Human Services[17] (HHS); each state has its own MRC units that operate under state and local jurisdictions.

In Massachusetts, the MRC[18] falls under the jurisdiction of the Massachusetts Department of Public Health[19] (DPH) and the Office of Preparedness and Emergency Management[20] (OPEM). MRC units across Massachusetts can enhance the state's emergency preparedness and response capabilities by recruiting and training medical and non-medical volunteers.

Regarding legal protections for MRC volunteers, many states, including Massachusetts, have enacted laws to provide liability protections for volunteers who serve in good faith and within the scope of their duties during emergencies or disaster responses. These laws, often known as Volunteer Protection Act[21] (VPA) or Volunteer Immunity Act, are designed to encourage volunteerism by limiting the liability of volunteers for any harm or damages that may occur while they are providing assistance.

The MRC is a group of volunteer healthcare professionals who assist with public health emergencies and events in their local communities.[22] It was established in 2002 as a component of the Office of the Surgeon General[23] in response to the September 11th terrorist attacks.[24] The MRC has since grown to become an integral part of the national response to public health emergencies. They also assist with public health education and outreach programs, health screenings, and community health fairs. In particular, the MRC provides a valuable resource to communities during times of crisis. Volunteers are trained to respond quickly and effectively to a wide range of

[16] Online: https://aspr.hhs.gov/Pages/Home.aspx. Accessed 19 October 2023.

[17] Online: https://www.hhs.gov/. Accessed 19 October 2023.

[18] Online: https://www.mamedicalreservecorps.org/. Accessed 19 October 2023.

[19] Online: https://www.mass.gov/orgs/department-of-public-health. Accessed 20 October 2023.

[20] Online: https://www.mass.gov/orgs/office-of-preparedness-and-emergency-management. Accessed 19 October 2023.

[21] Online: https://www.govinfo.gov/content/pkg/PLAW-105publ19/pdf/PLAW-105publ19.pdf. Accessed 19 October 2023.

[22] See the WGBH Boston story at https://www.wgbh.org/news/local/2021-02-17/the-key-to-speeding-up-vaccine-distribution-volunteers?fbclid=IwAR3MQ2kmIM_FTgOmH9e4QyMkfxW47oo3f5b91AvrVjw-jM6KrOTDnuoHQi8, accessed 6 April 2024.

[23] Online: https://www.hhs.gov/surgeongeneral/index.html. Accessed 19 October 2023.

[24] Online: https://en.wikipedia.org/wiki/September_11_attacks. Accessed 19 October 2023.

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medical emergencies, including natural disasters, infectious disease outbreaks, and acts of terrorism.

The MRC operates on a local level and is organized into units based on geographic location. Each unit has a designated leader who oversees training and operations. The MRC also has a national structure that provides guidance and support to local units. During a public health emergency, the MRC is activated by local health officials and emergency management personnel. Volunteers are deployed to provide medical care, support, and outreach services. The MRC also aids with logistics, communication, and other support services.

Anyone with a medical or public health background can join the MRC, although other disciplines are important as well. Volunteers include physicians, nurses, paramedics, dentists, veterinarians, and other healthcare professionals. Non-medical volunteers are also welcome to join and assist with administrative tasks and community outreach. Volunteers must complete a training program that includes basic disaster response skills, public health emergency management, and medical support for mass gatherings. Additional training may be required depending on the needs of the community and the type of emergency response required.

Joining the MRC provides numerous benefits for healthcare professionals and community members. Volunteers can develop new skills, gain experience in disaster response and public health emergencies, and make a positive impact in their own communities. In addition, MRC volunteers are eligible for liability protection under the Volunteer Protection Act. They may also be eligible for continuing education credits and other professional development opportunities.

1.1.2. Scope of Activities

The national network of MRC volunteers assists their communities during public health emergencies and other times of need. The MRC core competencies are a set of skills and knowledge areas that its volunteers should possess to effectively contribute to their communities during a public health emergency. These competencies are as follows:

- *Emergency Management:* MRC volunteers should understand the emergency management process, including incident command, and

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should be able to work effectively within the Incident Command System (ICS).

- *Public Health:* MRC volunteers should have knowledge of public health principles, disease prevention, and health promotion.
- *Emergency Medical Services:* MRC volunteers should have a basic understanding of emergency medical services, including First Aid and cardiopulmonary resuscitation (CPR)[25].
- *Community Preparedness and Response:* MRC volunteers should be knowledgeable about community preparedness and response, including risk communication, community engagement, and volunteer management.
- *Healthcare System:* MRC volunteers should understand the health care system, including health care delivery, health care facilities, and health care providers.
- *Mental and Behavioral Health:* MRC volunteers should understand mental and behavioral health issues that may arise during a public health emergency.
- *Cultural Competency:* MRC volunteers should understand cultural competency and the ability to work effectively with diverse populations.
- *Information Management:* MRC volunteers should understand information management, including data collection, analysis, and dissemination.
- *Legal and Ethical Issues:* MRC volunteers should have knowledge of legal and ethical issues related to emergency response, including confidentiality, liability, and informed consent.
- *Personal Preparedness:* MRC volunteers should have a personal emergency preparedness plan in place, including a family communication plan, and should be prepared to respond to an emergency at a moment's notice.

[25] Online https://en.wikipedia.org/wiki/Cardiopulmonary_resuscitation. Accessed 8 January 2024.

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These core competencies provide a framework for MRC volunteers to understand their roles and responsibilities during a public health emergency and to effectively contribute to their communities' response efforts.

1.1.3. Need for MRC Volunteers

The MRC recruits and trains volunteers from various health and non-health backgrounds, including healthcare professionals (doctors, nurses, pharmacists, etc.), mental health professionals, interpreters, logistics personnel, and administrative support staff. These volunteers undergo training specific to their roles and responsibilities, ensuring they are prepared to assist during emergencies and public health initiatives. By mobilizing these trained volunteers, the MRC helps alleviate burdens on the healthcare system during crises and enables a more effective response. Their contributions enhance community resilience, promote public health, and strengthen the overall capacity of the healthcare system.

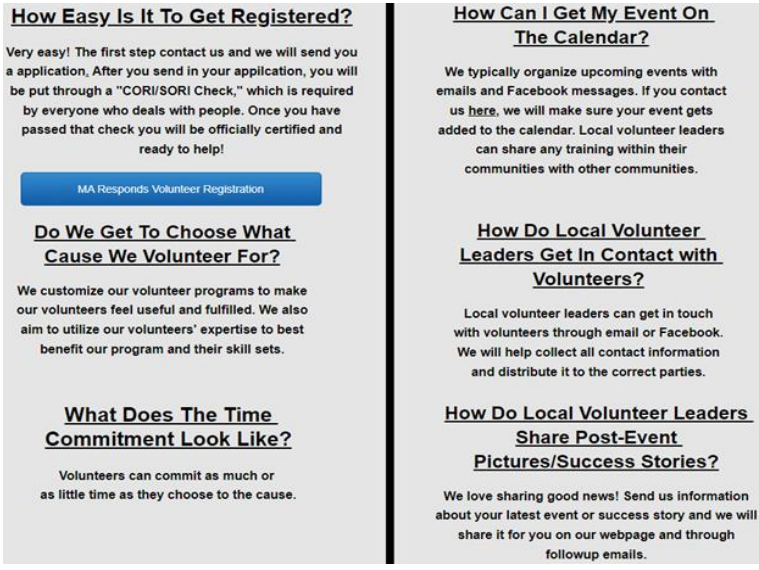

Figure 1.1. Frequently ask questions, from https://www.mrcvolunteer.org/mrc-faq-s-1.html.

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MRC volunteers are trained and prepared to assist in public health emergencies and supplement the existing healthcare system during times of need. We play a vital role in augmenting the healthcare system in several ways:

- *Emergency Response:* During public health emergencies, such as natural disasters, disease outbreaks, or acts of terrorism, the MRC volunteers can be activated to provide immediate assistance. They can help set up emergency medical facilities, provide medical care, distribute medications and supplies, and support other response efforts.
- *Public Health Initiatives:* The MRC is involved in various public health initiatives and community outreach programs. Volunteers can participate in health screenings, immunization campaigns, health education programs, and other preventive health activities. By engaging with communities, MRC volunteers help promote and improve public health.
- *Surge Capacity*: In times of medical staffing shortages, the MRC can offer backfill support. When healthcare facilities are overwhelmed or understaffed due to a surge in patients or a workforce shortage, MRC volunteers can step in to provide additional manpower. They may assist with patient care, administrative tasks, logistics, or any other duties within their scope of training.

1.1.4. How the MRC Serves Its Communities

The MRC is an important resource for communities during times of crisis. MRC volunteers are trained to provide medical care and support in response to public health emergencies, and they also assist with public health education and outreach programs. Joining the MRC provides numerous benefits for healthcare professionals and community members, including the opportunity to develop new skills, gain experience in disaster response and public health emergencies, and make a positive impact in their local communities. Its key roles include the following:

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- *Response to Emergencies and Disasters*: MRC units have provided critical support during emergencies and disasters, including hurricanes, wildfires, and disease outbreaks. For example, during the COVID-19 pandemic, MRC volunteers have played a key role in staffing vaccination clinics, conducting contact tracing, and providing surge capacity to healthcare facilities.
- *Public Health Education and Outreach:* MRC volunteers have conducted many public health education and outreach activities, including promoting healthy behaviors, conducting health screenings, and distributing educational materials. MRC volunteers have also worked to build partnerships between healthcare providers, public health agencies, and community organizations to improve health outcomes.

Figure 1.2. Volunteers giving each other COVID-19 injections during a drill.
Source: Liisa Jackson, MRC Coordinator/Leader.

- *Training and Exercises:* MRC units often participate in training, drills, and exercises to improve their readiness to respond to emergencies and disasters. For example, MRC volunteers may participate in mock disaster exercises to practice setting up and staffing emergency shelters or to simulate a disease outbreak response. These activities help to ensure that MRC volunteers are prepared to respond when called upon.

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Figure 1.3. MRC community support. Source: Liisa Jackson, MRC Coordinator/Leader.

- *Community Health Improvement:* MRC volunteers have worked to improve the health of their communities in a variety of ways, such as providing medical care to underserved populations, conducting health assessments, and promoting healthy lifestyles. Our volunteers have also worked with local public health agencies to develop and implement public health initiatives and policies.

Overall, the MRC has made significant contributions to public health and emergency response efforts across the country. The dedication and commitment of MRC volunteers have helped to strengthen the resilience of communities and improve the health and safety of all Americans.

1.2. A National Framework

The national MRC framework is a comprehensive approach to building and sustaining a network of trained volunteers who can support public health and emergency response efforts in their communities. The framework includes the following components:

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- *Local Capability:* The MRC is organized at the local level, with units in communities across the country. These units are typically led by a coordinator and are supported by a local sponsoring organization, such as a public health agency or hospital.
- *Volunteer Recruitment and Training:* MRC units recruit and train volunteers with a variety of skills and backgrounds, including medical and public health professionals, as well as individuals with non-medical skills, such as logistics, communications, and administrative support. Volunteers receive training in emergency preparedness, disaster response, and other relevant topics.
- *Partnerships and Collaboration:* MRC units work closely with local public health agencies, healthcare providers, emergency management agencies, and other community organizations to support public health and emergency response efforts. We also collaborate with other MRC units across the country to share best practices and resources.
- *Response and Recovery:* MRC volunteers are trained and ready to respond to emergencies and disasters in their communities, providing surge capacity to healthcare facilities, staffing vaccination clinics, conducting contact tracing, and performing other critical tasks. MRC units also play a role in community recovery efforts following disasters.
- *Sustainability:* MRC units work to sustain their operations by building partnerships and collaborations, recruiting, and retaining volunteers, and securing funding and other resources.

The national MRC framework provides a flexible and adaptable model for building and sustaining a network of trained volunteers who can support public health and emergency response efforts in their communities.

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Figure 1.4. Community and volunteer benefits. Source: Liisa Jackson, MRC Coordinator/Leader.

1.2.1. The MRC Organization

The MRC operates under the guidance and coordination of the Office of the Assistant Secretary for Preparedness and Response (ASPR) within the U.S. Department of Health and Human Services (HHS). The national framework of the MRC consists of the following key components:

1. *National Leadership:* The MRC is led by a national program office located within the ASPR. This office provides strategic direction, guidance, and support to local MRC units across the country. It helps establish national policies, standards, and best practices for MRC operations.
2. *Regional Coordinators:* The MRC employs regional coordinators who work closely with local MRC units within their respective regions. These coordinators serve as liaisons between the national program office and local units, providing support, training, and technical assistance to ensure effective MRC operations.
3. *State and Local Units:* The MRC is organized into state and local units, which are community-based volunteer organizations. At the state level, there may be state MRC coordinators who oversee and coordinate MRC activities within their respective states. Local units

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are established at the county, city, or regional level and are responsible for recruiting, training, and deploying MRC volunteers.

4. *Volunteer Recruitment and Training:* MRC units recruit and engage volunteers from various backgrounds, including healthcare professionals, medical students, public health workers, and community members. Volunteers receive training in emergency preparedness, disaster response, public health, and other relevant areas. Training programs are designed to ensure that volunteers are equipped with the necessary knowledge and skills to support public health and emergency response efforts.
5. *Deployment and Response:* During emergencies or public health events, MRC units can be activated and deployed to provide support and assistance. The specific roles and responsibilities of MRC volunteers may vary depending on the nature of the event and the needs of the community. MRC units collaborate with local public health departments, emergency management agencies, and healthcare facilities to integrate their response efforts effectively.

1.2.2. The National Association of County and City Health Officials

The National Association of County and City Health Officials[26] (NACCHO) is a professional organization that represents the interests of local health departments across the US. NACCHO provides support to the MRC in a variety of ways, including:

- *Training and Technical Assistance:* NACCHO provides training and technical assistance to MRC units to help them build and sustain their operations. For example, NACCHO offers webinars on topics such as volunteer recruitment and retention, emergency response planning, and community engagement.
- *Policy Advocacy:* NACCHO advocates for policies and funding that support the MRC and other public health initiatives. NACCHO works with federal and state policymakers to promote the importance of

[26] Online: https://www.naccho.org/. Accessed 19 October 2023.

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public health preparedness and to secure funding for public health programs.

- *Information Sharing and Networking:* NACCHO facilitates information sharing and networking among MRC units and other public health agencies. NACCHO hosts an MRC network that allows MRC units to connect with one another and share best practices and resources.
- *Collaborations and Partnerships:* NACCHO collaborates with other national organizations to support the MRC and other public health initiatives. For example, NACCHO works with the Centers for Disease Control and Prevention (CDC) to provide guidance and support to MRC units.

Overall, NACCHO plays an important role in supporting the MRC and promoting public health preparedness at the local level. Through its training, advocacy, networking, and collaborations, NACCHO helps to build and sustain a strong and effective MRC network across the US.

1.3. MRC Leadership

1.3.1. Typical Roles and Responsibilities

The role of the MRC Director-Coordinator in Massachusetts is to provide leadership, strategic direction, and oversight to the MRC program within the state. They provide leadership, guidance, and coordination within their local MRC unit. MRC also leaders play a critical role in ensuring the effective functioning of the MRC at the local level. While specific roles and responsibilities may vary, here are some common aspects of an MRC leader's role:

1. *Unit Management:* MRC leaders are responsible for managing the day-to-day operations of their local MRC unit. This includes overseeing volunteer recruitment, engagement, and retention efforts. They establish procedures and protocols for volunteer activities, maintain volunteer records, and ensure compliance with MRC guidelines and policies.

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2. *Volunteer Coordination:* MRC leaders coordinate the deployment and utilization of MRC volunteers during emergencies, public health initiatives, and community events. They assess the needs of the community and match volunteers' skills and expertise with those needs. Leaders may assign volunteers to specific roles or assignments, monitor their performance, and provide necessary support and guidance.
3. *Training and Education:* Leaders are involved in organizing and facilitating training programs for MRC volunteers. They identify training needs, develop training plans, and collaborate with local partners or subject matter experts to deliver relevant and high-quality training sessions, such as drills. Leaders may also promote ongoing education and professional development opportunities for MRC volunteers.
4. *Community Engagement:* MRC leaders actively engage with the local community to promote the MRC program, raise awareness about public health and emergency preparedness, and build partnerships. They represent the MRC unit in community meetings, events, and committees. Leaders may collaborate with local public health departments, emergency management agencies, healthcare organizations, and community groups to support community health initiatives.
5. *Planning and Preparedness:* MRC leaders contribute to the development and implementation of emergency response plans and preparedness activities at the local level. They work with local partners to integrate MRC capabilities into overall emergency response plans. Leaders may participate in drills, exercises, and simulations to ensure MRC volunteers are prepared to respond effectively during emergencies.
6. *Communication and Reporting:* MRC leaders serve as the primary point of contact for communication within their local MRC unit. They disseminate information, updates, and instructions to volunteers. Leaders also collect and report data on volunteer activities, deployments, and outcomes to the state or regional MRC coordinators.

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Figure 1.5. Drills – integrating training with practice. Source: Liisa Jackson, MRC Coordinator/Leader.

7. *Mentorship and Support*: MRC leaders provide mentorship, guidance, and support to MRC volunteers. They foster a positive and inclusive *environment* that encourages volunteers' professional growth and engagement. Leaders may offer advice, resources, and assistance to volunteers, ensuring their well-being and satisfaction within the MRC program.

1.3.2. Typical Coordinator Roles

MRC coordinators are hired by the state or local health department or other relevant agencies responsible for managing the MRC program. The coordinators may be employed as full-time staff or work on a part-time or contract basis. The role of MRC coordinators in leadership is crucial for the

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effective functioning of the MRC program. Their responsibilities often include:

1. *Program Management:* MRC coordinators oversee and manage the day-to-day operations of the MRC unit in their jurisdiction. They ensure that the program aligns with the goals and objectives of the state or local health department and complies with national MRC guidelines and standards.
2. *Volunteer Recruitment and Engagement:* Coordinators play a vital role in recruiting and engaging MRC volunteers. They develop recruitment strategies, establish partnerships with community organizations, and promote the MRC program to attract a diverse and skilled volunteer base. They also facilitate the onboarding process for new volunteers, ensuring that they meet the necessary requirements and receive appropriate training.
3. *Training and Education:* MRC coordinators are responsible for organizing and coordinating training programs for MRC volunteers. They identify relevant training needs, develop training curricula, and collaborate with subject matter experts to deliver high-quality training sessions. Coordinators may also facilitate ongoing education and professional development opportunities for MRC volunteers.
4. *Collaboration and Partnerships:* MRC coordinators serve as liaisons between the MRC unit and various stakeholders, including local health departments, emergency management agencies, healthcare facilities, and community organizations. They build and maintain partnerships to enhance the MRC's capacity to respond effectively during emergencies and public health events. Coordinators may participate in meetings, committees, and working groups related to emergency preparedness and response.
5. *Planning and Preparedness:* Coordinators contribute to the development and implementation of emergency response plans and preparedness activities. They work closely with other agencies and organizations to integrate MRC capabilities into overall emergency response plans. Coordinators may also assist in conducting drills, exercises, and simulations to test the readiness of MRC volunteers and their ability to collaborate with other response partners.

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6. *Administrative and Reporting Duties:* MRC coordinators handle administrative tasks such as maintaining volunteer records, managing budgets, and reporting program activities and outcomes to the state or local health department. They ensure that the MRC unit operates efficiently, adheres to policies and procedures, and meets reporting requirements.

Specific roles and responsibilities of MRC coordinators may vary depending on the jurisdiction and the needs of the MRC program. For detailed information on the hiring process and the specific duties of MRC coordinators in Massachusetts, contact the Massachusetts MRC or the relevant state or local health department.

1.3.3. Leader Selection Process

The process of choosing an MRC leader can vary depending on the structure and governance of the specific MRC unit. In general, the selection process involves a combination of nomination, application, review, and approval. Here is a general description of how an MRC leader may be chosen:

1. *Nomination:* Potential MRC leaders are typically nominated by individuals within the MRC or by community stakeholders. Nominations can come from MRC volunteers, local health departments, emergency management agencies, healthcare organizations, or other relevant entities. Nominations may be based on a person's experience, leadership qualities, knowledge, and commitment to public health and emergency response.
2. *Application:* Once nominated, individuals interested in becoming an MRC leader may be required to submit an application. The application may include information about the candidate's background, relevant experience, qualifications, and vision for the MRC unit.
3. *Review and Selection:* A selection committee, which may consist of MRC leadership, representatives from partnering organizations, and/or community stakeholders, reviews the applications. The committee assesses the qualifications, leadership potential, and alignment with the MRC's goals and objectives for each candidate.

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They may interview the candidates or request additional information as part of the selection process.

4. *Approval:* After the review process, the MRC leadership, in consultation with relevant stakeholders, makes the final decision regarding the selection of the MRC leader. The approval may be based on the committee's recommendations, considering factors such as the candidate's experience, leadership skills, knowledge, and ability to fulfill the responsibilities of the role.
5. *Transition and Onboarding:* Once selected, the new MRC leader undergoes a transition period during which they receive necessary training, orientation, and support to assume their leadership role effectively. This may involve familiarizing themselves with the MRC's policies, procedures, and operations, as well as building relationships with existing MRC leadership, volunteers, and community partners.

The specific process for choosing an MRC leader may vary depending on the MRC unit structure, local regulations, and organizational policies. Additionally, some MRC units may have specific leadership positions, such as unit coordinators or executive directors, while others may have a more collaborative leadership model with shared responsibilities among a group of leaders.

1.3.4. Intangible but Critical Leadership Skills

We have described the roles and responsibilities of the MRC leader and coordinator, who may be the same or different people in general. However, the often-stressful nature of extreme healthcare conditions and timeline for optimal response combined with the full range of people involved in crisis, creates challenging social situations among authorities, partnering agencies, MRC volunteers, suppliers, patients, and the public.

The leader-coordinator must ensure optimal collaboration among all those involved in MRC operations, from preparedness through deployment and self-assessment/improvement. We realize there is always an opportunity to collaborate and problems arise when there's miscommunication or a lack of understanding of the response partners role or the MRC roll during our deployments.

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1.4. History in the Commonwealth of Massachusetts

1.4.1. Background

The Massachusetts MRC was established in 2003,[27] shortly after the national MRC program was launched. The Massachusetts MRC is a statewide network of volunteers, coordinated by the Massachusetts Department of Public Health (MDPH) and local health departments. The Massachusetts MRC is made up of medical and public health professionals, as well as community members without medical training who are interested in volunteering their time to support public health and emergency response efforts.

Since its establishment, the Massachusetts MRC has been involved in a wide range of activities, including responding to public health emergencies such as the H1N1 influenza pandemic, providing medical and public health support at large-scale events such as the Boston Marathon, and participating in community health initiatives such as vaccination clinics and health fairs.

The Massachusetts MRC has also been involved in efforts to improve emergency preparedness and response in the state. The MDPH has worked with local health departments to establish emergency dispensing sites, where medications can be rapidly distributed to the public in the event of a public health emergency. The Massachusetts MRC has played a key role in staffing these sites and ensuring that medications are distributed safely and efficiently.

Overall, the Massachusetts MRC has been an important asset to the state's public health and emergency response efforts. Its volunteers have provided critical support during emergencies and have helped to build stronger, more resilient communities.

The Massachusetts MRC units often work closely with local public health coalitions throughout the Commonwealth to promote community health and preparedness. Public health coalitions in Massachusetts are groups of stakeholders who work together to identify and address public health issues in their communities. These coalitions typically include representatives from local health departments, hospitals, community organizations, schools, and other key groups.

[27] Online: https://static1.squarespace.com/static/5dc2d29663765140e639ce61/t/603d078b95e5346643d891c6/1614612364050/Medical+Reserve+Corps+overview_final.pdf. Accessed 6 April 2024.

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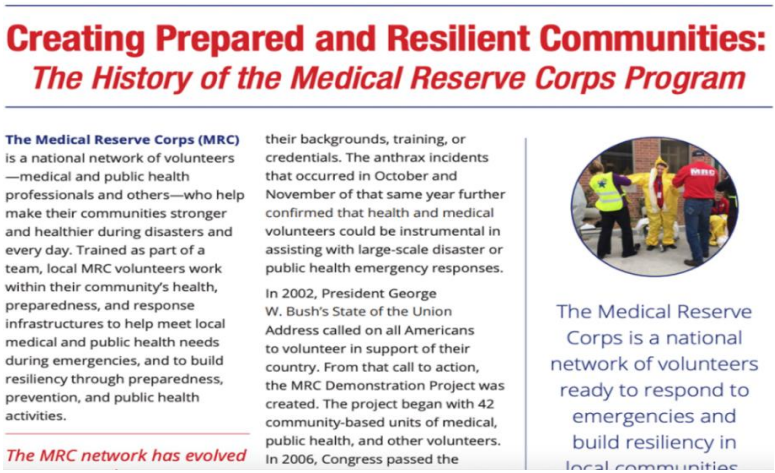

Figure 1.6. MRC history. Source: Liisa Jackson, MRC Coordinator/Leader.

1.4.2. Capabilities of the MRC in the Commonwealth

MRC volunteers may be called upon to support the work of local public health coalitions in a variety of ways. For example, MRC volunteers may help to staff vaccination clinics, assist with public health education campaigns, or provide surge capacity during emergencies or disasters.

In Massachusetts, there are several regional Public Health coalitions that work closely with MRC units. These coalitions often serve as a hub for local public health preparedness activities and may coordinate training and exercises to improve community readiness for emergencies. MRC volunteers are valuable to these coalitions, providing additional expertise and support to help ensure that communities are prepared to respond to public health threats.

Massachusetts has a comprehensive public health emergency preparedness planning system in place to ensure that the state is well-prepared to respond to a range of emergencies, including natural disasters, disease outbreaks, and acts of terrorism. The Massachusetts Department of Public Health (MDPH) is responsible for leading the state's emergency preparedness and response efforts and works closely with other state agencies, local health departments, and healthcare providers to develop and implement emergency plans. There are many supporting documents at all administrative levels of the MRC.

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Figure 1.7. Sample of available MRC support documentation. Source: Liisa Jackson, MRC Coordinator/Leader.

Key components of the public health emergency preparedness planning in Massachusetts are as follows:

- *Emergency Operations Center (EOC):* The MDPH operates an EOC, which serves as the central hub for coordinating emergency response efforts across the state. The EOC is staffed by representatives from various state agencies, including the MDPH, the Massachusetts Emergency Management Agency[28] (MEMA), and the Department of Homeland Security (DHS).
- *Emergency Preparedness and Response Plans:* The MDPH develops and maintains a range of emergency preparedness and response plans, including plans for responding to infectious disease outbreaks, chemical incidents, and radiological events. These plans are regularly updated to reflect changing threats and to ensure that response efforts are coordinated and effective.
- *Surveillance and Monitoring:* The MDPH maintains a robust surveillance and monitoring system to detect and track emerging health threats. This includes monitoring disease outbreaks, conducting environmental surveillance, and maintaining a network of laboratories to quickly identify and respond to emerging threats.

[28] Online: https://www.mass.gov/orgs/massachusetts-emergency-management-agency. Accessed 9 August 2023.

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Figure 1.8. A local (town) EOC in Massachusetts. Source: Liisa Jackson, MRC Coordinator/Leader.

Figure 1.9. Drive-thru COVID-19 Testing. Source: Liisa Jackson, MRC Coordinator/Leader.

- *Training and Exercises:* The MDPH provides training and conducts exercises to ensure that emergency responders, healthcare providers, and other stakeholders are prepared to respond to emergencies. This includes providing training on emergency response protocols, conducting drills and simulations, and participating in statewide and national exercises.
- *Communication and Outreach:* The MDPH maintains a range of communication channels to keep the public informed during

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emergencies. This includes providing timely updates through social media, websites, and other communication channels, as well as working with local media outlets to disseminate information to the public.

Figure 1.10. Training sessions, including drills. Source: Liisa Jackson, MRC Coordinator/Leader.

Figure 1.11. Multimedia sharing information about what we do. Source: Liisa Jackson, MRC Coordinator/Leader.

Overall, the public health emergency preparedness planning in Massachusetts is designed to ensure that the state is well-prepared to respond to emergencies and to protect the health and safety of its residents. By maintaining a robust system of surveillance, training, and communication, the state is better equipped to respond to a range of threats and to keep its communities safe.

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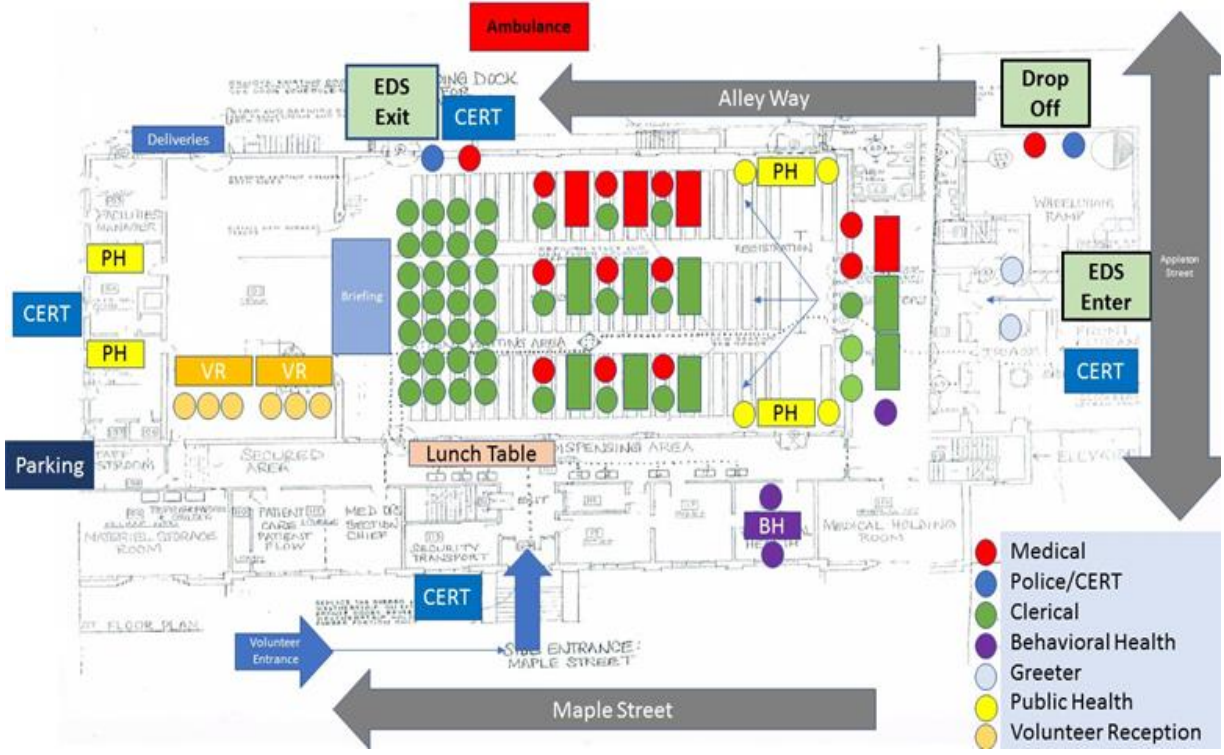

Figure 1.12. Typical Partnering Apparent in an EOC Facility, Source: Liisa Jackson, MRC Coordinator/Leader.

1.4.3. Regional Network

At the time of this writing, the Massachusetts MRC is divided into five regions, each of which is responsible for coordinating MRC activities in their respective area. The regions are based on the state's emergency preparedness and response regions, which were established to ensure that emergency response efforts are organized and coordinated across the state. The MRC regions in Massachusetts are defined as follows:

1. *Region 1 - Western Massachusetts:* This region includes Berkshire, Franklin, Hampshire, and Hampden counties. The MRC unit in this region is based in Springfield and works closely with local health departments, emergency management agencies, and healthcare providers to support emergency preparedness and response efforts.
2. *Region 2 - Central Massachusetts:* This region includes Worcester County. The MRC unit in this region is based in Worcester and collaborates with local health departments, emergency management agencies, and healthcare providers to enhance the region's emergency preparedness and response capabilities.
3. *Region 3 - Northeast Massachusetts:* This region includes Essex, Middlesex, and Suffolk counties. The MRC unit in this region is based in Boston and works closely with local health departments, emergency management agencies, and healthcare providers to support emergency preparedness and response activities in the region.
4. *Region 4 - Southeast Massachusetts:* This region includes Bristol, Norfolk, Plymouth, and Barnstable counties. The MRC unit in this region is based in Taunton and collaborates with local health departments, emergency management agencies, and healthcare providers to enhance the region's emergency preparedness and response capabilities.
5. *Region 5 - Metro Boston:* This region includes the City of Boston. The MRC unit in this region is based in Boston and works closely with local health departments, emergency management agencies, and healthcare providers to support emergency preparedness and response activities in the city.

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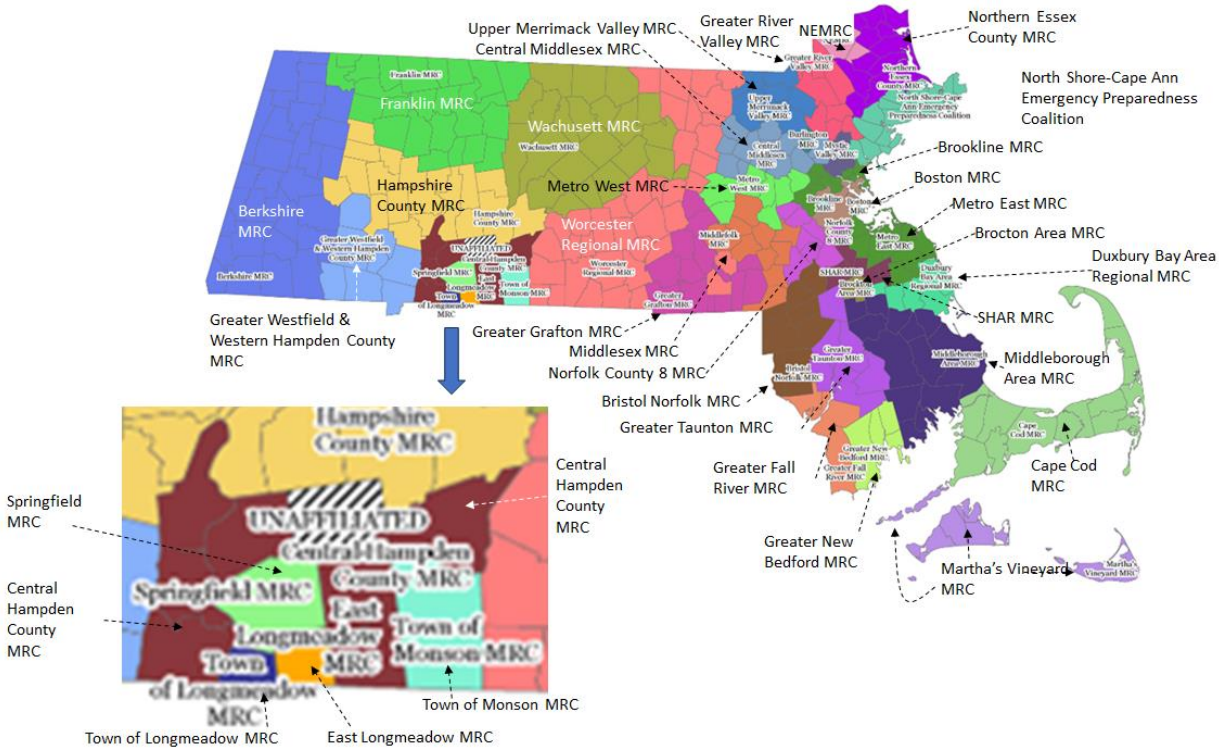

Figure 1.13. Massachusetts MRC Units. Source: Liisa Jackson, MRC Coordinator/Leader.

Overall, the MRC regions in Massachusetts play a critical role in coordinating and supporting emergency preparedness and response efforts across the Commonwealth. By working closely with local health departments, emergency management agencies, and healthcare providers, the MRC units in each region help to ensure that Massachusetts communities are prepared to respond to emergencies when they occur.

1.4.4. Partnerships

The MRC in Massachusetts works with a variety of response partners to enhance emergency preparedness and response capabilities across the state. These partners include:

- *Local Emergency Management Agencies (LEMA):* MRC units in Massachusetts partner with LEMAs to provide volunteer support during emergencies and disasters, including public health emergencies such as infectious disease outbreaks and mass casualty incidents. MRC volunteers can assist with a variety of tasks, such as staffing emergency shelters, providing medical care and triage, and supporting public health initiatives such as vaccination clinics.
- *Health and Medical Coordinating Coalition*[29] *(HMCC):* The HMCC is a coalition of healthcare organizations, public health agencies, and emergency management agencies that work together to coordinate healthcare and public health response during emergencies and disasters. The MRC partners with the HMCC to provide volunteer support, coordinate emergency response efforts, and enhance emergency preparedness and response capabilities across the healthcare system.
- *American Red Cross*[30]*:* The Red Cross is a humanitarian organization that provides emergency assistance, disaster relief, and education across the US, including in Massachusetts. The MRC partners with the Red Cross to provide volunteer support, coordinate emergency

[29] Online: https://www.mass.gov/info-details/learn-about-the-health-and-medical-coordinating-coalitions. Accessed 20 October 2023.
[30] Online: https://www.redcross.org/. Accessed 20 October 2023.

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response efforts, and enhance emergency preparedness and response capabilities across the state.

- *Community-based organizations:* MRC units in Massachusetts also partner with community-based organizations to support public health and emergency preparedness efforts. These organizations may include faith-based organizations, non-profit organizations, and other community groups that provide critical support during emergencies and disasters.

Overall, the MRC's response partners in Massachusetts play a critical role in enhancing emergency preparedness and response capabilities across the state. By working together, these partners can leverage their strengths and resources to provide more effective and efficient services to those in need.

Figure 1.14. Typical Partnering in an MRC-supported facility. Source: Liisa Jackson, MRC Coordinator/Leader.

1.4.4.1. A Coordinated Network

In Massachusetts, the individual MRC units are connected through a coordinated network that facilitates the sharing of training and resources. The Massachusetts MRC program operates under the Massachusetts Department of Public Health and employs several strategies to promote collaboration and resource sharing among MRC units. Here are some ways in which MRC units in Massachusetts connect and share training and resources:

- *State-Level Support:* The MDPH's Office of Preparedness and Emergency Management provides guidance, coordination, and support to all MRC units in the state. This includes disseminating

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information about training opportunities, best practices, and available resources to MRC leaders.

- *Regional MRC Coordinators:* Massachusetts is divided into several regions, and each region has a designated MRC coordinator. These coordinators serve as points of contact for MRC units within their respective regions and facilitate communication, collaboration, and resource sharing among the units.
- *Regular Meetings and Workshops:* The Massachusetts MRC program organizes regular meetings, workshops, and trainings that bring together MRC leaders and volunteers from across the state. These events provide a platform for networking, sharing experiences, and exchanging information on training programs and available resources.
- *Training Opportunities:* The Massachusetts MRC program, in collaboration with state and federal partners, offers various training opportunities to MRC units. These include trainings on emergency response, disaster preparedness, public health initiatives, incident command systems, and other relevant topics. Training resources are shared with MRC units to ensure consistent and standardized training across the state.
- *Resource Sharing Platform:* The Massachusetts MRC program may utilize online platforms or systems to facilitate resource sharing among MRC units. These platforms can include shared document repositories, communication tools, and databases that allow MRC leaders and volunteers to access and share training materials, templates, protocols, and other resources.
- *Mutual Aid Agreements:* MRC units in Massachusetts may participate in mutual aid agreements, which allow them to assist neighboring units during emergencies or large-scale events. These agreements formalize the process of requesting and providing assistance, ensuring that resources and personnel can be shared efficiently and effectively.

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By establishing these connections and mechanisms for sharing training and resources, the MRC units in Massachusetts have enhanced their collective capabilities, promoted standardization, and improved the overall readiness and response of the MRC network in the state.

1.4.4.2. Funding

The Massachusetts MRC is funded through a combination of Federal and Commonwealth sources. Specifically, the MRC program is funded by the Federal government through ASPR, which is part of HHS. The ASPR provides grants to state and local governments to support the development and operation of MRC units. In addition to Federal funding, each MRC unit in Massachusetts may also receive state funding from the MDPH. The MDPH provides funding to support MRC units' activities, such as training, emergency response, and community outreach.

Furthermore, MRC units in Massachusetts may receive funding from private sources, including grants from foundations, corporations, and individual donations. It is worth noting that the funding for the MRC in Massachusetts may vary from year to year depending on the availability of Federal and state funds and the MRC's priorities and needs. However, the core mission of the MRC to support emergency preparedness and response remains the same.

1.4.4.3. Training

The Massachusetts MRC was originally consisted of dedicated volunteers who were committed to providing medical assistance and support during times of crisis. These volunteers were doctors, nurses, Emergency Medical Technicians (EMTs), and other healthcare professionals who had undergone specialized training to prepare them for emergency situations.

At some point, our MRC volunteers gather for a training session. They are typically eager to learn new skills and techniques that would help them better serve their communities in times of need. The training often begins with a review of the MRC's emergency protocols and procedures. The volunteers then discuss the importance of communication, teamwork, and safety, emphasizing the need to work together to provide the best possible care to those in need.

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Next, the volunteers participate in a series of hands-on exercises designed to simulate emergency situations. They practice triaging patients, administering First Aid, and providing emotional support to those affected by disasters. The volunteers also receive training on specialized equipment, such as portable oxygen tanks and defibrillators. They learn how to use these devices to provide life-saving medical care in emergency situations.

As the training session continues, the volunteers grow more confident in their abilities and more committed to their mission. They know that their skills and expertise would be critical in helping their communities during times of crisis. Finally, the training session comes to an end, and the volunteers return home, ready to put their newfound knowledge and skills into action. They know that the next disaster could strike at any moment, but they are prepared and ready to respond.

Figure 1.15. Volunteer training, including hands-on drills. Source: Liisa Jackson, MRC Coordinator/Leader.

Over the years, the MRC volunteers continued to participate in regular training sessions, always working to improve their skills and stay up-to-date with the latest emergency protocols and procedures. Their commitment to their communities and their dedication to the MRC's mission had made them a vital resource in times of crisis, and they knew that their training was critical to their success, prepared to meet their community's needs as follows:

- *Disaster Response:* MRC volunteers should be trained in disaster response, including incident command, triage, and medical treatment in mass casualty settings. Examples of training courses in this area include FEMA's ICS and National Incident Management System (NIMS) courses, as well as the American Red Cross Disaster Health Services courses.
- *Public Health:* MRC volunteers should have a basic understanding of public health principles, including communicable disease control,

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epidemiology, and community health assessment. Examples of training courses in this area include the CDC Public Health Emergency Preparedness and Response (PHEPR) training courses and the MRC Public Health 101 course.

- *Emergency Medical Services:* MRC volunteers should be trained in emergency medical services, including basic life support (BLS) and advanced life support (ALS) techniques. Examples of training courses in this area include the American Heart Association's Basic Life Support (BLS) and Advanced Cardiac Life Support (ACLS) courses, as well as the National Association of Emergency Medical Technicians (NAEMT) Emergency Medical Responder (EMR) course.
- *Mental and Behavioral Health:* MRC volunteers should be trained in mental and behavioral health principles, including crisis intervention, psychological First Aid, and trauma-informed care. Examples of training courses in this area include the MRC Psychological First Aid course and the Substance Abuse and Mental Health Services Administration's (SAMHSA) Disaster Behavioral Health courses.
- *Cultural Competency:* MRC volunteers should be trained in cultural competency, including awareness of cultural differences and the ability to provide culturally appropriate care. Examples of training courses in this area include the MRC Cultural Competency course and the National Center for Cultural Competence's[31] online training courses.
- *Communication:* MRC volunteers should be trained in communication skills, including effective communication with patients, families, and other responders. Examples of training courses in this area include the MRC Effective Communication course and the FEMA Basic Communication Skills course.

These are just a subset of MRC training courses that fit into the core competencies. MRC units may also develop their own training courses or adapt existing courses to meet the specific needs of their communities.

[31] Online: https://nccc.georgetown.edu/. Accessed 2 July 2024.

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1.4.5. Extended Care and Wellness Support

1.4.5.1. Typical Activities

The MRC in Massachusetts supports an extended set of community healthcare and wellness priorities, including homelessness care, opiate programs, suicide prevention, soup kitchens, and other organizations that assist vulnerable populations in various ways. Several general examples demonstrating the extent of MRC support through 2021 include the following:

- *Volunteer Assistance:* MRC volunteers can lend their skills and expertise to organizations serving vulnerable populations. For example, healthcare professionals and mental health practitioners within the MRC can provide medical services, mental health counseling, or substance abuse support at clinics, shelters, or outreach programs. Volunteers can also offer non-medical assistance, such as administrative support or community outreach.
- *Health Screenings and Education:* MRC volunteers can conduct health screenings, provide health education, and distribute resources to individuals experiencing homelessness or those accessing soup kitchens. They can offer information on preventive measures, disease management, and available healthcare services. These activities help promote better health outcomes and empower individuals to make informed decisions regarding their well-being.
- *Outreach and Engagement:* MRC volunteers can actively engage with vulnerable populations through outreach efforts. They can participate in community events, collaborate with local organizations, and establish connections with individuals experiencing homelessness, substance use issues, or mental health challenges. This engagement helps build trust, identify needs, and connect individuals with appropriate resources and support services.
- *Training and Capacity Building:* The MRC can provide training and capacity building opportunities to organizations working with vulnerable populations. MRC volunteers can deliver training sessions on topics such as basic First Aid, mental health awareness, substance abuse prevention, or suicide prevention to staff and volunteers of these organizations. This training equips them with the necessary

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skills to address health-related concerns within their respective communities.

- *Collaborative Partnerships:* The MRC can forge partnerships and collaborate with organizations that serve vulnerable populations. By working together, they can leverage resources, share expertise, and collectively address the complex needs of these populations. The MRC contributes to emergency preparedness planning, response coordination, and support continuity of care during crises, such as natural disasters or disease outbreaks.

The specific ways in which the MRC supports extended healthcare and wellness organizations will vary depending on local needs, resources, and partnerships. The MRC units in Massachusetts have established collaborations with relevant community organizations. To get more detailed and current information about how the MRC supports vulnerable populations in Massachusetts, contact the Massachusetts MRC or local MRC units and relevant organizations directly. For example, see http://www.mrcvolunteer.org/.

1.4.5.2. Assistance to Refugees

Recent immigration challenges in the Commonwealth have necessarily expanded MRC offerings as follows:

- *Health Screenings and Assessments:* MRC volunteers, including healthcare professionals, conduct health screenings and assessments for refugees. These screenings and assessments involve checking vital signs, performing basic medical exams, and identifying any immediate health concerns or conditions that require further attention.
- *Language and Cultural Assistance:* MRC volunteers who are proficient in the languages spoken by refugee populations can provide interpretation services during medical encounters. They help bridge the language barrier and ensure effective communication between healthcare providers and refugees. Additionally, volunteers offer cultural sensitivity and awareness training to healthcare professionals,

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helping them understand and address the unique needs and beliefs of refugee communities.

- *Health Education and Outreach:* MRC units organize health education campaigns and outreach programs to promote health literacy and preventive care among refugee populations. These initiatives cover topics such as nutrition, hygiene, disease prevention, and access to healthcare services. Volunteers distribute educational materials in multiple languages and engage directly with refugees to answer questions and provide guidance.
- *Mental Health Support:* Many refugees have experienced traumatic events and may suffer from mental health issues such as post-traumatic stress disorder (PTSD) or depression. MRC volunteers with mental health training offer counseling, emotional support, and referrals to appropriate mental health services. They help connect refugees to resources in the community that specialize in trauma-informed care and support their overall well-being.
- *Emergency Preparedness:* MRC units play a crucial role in emergency preparedness and response. They work with local agencies and organizations to develop emergency plans that address the unique needs of refugee populations. Volunteers assist in setting up emergency shelters, providing medical care during crises, and coordinating with other healthcare providers and emergency management personnel.

Figure 1.16. Volunteer training, including drills with non-English-speaking multicultural shelter clients. Source: Liisa Jackson, MRC Coordinator/Leader.

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1.4.5.3. Hoarding

The MRC provides valuable support in addressing hoarding situations,[32] particularly in the context of public health and safety concerns. Several ways in which MRC units assist with hoarding situations include:

- *Collaborative Response:* MRC volunteers collaborate with local public health agencies, social services, and other relevant organizations to develop a coordinated response to hoarding cases. This collaboration involves participating in multidisciplinary teams that work together to assess and address the hoarding situation, ensuring a comprehensive and holistic approach.
- *Education and Awareness:* MRC volunteers participate in community outreach and education initiatives to raise awareness about hoarding disorder. They provide information on the health and safety risks associated with hoarding, as well as resources available for individuals and families affected by hoarding. By increasing public understanding, MRC volunteers help reduce stigma and encourage early intervention.
- *Health and Safety Assessments:* MRC units, comprising healthcare professionals and other trained volunteers, conduct health and safety assessments in hoarding situations. They evaluate the living conditions, sanitation, and potential hazards present in the environment. This assessment helps identify immediate risks to the individual's health and safety, as well as inform appropriate interventions.
- *Referrals and Assistance:* MRC volunteers connect individuals affected by hoarding to local resources and services. These referrals include mental health professionals, social workers, or hoarding task forces that specialize in addressing hoarding disorders. Volunteers provide support and guidance throughout the process, helping individuals access the appropriate help and services they need.

[32] Online: https://en.wikipedia.org/wiki/Hoarding_disorder. Accessed 27 March 2024.

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- *Emergency Preparedness:* In extreme cases, where hoarding poses significant health and safety risks, MRC units collaborate with local emergency management agencies to develop emergency plans. This collaboration involves identifying evacuation procedures, coordinating with First Responders,[33] and providing medical support during critical incidents associated with hoarding situations.

[33] Online: https://en.wikipedia.org/wiki/First_responder. Accessed 3 July 2024.

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Chapter 2

The MRC Operational Response

Abstract

This chapter describes the major stages of an MRC operation before, during, and after a response to a healthcare emergency. We describe and document both the tasks performed during each phase or step in our standard response process. We have also provided historical examples for emergencies for which we may have long-term awareness (e.g., pandemic), short-term awareness (violent storms, including tornadoes), and no awareness (e.g., gas explosions or terrorist attacks). In this way, we provide a description of MRC and its leadership activities for disasters following different levels of alert and warning.

2.1. Introduction

This section presents three types of historical scenarios, one with gradual advance warning (e.g., pandemic), the second with some early warning (e.g., tornado), and a third with no advance warning (e.g., gas explosions) to capture operational changes impacted by decreasing levels of pre-activation awareness. A description of these events is provided here, but the details of the sequential operations involved are presented in Subsections 2.3.1 through 2.3.6 as a way of illustrating each MRC action step.

2.1.1. Early Warning: The Response to Pandemic

2.1.1.1. Background

The COVID-19 pandemic is an ongoing global health crisis caused by the novel coronavirus SARS-CoV-2. It originated in late 2019 in Wuhan, China, and quickly spread to become a worldwide pandemic. COVID-19 is primarily transmitted through respiratory droplets when an infected person coughs, sneezes, talks, or breathes. In early 2020, the world experienced a pandemic

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caused by the novel coronavirus, COVID-19. The evolution of the pandemic has seen different phases and patterns in different regions. Initially, there were localized outbreaks in Wuhan and other parts of China. However, due to increased global travel, the virus quickly spread to other countries, leading to community transmission and subsequent waves of infections. As a result, the virus quickly spread across the globe, infecting millions of people, and overwhelming healthcare systems everywhere.

2.1.1.2. MRC Response

In the US, the MRC was activated to help respond to the crisis. When the COVID-19 pandemic emerged, MRC units across the country were immediately activated. In one city, a group of MRC volunteers helped set up a testing site for COVID-19. They worked alongside healthcare professionals to swab patients for the virus, collect samples, and ensure that everyone followed safety procedures. For weeks, they worked long hours, testing hundreds of people each day.

Figure 2.1. Our MRC Covid-19 hospital inoculations: (1) Pharmacy drawing vaccines; (2) Patients (healthcare staff having COVID-19 patient contact) registering; (3) First vaccine given; (4) Hospital Chief Medical Officer jabbed; (5-6) Other staff are inoculated; (7) Fifteen-minute observation before discharge. Images from *Covid-19 Vaccination Clinic* presentation, taken at the Beverly Hospital-Clinic by Liisa Jackson.

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In another location, MRC volunteers helped staff a hospital that was overwhelmed with COVID-19 patients. They assisted with tasks like taking vitals, delivering meals, and transporting patients around the hospital. They provided essential support to the overworked healthcare workers who were on the frontlines of the pandemic. At another site, MRC volunteers helped run a vaccination clinic. They helped people check in, fill out paperwork, and receive their shots. They answered questions and provided information about the vaccine to anyone who was hesitant or unsure.

Throughout the pandemic, MRC volunteers worked tirelessly to help their communities. They risked their own health to support others, and their efforts played a critical role in the fight against COVID-19. As the pandemic progressed, several key characteristics of those infected with COVID-19 became apparent:

- *Asymptomatic Cases:* Many individuals infected with SARS-CoV-2 experience mild or no symptoms. These individuals, known as asymptomatic cases, can still transmit the virus to others, making it challenging to control the spread of the disease. It is estimated that a significant proportion of COVID-19 infections are asymptomatic or mildly symptomatic.
- *Symptomatic Cases:* Symptomatic individuals infected with COVID-19 can experience a wide range of symptoms, which can vary in severity. Common symptoms include fever, cough, shortness of breath, fatigue, body aches, sore throat, loss of taste or smell, and respiratory symptoms. Severe cases may develop pneumonia and acute respiratory distress syndrome (ARDS), requiring hospitalization and intensive care.
- *High-Risk Groups:* Certain populations have been identified as being at higher risk for severe illness if infected with COVID-19. This includes older adults, individuals with underlying health conditions such as cardiovascular disease, diabetes, chronic respiratory disease, and compromised immune systems. Pregnant women and individuals with obesity are also considered at increased risk.

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- *Transmission Dynamics:* COVID-19 spreads primarily through close contact with an infected person, especially in enclosed spaces with poor ventilation. The virus can also be transmitted by touching contaminated surfaces and then touching the face. The *Delta* variant, a more transmissible variant of the virus, has become dominant in many countries, leading to increased transmission rates.
- *Vaccination:* Vaccines were developed and deployed globally to mitigate the impact of the pandemic. Vaccination efforts aim to reduce the severity of illness, hospitalizations, and deaths. Vaccines have shown effectiveness in preventing infection, reducing transmission, and providing protection against severe disease. However, vaccine availability, access, and vaccine hesitancy have influenced the vaccination rates and the course of the pandemic.

It is important to note that the COVID-19 pandemic is dynamic, and new information continues to emerge as scientists and health authorities study the virus. The characteristics of those infected and the evolution of the pandemic can vary over time and across different regions. Therefore, it is crucial to follow the guidance of local health authorities and stay informed about the latest developments to protect oneself and others.

By September 2021, the MRC response to COVID-19 has been multifaceted and highly dependent on local needs and resources. Specific information on the current response is continuously evolving, so it is necessary to regularly consult the latest information from local MRC units or public health agencies to receive the most up-to-date response. With that proviso, MRC units may have been historically involved in the COVID-19 response as follows:

- *Vaccination Support:* MRC volunteers have been instrumental in supporting vaccination efforts, including assisting with vaccination clinics, providing administrative support, helping with patient registration, and monitoring individuals post-vaccination. They have worked alongside healthcare professionals to ensure efficient and safe vaccine distribution.

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- *Testing and Screening:* MRC units have played a role in COVID-19 testing and screening initiatives. This can include setting up and operating testing sites, conducting tests, collecting samples, and providing logistical support. MRC volunteers may have been involved in contact tracing efforts as well, identifying and notifying individuals who have come into contact with confirmed cases.
- *Public Education and Outreach:* MRC volunteers have been involved in disseminating accurate information about COVID-19 prevention, vaccination, and other public health measures. They may have participated in community education campaigns, created informational materials, conducted virtual or in-person presentations, and answered questions from the public to address concerns and promote public health awareness.
- *Support for Healthcare Facilities:* MRC units may have provided support to healthcare facilities facing increased patient volumes during the pandemic. This support can include assisting with administrative tasks, helping with patient flow, providing non-medical aid to patients, and serving as a resource to healthcare staff.

Figure 2.2. COVID-19 Drive-in test facility.

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- *Emergency Response:* MRC units are also involved in emergency response efforts during the COVID-19 pandemic. This can include assisting in emergency operations centers, providing medical support during disasters or crises related to the pandemic, and coordinating resources and volunteers to address immediate needs.

The response efforts of MRC units vary based on local needs, available resources, and the nature of the pandemic in different regions. The specific activities and roles of MRC volunteers have evolved and adapted over time as the situation has changed. For the most accurate and up-to-date information on the current response of the MRC in your area, it is recommended that individuals contact their local MRC units or consulting official sources such as public health departments or emergency management agencies.

2.1.2. Minimal Warning: Weather-related Disasters

2.1.2.1. Overview

Violent storms encompass a range of severe weather conditions that can include thunderstorms, high winds, heavy rain, hail, and tornadoes. Tornadoes are particularly destructive and dangerous, characterized by rotating columns of air that can cause significant damage in a localized area. Massachusetts is not known for frequent occurrences of violent storms or tornadoes compared to some other regions of the US. In general, modern weather forecasting provides some probability-based alerting to their occurrence.

Severe weather events can happen in any location, and it is crucial to be prepared and understand the potential risks associated with such events. In the aftermath of a violent storm, the MRC can play a role in providing support and assistance to affected individuals and communities. Because each storm and its impacts are different, so the MRC provides an array of support protocols to those affected:

- *Medical Assistance:* MRC volunteers with medical training can provide immediate medical aid to injured individuals at the scene or in temporary medical facilities. They can assess and treat minor injuries, provide First Aid, and support emergency medical response teams.

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- *Public Health Support:* MRC units can assist with public health needs following a violent storm. This can involve addressing concerns related to water and food safety, assessing and mitigating public health risks, providing health education and resources, and supporting efforts to prevent the outbreak of waterborne or vector-borne[34] diseases.
- *Mental Health Support:* The aftermath of a violent storm can be emotionally distressing for individuals and communities. MRC volunteers with mental health training can offer psychological First Aid, crisis counseling, and referrals to appropriate mental health services. They can help survivors cope with trauma, grief, and stress-related issues.
- *Community Outreach:* MRC units can engage in community outreach to provide information, resources, and support to those affected by the storm. This can include setting up information centers, distributing educational materials on disaster preparedness and recovery, and connecting individuals to available services and resources.
- *Collaborative Efforts:* MRC volunteers can collaborate with local emergency management agencies, First Responders, healthcare facilities, and community organizations to coordinate response efforts. They can assist in setting up and operating emergency shelters, supporting evacuation and relocation efforts, and ensuring the continuity of healthcare services for affected individuals.

The specific response activities of the MRC following a violent storm, including tornadoes, may vary depending on the scale and impact of the event, as well as the needs of the affected community. The MRC works in coordination with local emergency management agencies and other response organizations to provide the most effective support to those affected by the storm.

[34] Online: https://www.cdc.gov/vector-borne-diseases/index.html. Accessed 9 June 2024.

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In the event of a tornado or other natural disaster in Massachusetts, the MRC would likely be called upon to provide support to the community. MRC volunteers are trained to respond to emergencies and disasters, and they have the skills and expertise needed to provide medical assistance, mental health support, and other critical services. During a tornado response, MRC volunteers work alongside First Responders and emergency management officials to provide medical care to those who have been injured. They may set up temporary medical clinics in shelters or community centers, offering everything from wound care and medication management to emotional support and counseling.

In addition to providing direct medical care, MRC volunteers may also assist with logistics, communication, and other critical functions. They may help to coordinate transportation for those who have been displaced, set up communication systems to keep families and loved ones informed, and work with local officials to ensure that the response effort is as organized and effective as possible.

Overall, the MRC plays an important role in responding to natural disasters and other emergencies in Massachusetts and across the country. Their dedication, skill, and expertise make a real difference in the lives of those who are impacted by these events, and they are an essential part of the emergency response system.

2.1.2.2. In Massachusetts

The "Big E," also known as the Eastern States Exposition,[35] is a large fairground located in West Springfield, Massachusetts. In June 2011, a powerful tornado tore through the region, causing widespread damage and destruction. The Big E, which was hosting a horse show at the time, quickly became a hub for tornado relief efforts.

As the tornado approached, staff at the Big E quickly mobilized to evacuate people from the fairgrounds and move them to safety. Many people took shelter in the Better Living Center,[36] a large building on the fairgrounds

[35] Online: https://www.easternstatesexposition.com/. Accessed 21 October 2023.

[36] Online: https://www.easternstatesexposition.com/p/rent-our-facilities/buildings/309. Accessed 21 October 2023.

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that was being used as an emergency shelter. The building quickly filled up, with people seeking refuge from the storm and its aftermath. Among the people seeking shelter at the Big E were a group of volunteers from the MRC. The MRC volunteers quickly set up a medical triage area in one corner of the Better Living Center, equipped with First Aid supplies, medical equipment, and a radio to communicate with emergency responders.

As the tornado passed, the MRC volunteers moved to provide medical care to those who had been injured in the storm. They treated a range of injuries, from minor cuts and bruises to more serious injuries requiring advanced medical care. They also provided emotional support to those who had lost their homes or were otherwise affected by the tornado.

Over the coming days and weeks, the Big E continued to serve as a hub for tornado relief efforts. The fairgrounds provided space for emergency responders to set up command centers, and volunteers from all over the region came to help with the recovery effort. Through it all, the MRC volunteers remained on hand, providing medical care and support to those in need.

The tornado had been a devastating event for the region, but the response of the Big E and its volunteers showed the power of community and the importance of being prepared for emergencies. The MRC and other volunteers who responded to the tornado demonstrated the value of having trained professionals and dedicated volunteers ready to help in times of crisis.

Other weather events that offer limited warning include:

- *The Blizzard of 1978*[37]*:* In February 1978, Massachusetts experienced a historic blizzard that resulted in heavy snowfall, hurricane-force winds, and coastal flooding. The storm caused widespread power outages, transportation disruptions, and significant property damage. It resulted in tragic loss of life and had a lasting impact on emergency preparedness and response in the state.

[37] Online: https://en.wikipedia.org/wiki/Northeastern_United_States_blizzard_of_1978. Accessed 27 March 2024.

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- *Cape Cod Tornado of 2019*[38]*:* On July 23, 2019, multiple tornadoes touched down in Cape Cod, Massachusetts. This was a relatively rare event for the region. The tornadoes caused property damage, uprooted trees, and disrupted power supply. Several injuries were reported, but fortunately, there were no fatalities.

With modern weather forecasting capabilities, which are continuously monitored by MRC leadership, early warning supports prepositioning of assets and alerting potential volunteers in the likely affected areas. During extreme heat or extreme cold, power outages pose significant risks to individuals. Here is what could happen in such scenarios:

- Extreme Heat
  - *Loss of air conditioning*: Power outages during extreme heat can result in the loss of air conditioning systems, leading to uncomfortable and potentially dangerous indoor temperatures.
  - *Health risks*: Prolonged exposure to extreme heat without access to cooling systems can increase the risk of heat-related illnesses, such as heat exhaustion or heatstroke.
  - *Impact on vulnerable populations*: Elderly individuals, young children, and people with pre-existing health conditions are particularly susceptible to heat-related illnesses. Power outages may exacerbate these risks, especially if they rely on medical equipment that requires electricity.
- Extreme Cold
  - *Loss of heating systems*: Power outages during extreme cold can cause heating systems, such as furnaces or electric heaters, to stop working, leading to a drop in indoor temperatures.
  - *Hypothermia risks*: Exposure to extremely cold temperatures without proper heating can result in hypothermia, a potentially life-threatening condition.
  - *Burst pipes*: In freezing temperatures, lack of heating can cause water pipes to freeze and potentially burst, leading to water damage.

[38] Online: https://eu.capecodtimes.com/story/news/2021/09/02/cape-cod-tornado-2021-dennis-hurricane-ida-severe-weather/5695322001/. Accessed 27 March 2024.

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Figure 2.3. Weston sheltering drill: (1) Weston Community Center, drill site; (2) Chief briefing shelter staff at 9 AM; (3) Health Director briefing shelter staff; (4) Shelter Trailer Arrives at 9 AM; (5) Shelter trailer mobilization at 9:10 AM; (6) Teamwork; (7) Registration briefing by Shelter Manager, 9:45 AM; (8-9) Drill starts at 10 AM; (10) Pet registration; (11) Medical and Behavioral Health Station; (12) Dormitory Station; (13) Food services; (14) Medical triage; (15) Psychological First Aid; (16) Registration medical triage; (17) Stolen phone scenario; (18) 11:00 AM Trailer Demobilization; (19) 12 PM drill “hot wash.”

2.1.3. No Warning: Unexpected Manmade Disasters

Although weather events can offer some level of warning, there have been some unforeseen disasters that have impacted the state in the past. These unforeseen disasters refer to events that are caused by human activities and can have significant impacts on the environment, infrastructure, and public safety; usually, they are unexpected. Two notable examples, long before the MRC existed, include:

- *Boston Molasses Disaster (1919)*[39]*:* In Boston's North End, a large molasses storage tank burst, releasing millions of gallons of molasses that flooded the streets at high speeds. This disaster resulted in 21 deaths and numerous injuries, as well as significant property damage.
- *Cocoanut Grove Fire (1942)*[40]*:* The Cocoanut Grove nightclub in Boston caught fire, leading to one of the deadliest nightclub fires in U.S. history. The fire claimed the lives of 492 people and resulted in the implementation of stricter fire safety codes and regulations.

Like any other part of the country, Massachusetts has faced manmade disasters throughout its history. The types of such manmade disasters can be categorized as:

- *Industrial Accidents:* Massachusetts has a history of industrial activities, and accidents in industries such as manufacturing, chemical plants, and power generation can lead to fires, explosions, toxic releases, and environmental contamination.
- *Transportation Accidents:* Given its dense population and extensive transportation infrastructure, Massachusetts is susceptible to transportation-related disasters, including train derailments, highway accidents, and aviation incidents.
- *Infrastructure Failure:* Aging infrastructure systems, such as bridges, dams, and pipelines, can pose risks if not adequately maintained or

[39] Online: https://en.wikipedia.org/wiki/Great_Molasses_Flood. Accessed 27 March 2024.
[40] Online: https://en.wikipedia.org/wiki/Cocoanut_Grove_fire. Accessed 27 March 2024.

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upgraded. Failure of critical infrastructure elements can result in significant damage and endanger lives.

- *Terrorism:* As a major economic and cultural hub, Massachusetts faces the risk of terrorism. Potential targets can include public spaces, transportation systems, critical infrastructure, and large gatherings. In the infamous Boston Marathon Bombing[41] (2013), two bombs were detonated near the finish line of the Boston Marathon, killing three people and injuring hundreds. This act of terrorism had a significant impact on public safety, leading to a manhunt and subsequent death and capture of the perpetrators.

An infrastructure disaster experienced in Massachusetts was the Merrimack Valley gas explosions[42]: In September 2018, a series of natural gas explosions occurred in the Merrimack Valley region of Massachusetts, particularly in the towns of Lawrence, Andover, and North Andover. The incident resulted in one fatality, numerous injuries, widespread property damage, and the evacuation of thousands of residents. The explosions and resulting fires were caused by over-pressurized gas lines operated by a utility company.

The incident led to the evacuation of thousands of residents, multiple injuries, and the destruction of homes and infrastructure. The explosions that left one person dead, dozens injured, and thousands of residents without heat or hot water. In the aftermath of the disaster, the MRC was activated to help respond to the crisis. When the gas explosions occurred, MRC units across the state were activated.

In the City of Lawrence,[43] one of the communities that was most severely affected by the explosions, MRC volunteers worked alongside First Responders to provide medical assistance to those who were injured. They helped triage patients, provided First Aid, and transported people to hospitals as needed. In addition to providing medical support, MRC volunteers also helped to coordinate the overall response effort. They worked with local

[41] Online: https://en.wikipedia.org/wiki/Boston_Marathon_bombing. Accessed 27 March 2024.

[42] Online: https://en.wikipedia.org/wiki/Merrimack_Valley_gas_explosions. Accessed 27 March 2024.

[43] Online: https://en.wikipedia.org/wiki/Lawrence,_Massachusetts. Accessed 27 March 2024.

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officials to set up emergency shelters and distribute supplies like food, water, and blankets to residents who had been displaced from their homes.

In the following days, MRC volunteers continued to provide support to the affected communities. They worked to ensure that everyone who needed medical attention received it, and they helped to coordinate care for those who required ongoing treatment. In the months that followed the explosion, MRC volunteers remained involved in the recovery effort. They helped to coordinate mental health services for those who had been traumatized by the disaster, and they worked to raise awareness about the ongoing impact of the explosions on the affected communities.

The response to the Merrimack Valley gas explosion was a challenging and complex undertaking, but the dedication and selflessness of the MRC volunteers helped to ensure that those affected received the care and support they needed. Their efforts played a critical role in the recovery effort, and their example serves as a reminder of the importance of community and compassion in times of crisis.

2.1.3.1. Disasters Outside Massachusetts

There have been numerous historical scenarios in the US where volunteers, including those from organizations like the Massachusetts MRC, played a crucial role in supporting the needs of those affected by natural or man-made disasters. Some well-known examples spanning those with significant warning, some warning, and no warning include the following:

- Disease Outbreaks: Disease outbreaks, such as the H1N1 influenza pandemic in 2009[44] and the COVID-19 pandemic starting in 2020, have required extensive volunteer support. MRC members and other volunteers have played critical roles in public health outreach, vaccination campaigns, contact tracing, testing, and supporting healthcare facilities overwhelmed by patient surges.
- Hurricane Katrina (2005)[45]: Hurricane Katrina, one of the most devastating hurricanes in U.S. history, caused widespread destruction along the Gulf Coast, particularly in Louisiana and Mississippi. Volunteers, including MRC members, provided medical aid,

[44] Online: https://en.wikipedia.org/wiki/2009_swine_flu_pandemic. Accessed 27 March 2024.
[45] Online: https://en.wikipedia.org/wiki/Hurricane_Katrina. Accessed 27 March 2024.

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conducted search and rescue operations, distributed supplies, and supported evacuation and sheltering efforts.

- Superstorm Sandy (2012)[46]: Superstorm Sandy caused significant damage along the East Coast, particularly in New York and New Jersey. Volunteers, including MRC members, assisted with medical care, distributed emergency supplies, conducted wellness checks,[47] and supported recovery operations in affected communities.
- California Wildfires[48]: California has experienced numerous devastating wildfires over the years. Volunteers, including MRC members, have provided support by assisting with evacuations, operating medical shelters, providing medical care to firefighters and affected individuals, and offering mental health support to those impacted by the fires.
- Tornado Outbreaks[49]: Tornado outbreaks in various parts of the US have resulted in significant damage and the need for volunteer support. In response, volunteers, including MRC members, have offered medical assistance, conducted damage assessments, and provided support in debris removal and recovery efforts.
- September 11 Attacks (2001)[50]: Following the terrorist attacks on September 11, 2001, volunteers, including medical professionals and MRC members, provided medical assistance, emotional support, and logistical support to emergency responders and affected individuals. They played a crucial role in the immediate response and ongoing recovery efforts.

These are but a few examples, but there are numerous other instances where volunteers have supported their communities as well as distant areas during times of crisis. The MRC and other volunteer organizations play a vital role in preparedness, response, and recovery efforts in the face of natural and man-made disasters throughout the US and worldwide.

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[46] Online: https://en.wikipedia.org/wiki/Hurricane_Sandy. Accessed 27 March 2024.
[47] Online: https://en.wikipedia.org/wiki/Wellness_check. Accessed 18 March 2024.
[48] Online: https://en.wikipedia.org/wiki/List_of_California_wildfires. Accessed 27 March 2024.
[49] Online: https://en.wikipedia.org/wiki/Tornado_outbreak. Accessed 27 March 2024.
[50] Online: https://en.wikipedia.org/wiki/September_11_attacks. Accessed 27 March 2024.

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2.2. MRC Operational Phases

2.2.1. MRC Operational Procedures

This subsection describes the sequential response phases or operational steps used by the Massachusetts and other MRC leaders to prepare, respond, and recover from a deployment. We must first describe the day-to-day period, which we call "Preparedness and Situational Awareness – Before the Call." The deployment of MRC volunteers in Massachusetts is coordinated by MDPH in collaboration with local health departments and other partner organizations. Beyond day-to-day preparedness and awareness, the Massachusetts MRC deployment protocol includes the following phases described below:

1. *Preparedness:* Performing all the tasks to ensure our leadership and volunteers are aware of potential disasters to the extent possible and have the training and coordination to respond when there is little or no warning.
2. *Activation:* The MDPH will activate the MRC in response to an emergency or disaster. Activation may occur at the local, regional, or statewide level, depending on the nature and scope of the emergency.
3. *Notification:* MRC volunteers will be notified of the activation through various channels, including email, phone, and text message. The notification will include information about the nature of the emergency, the location of the deployment site, and the time and date of the deployment.
4. *Volunteer Response:* MRC volunteers who are available and willing to respond will be asked to confirm their availability and provide information about their skills and experience. Volunteers who are selected for deployment will receive further instructions about the deployment site and their role in the response.
5. *Deployment:* MRC volunteers will be deployed to the designated site, where they will work under the direction of the incident commander and in coordination with other response agencies and organizations. The specific duties of MRC volunteers will depend on the nature of the emergency and the needs of the response.
6. *Debriefing:* After the deployment, MRC volunteers will participate in a debriefing session to discuss their experiences and provide feedback

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on the response. This information will be used to improve future response efforts and to enhance the training and preparedness of MRC volunteers.

7. *Improvement:* Use the recommendations derived from deployment debriefing to make improvements to all aspects of MRC operations identified as necessary.

Overall, the Massachusetts MRC deployment protocol is designed to ensure that volunteers are activated and deployed in a coordinated and efficient manner, and that they are provided with the necessary support and resources to effectively respond to emergencies and disasters. After "Debriefing," the leadership returns to the posture described by "Necessary and Suggested Improvements." Subsections 2.2.2 through 2.2.8 will provide details of the pre-activation preparedness-and-awareness phase and from Preparedness through Debriefing. Each of the phases, or steps, taken by the MRC before, during and after a deployment are described below.

2.2.2. Preparedness

Most of the calendar is not filled with MRC deployments, but it is packed with opportunities to improve MRC preparedness, providing readiness for the full range of early warning, little warning, no no-warning medical disasters and both short- and long-term community needs.

2.2.2.1. Knowing the Available Tools and Resources

In Massachusetts, there are various organizational resources and tools available to predict and prepare for natural, man-made, and public health disasters. Here are some key resources and tools:

- *MEMA:* MEMA is the state agency responsible for coordinating emergency management efforts in Massachusetts. They provide information, resources, and tools to predict, respond to, and recover from disasters. MEMA's website offers real-time updates, preparedness guides, and emergency management plans. MEMA collaborates with local, state, and federal agencies to monitor and respond to emergencies, including natural disasters, severe weather

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events, and public health emergencies. Their website serves as a hub for information, alerts, and resources related to disaster preparedness and response in Massachusetts.

- *National Weather Service (NWS):* The NWS[51] provides weather forecasts, warnings, and alerts for severe weather events such as hurricanes, storms, and floods. They have local offices throughout Massachusetts that issue severe weather warnings, including those for hurricanes, storms, floods, and extreme temperatures. The NWS utilizes various tools and technologies to monitor weather conditions and disseminates information through their website, weather radio, mobile apps, and social media channels.
- *Massachusetts Department of Public Health (MDPH):* The MDPH is responsible for safeguarding public health in Massachusetts. It monitors public health trends and provides information on potential health hazards and outbreaks. They offer tools and resources related to disease surveillance, emergency preparedness, and response planning. During emergencies, they monitor and respond to public health risks, including disease outbreaks, heatwaves, and cold snaps. The MDPH provides guidance, resources, and educational materials on emergency preparedness and response, including information on staying safe during extreme weather conditions.
- *Hazard Mitigation and Climate Adaptation Clearinghouse:* This online resource, managed by the Massachusetts Executive Office of Energy and Environmental Affairs, provides information on climate change impacts and strategies for mitigation and adaptation. It offers tools and resources to assess risks, develop resilience plans, and implement strategies to minimize the impact of disasters. The clearinghouse provides access to data, reports, case studies, and best practices related to disaster preparedness and climate resilience.
- *The Massachusetts All-Hazards Planning Framework:* This planning framework, developed by MEMA, provides guidance on comprehensive emergency management planning. It includes tools and resources for hazard identification, risk assessment, emergency response planning, and community preparedness.

[51] Online: https://www.weather.gov/. Accessed 8 January 2024.

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- *ICS:* ICS is a standardized management system used for the command, control, and coordination of emergency response efforts. It provides a structure and set of processes to manage disasters effectively. Training programs and resources are available to familiarize emergency management personnel with ICS principles and practices.
- *Hazardous Materials Emergency Response Plan:* Massachusetts requires facilities handling hazardous materials to develop and maintain emergency response plans. These plans outline procedures for responding to chemical spills, releases, and other hazardous material incidents. The plans are reviewed and approved by the Massachusetts Department of Fire Services.
- *Email power outage maps:* Some utility companies offer online services that allow customers to sign up for email alerts and access power outage maps. These maps provide real-time information on the areas affected by power outages, estimated restoration times, and updates on the progress of restoration efforts. Customers can subscribe to these services and receive notifications via email or text message, helping them stay informed about power outages in their area.

The availability and utilization of these tools may vary depending on the specific circumstances and agencies involved. Staying informed through official government websites, local emergency management agencies, and public health departments is crucial for accessing the most up-to-date information and resources for disaster prediction and preparedness in Massachusetts and nationwide.

2.2.2.2. Sustaining MRC Readiness

Preparing the MRC to respond to emergencies and disasters requires a coordinated effort between MRC leadership, volunteers, and partner organizations. For this reason, the MRC engages in various activities to prepare for emergency activations and enhance situational awareness. It naturally includes the steps performed following the last MRC deployment, creating a cyclic improvement of the MRC response based on feedback. Here are some common interrelated steps taken by MRC units to ensure readiness:

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- *Recruitment and Training:* One of the most important steps in preparing the MRC for a response is to recruit and train volunteers. In this regard, MRC units actively recruit and train volunteers with a range of medical and non-medical backgrounds, including healthcare professionals, public health workers, mental health professionals, and community members. Volunteers undergo training on emergency preparedness, disaster response protocols, incident management, and specific skills relevant to public health emergencies. MRC units identify volunteers with the necessary skills and expertise to respond to emergencies, and provide ongoing training to ensure that they are prepared to handle a variety of situations, both expected and unexpected.
- *Establish partnerships with other organizations:* MRC units should work to establish partnerships with other organizations that may be involved in emergency response, such as hospitals, public health agencies, and community organizations. These partnerships can help to facilitate communication and coordination during emergencies.
- *Develop Response Plans:* MRC units work with local emergency management agencies and other partner organizations to develop response plans that outline the roles and responsibilities of MRC volunteers during emergencies. Response plans also identify the resources that will be needed to support MRC operations, such as equipment, supplies, facilities, and transportation.
- *Participate in Drills and Exercises:* MRC units conduct staged emergency response activations in collaboration with local public health agencies and emergency management organizations. These drills and exercises both test and verify the roles and responsibilities of MRC volunteers during different types of emergencies. Regular exercises and drills are conducted to test and refine these plans, ensuring that volunteers are familiar with their roles and can effectively respond in a crisis.
- *Maintain Resource Inventory:* MRC units maintain an inventory of equipment, supplies, and medical resources that may be needed during an emergency. This can include medical equipment, personal

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protective equipment[52] (PPE), pharmaceuticals, and other essential supplies. Regular checks and restocking activities are carried out to ensure the availability and functionality of these resources.

- *Collaboration and Networking:* MRC units actively collaborate with other response organizations, community partners, and local stakeholders. This includes establishing relationships with hospitals, healthcare facilities, emergency management agencies, and community-based organizations. These partnerships help facilitate effective coordination, resource sharing, and information exchange during emergencies.
- *Situational Awareness:* MRC units monitor and maintain situational awareness by staying informed about emerging threats, public health incidents, and potential emergencies. They receive regular updates from local public health agencies, emergency management organizations, and national authorities. This allows MRC volunteers to quickly respond and adapt to changing circumstances during an activation.
- *Communication and Reporting:* MRC units establish communication channels to effectively communicate with volunteers, partner organizations, and the public during emergencies. They disseminate critical information, instructions, and updates to ensure a coordinated response. MRC units also collect and report data on the activities, resources utilized, and outcomes of their deployments to contribute to situational awareness and continuous improvement.

By engaging in these preparedness activities, the MRC will have trained and ready volunteers, well-defined response plans, necessary resources, strong partnerships, and up-to-date situational awareness. This enables us to effectively respond to emergencies, support public health initiatives, and aid communities in times of need. MRC units should maintain readiness by regularly reviewing and updating their response plans, conducting ongoing training and education for volunteers, and ensuring that equipment and supplies are properly maintained and stocked.

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52 Online: https://en.wikipedia.org/wiki/Personal_protective_equipment. Accessed 27 December 2023.

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By taking these steps, MRC units can be better prepared to respond to emergencies and disasters, and can help to improve the health and safety of their communities. MRC volunteers receive training in a variety of areas, such as emergency preparedness, disaster response, and public health initiatives. These training sessions are designed to prepare volunteers to respond effectively to public health emergencies and disasters, as well as to support ongoing public health initiatives in their communities.

As an individual MRC volunteer prepares for their possible expected or unexpected deployment and maintains readiness in the following ways:

- *Attend all required training:* Depending on the nature of the deployment, you may be required to attend specific training sessions to prepare for your role. This attendance could include courses on disaster response, public health emergency management, or other relevant topics.
- *Review your deployment responsibilities:* Make sure you understand your role and responsibilities during the deployment. This could include tasks such as providing medical care, administering vaccines, assisting with logistics, or other duties.
- *Ensure your personal readiness:* Make sure you are physically and mentally prepared for the deployment. This could include getting any necessary vaccinations or medical clearances, ensuring you have the appropriate PPE, and taking care of any personal matters before you deploy.
- *Check your equipment and supplies:* Make sure you have all the necessary equipment and supplies for your deployment. This could include medical equipment, medications, communication devices, and other essential items.
- *Stay informed:* Stay up-to-date on any developments related to the deployment, including changes in the situation on the ground, new information about the health risks you may encounter, or any changes to your deployment responsibilities.

By taking these steps, an MRC volunteer can help ensure that they are prepared and ready to make a valuable contribution to your community during deployment as an MRC volunteer.

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2.2.3. Detailed Elements of MRC Preparedness Activities

In this subsection, we perform a more detailed review of critical MRC tasks to remain optimally prepared for their next activation.

2.2.3.1. Recruit and Train Volunteers

The MRC in Massachusetts recruits and trains volunteers to support disaster response efforts and public health initiatives. Here is an overview of how the MRC finds and recruits volunteers to support their communities, their state, the nation and beyond:

2.2.3.1.1. Outreach and Promotion

The Massachusetts MRC engages in outreach activities to raise awareness about the program and recruit volunteers. This includes participating in community events, health fairs, and using various communication channels to reach potential volunteers.

- *Volunteer Registration:* Interested individuals can register to become MRC volunteers through an online registration system or by contacting the local MRC unit. The registration process typically involves providing personal information, professional background, and areas of interest/expertise. Potential volunteers undergo a credentialing process that verifies their qualifications, licenses, and certifications to ensure they can contribute effectively during emergencies.
- *Orientation and Training:* Once registered, MRC volunteers undergo an orientation session to familiarize themselves with the mission, goals, and operations of the MRC. They receive basic training on emergency preparedness, disaster response, and public health topics.
- *Core Competency Training:* MRC volunteers receive training specific to their roles and responsibilities. This training may include training on incident command systems, medical surge capacity, emergency shelter operations, psychological First Aid, disaster mental health, and other relevant topics.

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2.2.3.1.2. Establish Core Competencies

MRC core-competency training encompasses several domains that help prepare MRC volunteers for their roles in disaster response and public health emergencies. While the specific capabilities may vary slightly between MRC units, the most common training topics covered in the MRC core competencies are as follows:

- *Incident Management:* Training in incident command systems and the NIMS helps volunteers understand the structure, roles, and communication protocols used in emergency response operations.
- *EOC Functions:* This training covers the functions and operations of EOCs, which serve as command centers during emergencies. Volunteers learn about EOC roles, information management, and coordination with other agencies and organizations.
- *Disaster Medical Operations:* Training in disaster medical operations focuses on providing medical care in austere or resource-constrained settings. Volunteers learn about triage, basic First Aid, patient assessment, and mass casualty management.
- *Public Health Principles:* Volunteers receive training on public health principles and practices, including topics such as disease surveillance, outbreak investigation, infection control, and community health assessments.
- *Emergency Shelter Operations:* This training prepares volunteers to support emergency shelter operations, including shelter setup, registration processes, logistics, and addressing the needs of shelter residents.
- *Psychological First Aid:* Training in psychological First Aid equips volunteers with the skills to provide emotional and psychological support to individuals affected by emergencies or traumatic events.
- *Volunteer Management:* Training in volunteer management covers recruitment, screening, orientation, deployment procedures, and the coordination of MRC volunteers during response activities.
- *Communication and Information Management:* Volunteers receive training in effective communication strategies, use of communication

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equipment, information sharing protocols, and media relations during emergencies.

- *Cultural Competency:* Training in cultural competency helps volunteers understand and respect diverse cultural, ethnic, and language backgrounds to better serve the community during response efforts.
- *Legal and Ethical Considerations:* Volunteers learn about legal and ethical frameworks relevant to emergency response, including patient privacy, confidentiality, liability, and informed consent.
- *Personal Preparedness:* MRC volunteers are encouraged to undergo personal preparedness training to ensure they are ready to respond when called upon. This includes training on personal emergency kits, family preparedness plans, and individual resilience strategies.
- *Pre-deployment Training:* MRC units regularly conduct training sessions and educational programs to prepare volunteers for potential deployments. These training sessions cover essential topics related to disaster response, public health emergencies, incident command systems, and specific roles and responsibilities within the MRC. By providing comprehensive training beforehand, MRC volunteers are better equipped to respond effectively during deployments.
- *Alert and Activation System Training:* When a disaster or public health emergency occurs, MRC units utilize alert and activation systems to quickly notify and mobilize volunteers. The system may involve phone calls, text messages, email notifications, or a dedicated online platform. Volunteers are informed about the nature of the deployment, their roles, and any additional information or training requirements.

2.2.3.1.3. Perform Just-in-Time Training[53]

The MRC provides Just-in-Time (JIT) training to its volunteers in the event of a deployment for a disaster or pandemic. In the event of a deployment, MRC units provide JIT training to ensure that volunteers have the necessary knowledge and skills specific to the particular deployment scenario they will face. These trainings are focused, concise, and tailored to the immediate needs

[53] Online: https://en.wikipedia.org/wiki/Just-in-time_learning. Accessed 27 March 2024.

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of the deployment. Examples of JIT trainings might include updates on the specific incident, refresher courses on protocols and procedures, training on new equipment or technology, and guidance on emerging public health concerns. Some examples include:

- *Online Resources and Materials:* MRC units often maintain online platforms or resource libraries where volunteers can access training materials, guidelines, and reference documents. These resources can be updated in real-time to provide volunteers with the most current information related to the deployment.
- *On-Site Training and Briefings:* During deployments, MRC units may conduct on-site training and briefings to ensure that volunteers are well-informed about the local situation, incident objectives, safety protocols, and specific tasks they are expected to perform. These briefings provide essential context and reinforce key information before volunteers begin their response activities.
- *Ongoing Support and Communication:* Throughout the deployment, MRC units maintain regular communication with volunteers, providing updates, addressing questions or concerns, and offering additional training or resources as needed. This ongoing support helps volunteers adapt to evolving circumstances and ensures they have the necessary knowledge and skills to fulfill their roles effectively.

2.2.3.1.4. Provide Psychological First Aid Training

Psychological First Aid (PFA)[54] is a key component of the MRC's response efforts, as it helps to address the emotional and psychological needs of individuals affected by a disaster or emergency. PFA is an evidence-based approach to helping individuals cope with the immediate aftermath of a traumatic event. It is designed to reduce distress, promote adaptive functioning, and facilitate coping and resilience. PFA is typically provided by trained mental health professionals, but MRC volunteers can also receive training in PFA to provide support to their communities during a public health emergency. The MRC provides PFA training to its volunteers, which includes the following key principles:

[54] Online: https://www.who.int/publications/i/item/psychological-first-aid. Accessed 27 March 2024.

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- *Contact and Engagement:* Establishing a connection with the affected individual and creating a safe and supportive environment.
- *Safety and Comfort:* Ensuring that the individual's basic needs are met, such as food, water, and shelter.
- *Stabilization:* Helping the individual to manage their emotions and cope with the immediate aftermath of the traumatic event.
- *Information Gathering:* Collecting information about the individual's needs and concerns, and providing information about available resources.
- *Practical Assistance:* Providing practical assistance, such as helping the individual to access medical care or find temporary housing.
- *Connection with Social Supports:* Helping the individual to connect with social supports, such as family, friends, or community resources.
- *Information on Coping:* Providing information on coping strategies and resources for ongoing support.

By providing PFA, MRC volunteers can help to reduce the emotional and psychological impact of a traumatic event on individuals and communities. This assistance can help to promote resilience and facilitate recovery in the aftermath of a public health emergency. By implementing these strategies, the MRC provides timely and relevant training to volunteers, enabling them to respond efficiently and contribute effectively during deployments for disasters or pandemics.

2.2.3.2. Establish Partnerships with Other Organizations

The MRC establishes partnerships with various organizations, including HMCC partners, to enhance emergency response capabilities and coordination. Here is an overview of how the MRC establishes partnerships:

- *Identify Relevant Partners:* The MRC identifies organizations and agencies that are essential for effective emergency response and align with its mission. These partners can include local health departments, hospitals, emergency management agencies, community

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organizations, healthcare providers, faith-based organizations, and others involved in public health and emergency preparedness.

- *Outreach and Networking:* The MRC engages in outreach activities to connect with potential partners. This outreach can involve attending community meetings, participating in local emergency planning committees, joining coalitions or task forces related to emergency preparedness, and establishing relationships with key stakeholders in the community.
- *Collaboration and Memoranda of Understanding:* The MRC initiates discussions with potential partners to explore collaboration opportunities. These discussions may involve sharing information about the MRC's mission, capabilities, and volunteer resources. To formalize the partnership, the MRC may develop Memoranda of Understanding or Agreements (MOUs/MOAs) that outline the roles, responsibilities, and expectations of each partner.
- *Joint Planning and Training:* Once a partnership is established, the MRC and its partners collaborate on emergency planning and training activities. This can involve joint exercises, drills, and tabletop discussions to enhance coordination, identify areas for improvement, and familiarize all parties with each other's roles and procedures.
- *Resource Sharing and Integration:* The MRC and its partners explore opportunities for resource sharing and integration. This can include sharing equipment, supplies, and personnel during emergencies, as well as integrating the MRC into existing emergency response systems and structures.
- *Information Sharing and Communication:* Effective communication and information sharing are crucial for successful partnerships. The MRC and its partners establish communication channels and protocols to exchange information during emergencies and regular operations. This communication can involve sharing situational updates, resource status, and coordination efforts.
- *Ongoing Collaboration and Evaluation:* Partnerships are nurtured through ongoing collaboration, regular meetings, and evaluation of joint activities. The MRC and its partners assess the effectiveness of

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the partnership, address any challenges or gaps, and adjust as needed to improve coordination and response capabilities.

Regarding HMCC partnerships specifically, the MRC may collaborate with local HMCCs or similar coalitions that bring together various healthcare and public health organizations to coordinate response efforts. The MRC and HMCC partners work together to ensure seamless integration of medical and public health resources during emergencies. The process of establishing partnerships can vary depending on the local context and the specific goals of the MRC and its partners. To learn more about the partnership development approach followed by your local MRC unit or for information on HMCC partnerships.

2.2.3.3. Develop Response Plans

The MRC is a network of community-based volunteer groups that nationwide. In this regard, we present general information on how the MRC typically develops response plans. Specific approaches may vary depending on the region and organization involved. Here are the common steps involved in developing response plans:

- *Needs Assessment:* The MRC conducts a thorough assessment of the community's healthcare and public health needs, vulnerabilities, and resources. This assessment helps identify potential risks and informs the development of response plans.
- *Collaboration:* The MRC collaborates with local public health agencies, emergency management organizations, healthcare providers, and other relevant stakeholders. This collaboration ensures that response plans align with existing emergency response frameworks and leverage available resources.
- *Risk Analysis:* The MRC assesses the potential risks and hazards that the community may face, such as natural disasters, disease outbreaks, or other emergencies. This analysis helps prioritize response efforts and allocate resources effectively.
- *Plan Development:* Based on the needs assessment and risk analysis, the MRC develops specific response plans tailored to the community's requirements. These plans typically include elements

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such as resource mobilization, volunteer coordination, emergency communication strategies, medical surge capacity, and collaboration with partner organizations.

- *Training and Education:* The MRC provides training and education to its volunteers, ensuring they have the necessary skills and knowledge to support emergency response efforts. This may include training in disaster response, incident management, medical procedures, psychological First Aid, and community outreach.
- *Exercises and Drills:* The MRC conducts exercises and drills to test and evaluate the effectiveness of response plans. These simulations help identify strengths, weaknesses, and areas for improvement. Lessons learned from these exercises are incorporated into the ongoing plan development process.
- *Plan Review and Updates:* The MRC periodically reviews and updates its response plans to reflect changes in the community's needs, emerging threats, or lessons learned from previous incidents. This ensures that the plans remain relevant, effective, and adaptable to evolving circumstances.

The MRC operates within the framework established by the HSS ASPR. ASPR provides guidance, resources, and support to MRC units across the US.

2.2.3.4. Participate in Drills and Exercises

MRC volunteers are encouraged to participate in training exercises and drills conducted by local, state, and Federal response organizations. These exercises simulate emergency scenarios and allow volunteers to practice their skills, test their capabilities, and collaborate with other response agencies. Several types of exercises are used to sharpen volunteer readiness, including:

- *Full-Scale Exercises:* Full-scale exercises are comprehensive drills that simulate large-scale emergencies. They involve multiple response organizations and test the coordination, communication, and response capabilities of the MRC and other agencies. These exercises help identify areas for improvement and refine response plans.
- *Functional Exercises:* Functional exercises focus on specific aspects of emergency response, such as setting up medical shelters, mass

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vaccination clinics, or conducting medical triage. These drills allow MRC volunteers to practice their specific roles and responsibilities in a controlled environment.

- *Tabletop Exercises:* Tabletop exercises involve discussion-based scenarios and are conducted in a group setting. They provide an opportunity for MRC volunteers to collaboratively address simulated emergency situations, assess response plans, and identify gaps or areas requiring improvement.
- *Community-Based Drills:* MRC units organize community-based drills to enhance preparedness at the local level. These drills can involve community partners, local response organizations, and the public, focusing on specific hazards or response activities relevant to the community.

Through active participation in drills and exercises, MRC volunteers gain practical experience, enhance their skills, and learn how to effectively support and collaborate with response organizations during actual disaster events. These activities also provide opportunities for response organizations to assess the capabilities of MRC volunteers and identify areas for further training and development.

The MRC conducts exercises and drills to train and evaluate the readiness of its volunteers and response plans. While specific approaches may vary across different MRC units, here are some common practices in conducting exercises and drills:

- *Scenario Development:* The MRC develops realistic scenarios that simulate emergency situations relevant to their community's needs and risks. These scenarios could include a disease outbreak, natural disaster, mass casualty incident, or other public health emergencies.
- *Objectives and Exercise Goals:* Clear objectives and exercise goals are established to guide the exercise. These objectives include assessing communication protocols, testing resource management, evaluating medical surge capacity, or practicing specific response procedures.
- *Participant Roles:* Volunteers are assigned specific roles and responsibilities based on their expertise and training. These roles

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include medical professionals, incident commanders, communication specialists, logistics coordinators, or community outreach personnel.

- *Activation and Mobilization:* The MRC activates its volunteers and response teams as they would during a real emergency. This involves notifying volunteers, coordinating their deployment to designated locations, and ensuring they have access to necessary equipment and supplies.
- *Simulation and Implementation:* The exercise unfolds based on the predetermined scenario. Volunteers simulate their response actions, following established protocols and procedures. This may involve setting up medical triage areas, providing medical care, conducting public health interventions, or coordinating with other response agencies.
- *Evaluation and Feedback:* Trained evaluators assess the performance of volunteers and response plans against the exercise objectives. Feedback is provided to participants to identify strengths, weaknesses, and areas for improvement. This evaluation helps identify gaps in knowledge, skills, or procedures that need to be addressed.
- *After-Action Review:* Following the exercise, a comprehensive after-action review is conducted. This involves analyzing the exercise's outcomes, identifying successes and areas for improvement, and developing an action plan to address any identified gaps. Lessons learned from the exercise are used to update response plans, training curricula, and standard operating procedures.

Exercises and drills can vary in scope and complexity, ranging from tabletop exercises (discussion-based) to full-scale simulations involving multiple response agencies. The MRC may also collaborate with other organizations, such as local health departments, emergency management agencies, and hospitals, to conduct joint exercises and enhance interoperability.

2.2.3.5. Maintain Resource Inventory

The MRC ensures the availability and readiness of essential resources and assets needed for emergency response. This includes maintaining an inventory

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of medical supplies, equipment, and logistical support. Regular checks, maintenance, and replenishment of resources are conducted to ensure they are operational and readily available when needed. In this regard, the MRC maintains an up-to-date inventory of resources and assets that can be mobilized during disasters. This inventory must account for medical supplies, equipment, pharmaceuticals, and other necessary resources. Regularly review and replenish of these resources is required to ensure readiness. Additionally, establish partnerships with local healthcare facilities, pharmacies, and other organizations to quickly acquire additional resources when needed.

2.2.3.6. Collaboration and Networking

The Massachusetts MRC has worked closely with local emergency management agencies, healthcare providers, and other response organizations to ensure a coordinated and effective response. MRC volunteers participated in emergency response meetings, shared information, and collaborated with various stakeholders to address the evolving needs of the affected communities in a disaster.

We establish strong partnerships and collaboration with local emergency management agencies, weather services, and other relevant organizations. This collaboration ensures that MRC volunteers have access to the latest information, resources, and guidance during severe weather events. Foster strong partnerships and collaborations with local emergency management agencies, healthcare organizations, community groups, and other relevant stakeholders. Participate in regular meetings, joint exercises, and planning sessions to enhance coordination and ensure a unified response during disasters.

The Merrimack Valley gas explosions required Multi-Agency Coordination,[55] including the MRC, fire departments, law enforcement, utility companies, and healthcare providers. The incident emphasized the need for pre-established partnerships, shared training, and coordinated response plans among these entities. Collaborative exercises and drills were conducted to enhance multi-agency coordination and responsiveness in similar emergencies.

The MRC leader works closely with local emergency management agencies, healthcare providers, and other response organizations to ensure effective coordination and integration of MRC volunteers into the broader

[55] Online: https://emilms.fema.gov/is_0552/groups/52.html. Accessed 21 October 2023.

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response efforts. This coordination and integration include participating in collaborative planning meetings, sharing information, and aligning volunteer activities with the overall response strategy.

2.2.4. Activation

2.2.4.1. The Call and MRC Activation

The activation process of our MRC varies depending on the specific region in the state or beyond. However, the general steps involved in activating the MRC at the local, regional, or state level, are as follows:

1. *Emergency Declaration:* The activation of the MRC typically begins with an official emergency declaration by the local, regional, or state authorities. This declaration may be made by the mayor, county executive, governor, or other relevant officials. The declaration acknowledges the need for additional healthcare personnel and resources to respond to the emergency.
2. *MRC Notification-Activation:* Once the emergency declaration is made, the MRC leadership is notified. The MRC coordinator or a designated representative receives the activation order and initiates the process of mobilizing volunteers.
3. *Volunteer Notification:* The MRC coordinator or designated personnel then contact MRC volunteers through established communication channels. This can include phone calls, text messages, email, or a dedicated emergency notification system. Volunteers are informed of the activation, the nature of the emergency, and any specific instructions or requirements.
4. *Volunteer Availability and Deployment:* MRC volunteers are asked to confirm their availability and willingness to respond. Depending on the needs of the emergency, volunteers with specific skills or expertise may be requested. The MRC coordinator or designated personnel assess the availability and skill sets of volunteers to determine the deployment strategy.
5. *Orientation and Briefing:* Prior to deployment, activated MRC volunteers are provided with an orientation and briefing. This includes a review of the emergency response plan, specific roles and responsibilities, safety protocols, and any necessary training or

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refresher courses. Volunteers are also provided with information on reporting locations, deployment schedules, and logistics.

6. *Deployment and Assignment:* Activated MRC volunteers are then deployed to the designated locations or assigned tasks as per the emergency response plan. Volunteers may be stationed at healthcare facilities, emergency shelters, community support centers, or other locations where their skills and expertise are needed. They work under the direction of the incident command structure, which may include local or state emergency management, public health agencies, or healthcare organizations.
7. *Ongoing Communication and Support:* Throughout the activation period, the MRC coordinator or designated personnel maintain regular communication with deployed volunteers. This includes providing updates, addressing concerns or questions, and ensuring the well-being and safety of the volunteers. Volunteers may also receive additional training, guidance, or resources as needed.
8. *Demobilization and Recovery:* Once the emergency stabilizes and the need for MRC assistance decreases, the demobilization process begins. Volunteers are debriefed, thanked for their service, and provided with any necessary follow-up support or resources. The MRC conducts an after-action review to assess the response, identify lessons learned, and make improvements for future activations.

It is important to note that the exact activation process may vary based on the jurisdiction and specific emergency response protocols in place. MRC units often work closely with local emergency management agencies and healthcare partners to ensure a coordinated and effective response during emergencies.

2.2.4.2. Deployment Checklist

A deployment checklist is a set of notes or documentation used to assess the readiness and availability of MRC volunteers for deployment during emergencies or other events. These check notes help ensure that volunteers are properly prepared, qualified, and available to respond when activated. Here is how it is used:

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1. *Availability Confirmation:* The deployment check notes include a section where volunteers indicate their availability to respond. This allows the MRC coordinator or designated personnel to determine which volunteers are able to participate in the deployment.
2. *Contact Information:* The check notes include volunteers' contact information, such as phone numbers, email addresses, and emergency contact details. This ensures that the MRC coordinator or designated personnel can reach the volunteers promptly and effectively during the deployment process.
3. *Skill Assessments:* The deployment check notes often include a section to assess volunteers' skills, qualifications, and areas of expertise. This helps match volunteers with specific roles or tasks based on their abilities and ensures that the appropriate skills are available during the deployment.
4. *Credential Verification:* Depending on the nature of the deployment, certain credentials or certifications may be required. The check notes include a section to verify that volunteers possess the necessary credentials, such as medical licenses, CPR certifications, or specialized training, to perform their assigned duties.
5. *Medical Considerations:* In some cases, volunteers may have specific medical considerations or limitations that need to be considered during deployment. The check notes include a section to capture this information, such as allergies, chronic conditions, or medication requirements, to ensure the safety and well-being of the volunteers.
6. *Equipment and Resource Needs:* If volunteers are expected to bring specific equipment or resources, such as PPE or medical supplies, the check notes may include a section to note these requirements. This helps ensure that volunteers are adequately prepared and have the necessary resources to perform their duties during deployment.
7. *Special Instructions or Preferences:* The check notes allow volunteers to provide any special instructions, preferences, or limitations they may have during the deployment. This can include transportation needs, language capabilities, or other considerations that may impact their participation.

The deployment check notes serve as a comprehensive record of each volunteer's availability, qualifications, and specific requirements. They are used by the MRC coordinator or designated personnel to effectively manage

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and coordinate the deployment process, ensuring that the right volunteers are assigned to the appropriate roles and tasks based on their availability and capabilities. The information captured in the check notes helps streamline the deployment process and ensures that the MRC can efficiently respond to emergencies while meeting the needs of the affected community.

2.2.4.3. Job Action Sheets

Job Action Sheets (JAS) for deployment in the MRC provide volunteers with detailed instructions and guidance on their specific roles and responsibilities during emergency deployments. These sheets outline the tasks, procedures, and protocols that volunteers need to follow to fulfill their assigned duties effectively. While the specific content of the JAS may vary depending on the situation and the MRC's jurisdiction, here are some common elements that may be included:

1. *Volunteer Information:* The JAS typically begins with basic information about the volunteer, including their name, contact details, and any special considerations or limitations.
2. *Deployment Details:* This section provides an overview of the deployment, including the location, dates, and expected duration of the assignment. It may also include specific reporting instructions, such as where volunteers should check-in upon arrival.
3. *Job Description:* The JAS outlines the volunteer's assigned job or role during the deployment. It provides a clear description of their responsibilities, tasks, and objectives. This section may include details on the specific medical or non-medical duties they are expected to perform.
4. *Procedures and Protocols:* This section includes step-by-step instructions on how to carry out specific procedures or protocols related to the assigned job. It may cover topics such as patient triage, medical treatment, infection control measures, documentation, or communication protocols.
5. *Safety and PPE:* The JAS emphasizes the importance of safety during deployment. It provides guidance on the proper use of PPE and infection control measures. This section may also include safety reminders and emergency procedures that volunteers should follow in case of adverse events.

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6. *Equipment and Resource Needs:* If volunteers are required to bring specific equipment or resources, such as medical kits, PPE, or documentation forms, the JAS may include a list of these requirements. This ensures that volunteers come prepared with the necessary tools and supplies for their assigned tasks.
7. *Communication and Chain of Command:* The JAS provides information on the communication channels volunteers should use to stay in contact with their supervisors and the incident command structure. It may include the names and contact details of key personnel and the chain of command to follow in case of questions, concerns, or updates.
8. *Reporting and Documentation:* This section outlines any reporting or documentation requirements for the assigned job. It may include forms, templates, or specific information that volunteers need to record or report during the deployment. This ensures that essential data is captured for tracking and evaluation purposes.
9. *Additional Resources:* The JAS may include references or links to additional resources or references that volunteers can consult for further information or support. This can include relevant guidelines, protocols, or online training materials.

The JAS provide volunteers with a comprehensive and concise reference that helps them understand their roles and perform their assigned tasks effectively during MRC deployments. These sheets are typically customized to reflect the specific needs and protocols of the MRC and the emergency at hand.

2.2.5. Notification

The MRC used various communication channels to notify response partners about their capabilities, activation status, and available resources. Here are some common methods they may have used:

- *Direct communication:* MRC coordinators would have directly contacted relevant response partners, such as local emergency management agencies, hospitals, healthcare providers, and public

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health departments. They would have communicated the MRC's activation status, the services they can provide, and any specific resources or expertise available within their volunteer pool.

- *Emergency Management Systems:* The MRC may have utilized emergency management systems, such as the EOC or incident management software, to communicate with response partners. These systems allow for real-time information sharing, coordination, and resource management during emergencies.
- *Interagency Meetings and Briefings:* MRC representatives may have attended interagency meetings or briefings conducted by emergency management agencies. These meetings provide an opportunity to directly communicate the MRC's activation status, capabilities, and available resources to other response partners in attendance.
- *Public Health and Emergency Alerts:* The MRC may have leveraged public health and emergency notification systems to disseminate information to response partners and the public. These alerts can include details about the MRC's activation, their role in the response, and the specific resources they can provide.
- *Collaborative Platforms:* Online platforms and information-sharing systems, such as web portals or shared databases, could have been used to provide response partners with access to MRC resources and capabilities. These platforms facilitate efficient coordination, resource allocation, and communication among multiple response organizations.
- *Partner Outreach and Networks:* MRC coordinators may have reached out to response partners individually or through established networks to inform them about the MRC's capabilities and activation status. This could include phone calls, emails, or in-person meetings to provide specific details and answer any questions.
- *Social Media and Websites:* The MRC may have used their social media accounts and official websites to update response partners on their activation, services, and available resources. These platforms provide broad reach and allow for real-time updates and information sharing.

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It is important to note that the specific communication methods used during the Merrimack Valley gas explosions would depend on the existing communication protocols and relationships between the MRC and the response partners in that particular area. The MRC would have sought to establish effective channels to ensure timely and accurate communication of their capabilities and resources to support the response efforts.

2.2.6. Volunteer Response

When a disaster occurs, the leader of our MRC unit plays a critical role in coordinating the volunteer response efforts. Several of the general steps that an MRC leader takes to coordinate the MRC volunteer response are as follows:

- *Activation:* The MRC leader first activates the MRC unit in response to the disaster. This involves assessing the situation, determining the level of response required, and deciding whether to activate all volunteers or specific teams based on their skills and capabilities.
- *Communication:* The MRC leader establishes communication channels to effectively relay information and instructions to the volunteers. This can include email lists, phone trees, or messaging platforms. It's important to ensure that all volunteers receive timely and accurate information about the disaster, response plans, and their roles.
- *Volunteer Mobilization:* The MRC leader identifies the specific skills, expertise, and availability of volunteers within the unit. They may request volunteers to report for duty through various communication channels, such as phone calls, emails, text messages, or a dedicated volunteer management system.
- *Task Assignment:* Based on the needs of the disaster response, the MRC leader assigns tasks and roles to the available volunteers. This could include medical professionals providing direct care, non-medical volunteers assisting with logistics and support services, or specialized teams focusing on specific areas like mental health or emergency communication.

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- *Training and Briefing:* The MRC leader ensures that volunteers receive the necessary training and briefing on disaster response protocols, safety procedures, and any specific tasks they need to perform. This may involve conducting training sessions, sharing relevant documents or videos, or organizing briefings prior to deployment.
- *Deployment and Support:* The MRC leader coordinates the deployment of volunteers to the disaster-affected areas or designated response sites. They establish support systems to meet the needs of volunteers, including transportation, lodging, meals, and necessary supplies. The leader also maintains communication with deployed volunteers to address any concerns or issues that may arise.
- *Collaboration with Partners:* The MRC leader works closely with local emergency management agencies, healthcare providers, and other response organizations to ensure effective coordination and integration of MRC volunteers into the broader response efforts. This includes participating in collaborative planning meetings, sharing information, and aligning volunteer activities with the overall response strategy.
- *Documentation and Evaluation:* Throughout the response, the MRC leader maintains records of volunteer activities, including hours worked, tasks performed, and any notable accomplishments or challenges. This information is valuable for reporting, future planning, and evaluating the effectiveness of the MRC volunteer response.

The specific coordination process may vary depending on the nature of the disaster, the jurisdiction, and the established protocols of the MRC unit. MRC leaders often receive training and guidance from the MRC program at the state or national level to enhance their coordination skills and ensure effective disaster response.

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2.2.7. Deployment

During a Deployment of MRC volunteers, MRC leadership plays a crucial role in coordinating and overseeing the response efforts. Here are some key responsibilities that MRC leaders may have during a deployment:

- *Activation and Mobilization:* MRC leaders initiate the activation of the MRC unit in response to an emergency or disaster. They assess the situation, determine the scope of the response required, and decide which volunteers and resources need to be mobilized. MRC leaders coordinate the communication and mobilization process to ensure that the right volunteers are deployed to the appropriate locations.
- *Volunteer Coordination:* MRC leaders are responsible for coordinating and managing the MRC volunteers during the deployment. They assign volunteers to specific roles and tasks based on their skills, training, and availability. MRC leaders ensure that volunteers are properly trained, briefed on their assignments, and equipped with the necessary resources and supplies.
- *Communication and Information Management:* MRC leaders establish and maintain effective communication channels with deployed volunteers, local emergency management agencies, healthcare facilities, and other response partners. They provide regular updates, instructions, and guidance to volunteers throughout the deployment. MRC leaders also collect and disseminate relevant information to ensure that all parties have the necessary information to carry out their roles effectively.
- *Resource Management:* MRC leaders oversee the management of resources during the deployment. This includes coordinating the procurement and distribution of medical supplies, equipment, and other necessary resources. They ensure that volunteers have access to the resources they need to perform their duties and that resources are utilized efficiently and effectively.
- *Liaison and Collaboration:* MRC leaders serve as the primary point of contact and liaison between the MRC unit and other response organizations and agencies. They collaborate with local emergency management agencies, healthcare providers, public health

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departments, and community organizations to ensure a coordinated and integrated response. MRC leaders participate in coordination meetings, share information, and align MRC activities with the overall response strategy.

- *Support and Guidance:* MRC leaders provide support and guidance to deployed volunteers throughout the deployment. They address any issues or concerns raised by volunteers, provide assistance in problem-solving, and ensure that volunteers have the necessary support to carry out their roles effectively. MRC leaders also prioritize the safety and well-being of volunteers, ensuring that appropriate measures are in place to mitigate risks and address any emergent needs.
- *Documentation and Reporting:* MRC leaders maintain accurate records of the deployment activities, including volunteer assignments, hours worked, tasks performed, and any notable incidents or accomplishments. They ensure that necessary documentation is completed, such as incident reports, reimbursement requests, and evaluation forms. MRC leaders may also be responsible for preparing post-deployment reports to evaluate the effectiveness of the deployment and identify areas for improvement.

Overall, MRC leaders play a critical role in coordinating, managing, and supporting MRC volunteers during deployments. They ensure that the MRC unit operates effectively and efficiently, and that volunteers are empowered to provide valuable support to emergency response efforts.

2.2.8. Debriefing

MRC volunteers are typically debriefed following their deployments to ensure their well-being and address any concerns or issues that may have arisen during their service. The debriefing process may vary depending on the specific circumstances and the organization overseeing the MRC unit. However, here are some common practices for debriefing MRC volunteers:

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- *Group Debriefing Sessions:* After a deployment, MRC units often organize group debriefing sessions to provide a forum for volunteers to share their experiences, emotions, and challenges encountered during their service. These sessions may be facilitated by mental health professionals, experienced MRC leaders, or trained peer supporters. Group debriefings allow volunteers to express their feelings, validate their experiences, and gain support from their peers.
- *Individual Check-Ins:* MRC leaders or supervisors may conduct individual check-ins with volunteers to have one-on-one discussions about their deployment experiences. These conversations provide an opportunity for volunteers to share their thoughts, express any concerns or issues they may have encountered, and receive personalized support or guidance.
- *Psychological Support:* If volunteers have been exposed to particularly challenging or traumatic situations during their deployment, access to psychological support services may be offered. This can include referrals to mental health professionals or resources specializing in trauma counseling or critical incident stress management. Volunteers who may be experiencing significant emotional distress or symptoms of PTSD can benefit from these services.
- *Evaluation and Feedback:* MRC leadership may conduct evaluations or feedback sessions to gather input from volunteers about the deployment process, identify areas for improvement, and assess the effectiveness of the MRC's response. Volunteers may be asked to provide feedback on logistics, communication, training, and overall support received during their deployment.
- *Training and Education:* Debriefing sessions may also be used as an opportunity to provide additional training or education to volunteers. This might include reviewing lessons learned from the deployment, discussing best practices, and providing updates on relevant policies or procedures.

The debriefing process is designed to support the well-being of MRC volunteers and address any concerns they may have. It aims to foster resilience, promote self-care, and ensure that volunteers receive the necessary

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support to cope with any emotional or psychological challenges that may have arisen during their service.

When the MRC completes a deployment or a specific emergency response, there is typically a process for standing down the volunteers. The exact procedures may vary depending on the specific circumstances and the local MRC unit's policies. However, here are some general steps that may be involved in standing down the MRC after a deployment:

- *Debriefing:* Volunteers may participate in debriefing sessions to discuss their experiences, challenges faced, lessons learned, and provide feedback for future improvement. This helps ensure that valuable insights are captured and can be used to enhance future emergency response efforts.
- *Documentation and Reporting:* Volunteers may be required to complete documentation and reporting related to their activities and their deployment. This may include finalizing and submitting any necessary paperwork, reports, or data collected during the deployment.
- *Return of Resources:* Volunteers may need to return any borrowed or issued equipment, supplies, or resources that were utilized during the deployment. This can include medical equipment, PPE, communication devices, or any other items provided by the MRC.
- *Evaluation and Assessment:* The MRC leadership and relevant authorities may conduct an evaluation or assessment of the overall response, including the MRC's performance and contribution. This evaluation helps identify areas of success and areas for improvement for future deployments.
- *Recognition and Appreciation:* MRC volunteers may receive recognition or appreciation for their service. This can come in the form of certificates, letters of appreciation, or public acknowledgment of their efforts in contributing to the emergency response.

The specific procedures for standing down the MRC can vary depending on the situation, local protocols, and the organization overseeing the MRC unit.

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Chapter 3

Our Plans, Protocols, and Procedures

Abstract

Overall, the MRC plays a critical role in enhancing the preparedness and response capabilities of communities across the US. By leveraging the skills and expertise of local volunteers, the MRC helps to ensure that communities are better equipped to respond to emergencies and protect the health and safety of their residents. Policies, protocols (i.e., procedures), and plans define how our volunteers are expected to perform these response operations as well as day-to-day activities. They provide guidance to the MRC stakeholders, volunteers, and response partners about all our operations.

The MRC leadership knows that our policies, protocols, and plans are "living" documents (i.e., always evolving). As such, they must be updated on a regular basis as lessons are learned from deployment experience. There lessons include feedback from our stakeholders, response partners, and, most importantly, volunteers themselves. The updated policies, protocols, and plans are extensively reviewed and then drive improvement of our volunteer training materials and operational drills that we conduct. It helps the volunteers understand the policy and procedures as well as the changes made to them, particularly those that they themselves have recommended. In addition, we also update essential contact information as well as any additional information about our response partners and changes in shelter locations or emergency dispensing-site locations.

3.1. Policies, Protocols, Procedures, and Plans

3.1.1. Definitions and Descriptions

3.1.1.1. Policies

Policies define our guidance for domains of our expected organizational behavior in which specific actions are covered by procedures and protocols.

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They also govern expected behavior when specific actions are not defined. The following is a list of our current MRC policies:

3.1.1.2. Protocols and Procedures

Protocols are sets of procedures we use to achieve certain collective MRC volunteer healthcare objectives, such as sheltering, vaccine testing or distribution, contact tracing, etc. Protocols contain more detailed procedures, which are the specific steps we define and authorize to achieve specific MRC healthcare activities or objectives. Our current (March 2024) procedures spanning our deployment domains include a deployment protocol, a sheltering protocol, and an emergency dispensing site protocol. We also have a volunteer handbook that explains each volunteer's responsibilities. They are updated every year and shared with our response partners and asked to be integrated into their protocols and procedures.

3.1.1.3. Plans

Our MRC plans describe how we interoperate with our response partners that accommodate our policies, including in the domains of local emergency dispensing site plans, local sheltering plans, deployment, training, and operations. All these plans are important to be shared with our stakeholders with our response partners and other MRC volunteer groups. These plans are also the subject of training and drills we conduct. We also ask that these plans be included and local emergency plans and include the MRC deployment protocols in our training and operational plans.

3.1.2. Development and Test

Developing and testing MRC protocols, procedures and plans are important activities in ensuring that the MRC is prepared to respond effectively to disasters and other emergencies. The key sequential steps that we use in developing and testing MRC protocols and procedures are as follows:

- *Identify key tasks and activities:* Identify the key tasks and activities that MRC volunteers will be responsible for during a disaster. This may include setting up and operating emergency shelters, providing

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medical and public health services, and assisting with logistics and communication.

- *Define protocols and procedures:* Develop procedures for each overarching protocol that outline the steps and guidelines for performing each task. These instructions are based on best practices and established emergency response standards.
- *Document protocols and procedures:* Document the procedures and protocols in a clear and concise manner, and ensure that they are easily accessible to MRC volunteers. This work may include creating a manual or online resource.
- *Train MRC volunteers:* Provide training to MRC volunteers on the procedures and protocols, and ensure that they are familiar with the guidelines and steps for each task. This may include classroom training, hands-on exercises, and drills.
- *Conduct tabletop exercises:* Conduct tabletop exercises to test the procedures and protocols in a simulated disaster scenario. This can help identify gaps and areas for improvement in the procedures and protocols.
- *Conduct real-world exercises:* Conduct real-world exercises, such as drills or full-scale exercises, to test the procedures and protocols in a more realistic setting. This can help identify additional gaps and areas for improvement, and provide opportunities to practice and refine response efforts.
- *Review and update protocols and their procedures:* Regularly review and update the protocols and their procedures based on feedback, lessons learned, and changes in emergency response standards or best practices.

Overall, developing and testing MRC protocols and procedures requires careful planning, training, and evaluation. By following these steps, the MRC works to ensure that its volunteers are prepared and equipped to respond effectively to disasters and other emergencies.

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3.1.3. Operational Use and Adaptation

The MRC is composed of medical and non-medical volunteers who are trained to respond to public health emergencies and disasters. The volunteers are organized in units at the local level, and they work closely with public health agencies, emergency management agencies, and other organizations to improve the preparedness and response capabilities of their communities.

The policies and protocols of the MRC are designed to ensure that volunteers are trained and equipped to respond to a wide range of emergencies, including natural disasters, disease outbreaks, and terrorist attacks. These policies and protocols cover a variety of topics, including volunteer recruitment and training, deployment procedures, communication protocols, and personal protective equipment.

The operational use of MRC policies and protocols can vary depending on the specific needs and circumstances of a given emergency. In general, MRC volunteers may be called upon to provide a range of services, including:

- Assisting with mass vaccinations or medication dispensing
- Providing medical care and triage services
- Conducting community outreach and education
- Providing logistical support and staffing emergency shelters

In addition to these services, MRC volunteers may also be called upon to assist with other emergency response activities, such as search and rescue, debris removal, or communications support.

3.1.4. Updates and Distribution

If updating MRC policies and protocols, it is important to ensure that they are distributed to the appropriate stakeholders within your organization and community. Here are some key groups that should receive the updated policies and protocols:

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- *MRC volunteers:* The updated policies and protocols should be shared with all MRC volunteers to ensure that they are aware of any changes and are able to follow the latest guidelines and procedures.
- *MRC leadership:* The leadership of your local MRC unit should also receive the updated policies and protocols so that they can provide guidance and support to volunteers as needed. This guidance and support include the MRC unit coordinator, medical director, and other key leaders.
- *Partner organizations:* MRC units often work closely with other organizations, such as local health departments, emergency management agencies, and community groups. It may be necessary to share the updated policies and protocols with these partner organizations to ensure that everyone "is on the same page" and working together effectively.
- *Local officials:* Depending on the scope and nature of the updated policies and protocols, it may be appropriate to share them with local officials, such as mayors, city councils, and county commissioners. This outreach can help to ensure that local officials are aware of the MRC's role in emergency preparedness and response, and can provide support as needed.
- *The public:* Finally, it may be appropriate to make the updated policies and protocols available to the public, either through a public meeting or by posting them on your organization's website. This posting can help to build awareness and support for the MRC's work in the community, and can help to ensure public preparation for emergencies.

3.2. Analysis of Current Protocols

This subsection provides an overview of our principal MRC protocols as of March 2024. As our protocols are available to the public, we will use this space to provide description of two different protocols, our Mass Care and Sheltering Standard Operating Guidelines (SOG) and our Covid Testing Site Operations Plan for the Town of Randolf in their entirety to provide an understanding of

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the scope of our documentation. In general, our guidelines protocols are in the form of detailed checklists.[56] We have also provided descriptions of our MRC JAS and volunteer support guide.

Interestingly, the checklist format is a visual "artificial intelligence" (AI) tool for a human being to (i) make sure not to forget an important action or consideration to minimize or reduce risk, but also (ii) provide a recommended experience-based rational sequencing of these actions or considerations. The checklists are vital when human beings are in an immediate stressful environment as is natural for emergency and disaster preparedness and response. All of these guidance documents are available through the author's website or book footnote urls.

3.2.1. Public Health Standard Operating Guidelines (SOG): Mass Care and Sheltering

Our Mass Care and Sheltering Protocol is a 40-page document whose objective is to "determine and meet public health and safety jurisdictional roles and responsibilities and ensure the ability of partner agencies to address the public health, medical, behavioral health and sheltering needs of individuals at a congregate location."[57] It is used for our sheltering operations, which has historically been one of our primary types of deployments.

3.2.1.1. Primary Checklists

The document provides a checklist of activities for a volunteer manager to conduct, or verify, and the expected time required to do so as outlined in Figure 3.1.

We will review the checklist items for each of four entries in the figure in the following subsections. The purpose of this extensive outline is to demonstrate the breadth and scope of the protocols and not to discuss every detailed procedure or checklist item.

[56] Online: https://en.wikipedia.org/wiki/Checklist. Accessed 28 March 2024.

[57] Massachusetts Public Health, Public Health Emergency SOG: Mass Care and Sheltering. March 2024, p. 1.

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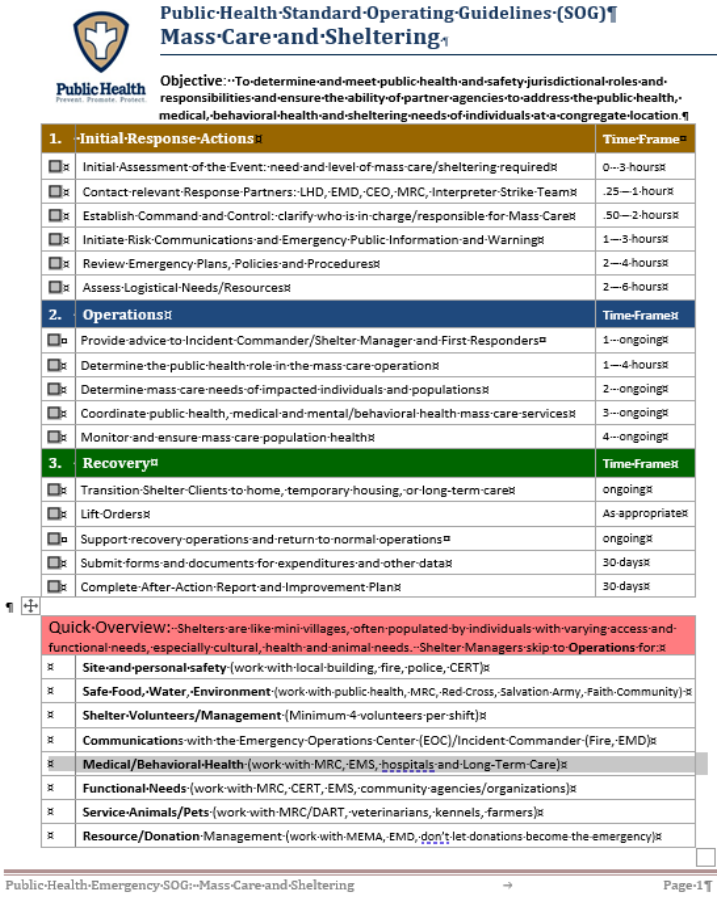

Public Health Standard Operating Guidelines (SOG)
Mass Care and Sheltering

Public Health
Prevent. Promote. Protect.

Objective: To determine and meet public health and safety jurisdictional roles and responsibilities and ensure the ability of partner agencies to address the public health, medical, behavioral health and sheltering needs of individuals at a congregate location.

1. Initial Response Actions	Time Frame
Initial Assessment of the Event: need and level of mass care/sheltering required	0—3 hours
Contact relevant Response Partners: LHD, EMD, CEO, MRC, Interpreter Strike Team	.25—1 hour
Establish Command and Control: clarify who is in charge/responsible for Mass Care	.50—2 hours
Initiate Risk Communications and Emergency Public Information and Warning	1—3 hours
Review Emergency Plans, Policies and Procedures	2—4 hours
Assess Logistical Needs/Resources	2—6 hours
2. Operations	**Time Frame**
Provide advice to Incident Commander/Shelter Manager and First Responders	1—ongoing
Determine the public health role in the mass care operation	1—4 hours
Determine mass care needs of impacted individuals and populations	2—ongoing
Coordinate public health, medical and mental/behavioral health mass care services	3—ongoing
Monitor and ensure mass care population health	4—ongoing
3. Recovery	**Time Frame**
Transition Shelter Clients to home, temporary housing, or long-term care	ongoing
Lift Orders	As appropriate
Support recovery operations and return to normal operations	ongoing
Submit forms and documents for expenditures and other data	30 days
Complete After-Action Report and Improvement Plan	30 days

Quick Overview: Shelters are like mini villages, often populated by individuals with varying access and functional needs, especially cultural, health and animal needs. Shelter Managers skip to **Operations** for:

Site and personal safety (work with local building, fire, police, CERT)	
Safe Food, Water, Environment (work with public health, MRC, Red Cross, Salvation Army, Faith Community)	
Shelter Volunteers/Management (Minimum 4 volunteers per shift)	
Communications with the Emergency Operations Center (EOC)/Incident Commander (Fire, EMD)	
Medical/Behavioral Health (work with MRC, EMS, hospitals and Long-Term Care)	
Functional Needs (work with MRC, CERT, EMS, community agencies/organizations)	
Service Animals/Pets (work with MRC/DART, veterinarians, kennels, farmers)	
Resource/Donation Management (work with MEMA, EMD, don't let donations become the emergency)	

Public Health Emergency SOG: Mass Care and Sheltering → Page 1

Figure 3.1. Mass Care and Sheltering protocol overview.

3.2.1.1.1. Initial Response Actions

Seven of the 40 pages is devoted to the "Initial Response Actions" of the on-site MRC volunteers. It contains the following major subsections guiding this initial assessment:

- *Initial Assessment of the Event* – which contains the following major checklist items in two columns, one for the action to be taken and the second labeled for the resources available to support this action (See Figure 3.2):

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- *Assess and verify the scope of the emergency/threat*: does it need immediate emergency response/action, with the major resource being the ICS Form 201 Incident Briefing Form[58]
- *Call the local Emergency Management Director (EMD)*
- *Summarize the event; estimate how long the situation will last. Determine what type of shelter is needed*, with nine subsidiary entries
- *Where/when/source/scope*: how many individuals/communities
- *Risk Factors/Exposure/Protective Actions*
- *Assess impacted population and population health needs*
- *Language needs and Interpreter resources and other access and functional needs assessment*

Immediately following these recommended sequential steps is a highlighted "Risk Communication Activities" subsection, including the following entries:

- *Develop and Send Initial Public Messages* – seven optional initial message phrasing options are provided along with media resources.
- *Activate the local emergency public joint information system (JIS)*[59]
- *Establish situational awareness with neighboring jurisdictions through the EOC*.

- *Contact Relevant Response Partners* – which contains the following major checklist items in two columns, one for the action to be taken and the second labeled for the resources available to support this action:
  - *Begin Notification*: Ensure all response partners maintain accurate Situational Awareness and understand the emergency
  - *Call Internal Contacts* – six rows of contacts or contact types
  - *Call External Contacts* as needed – 18 rows listing 18 contacts or contact types

[58] Online: https://training.fema.gov/emiweb/is/icsresource/assets/ics%20forms/ics%20form%20201,%20incident%20briefing%20(v3).pdf. Accessed 28 March 2024.

[59] Online: Activate the local emergency public joint information system (JIS). Accessed 28 March 2024.

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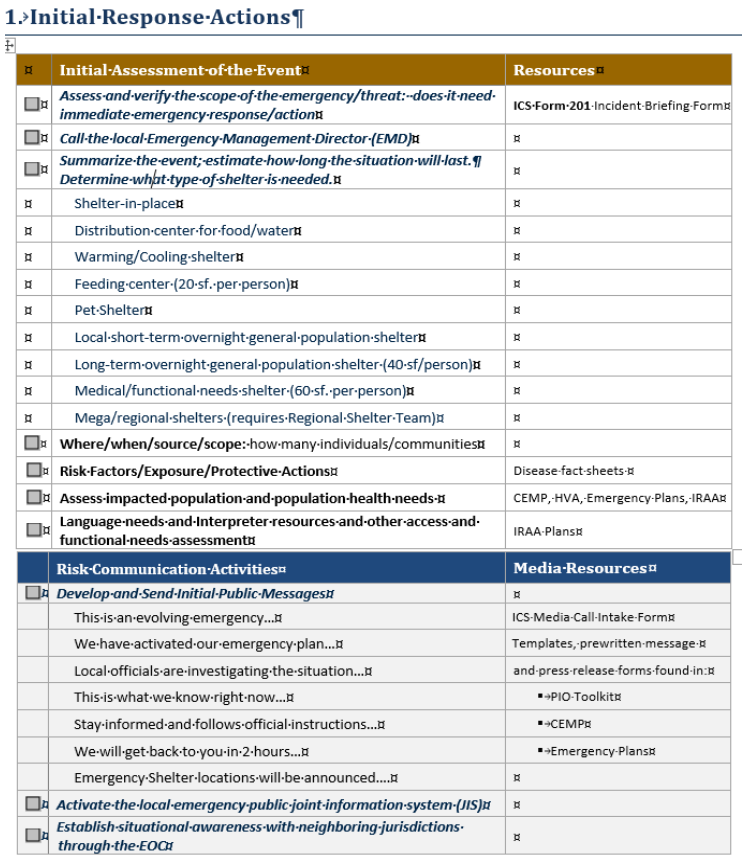

1.›Initial·Response·Actions¶

	Initial·Assessment·of·the·Event¤	Resources¤
☐	*Assess·and·verify·the·scope·of·the·emergency/threat:··does·it·need·immediate·emergency·response/action*¤	**ICS·Form·201**·Incident·Briefing·Form¤
☐	*Call·the·local·Emergency·Management·Director·(EMD)*¤	¤
☐	*Summarize·the·event;·estimate·how·long·the·situation·will·last.¶ Determine·what·type·of·shelter·is·needed.*¤	¤
¤	Shelter-in-place¤	¤
¤	Distribution·center·for·food/water¤	¤
¤	Warming/Cooling·shelter¤	¤
¤	Feeding·center·(20·sf.·per·person)¤	¤
¤	Pet·Shelter¤	¤
¤	Local·short-term·overnight·general·population·shelter¤	¤
¤	Long-term·overnight·general·population·shelter·(40·sf/person)¤	¤
¤	Medical/functional·needs·shelter·(60·sf.·per·person)¤	¤
¤	Mega/regional·shelters·(requires·Regional·Shelter·Team)¤	¤
☐	**Where/when/source/scope:**·how·many·individuals/communities¤	¤
☐	**Risk·Factors/Exposure/Protective·Actions**¤	Disease·fact·sheets·¤
☐	**Assess·impacted·population·and·population·health·needs·**¤	CEMP,·HVA,·Emergency·Plans,·IRAA¤
☐	**Language·needs·and·Interpreter·resources·and·other·access·and·functional·needs·assessment**¤	IRAA·Plans¤
	Risk·Communication·Activities¤	**Media·Resources**¤
☐	*Develop·and·Send·Initial·Public·Messages*¤	¤
	This·is·an·evolving·emergency...¤	ICS·Media·Call·Intake·Form¤
	We·have·activated·our·emergency·plan...¤	Templates,·prewritten·message·¤
	Local·officials·are·investigating·the·situation...¤	and·press·release·forms·found·in:¤
	This·is·what·we·know·right·now...¤	▪·⇒PIO·Toolkit¤
	Stay·informed·and·follows·official·instructions...¤	▪·⇒CEMP¤
	We·will·get·back·to·you·in·2·hours...¤	▪·⇒Emergency·Plans¤
	Emergency·Shelter·locations·will·be·announced....¤	¤
☐	*Activate·the·local·emergency·public·joint·information·system·(JIS)*¤	¤
☐	*Establish·situational·awareness·with·neighboring·jurisdictions·through·the·EOC*¤	¤

Figure 3.2. Initial Assessment of the Event.

Immediately following these recommended sequential steps is a highlighted "Risk Communication Activities" subsection, including the following entries:

- *Develop and Send Workforce/Responder Protection Messages*, saying "Responders should take the following protective actions…"
- *Continue to Inform the Public* – six rows of contacts or contact types including 24 recommended options and sub-options for such communication

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- *Establish Command and Control* – which contains the following major checklist items in two columns, one for the action to be taken and the second labeled for the resources available to support this action:
- *Clarify Incident Command Structure and Chain of Command*: containing seven row entries
- *Determine and assign incident command roles* – 11 rows of contacts or contact types
- *Respond to designated command location: EOC or Incident Command Post (ICP)* – EOC location and phone
- *Receive situation awareness report from the Emergency Management Director (EMD) or Incident Commander (IC)* - ICS 201: Incident Briefing Report and ICS 202 Incident Objectives[60]
- *Continue Ongoing Activities* – in which there are five options with resources.
- *Initiate Risk Communications/Public Information Warning* – which contains the following major checklist items in two columns, one for the action to be taken and the second labeled for the resources available to support this action:
- *Risk Communication Roles, Positions, Locations* – containing nine one-line items
- *Review/Revise the Risk Communication Plan/Media Policies with the EMD, PIO, CEO, JIS/JIC, based on the Incident Action Plan* - Risk Communication Plan Communications Plan (ICS 205)[61]
- *Determine the essential messages/public information* – includes seven one-line entries
- *Sources of more information* – includes six entries with check boxes

[60] Online: https://training.fema.gov/emiweb/is/icsresource/assets/ics%20forms/ics%20form%20202,%20incident%20objectives%20(v3.1).pdf. Accessed 28 March 2024.

[61] Online: https://training.fema.gov/emiweb/is/icsresource/assets/ics%20forms/ics%20form%20205,%20incident%20radio%20communications%20plan%20(v3.1).pdf. Accessed 28 March 2024.

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- *Draft messages appropriate to media used and public reached* – includes three one-line entries
- *Brief Incident Spokesperson(s)* – three key messages above
- *Monitor public reaction and establish methods for public interaction/information exchange* – contains six options for monitoring public reaction
- *Issue Public Information, Warnings, Notifications* – contains four-line items and one set of five check-box options.
- *Review Emergency Plans, Policies and Procedures* – which contains the following major checklist items in two columns, one for the action to be taken and the second labeled for the resources available to support this action:
- *Review Legal Authority* – containing four one-line items
- *Review Food Establishment Emergency Plans* - Food Establishment Emergency Plans
- *Review IT/Data Management Systems and Protocols*
- *Assist IC with development of the Incident Action Plan (IAP)* – the Incident Action Plan
- *Use Incident Command System (ICS) forms* – six plans listed, including Incident Objectives (ICS 202), Division/Group Assignments (ICS 204),[62] Organizational Assignment List (ICS 203),[63] Incident Map (ICS 225),[64] Communications Plan (ICS 205), and Medical Plan (ICS 206).[65]
- *Assess Logistical Needs/Resources* – which contains the following major checklist items in two columns, one for the action to be taken

[62] Online: https://training.fema.gov/emiweb/is/icsresource/assets/ics%20forms/ics%20form%20204,%20assignment%20list%20(v3.1).pdf. Accessed 28 March 2024.

[63] Online: https://training.fema.gov/emiweb/is/icsresource/assets/ics%20forms/ics%20form%20203,%20organization%20assignment%20list%20(v3).pdf. Accessed 28 March 2024.

[64] Online: https://training.fema.gov/emiweb/is/icsresource/assets/ics%20forms/ics%20form%20225,%20incident%20personnel%20performance%20rating%20(v3).pdf. Accessed 28 March 2024.

[65] Online: https://training.fema.gov/emiweb/is/icsresource/assets/ics%20forms/ics%20form%20206,%20medical%20plan%20(v3).pdf. Accessed 28 March 2024.

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and the second labeled for the resources available to support this action:

- *Water supplies*– Containing four checklist items
- *Food supplies*– Containing four checklist items
- *Medical supplies and services* (see Shelter Medical Supply Checklist) below – Contains 14 listed items and services
- *General Sheltering Supplies and Equipment* – Contains 20 checklist items
- *Environmental Health Inspection Kits* – Contains 12 checklist items
- *Other supplies* – Contains eight checklisted items
- *Functional and access needs* – Containing eight items
- *Staffing needs* – Contains the following people, organizations, and capabilities:
  - *Shelter Staff per shift (min. 4-6; maximum 12 hour/7-day shifts)* – Contains six staff skill types
  - *Health and Safety Inspection Team: (2 inspections per day)* – Contains four staff skill types
  - *Credentialing requirements* – Contains two categories of requirements
  - *Staff Support* – Four support requirements
  - *Type and content of needed educational materials/methods* – Contains a single checklist item
  - *Develop resource management/inventory/accountability* – Contains a single checklist item
  - *Required forms, documentation, paperwork* – Contains a single checklist item

Immediately following these recommended sequential steps is a highlighted "Risk Communication … Logistica Needs" subsection, containing eight checklisted communications-related items.

3.2.1.1.2. Operations

This section contains eight pages of checklisted items and sets of items as follows:

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- Mass Care Operations
  - *Provide advice to Incident Commander/Shelter Manager and First Responders*
  - *Determine Public Health Role in Mass Care Operation*
  - *1. Confirm Incident Command System (ICS) Elements* – Contains ten people or capabilities in this role
  - 2. Shelter Operations include ability to provide – references planning document[66] and includes ten shelter capability requirements
    - *Determine Mass Care needs of impacted individuals & populations*
  - *3. Assist with completion of Shelter Facility Walk-through/Assessment. Consider [the following]:* – Contains the following categories for consideration:
    - *Life/Safety issues of the Facility* – Contains seven one-line considerations
    - *Universal Design/Accessibility* – Contains a single checklist item – Contains ten-line items and lists maintaining C-MIST[67] as a requirement.
    - *Facility Services/Resources* – Contains 21 capabilities or physical spaces
  - *4. Confirm Shelter Set-up* – Contains the following shelter aspects:
    - *Incident Command Post (ICP)* or Manager's Station designated
    - *ICS Shelter Staffing Chart* posted
    - *Shelter Operating Policies and Procedures* posted
    - *Shelter Emergency Evacuation Plan* posted
    - *Shelter Log* maintained
    - *Shelter Staff*: post staff shifts and staff meeting schedules – Contains six types of staff or capabilities

[66] Online: http://www.cdc.gov/nceh/ehs/Docs/Guide_for_Local_Jurisdictions_Care_and_Shelter_Planning.pdf, but document not found at this url.

[67] Communication, Medical, (Medical/Functional) Independence, Supervision, and Transportation.

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- *Shelter Client Registration* – Contains three needed capabilities
- *Logistics/Supplies Area* – Contains four services and one three-part considerations
- *Health, Medical and Mental Health Services Area* – Contains 11 items, capabilities, or plans
- *Food and Water Service Area* – Contains 15 single and three sub-listed sets of considerations
- *Dormitory Area* – Containing "Bed spacing: 3 ft. between cots" and "Family Areas with extra space for personal items"
- *Recreation Areas (safe and separate)* – Contains four capabilities
- *Service Animals/Pet Care Area* (See Animal Shelter SOP)
- *Special Needs Areas* – Contains "Isolation/Quarantine Area for mildly ill clients" and "Quiet area for functional needs clients"
- General Shelter Rules Posted – Contains 17 required (and important) shelter characteristics to be sustained, including "Respected Phone-Free Areas"

- *5. Volunteer Management Policies* – Contains 17 staff (volunteer) requirements
- *6. Transportation* – Contains "Parking – lighting, safety, adequate spaces, ADA[68]" and four options under "Functional/Access Needs Transportation Options."
- *7. Environmental Health/Safety Inspections* – Contains three inspection requirements and references environmental and food supplemental checklists below

- *Coordinate public health, medical and mental/behavioral health mass care services* – Contains 11 service one-line requirements and three multi-option requirements
- *Monitor and ensure mass care population health* – Contains four major and several sub-listed actions
- *Refer individuals with health needs to appropriate agencies* – Contains four options

[68] Americans with Disabilities Act.

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- *Prepare for Demobilization and Recovery* – Contains two actions
- *Ongoing Activities* – Contains seven required activities

Immediately following these recommended sequential steps is a highlighted "Risk Communications, containing the following activities:

  - *Refer individuals with health needs to appropriate agencies* – Contains four options
  - *Prepare for Demobilization and Recovery* – Contains two actions
  - *Ongoing Activities* – Contains seven required activities, including:
    - *Update and inform the public* – Containing seven items
    - *Monitor Social Media to keep ahead of rumors*
    - *Maintain communication with other jurisdictions to ensure that messages are consistent, timely and accurate*

3.2.1.1.3. Recovery

The Recovery checklist actions are as follows:

- *Transition Clients* to Home, Temporary Housing or LTC [Long-term Care]
- *Lift orders*[69] that are no longer needed
- *Inspect and clean all facilities;* return them to normal operations
- *Disposal of solid/medical wastes* coordinated with DPH/DEP/LPH as needed
- *Assist with Ongoing Recovery*
- *Submit forms* for emergency expenditures
- *After Action Report* with Improvement Plan and revise plans accordingly

Immediately following these recommended sequential steps is a highlighted "Risk Communications, containing the following activities:

[69] Online: https://en.wikipedia.org/wiki/Patient_lift. Accessed 28 March 2024.

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- Continue to develop Media Messages – Contains four actions
- Monitor Social Media to keep ahead of rumors
- Maintain communication with other jurisdictions to ensure that messages are consistent, timely and accurate.

3.2.1.2. Supplementary Checklists

The protocol also contains useful detailed supplementary checklists for the following:

- "Environmental Health Assessment Form for Shelter for Rapid Assessment of Shelter Conditions During Disasters," two pages, including sections such as
  i. *Assessing agency (site owner) data* - four entries
  ii. *Facility type, name, and census data* - 21 entries
  iii. *Facility* - 13 "standard" checklist entries shown as "Yes," "No," and Unknown ("Unk") or Not Applicable ("NA")
  iv. *Food* - 10 entries in the standard checklist format, also stating "use Food Establishment Inspection Form"
  v. *Drinking water and ice* - four entries in the standard checklist format
  vi. *Health/Medical* - three entries in standard checklist format, specifically, (i) Reported outbreaks, unusual illness/injuries, (ii) Medical care services on site, and (iii) Counseling services available
  vii. *Sanitation* – six entries in standard format
  viii. *Solid waste generation* – five entries in standard format and the sixth as options describing waste type
  ix. *Childcare area* - seven entries in standard format
  x. *Sleeping area* - five entries in standard format
  xi. *Companion animals* - four entries in standard format
  xii. *Other considerations* - five entries in standard format, plus sewage type checklist
  xiii. *Comments* - list critical needs on "Immediate Needs Sheet"
  xiv. *Immediate needs sheet* - a page-long sheet of multiple entries for "Item" and "Description."

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- "Mass Care Access and Functional Needs Intake Form: Communications, medical, independence, supervision/support, Transportation," a two-page form with the following entries:
  - *Family identification* – 11 or more (depending on number in family), plus a warning in red highlighted spreadsheet row that reads, "Do you have a medical or safety concern or issue right now? If yes, STOP and call for assistance NOW! Or call 911"
  - *Communication* – with eight questions total formatted as "Yes/no," "Actions to be taken," and "Name of individual with need," options, including:
  - "Hearing" – three multiple choice entries, and "Languages," with three multiple-choice entries
  - "Vision/sight" – five multiple choice entries/options
  - *Medical* – Ten entries, with question, "Yes/no" option, "Actions to be taken," and "Name of individual with need"
  - *Independence for daily living* – 12 spreadsheet entries formatted as "Yes/no," "Actions to be taken," and "Name of individual with need," options
  - *Supervision and support* – Five spreadsheet entries formatted as "Yes/no," "Actions to be taken," and "Name of individual with need," options
  - *Transportation* – Two options, asking "Do you need assistance with transportation?" and "Do you have any other transportation needs?" both formatted as "Yes/no," "Actions to be taken," and "Name of individual with need," options.
  - *Additional Questions to Interviewer* – four options formatted as "Yes/no," "Actions to be taken," and "Name of individual with need."
  - *Signature* line for HS/DMH interviewer.
- "Shelter Access and Functional Need Memoranda of Understanding" between the MRC and the facility-owning agency, with a two-page matrix of column entries of Vendors, Detail/Account Number, Capacity, Address, Phone, Email, Location of MOU, and MOU-signed date, including rows for the following:

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  - *Communication Providers* – five rows, including "Interpreters," "Spanish," "Sign-language," "Television with captioning," and "Mass 211."[70]
  - *Information Technology/Computer Services* – three matrix rows
  - *Medical Staffing Services* – 11 rows
  - *Food Services* – three rows
  - *Transportation Services* – two rows, "Paratransit Services" and "Public Transportation"
  - *Service Animals* – one row with "Emergency Veterinary Services"
  - *Shelter Maintenance Services* – four rows
  - *Healthcare Institutions* – three rows for Hospitals, Long-term Care, and Group Homes.

- "Durable Medical Equipment List for Children and Adults" from FEMA Guidance Document[71] 2011 contains 29 Items, and columns for their number and location (or MOU). Examples include "Bedside commodes," "Medical Cot w/mattress & half side rails," Wheelchair transfer boards," and "Wedge pillows."

- Mass Care and Sheltering: Consumable Medical Supplies for Children and Adults: Planning estimate is based on 100-person shelter population for one week – contains five columns, that is, #, Item, Description, Quantity, and Notes with 90 items listed. Examples include "Nutritional Supplemental Drinks for Kids/Children (over 12 months of age), ready to drink (i.e., Pediasure)," "Bio-hazard Bags," "Sterile Gauze Sponges 2 in x2in," "External Catheter, male," "Battery Chargers, universal," and Chemical-free Spray Cleaners."

- Shelter Client Health Care Record, asking for "Name of Client," Client ID #," DOB [Date of Birth]," and "Sex, Male or Female," followed by four columns of any number of line-item entries labeled "Date," "Time," Complaint," and "Treatment."

- PUBLIC HEALTH: Shelter Confidentiality Agreement – Contains a checklist of five statements attested to by shelter volunteers and other

[70] Online: https://en.wikipedia.org/wiki/2-1-1. Accessed 28 March 2024.
[71] Online: https://www.fema.gov/about/reports-and-data/guidance. Accessed 29 March 2024.

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workers to sign/date the document agreeing to "to safeguard and protect confidential information."

- Shelter Client Health Care Record – Contains spaces asking for "Name of Client," Client ID #," DOB [Date of Birth]," and "Sex, Male or Female," in five columns for each patient in any number of rows asking for "Date," "Time," Medication, "Dosage," Route," and "Nurse Initials." Each nurse's name and corresponding initials are also requested.
- TRANSPORTATION REQUEST FORM – Includes two pages of multiple choice and fill-in-the-blank items defining a specific transportation request, including people/person transported, from/to locations, and much other data.
- FOOD ESTABLISHMENT INSPECTION REPORT – One-and-a-half pages describing the food establishment, any violations, and presenting a "One Day Menu for Shelter Providing Functional Needs Support Services," see Figure 3.3.
- Guidance for Emergency Action Planning for Retail Food Establishments Massachusetts Food Protection Program – Containing seven "COMMONLY ASKED QUESTIONS REGARDING BOIL WATER ADVISORIES," and seven "General Precautions," including translation of these precautions "for anybody who does not understand English." The document also describes "Specific Activities," washing and cleaning items as well as personal hygiene. Several online sources for "Additional Resources" are provided. Finally, there is a section providing guidance called "Instructions for Post-Boil-Water Orders," containing several instructions for cleanliness.

3.2.1.3. Summary

This SOG provides detailed guidance for scenarios in which MRC volunteers must establish and operate a mass shelter, whether working with other emergency healthcare entities or alone. Its need, applicability and use are included in volunteer training, and demonstrates the complexity as well as completeness of the guidance founded on the experience and lessons-learned from many deployments. As the introduction to the document states in the Quick Overview (see Figure 3.1), "Shelters are like mini villages, often

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One·Day·Menu·for·Shelter·Providing·Functional·Needs·Support·Services¶

¤	Regular¤	Diabetic¤	Reduced·Sodium¤	Pureed¤	Infant¤
Breakfast¤	Orange·Juice·6·oz·¶ Grits¶ Scrambled·Egg¶ Bacon¶ Biscuit/Margarine¶ Coffee·or·Tea¶ Milk·skim·or·2%·8oz¤	Orange·juice·6·oz¶ Grits¶ Scrambled·Egg¶ Bacon·¶ Biscuit/Margarine¶ Coffee·or·Tea¶ Milk·skim·8oz¤	Orange·Juice·6·oz¶ Grits¶ Scrambled·Egg—no·salt·when·cooking¶ Biscuit/Margarine¶ Coffee·or·Tea¶ Milk·skim·8oz·¤	Orange·juice·6·oz¶ Grits¶ Scrambled·Egg·pureed¶ Biscuit/Margarine·pureed¶ Coffee·or·Tea¶ Milk·skim·8oz¤	Formula·and·baby·food¤
Lunch¤	Hamburger·on·bun¶ Potato·chips¶ Peaches·in·juice¶ Cookie¶ Ketchup/Mustard¶ Coffee·or·Tea¶ Milk·skim·or·2%·8·oz¤	Hamburger·on·bun¶ Potato·chips¶ Peaches·in·Juice·¶ Sugar·free·cookie¶ Ketchup/Mustard¶ Coffee·or·Tea¶ Milk·skim·8·oz¤	Hamburger·(no·salt·when·cooking)·on·bun¶ Potato·chips¶ Peaches·in·juice¶ Cookie¶ Ketchup¶ Coffee·or·Tea¶ Milk·skim·8·oz¤	Hamburger·on·bun·pureed¶ Mashed·potatoes¶ Peaches·in·juice·pureed¶ Cookie·pureed¶ Ketchup/Mustard¶ Coffee·or·Tea¶ Milk·skim·8·oz¤	Formula·and·baby·food¤
Dinner¤	Turkey·and·Gravy¶ Dressing¶ Carrots¶ Pears·in·juice¶ Bread·2·slices·Margarine¶ Coffee·or·Tea¶ Milk·skim·or·2%·8·oz¤	Turkey·and·Gravy¶ Dressing¶ Carrots¶ Pears·in·juice¶ Bread·2·slices¶ Margarine¶ Coffee·or·Tea¶ Milk·skim·8·oz¤	Turkey·and·low·sodium·gravy¶ Dressing¶ Carrots¶ Pears·in·juice¶ Bread·2·slices¶ Margarine¶ Coffee·or·Tea¶ Milk·skim·8·oz¤	Turkey·and·gravy·pureed¶ Dressing·pureed¶ Carrots·pureed¶ Pears·in·juice·pureed¶ Bread·2·slices·Margarine¶ Coffee·or·Tea¶ Milk·skim·8·oz¤	Formula·and·baby·food¤

Figure 3.3. One-day menu.

populated by individuals with varying access and functional needs, especially cultural, health and animal needs."

3.2.2. SHAR-MRC Operations Plan: Randolph Board of Health COVID Testing Site

SHAR-MRC OPERATIONS PLAN

RANDOLPH BOARD OF HEALTH COVID TESTING SITE
WEDNESDAY, SEPTEMBER 23, 2020
WE RECOMMEND THAT YOU PRINT THIS DOCUMENT AND BRING IT WITH YOU

EVENT DATE	WEDNESDAY, SEPTEMBER 23, 2020
EVENT TIME	Start: 1330hrs (1:30pm) End: 20:00hrs (8:00pm)
PREPARED BY	Rick Reuss, SHAR-MRC Unit Coordinator
SUMMARY	We will be assisting at a COVID19 testing site.
LOCATION	RICC, 128 Pleasant Street, Randolph.
REPORT TIME and LOCATION	1330hrs (1:30pm) RICC, 128 Pleasant Street, Randolph. Briefing and any Just in time training will start at 1330hrs. All personnel must sign in on roster form and provide cellphone number.
MRC CONTACT	Rick Reuss SHAR-MRC Unit Coordinator. 781-630-2201
EVENT LEADERSHIP	Gerry Cody, Randolph Health Department
FOOD	Some food may be provided, but please bring whatever you require in case no food is available.
BATHROOMS	There will be bathrooms inside building!
WEATHER FORECAST **MODERATELY STRONG WINDS POSSIBLE**	Tuesday Night: Mostly cloudy, with a low around 50. Northwest wind around 18 mph, with gusts as high as 29 mph. Wednesday: Mostly sunny, with a high near 76. West wind 13 to 15 mph, with gusts as high as 26 mph.

Figure 3.4. SHAR-MRC Operations Plan.

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SHAR-MRC OPERATIONS PLAN

RANDOLPH BOARD OF HEALTH COVID TESTING SITE
WEDNESDAY, SEPTEMBER 23, 2020
WE RECOMMEND THAT YOU PRINT THIS DOCUMENT AND BRING IT WITH YOU

WHAT TO BRING / WEAR	• Recommend everyone dress for the weather. • Please bring a small pad of paper and a pen. • Please bring any needed medications that you may require. • Do NOT wear sandals, clogs, crocs, or other open footwear.
OPERATIONS PLAN	The MRC will be assisting with the covid site, both doing testing and directing onsite traffic. All personnel must sign in on roster form and provide cellphone number. Actual assignments will be given out based on number of MRC Volunteers present. Anyone available is requested to help set-up instant canopies at the start of the event Medical Positions: Assist with screening and testing of patients Support Positions: Greeting of Patients Registration Traffic Control Point (access) Traffic Control Point (midpoint) Traffic Control Point (exit)
EMERGENCY CONTINGENCY PLAN	If an emergency is declared on site, all volunteers will assemble at the Hockey Rink or at another location for Personnel Accountability Report (PAR)
COMMUNICATIONS PLAN	Cellphones and some handheld radios will be used for communications at the event.
CANCELLATION OF EVENT	A list of cell-phone and email address of participants for MRC Volunteers who have preregistered to attend has been created. If the MRC receives a cancellation notice, an email and a text message will be sent out.

Figure 3.4. SHAR-MRC Operations Plan (Continued).

This plan, shown in Figure 3.4, describes guidance to MRC volunteers in support of the Town of Randolf, Commonwealth of Massachusetts, at its Board of Health COVID testing site, stating to the assigned volunteers to "PRINT THIS DOCUMENT AND BRING IT WITH YOU." As shown in the figure, it contains high-level guidance needed for the assigned MRC volunteers to know the time and location of the event, operational expectations, contingency plan, Communications Plan and Cancellation notice approach.

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3.2.3. Medical Reserve Volunteer Management Plan: Job Action Sheets

As stated in the JAS introduction, "The Medical Reserve Volunteer Management Plan provides guidance for safe, efficient, and scalable volunteer management. The Plan includes integration with incident management systems; communication with community members and voluntary organizations; volunteer reception, screening, training, matching, deployment, and retention." The document contains JAS guidance for the Volunteer Management System Director, Logistics: MRC Coordinator, Registration Team Leader, Credentialing Team Leader, Assignment Team Leader, Support Team Leader, Demobilization Team Leader, Facilities Team Leader, and MRC Liaison (Command Staff), and the Finance: Data Management Team. The MRC Coordinator (this book's author) JAS are shown in Figure 3.5. The figure shows the many functions from preparedness to closure and improvement of MRC deployments, and whose activities define, develop training and improve all MRC operations as well as develop and sustain healthcare partnerships and vendor relationships.

Job Description	
▪ Responsible for all aspects of Volunteer Reception Center (MRC) management	
▪ Coordinates volunteers processed by the MRC for the response	
▪ Ensures the health and safety of all MRC volunteers	
▪ Recommends all MRC expenditures to the logistics section chief for approval by the incident commander	
▪ Collects and maintains MRC Activity Logs and submits all reports for MRC management	
Reports to	**Contact Information**
Volunteer management system director	
Supervises	
Volunteer Reception Center staff	
Partner Agencies	Contact Information
MEMA – Region III/IV	MEMA 24/7 call line 508-820-2000
MEMA State Emergency Operations Center (SEOC)	MEMA SEOC – 508-820-2000 – ESF 6 (sheltering desk)
Department of Public Health (DPH)	MEMA 24/7 call line 508-820-2000– ESF 8 (medical desk)
American Red Cross (ARC)	24-hour phone: 617-274-5296
Salvation Army	(617) 542-5420
Medical Reserve Corps	www.mrcvolunteer.org
Massachusetts MRC	http://www.mamedicalreservecorps.org/
Boards of health	
Local voluntary agencies	
Local faith community organizations	
Voluntary Organizations Active in Disasters	

Figure 3.5a. MRC Coordinator JAS Job Description.

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	Forms, Protocols, and Other Resources		
	Item	**Description/Notes**	**Quantity/Location**
☐	Medical Reserve Volunteer Management (SVM) Plan		
☐	Job Action Sheets for all positions (JAS)		
☐	VMS Standard Operating Guide		
☐	Regional Shelter Plan with forms/lists/JAS		
☐	Emergency Dispensing Site Plan		
☐	Regional Shelter SOP		
☐	Facility Opening/Closing Assessment Form	In Forms Section	
☐	Resource Request ICS 308 (FORM)	In Forms Section	2 per JAS
☐	Incident Action or Activity Log ICS 214 (FORM)	In Forms Section of Shelter Plan	
☐	Volunteer/Medical Vol. Registration Forms (FORM)	Forms Section	
☐	Personnel Sign In/Out Time Sheets (FORM)	Forms Section	
☐	Incident Report Forms (FORM)	Accidents/Complaints – Plan Forms Section	First Aid Kit
☐	Equipment Recommendations	Radio, cell phone, laptop, printer, internet, copier, camera, cables, power strip, lights	Also need directional/informational signage

Figure 3.5b. MRC Coordinator JAS Job Description: Forms, protocols, and other resources.

	Initial Planning Actions
☐	Plan for volunteer management with the logistics section/incident command/EOC
☐	Designate and activate volunteer management staff positions as needed
☐	Determine the need for Medical Reserve volunteers
☐	Work with IC and PIO to provide appropriate guidance to the public
☐	Determine the need for a Volunteer Reception Center

Figure 3.5c. MRC Coordinator JAS Job Description: Initial planning actions.

	Initial Response
☐	Check in volunteer management staff as they arrive and distribute Job Action Sheets (JAS)
☐	Conduct Volunteer Reception Center facility walk-through (MRC Assessment Form) as available to determine: • Adequate space for all MRC functions • Multiple rooms, areas available • Safety/security • Availability of secure parking

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	Initial Response
	• Availability of food, rest areas for staff • Internet access including Wi-Fi or "hot spot" • Communication capabilities • Accessible and in close proximity to the affected area
☐	Set up the MRC stations: • Registration: Welcome, triage, orientation, information, registration, phone center and message center • Credentialing: Identification and credentialing • Assignment: Liaison with IC/operations; matching; badging/vests; deployment • Training: Safety and Just-in-Time training • Support: Transportation and trouble desk • Demobilization: Debriefing, evaluation and volunteer retention/follow-up • Facilities: Volunteer and staff food, sanitation/cleaning and rest area • Data Management: Documentation Logs of all Actions, Volunteer Time, Volunteer Records, Forms, Expenses
☐	Hold initial staff briefing: • Thank volunteers for their service • Brief on situational awareness and safety • Distribute JAS, Activity Logs, Resource Request forms
☐	Determine the extent of safety needs for MRC/VMS operations • Address life safety issues for the facility during the pre-occupancy inspection. Document all repairs and actions. • Make sure all exits are clearly marked. • Limit the number of entrances and exits to control who enters and exits the facility. Unused doors should be secured. Work with the fire marshal to make sure restricted entrances/exits are not used. • In the case of hurricane, tornado, or high winds, make sure that doors and windows remain closed, since the structural building codes are created with the presumption that doors and windows are closed. Failure to follow these procedures can cause a building to fail and suffer structural damage, even if it is built to storm shelter standards.
☐	Confirm MRC set-up with section chief/IC

Figure 3.5d. MRC Coordinator JAS Job Description: Initial response.

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	Daily MRC Operations
☐	Monitor staff for "burn-out" and inappropriate behavior. • Provide for staff breaks and rest periods • Complete Incident Form documenting any accidents or safety/security problems • Report any concerns to your immediate supervisor and safety officer
☐	Hold shift change briefings with staff and collect Activity Logs: • Situational updates • Collect/distribute Forms: JAS; Activity Logs; Medical Logs; Expense Sheets, Inspections, etc. • Emphasize the importance of documenting everything, especially injuries and complaints • Sign in/out staff • Discuss needs or concerns for the next shift • Create update for the supervisor/IC
☐	Monitor MRC Operations for safety and address safety issues as they arrive
☐	Ensure MRC Operations: • Registration: Welcome, orientation, registration and message center • Credentialing: Identification and credentialing • Assignment: Liaison with IC/operations; matching; badging/vests; deployment • Training: Safety and Just-in-Time training • Support: Transportation, support and trouble desk • Demobilization: Debriefing and volunteer retention/follow-up • Facilities: Volunteer and staff food, sanitation and rest • Data: Log all actions, volunteer time, expenses, incident reports
☐	Volunteer Registration Desk: • Volunteer Welcome: Make each volunteer feel valued • Volunteer Triage: Work with security to assess the appropriateness of all volunteers presenting (Rapid Interviews) • Volunteer Orientation: Provide situational awareness on incident and volunteer opportunities, including affiliations • Volunteer Message Center: Maintain a volunteer message board and phone bank • Volunteer Registration: Ensure all required forms are completed with an expedited process for affiliated volunteers • Forms: (Must show government issued photo ID). o Personnel Sign-in Sheets o Message/Resource Request FORM; Call Center Intake Scripts o Volunteer Registration FORMS and Checklists: skills, interests, availability, licenses, equipment o Code of Conduct and FEMA Readiness FORM o Volunteer Releases and Confidentiality FORM • Data Management: Documentation logs of all actions, volunteer time, volunteer records, forms, expenses

Figure 3.5e. (Continued).

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	Daily MRC Operations
☐	Volunteer Credentialing Desk: • Identification: Must have a government issued photo ID • Licenses: Must provide copies of all licenses and certifications such as o Commercial driver's; hydraulic lift; crane operator; construction supervisor license o CPR/First Aid cards; medical license; must complete Medical License Form o MRC, DART, ARC, or other affiliation ID; health officer/agent; inspector of buildings; DPW; first responder • Verification: Must obtain official verification of all licenses, certifications, affiliations o MAResponds may be able to do real time license checks: www.maresponds.org. You must be registered to use this system. Most MRC unit leaders are registered users. o MAResponds may do CORI checks, but they may take as long as a week o SORI Level III checks can be done on the Mass. Sexual Offender Database http://sorb.chs.state.ma.us/ o CORI checks can sometimes be done in an emergency by local law enforcement o Medical licenses can also be checked at https://checkalicense.hhs.state.ma.us/
☐	Volunteer Assignment Desk: • Liaison: Establish communications with volunteer liaison to coordinate volunteer needs and assignments • Matching: Work with available volunteers and requesting agencies to match volunteer skills/wants with needs • Assignment Briefing: Use Assignment Briefing FORM; provide details of assignment and Volunteer Tracking FORM • Badges: Issue official, dated incident badges or identification • Vests: Issue as available volunteer Identification shirts, vests, wristbands, or hats • Returning: Provide information on returning volunteer identification items • Deployment: Deploy volunteers with assignment instructions and Volunteer Tracking FORM • Demobilization: Provide volunteers with demobilization instructions
☐	Volunteer Training Desk: (See Just-in-Time Training SOG) • Welcome: Thank you for volunteering, purpose of training • Volunteer Health and Safety Training: o Take care of yourself first; ask for behavioral health First Aid support if needed o Work within the scope of your training, experience and comfort/personal limitations o All incident work sites can be potentially hazardous or uncomfortable ▪ Potential security issues; health safety issues ▪ Local weather conditions; and local living/work conditions o Required immunizations/prophylaxis or personal protective equipment o Identification to carry o Work-to-rest ratio should not exceed 2:1 (16 hours work, 8 hours rest) o Report promptly all accidents or injuries o Critical response for any accident involving a vehicle – contact 9-1-1, supervisor or team leader

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	Daily MRC Operations
	• MRC 101 Core Competences: o Personal and family protection and preparedness o Incident Command System and MRC support roles o Mental health and personal limitations o Communications and volunteer deployment protocols, including volunteer protection laws • Volunteer Code of Conduct: o Treat all with respect - honor all victims, volunteers and responders; honor all confidentiality agreements o Communicate clearly; ensure volunteer safety
☐	Volunteer Support Desk: • Transportation: Coordinate and arrange safe transportation for volunteers • Supervision: Provide volunteer support, supervision, and evaluation as able • Trouble Shooting: Staff the trouble desk and coordinate volunteer issues, requests and complaints • Support: Coordinate with logistics to provided volunteers with support
☐	Volunteer Demobilization Desk: • Badge Return: Collect all volunteer identification such as badges and vests • Reports: Collect all final reports and Activity Logs • Exit Information: Ensure that all volunteers receive exit Information • Sign-Out: Ensure that all volunteers sign out and leave promptly • Data: Create a data base for medical follow-up and study as appropriate • Volunteer Affiliations: Provide information on affiliated volunteer opportunities and organizations such as the MRC • Stress Management: Provide Behavioral Health First Aid or Critical Incident Stress Management as appropriate
☐	MRC Facilities Team • Food, water, sanitation, cleaning, rest area, First Aid kit • Phones, TV, Internet, secure power supply, HVAC • Secure storage area for volunteer items, if available
☐	Data Management: • Documentation: Data management system both paper and electronic • Security: Security and privacy protection for all data • Files: Individual volunteer files, forms, information, logs • Reporting: Reporting protocols at the end of each shift/operational period
☐	Coordinate with logistics to ensure adequate staffing for the next operational period

Figure 3.5f. MRC Coordinator JAS Job Description: Daily MRC Operations.

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	MRC Closing
☐	Monitor demobilization for safety
☐	Address safety issues as needed
☐	Remove and store safety signage and safety equipment
☐	Assist with clean up and equipment return • Refresh (clean and sanitize facility and equipment) • Repair (if practical) • Restore (if able, otherwise replace) • Return (borrowed equipment) • Replace • Remove (trash and broken equipment)
☐	Conduct facility closing walk-through with facility manager/representative
☐	Turn in all logs to supervisor
☐	Participate in the After-action Report process, including identification of areas for improvement

Figure 3.5g. MRC Coordinator JAS Job Description: Daily MRC Closing.

3.2.4. Volunteer Handbook: Adapted April 2020

The volunteer handbook has the Table of Contents shown in Figure 3.6 In this case, edited for new volunteers in from the Town of Medford, containing the background information needed for MRC volunteers to appreciate and operate within their adopted organization. It provides an extensive set of guidance for the typical volunteer.

The document provides a complete—though always evolving for improvement—guidance for every MRC volunteer, and can be tailored for every locality in the Commonwealth in order to adapt to specific local conditions and organizations in place. As the document states, its goal (Page 5) is to:

> …improve the public health infrastructure by ensuring adequate staff to support Emergency Dispensing Site (EDS), to respond in the event of public health emergencies and non-emergencies events, and to ensure a trained and credentialed response team(s).

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TABLE OF CONTENTS

Figure 3.6. Table of Contents of the MRC Volunteer Handbook Table of Contents.

Further, it explains the purpose of the regional organization as follows:

The Mystic Valley MRC works with local municipalities to develop and maintain a pool of qualified volunteers who will be available to respond

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to local and regional public health emergencies and to support community service activities that promote public health.
The Mystic Valley MRC recruits and credentials volunteers, coordinates the distribution of training information, and maintains a database of MRC volunteer information.

MRC volunteers may be deployed for:

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

This guidance, adapted to each volunteer's community, emphasizes their support for their local area as well as their inherent value to MRC response beyond their own town, to the region, Commonwealth, country, and world at large.

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Chapter 4

The Tools We Use and Relationships We Build

Abstract

This chapter describes the tools as well as organizational and personal relationships that optimize, including speed and quality of response, our success in meeting Massachusetts emergency healthcare needs. The "tools" include communications and medical equipment our volunteers need to perform the operations described in Chapter 2, which include devices employed as well as material resources "used up" in those operations. The "organizational and personal relationships," or partnerships, provide important operational capabilities not directly relevant to MRC day-to-day operations, but critical in the diverse responses for which we are bound to be activated and deployed.

4.1. Voice and Data Communications

4.1.1. Tools and Protocols Used

Effective person-to-person and conference-call (e.g., *Zoom*, *Webex*, etc.) communication is essential for the MRC to respond to emergencies and public health crises. In Massachusetts, the MRC uses several communication protocols to ensure that volunteers and partner agencies can communicate effectively and efficiently. Here are some of the key protocols used by the Massachusetts MRC:

- *Cellular and wireless communications.* Cellular, WiFi, satellite-based navigation, and other wireless communications has evolved in coverage and capacity in Massachusetts to provide the foundation of MRC information sharing.
- *Massachusetts Responds:* A Web-based tool supporting MRC volunteer and other medical professional credential verification

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- *WebEOC: WebEOC* is an online emergency management web platform[72] used by MEMA and partner agencies to coordinate emergency response efforts. The MRC uses *WebEOC* to coordinate with MEMA and other agencies during emergency responses.
- *MRC Connect:* MRC Connect is an online volunteer management system used by the MRC to manage volunteer information, training, and deployment. Volunteers can use *MRC Connect* to sign up for shifts, track their training, and communicate with MRC leadership.
- *Mass Health Alert Network (HAN):* The *Mass HAN* is a secure, web-based communication system used by public health officials to share information about public health emergencies, outbreaks, and other health-related events. The MRC uses the *Mass HAN* to receive alerts and updates related to public health emergencies.
- *Social media:* The MRC also uses social media platforms, such as *Twitter* and *Facebook*, to communicate with volunteers and the public about emergency response efforts, volunteer opportunities, and other important information.

By using these and other communication protocols, the Massachusetts MRC can quickly and effectively communicate with volunteers and partner agencies during emergency response efforts, ensuring that resources are deployed efficiently and effectively to protect the health and safety of residents and communities.

4.1.1.1. Cellular Communications

Using cellular communication is a necessary communications tool. You can use text social media e-mail and multiple other communication tools through cellular phones. The MRC Leadership use cellular phones to check in and check out volunteers when they arrive to a disaster shelter or emergency dispensing site plus, we use this tool as well to share photos and other important information that needs to be passed on during a deployment. Cellular is probably the most used form of communication with the volunteers and with local disaster shelter and emergency site management. During

[72] Online: https://en.wikipedia.org/wiki/Emergency_management_software. Accessed 26 December 2023.

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deployment you generally do not have your computer right in front of you and this is a quick and easy and efficient way to communicate information effectively.

Sometimes there is a challenge onsite, which are often municipal or school buildings, because cellular does not work. However, if there is Wi-Fi in the building, the cell phones can tie into it, and we can communicate that way. Over the years, the cellular capabilities have drastically improved, and so we include it as part of our communication and call-down drills. Furthermore, most people are accustomed to using cellular on a daily basis. Thus, we use cell phones to locate volunteers geographically, which is a useful capability during difficult travel conditions, providing another tool to "check in" and "check out" volunteers. Overall, cellular communication has become the primary tool used during disasters and other public health events.

4.1.1.1.1. Usage and Applications

Over the years, cell phones have proven valuable in most MRC-deployment scenarios. We have a deployment protocol, which describes some of our communication tools. A web link is provided that gives a short tutorial on how to use different applications and how to get the most use out of your cell phone during a deployment. Their inherent mobility and ease of car charging as well as the use of external batteries to extend cellphone lifetime has further increased their value to MRC operations.

In the early 2000s, cellphones did not yet have the coverage or capacity in many areas requiring MRC deployments – so they could not be relied upon. Advancements in coverage, capacity (3G to 5G), online connectivity (e.g., mobile apps), WiFi-enabling, and GPS-phone location and destination navigation features have further increased its utility.

Cellphone location trackers and navigation apps allow us to provide preferred routes as well as track a volunteer's location for their own safety. If they are deploying to a shelter when there are travel concerns—such as road closures due to flooding, snow, or ice—we are able to provide them with route directions through MEMA information. This MEMA route guidance to the volunteers shelter destination ensures the roads and bridges used by them are safe to use. Part of our protocol is to have the volunteers "text" the leadership upon their arrival at the designated shelter as well as once their shift is over. In this way, the MRC leader can monitor and verify the status of each site and mitigate any unexpected issues that arise.

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Some people can shelter in place (e.g., at home), but they have no way in power outage (assuming they have no home generator) to charge their cell phones for communication with family, friends, or authorities (e.g., e911). So, charging stations are a key element of our shelters, enabling people to charge their cell phones.

After the Lawrence gas explosion, for example, we had a locker system set up that could be rented, including multiple power ports to charge different types of phones. People could drop off their phone and leave it in the locker to be charged along with other electronics. In this way, people did not have to stay at the shelter while their phone or external battery packs were charging.

Every year, smartphones add apps and features that further improve their value in a disaster. We have conducted training for volunteers and response planners on how to use these applications as well as to offer practice session. We have found that many people do not know the latest apps and other feature capabilities. For this reason, the MRC leadership share this evolving technological information, so volunteers and partners can have full access to the most useful phone capabilities available.

The communication methods we use today were described above, but it is important to add that the tools and protocols we use are always evolving. For this reason, they must be repeatedly tested. To this end, we conduct four call-down drills each year. We also use any relatively small deployment as an event of opportunity to practice these protocols. These protocols are always adapted to suit the needs of each situation, proving the value of the resources available to us. The MRC leadership emphasizes people not to enamored in the actual protocols we use at any time, but instead to repeatedly test them.

4.1.1.1.2. In Disaster

During storms and other overt physical disasters, cell towers can be damaged or destroyed, creating a decrease in coverage or capacity. In long-term power outages, cell tower generator power can drop because backup power generators exhaust their fuel supply. Given our primary reliance on cellphones and smartphones for shelter deployment management and control, it is challenging when the associated cell towers fail that provided coverage and capacity one of our shelters.

As most cellphones, particularly smartphones, incorporate Wi-Fi, which may be supported at the shelter, we have a workaround if this situation occurs. The phone's WiFi provides the mechanism to reach the Internet to the apps we deploy, provide several communication alternatives. For example,

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Facebook Messenger reaches our MRC *Facebook* profile. In addition, Smartphone apps such as *WhatsApp*, *Zoom*, *Instagram*, and other apps provide domain-specific connectivity. Sometimes during a disaster, all modes of communication must be tried when their cellular and WiFi connectivity are initially uncertain.

4.1.1.2. Massachusetts Responds

Massachusetts Responds[73] is a useful MRC Web-based tool and has improved over the years. As with any application, there are some things the it does well and other capabilities that are less useful. To this end, it is necessary to have the volunteers practice use of the *Massachusetts Responds* system, so they become adept at using the portal to get into their messages if they cannot get them any other way. Over the years, it has proven to be an effective tool for communication with volunteers and response partners. We have asked many response partners to sign up within the *Massachusetts Responds* system so they can get alerts from MRC leadership in real time. To this end, the MRC leadership uses *Massachusetts Responds* heavily, particularly during disaster.

Through the e-mail response system, the MRC leadership can set up missions or use the messaging system to recruit volunteers for a certain shift, providing location and any other information regarding what they will be asked to do when they arrive. It also enables the download of an *MS Excel* spreadsheet or PDF file attached to the email message. It is value is further by a texting feature, its e-mail feature, and its pager feature. We practice quarterly call-down[74] drills using the Massachusetts Responds system.

The state provides built-in *Massachusetts Responds* practice or training scenarios to "play" through within the system, or we can write our own scenarios during these drill sessions. We often use this practice-scenario feature to poll our volunteers to see what trainings and drills that and community service areas they would like to serve in.

The MRC leadership has also used the smartphone to access the *Massachusetts Responds* system. Doing so is more difficult than using a computer, but it is doable. In fact, in a past drill, the smartphone *Massachusetts Responds* app was used as a drill method to test its effectiveness. Within the *Massachusetts Responds* system, you can assign multiple administrators to your MRC unit. Our MRC unit leadership collaborates with other MRC

[73] Online: https://www.maresponds.org/. Accessed 26 December 2023.

[74] A list of people to be called in the event of an emergency.

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leaders through a signed Memorandum of Understanding (MOU), assigning them as administrators to our units. It is a two-way MOU, so they may use our unit's leadership as a backup, thus being able to deploy and communicate with volunteers through the system. It enables backup MRC management if and when a unit leader is unable to act or communicate effectively with their own MRC unit.

Often, a shelter will have landline network connectivity, which may be used to convey messages to your MRC administrators. It is also the fastest way to share information with volunteers and avoid dependence on the cellphone or smartphone. You can add attachments, URL links, and any other information that is needed for deployment. The system has been improved to be effective during disasters, but the key is to understand how to use the application. Presently, the MRC leadership logs into *Massachusetts Responds* almost daily, using it as a communication tool to share training, weather information, and situational-awareness reports. It will also download an MS Excel spreadsheet file or a PDF that can be printed and taken with the user as a physical information backup. The MRC leadership also provides backup information for our volunteers on a thumb drive, so it is portable and accessible. Within the downloads of the volunteers, you get all the communication tools, e-mail, cell phone numbers, home phone numbers, and pager numbers, all within their profile.

Massachusetts Responds can also be used as a tool to look at the geographic location where the volunteer is located and the shelters to which they might be deployed. In this way, the MRC leadership can attempt to assign them to a location or area closest to them as well as the easiest and safest way to travel to that location.

The *Massachusetts Responds* developers add new capabilities to the system and it is part of the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP)[75] ESAR-VHP is a state-by-state system which may use different applications, so it is imperative that the volunteer coordinators and their administrators know how to use this system. It also tracks volunteers and their intended location, from where they have left, and any other special instructions. There is a planned feature in which you can

[75] Online: https://www.phe.gov/esarvhp/pages/about.aspx. Accessed 26 December 2023. "The goal of the ESAR-VHP program is to eliminate a number of the [credentialing] problems that arise when mobilizing health professional volunteers in an emergency response."

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send it out to thousands of people and it does not impose a limit of 50 as does MS Outlook.

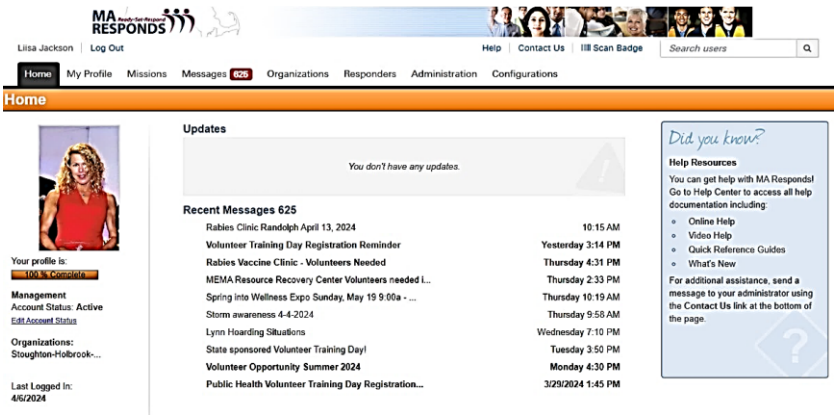

Figure 4.1. *Massachusetts Responds* home page for Liisa Karin Jackson given her MRC position.

Figure 4.2. Massachusetts Responds registering page.

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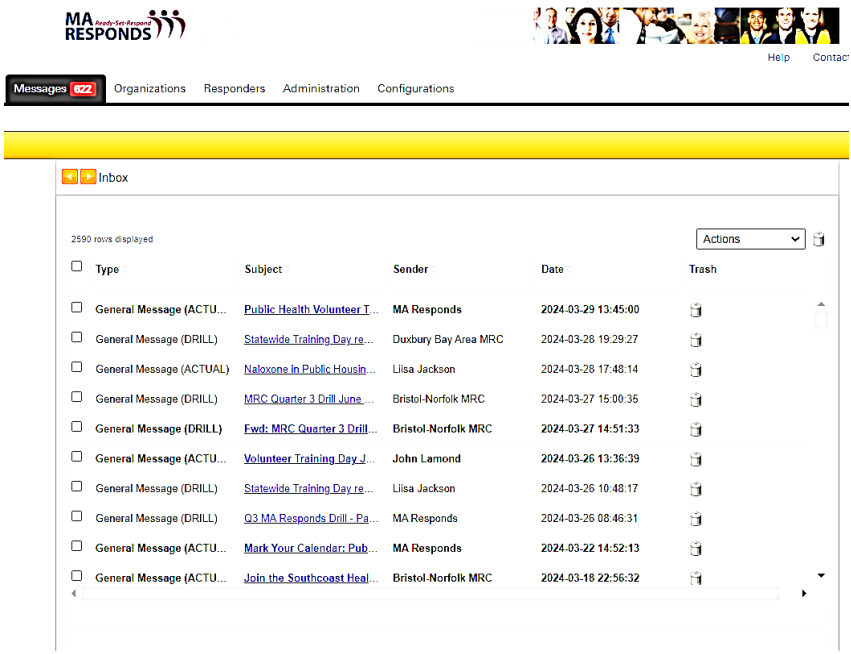

Figure 4.3. *Massachusetts Responds* messages for Liisa Jackson

4.2 Situational Awareness and Command Coordination Tools

4.2.1. WebEOC

Although *WebEOC*[76] is not available to all MRC unit leaders, it is a tool that the Commonwealth configured for municipalities to have situational awareness across the state. It can also input data specific to their community. It is a proven tool for First Responders and municipalities to communicate in a National Incident Management System[77] (NIMS) structured environment. It is licensed and operated by the Commonwealth and can be used to make requests for supplies or volunteers.

WebEOC has proven to be an effective way to get real-time information about a current situation, including road closings or road flooding, snow or ice

[76] Online: https://www.juvare.com/webeoc/. Accessed 26 December 2023.
[77] Online: https://www.fema.gov/emergency-managers/nims. Accessed 26 December 2023.

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conditions, anything that would impair First Responders from accessing a given location. That information is collated and communicated through MEMA and can be relayed if needed to other responder organizations, like the MRC. It also a situational-awareness report published twice a day during a disaster. It describes what is expected in the next 12 hours and what has occurred in the past 12 hours. It provides important information during a disaster, including conditions requiring "work arounds."

WebEOC capabilities also include tracking materials or resources that are deployed to different municipalities. Over the years, we have found to be more effective for municipalities than the MRC. They are required by the Commonwealth to do four call-down drills a year in *WebEOC*. These drills ensure that municipalities can understand how to use this information-sharing tool, which provides an important resource to everyone during a disaster. MRC leadership has what happened prior to *WebEOC*, when information flows were much slower, so disaster response times were much longer.

Figure 4.4. WebEOC screenshot.

4.2.2. MRC LISTSERV

The MRC LISTSERV[78] is a nationwide multimedia service capability for MRC unit leaders and partners. It serves as a high-level communications tool for MRC units to give an update on their status. It is also an important tool for sharing resources with other states and counties, and it serves as a useful mechanism for discussing potential ideas that MRC volunteer leaders want to share. This forum has been useful to gain policies and practice from different MRC's across the country. It has offered our MRC many resources and

[78] Online: https://aspr.hhs.gov/MRC/Pages/MRC-Listservs.aspx. Accessed 1 April 2024.

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adapted them to suit our various units. In this way, the nationwide MRC community is collaborative, and their ideas are shared on a continuous basis. Our network of volunteer leaders uses the LISTSRV to continually share ideas as well as ask for volunteer and other resources frequently during disasters. MRC leaders from other states will provide situation updates for their respective jurisdictions, because the broadest or social media information often proves to be inaccurate.

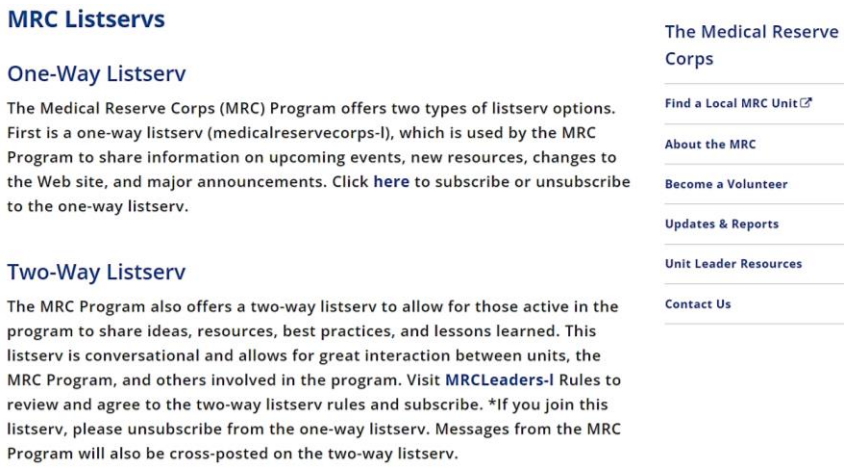

Figure 4.5. *LISTSRV* home screen.

4.2.3. Massachusetts HHAN

The HHAN[79] is an older system and was set up many years ago by the Commonwealths MDPH. There are similar systems as HHAN in other states. It provides yet another way to communicate information practice drills and to share resources with public health authorities and other response organizations. It is not as nimble as the *Massachusetts Responds* system, but it nevertheless has proven to be a useful public health information-sharing tool. At a minimum, it serves as another backup platform if (and when) other systems go down.

[79] Online: https://accelerator.childrenshospital.org/digital-rd/hhan/. Accessed27 December 2023.

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We know that such communications redundancy is imperative; so, if one tool does not work, you can move to another tool, particularly during a disaster. It is therefore important to know how to use these systems, so we do drills with the HHAN. Some MRC unit leaders still use it as a primary communication tool to their volunteers. Unit leaders can add attachments, URL links, and any other emergency public health-related information to be shared. It is an important, established, and dependable tool in the MRC toolkit.[80]

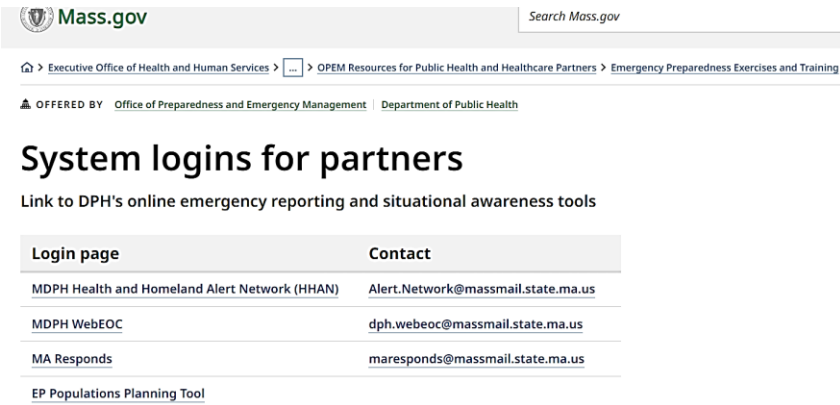

Figure 4.6. Access page to HHAN and other tools on Mass.gov.

4.2.4. *MS Outlook*[81]

We have found *MS Outlook* to be an effective tool for the purpose of redundant communications. Meetings can be proposed in which the invitation is notably accepted, a spreadsheet of volunteers can be downloaded listing the volunteers available to help, and special instructions they may need for deployment, all in the *Outlook* meeting invitation. We had not used this approach prior to COVID, but then realized it was an effective way to share information with partners, our volunteers, and any other parties involved in the deployment.

[80] Online: https://www.mass.gov/info-details/system-logins-for-partners. Accessed 1 April 2024.
[81] Online: https://en.wikipedia.org/wiki/Microsoft_Outlook. Accessed 27 December 2023.

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4.2.5. YouTube Videos

Though there is a need for training and drills to ensure that these processes are in place, there were many "just-in-time"[82] volunteers that arose during COVID and other deployments. These new volunteers had not had the opportunity for our MRC training, so we made *YouTube*[83] videos and *MS PowerPoint*[84] briefings as well as other printed materials so that people could use to educate themselves to be the best prepared when they were deployed. This just-in-time training and is widely used across the country and is an effective tool to give our volunteers and the requesting agencies an understanding of what the volunteers can do and what resources we can provide, particularly during COVID outbreaks.

4.2.6. Social Media

Social media, accessed as stated above via cellphone or smartphone, provides potentially valuable—albeit often requiring verification and validation—situational awareness. As the volunteer population ages in our MRC units, many of them have come to rely only on certain apps, like *Facebook*,[85] *Messenger*,[86] Short Message Service[87] (SMS) texting, and e-mail. Our leadership has found that younger generations (e.g., younger volunteers) also use applications such as *WhatsApp*,[88] *Instagram*,[89] *Twitter*,[90] and multiple other applications available online. MRC leadership has found from years of experience that these additional social media platforms provide useful tools to communicate with those that use those applications.

These tools are particularly useful when conducting call-down drills to evaluate their effectiveness depending on the number and speed of volunteers

[82] Online: https://en.wikipedia.org/wiki/Just-in-time_learning. Accessed 27 December 2023.
[83] Online: https://en.wikipedia.org/wiki/YouTube. Accessed 27 December 2023.
[84] Online: https://en.wikipedia.org/wiki/Microsoft_PowerPoint. Accessed 27 December 2023.
[85] Online: https://en.wikipedia.org/wiki/Facebook. Accessed 27 December 2023.
[86] Online: https://en.wikipedia.org/wiki/Messenger_(software). Accessed 27 December 2023.
[87] Online: https://en.wikipedia.org/wiki/SMS. Accessed 27 December 2023.
[88] Online: https://en.wikipedia.org/wiki/WhatsApp. Accessed 27 December 2023.
[89] Online: https://en.wikipedia.org/wiki/Instagram. Accessed 27 December 2023.
[90] Online: https://en.wikipedia.org/wiki/Twitter. Accessed 27 December 2923.

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responding. Some volunteers have alerts tied to their smartphone apps, while others do not. For this reason, MRC leadership knows that having multiple alerting and information-sharing resources available during a disaster is mandatory. Often, you encounter unique situations in which certain methods fail. Thus, MRC leadership must be "on top of it" (social media operation) all the time, that is, understanding how to use these applications.

We have asked our volunteers to share applications they use prior to their deployment. In this regard, it has proven useful to get onsite information, travel information, and any other needs that could be required at a shelter. These applications generally work well for our needs. When cell coverage is down—often the location of a shelter in a school or older building offers poor cell coverage in any case—WiFi enabled by a backup generator, provides valuable disaster connectivity through the less-vulnerable cable internet-provider infrastructure.

We see improvements in WiFi availability each year, particularly as many communities invest in their broadband systems at the designated shelter locations. For this reason, it is imperative that MRC leadership drill these systems at least annually to verify their operation and make sure they function properly *before* the next disaster. Many times, authorities have not tested these systems in advance, and we were not able to use a shelter location because the generator did not work when tested or something else failed that made it unsafe as a shelter location.

4.3. Materials and Equipment

4.3.1. Staged Equipment and Materials

The MRC units store equipment purchased using different types of funding grants from the Commonwealth or the Federal Government as well as local donations. For example, we have purchased many transportable trailers, and we use them as storage units to house our supplies. We go through these trailers periodically to ensure that all expired items are removed. We prepare a list of what is needed to be replaced or added. Generally, municipalities may put a city or town plate on the trailer so it can be towed by any municipal vehicle, or even a personal vehicle if necessary. In our drills and exercises, we go through the list of items suggested to have at a shelter, then look for ways to purchase materials and maintain perishable supplies. Many times, it is not

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just MRC material and equipment stored in a trailer that we use as our needs may also be fulfilled from multiple available (local) sources for durable medical goods.

We partner with many senior-citizen care centers, seeking donations for unused durable medical goods, wheelchairs, walkers, shower seats, and slide boards[91]; all things that may be needed to care for people with access functional needs in a shelter situation. Over the years, there has been purchase of bariatric[92] cots and other essential equipment, because those with physical access and functional-need issues are unable to safely get on and off a conventional cot.

Many times, a shelter location will be an old school with toilets sized for elementary students, but many people need higher seats and railings to use them effectively and safety in a shelter during or following a disaster. Those with physical-access functional needs and mental health needs are usually among the first to need care at the shelter. They do not have adequate community personnel resources or family resources—nor do they can care for themselves at home. Each time we have opened a shelter, we have identified new equipment that would be useful to have in a shelter situation. It is also imperative to have an adequate supply of these durable medical goods to protect our volunteers and others who could be caring for the shelter patients.

There are also perishable goods that we keep available for volunteer deployment, such as gloves, masks, gowns, face shields, adult diapers, needles, and other *soft* goods that may be needed in a shelter. We also have uniforms and badges available to be deployed, making it easier to identify volunteers in a shelter.

We have developed a sheltering "go kit" that has all the paperwork needed to start and document shelter operations. This kit has JAS (see Chapter 3) for all volunteer positions needed to be filled in a shelter. It also includes clipboards and other office supplies that experience shows may be needed to run a shelter manually when wireless or computer-based technology are unavailable or not functioning. Thus, a paper form backup is available for documenting after-action reports and to log what must be replaced in the kit as well as other possible new kit or stored resources that were indicated during a deployment or a drill.

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[91] Online: https://en.wikipedia.org/wiki/Transfer_board. Accessed 27 December 2023.

[92] Online: https://en.wikipedia.org/wiki/Bariatrics. Accessed 27 December 2023.

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Each community and emergency differ in several ways, so it is necessary that we determine what works best for each community. Healthcare and other responders in two of the Commonwealth regions rely on our supplies, so we have developed a shared inventory of these supplies. Generally, we use our inventory as one factor in annual training of our volunteers, so they know the cash of supplies available to them when deployed. Since the MRC employs multiple volunteer disciplines, a volunteer may identify needs that would benefit them during a shelter operation. Over the years, MRC leadership has found it not only imperative to have the necessary supplies available for the volunteers, but also to ensure they know these resources will be present for their use and safety.

Many times, our supplies are shared with other MRC units, so they can be deployed and tracked within a region to where they are most needed. In this regard, it is very important to perform annual drills and inventories of our supplies, so we know what we have available and what must be replenished. Often during the disaster deployment or pandemic response, many of supplies were used and volunteers did not have the time to log what was used or what else was needed. Thus, if there is an awareness level by the municipalities and the volunteers of what is available to them, it makes them much more comfortable during deployment.

If funding is not available for necessary items, donations can be solicited from hospitals, nursing homes, medical supply companies, printing agencies, and other organizations that can support your mission. Sometimes, MRC leadership must be innovative in figuring out ways to get the supplies needed, which is good preparation for an actual disaster response.

4.3.2. Volunteer Deployment Requirements

The requirements and protocols for MRC volunteers to deploy (see Chapter 3) to a specific disaster-response site, such as a pandemic-response clinic (e.g., a COVID-19 clinic), may vary depending on the specific clinic and location. Some deployment sites can have adequate Internet bandwidth, poor cellular coverage, or vice versa. Thus, general guidelines and protocols that MRC volunteers are be expected to employ are as follows:

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- *Requirements for deployment:* Volunteers may be required to meet certain requirements to deploy for a pandemic-response clinic. This could include completing specific training, obtaining necessary certifications, and meeting any health or safety requirements.
- *PPE:* Volunteers may be required to wear appropriate PPE, such as masks, gloves, and gowns, while working at the clinic. The specific PPE requirements may vary depending on the nature of the clinic and the level of risk.
- *Deployment-site protocols:* Volunteers should be familiar with the protocols and procedures in place, such as at a specific pandemic-response clinic. These protocols could include patient-flow, registration procedures, and safety protocols.
- *Vaccine administration:* If the clinic involves administering vaccines, volunteers may be required to complete specific training on vaccine administration, storage, and handling.
- *Communication protocols:* Volunteers should be familiar with the communication protocols in place for the clinic, including how to contact other volunteers, clinic staff, and emergency services if needed.

Overall, MRC volunteers deploying for a pandemic clinic or other deployment site should be prepared to follow all applicable protocols and guidelines to ensure the safety of patients, volunteers, and staff. The specific requirements and protocols may vary depending on the location and nature of the clinic, so volunteers should check with their local MRC unit or clinic coordinator for more information.

4.3.3. Personal Preparedness Kits

During deployment, we ask that our volunteers have both a personal preparedness, or readiness, kit and a vehicle preparedness kit. These kits must have all the essential items they envision needing if they must leave their home and are assigned a location for longer than 24 hours. This kit includes toothpaste, toothbrush, socks, possibly a blanket, a small pillow, books, and other essential personal item that a volunteer may need at a shelter, so

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volunteers are more willing and able to deploy. Only basic needs should be met in these kits. We asked that they build their own kits, so they have what they need when they deploy. Our volunteers annually describe their personal kit contents in September for preparedness month and often throughout the year.

Each of the preparedness kits are personal and need to be made for and by each person. We have received funding over the years for backpacks, shirts, emergency blankets, hand-crank chargers, and "stop-the-bleed"[93] kits, so our volunteers have supplies they need when deployed. These events also present an opportunity to help them evaluate the contents of their kit, particularly when they see what others have included in them and why.[94]

Figure 4.7. A readiness kit.[95]

4.3.4. The Hummer Club

One of the first questions asked by the MRC leadership when deploying a volunteer is "Are both you and your family safe?" We consider it unfair to ask a volunteer to deploy if things are not safe at home or they may have a vehicle that is unsafe in winter weather. If they cannot get to a location due to their vehicle or access to the roads, we arrange carpooling, sometimes asking our volunteers just to do transport. We have joined four-by-four clubs, such as the

[93] Online: https://www.dhs.gov/stopthebleed. Accessed 27 December 2023.

[94] It has been an effective way to give back to the volunteers and share information on how to be best prepared during a disaster, both for themselves and their families when they deploy.

[95] Online: https://www.ready.gov/kit. Accessed 1 April 2024.

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Hummer[96] Club, and they are always very willing and able to transport volunteers and or supplies during the disasters if needed. In addition, they towed our trailers and appreciated using their military-purpose-built vehicles to transport people and move supplies.

This partnership developed during the 2007 ice storms. We had a doctor that lived in Concord, Massachusetts, and would be traveling to Pittsfield. On a clear day, this was a one-hour travel time, but she explained her tires had tread as thin as "baloney skins." This situation justified our leadership asking about her travel capability in bad weather conditions. If she had had an accident because of unsafe driving conditions, she could have become another person needing rescue, or worse. We do not want MRC volunteers or other collaborators adding to the disaster problem.

Figure 4.8. Home page for the *Hummer Club*.

[96] Online: https://en.wikipedia.org/wiki/Hummer. Accessed 27 December 2023.

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4.3.5. Personal Protective Equipment

PPE is a necessary tool during most deployments. It is imperative that clinical and non-clinical volunteers have access to PPE to protect themselves and others from the first potential disease outbreak and ensure overall cleanliness. The PPE gives a comfort level to our volunteers, both when they know they have PPE available to them when they are deployed. It has been challenging at times, because we had not had access to adequate supplies, particularly before the COVID-19 pandemic. When needed, we may request MEMA to get PPE supplies to a shelter, utilize our own shelter supplies, or use PPE supplies we have stockpiled in our MRC trailers or storage areas.

For this reason, it is important to know what supplies are needed at a location as much as possible beforehand. Of course, a general "rule of thumb" is to have more available than is expected to be needed rather than less. Most clinical volunteers are accustomed to using PPE throughout their working day. They have long understood its critical need for shelter operations during the COVID pandemic, no matter the nature of the disaster.

Often, volunteers had to make their own cloth masks—which was another request we made of them—as well as face shields.[97] At one time, we had a network of volunteers that would pick up PPE and deploy it where it was most needed. At one point, we even worked with a high school STEM[98] teacher that helped us using 3D printers. We also deployed over 15,000 face shields that were constructed from old overhead projector clear slide or viewgraph materials. We were encouraged by how much PPE was donated. At one point, our MRC leader's garage served as a clearinghouse where donated supplies could be picked up. We improvised many methods of acquiring and dispersing the needed PPE before manufacturer supply could be adequately sustained.

We also provided guidance on how to properly "don and doff" PPE, and how to prevent the spread of infection and at a time when people were using N95 masks.[99] We shared information on the best way to store them and how they could safely reuse them it. At the inception of COVID-19,[100] no one really knew the virulence of COVID-19. First Responders were exhausted and

[97] Online: https://en.wikipedia.org/wiki/Face_shield. Accessed 27 December 2023.

[98] Online: https://en.wikipedia.org/wiki/Science,_technology,_engineering,_and_mathematics. Accessed 27 December 2023.

[99] Online: https://en.wikipedia.org/wiki/N95_respirator. Accessed 27 December 2023.

[100] Robert Irving Desourdis, Ed. *The COVID-19 Disaster: Historic Lessons Learned and Benefits of Human Collaboration*. New York: NOVA Science Publishers, 2021, pp.394-410.

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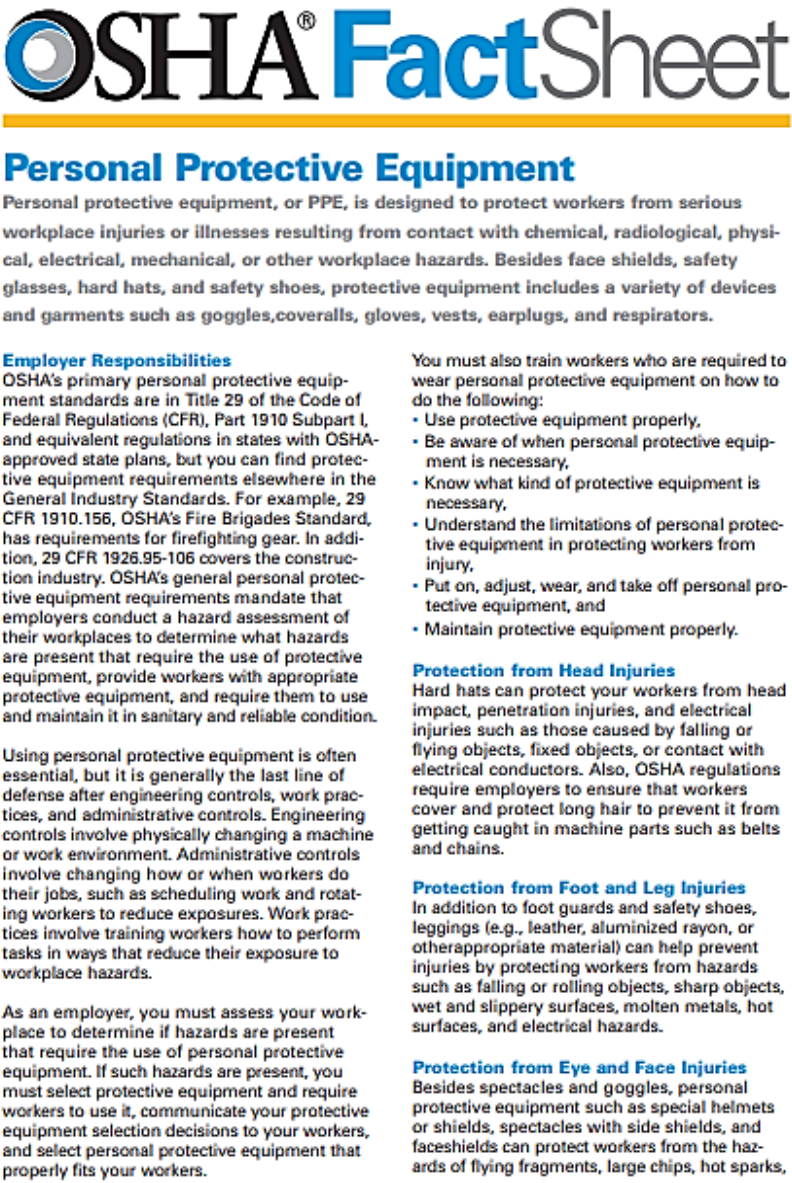
grateful to receive anything that we could provide to keep them safe during the pandemic.



OSHA® FactSheet

Personal Protective Equipment

Personal protective equipment, or PPE, is designed to protect workers from serious workplace injuries or illnesses resulting from contact with chemical, radiological, physical, electrical, mechanical, or other workplace hazards. Besides face shields, safety glasses, hard hats, and safety shoes, protective equipment includes a variety of devices and garments such as goggles,coveralls, gloves, vests, earplugs, and respirators.

Employer Responsibilities

OSHA's primary personal protective equipment standards are in Title 29 of the Code of Federal Regulations (CFR), Part 1910 Subpart I, and equivalent regulations in states with OSHA-approved state plans, but you can find protective equipment requirements elsewhere in the General Industry Standards. For example, 29 CFR 1910.156, OSHA's Fire Brigades Standard, has requirements for firefighting gear. In addition, 29 CFR 1926.95-106 covers the construction industry. OSHA's general personal protective equipment requirements mandate that employers conduct a hazard assessment of their workplaces to determine what hazards are present that require the use of protective equipment, provide workers with appropriate protective equipment, and require them to use and maintain it in sanitary and reliable condition.

Using personal protective equipment is often essential, but it is generally the last line of defense after engineering controls, work practices, and administrative controls. Engineering controls involve physically changing a machine or work environment. Administrative controls involve changing how or when workers do their jobs, such as scheduling work and rotating workers to reduce exposures. Work practices involve training workers how to perform tasks in ways that reduce their exposure to workplace hazards.

As an employer, you must assess your workplace to determine if hazards are present that require the use of personal protective equipment. If such hazards are present, you must select protective equipment and require workers to use it, communicate your protective equipment selection decisions to your workers, and select personal protective equipment that properly fits your workers.

You must also train workers who are required to wear personal protective equipment on how to do the following:

- Use protective equipment properly,
- Be aware of when personal protective equipment is necessary,
- Know what kind of protective equipment is necessary,
- Understand the limitations of personal protective equipment in protecting workers from injury,
- Put on, adjust, wear, and take off personal protective equipment, and
- Maintain protective equipment properly.

Protection from Head Injuries

Hard hats can protect your workers from head impact, penetration injuries, and electrical injuries such as those caused by falling or flying objects, fixed objects, or contact with electrical conductors. Also, OSHA regulations require employers to ensure that workers cover and protect long hair to prevent it from getting caught in machine parts such as belts and chains.

Protection from Foot and Leg Injuries

In addition to foot guards and safety shoes, leggings (e.g., leather, aluminized rayon, or otherappropriate material) can help prevent injuries by protecting workers from hazards such as falling or rolling objects, sharp objects, wet and slippery surfaces, molten metals, hot surfaces, and electrical hazards.

Protection from Eye and Face Injuries

Besides spectacles and goggles, personal protective equipment such as special helmets or shields, spectacles with side shields, and faceshields can protect workers from the hazards of flying fragments, large chips, hot sparks,

Figure 4.9. OSHA Fact Sheet on PPE.

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optical radiation, splashes from molten metals, as well as objects, particles, sand, dirt, mists, dusts, and glare.

Protection from Hearing Loss
Wearing earplugs or earmuffs can help prevent damage to hearing. Exposure to high noise levels can cause irreversible hearing loss or impairment as well as physical and psychological stress. Earplugs made from foam, waxed cotton, or fiberglass wool are self-forming and usually fit well. A professional should fit your workers individually for molded or preformed earplugs. Clean earplugs regularly, and replace those you cannot clean.

Protection from Hand Injuries
Workers exposed to harmful substances through skin absorption, severe cuts or lacerations, severe abrasions, chemical burns, thermal burns, and harmful temperatureextremes will benefit from hand protection.

Protection from Body Injury
In some cases workers must shield most or all of their bodies against hazards in the workplace, such as exposure to heat and radiation as well as hot metals, scalding liquids, body fluids, hazardous materials or waste, and other hazards. In addition to fire-retardant wool and fireretardant cotton, materials used in whole-body personal protective equipment include rubber, leather, synthetics, and plastic.

When to Wear Respiratory Protection
When engineering controls are not feasible, workers must use appropriate respirators to protect against adverse health effects caused by breathing air contaminated with harmful dusts, fogs, fumes, mists, gases, smokes, sprays, or vapors. Respirators generally cover the nose and mouth or the entire face or head and help prevent illness and injury. A proper fit is essential, however, for respirators to be effective. Required respirators must be NIOSH-approved and medical evaluation and training must be provided before use.

Additional Information
For additional information concerning protective equipment view the publication, Assessing the Need for Personal Protective Equipment: A Guide for Small Business Employers (OSHA 3151) available on OSHA's web site at www.osha. gov. For more information about personal protective equipment in the construction industry, visit www.osha-slc.gov/SLTC/constructionppe/ index.html.

Contacting OSHA
To report an emergency, file a complaint or seek OSHA advice, assistance or products, call (800) 321-OSHA or contact your nearest OSHA regional or area office.

This is one in a series of informational fact sheets highlighting OSHA programs, policies or standards. It does not impose any new compliance requirements. For a comprehensive list of compliance requirements of OSHA standards or regulations, refer to Title 29 of the Code of Federal Regulations. This information will be made available to sensory impaired individuals upon request. The voice phone is (202) 693-1999; teletypewriter (TTY) number: (877) 889-5627.

For more complete information:

OSHA Occupational Safety and Health Administration

U.S. Department of Labor
www.osha.gov
(800) 321-OSHA

DOC 4/2006

Figure 4.9. OSHA Fact Sheet on PPE (Continued).

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4.3.6. Maintaining Supplies

We have described our prepositioned resources in trailer-storage areas and onsite at shelters and point-of-distribution centers. For this reason, we verify our inventory to make sure we have the supplies we anticipate will be needed and that are viable to be used. During the process prior to COVID pandemic, we had developed a mapping system in Google Maps[101] that (i) had an inventory of each of the cashes and resources available to us; (ii) where it was located; (iii) how it was to be accessed; and (iv) who had the authority to use it during a disaster. Conditions are never as organized as just before a planned day-to-day drill, training, or other scheduled activity, but rarely during an actual deployment.

For this reason, it is necessary to adapt to any situation and determine the best way to acquire the needed resources. Included in those resources is the printed (hard copy) information needed on site. These documents change significantly during the deployment as people determine what works best, or the Commonwealth distributes resources to be used for continuity of information.

Again, it is imperative that our MRC operations remain flexible and innovate when evolving the optimum way to support and respond to any natural disaster. This innovation includes accessibility to a cache of supplies. The verification and validation of this cache is an ongoing effort and each disaster or deployment identifies needs that we had not yet foreseen. For this reason, every training, drill, deployment, or other MRC response generates an after-action report needed identify to close any identified capability gaps.

4.3.7. Deployment Site Protocols

For the safety of our MRC volunteers and to provide the best service to the entity requiring our support, it is best to have volunteers prepared through understanding of deployment protocols, shelter, and point-of-distribution operations (see Chapter 3). Onsite at a deployment location, whether it be a clinic, a testing site, or a shelter, we provide both electronic and hardcopy information with the inventory of supplies. We use the paper backups for sign-

[101] Online: https://en.wikipedia.org/wiki/Google_Maps. Accessed 27 December 2023.

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in sheets. During the pandemic, we needed them as a backup because there was not a system in place to track the vaccinations.

2021 DEPLOYMENT READINESS GUIDE	2019 DEPLOYMENT READINESS GUIDE
Points of Dispensing (PODs): • Comprehensive POD Support • Basic POD Support • COVID-19 Drive-Through Vaccination POD Support • Influenza Immunization PODs During the COVID-19 Pandemic • Mass PODs	Sheltering Operations: • Medical Shelter Management Team • Non-Medical Emergency Shelter Management, Operations, and Donations Management Teams
Medical Surge: • Code Triage Response (Emergency Department Support) • Clinical and Non-Clinical Healthcare Settings Support • Long Term Care Facility Support	Alternate Care Sites (ACS)/ Medical Surge: • Basic Alternate Care Site • Alternate Care Sites/Co-located Medical Clinics • Pharmacy Management Liaison/Pharmacy Cache for ACS • Medical Surge Teams • Family Assistance Center Task Force • Patient Reception Area (PRA) for National Disaster Medical Systems (NDMS) • Pharmacy Management Liaison/Pharmacy Cache for ACS

Figure 4.10. Deployment readiness guides.[102]

Our MRC leadership provides volunteers with a list of what they need to bring if they do not have a "72-hour kit," that is, the available supplies to be expected at a deployment site. This information is provided in their JAS (see Chapter 3), so they have expectations of what they could need when they are deployed. As described above, we employ several methods of communication with our volunteers when they are deployed. They are provided with the assigned JAS, onsite emergency contact numbers, and relevant travel information they need to know. Along with what was provided at the shelter or point of distribution, it is imperative that we drill these protocols so people are prepared to deploy without having difficulty assembling the supplies they may need within their kits.

We also ask our volunteers to include their own PPE, so they have them available if there are inadequate PPE onsite. These drills are done throughout the year, so people understand their potential needs, identify supplies they may

[102] Online: https://www.naccho.org/programs/public-health-preparedness/medical-reserve-corps/mrc-deployment-readiness-resources#mission-sets. Accessed 1 April 2024.

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need, and what to expect when they arrive in an unknown situation. This information is included in the deployment information that is given to the volunteers and shared with the requesting agencies, so everybody is "on the same page."

We update our deployment protocols annually and submit to them to the Commonwealth, which has provided the MRC with templates that we can use to develop our own deployment protocols. As we have stressed, it is essential to conduct drills using these protocols, so people thoroughly understand the deployment process. Occasionally, there is a volunteer that has not had the opportunity to learn our protocols before being asked to deploy. For this reason, this documentation is shared with them at their assigned shelter when they are deployed, which maximizes their safety and effectiveness through redundancy of available MRC information.

4.3.8. Vaccine Administration

The H1N1 and COVID pandemics served to demonstrate the value of available material assets and our adaptive training and practice protocols.

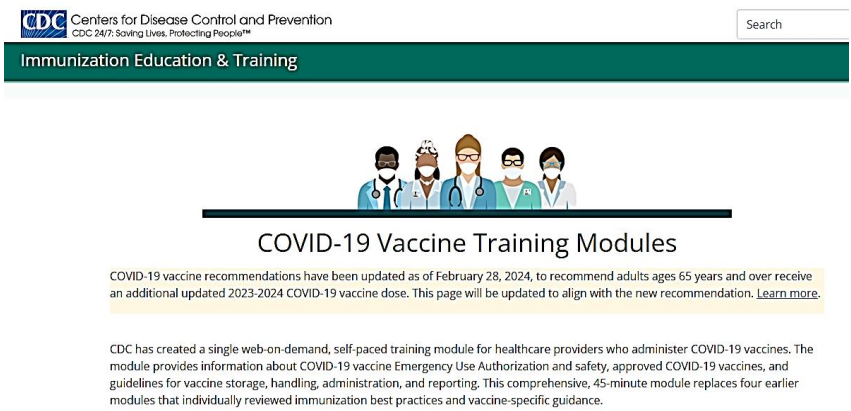

Figure 4.10. COVID-19 Training Modules.[103]

[103] Online: https://www2.cdc.gov/vaccines/ed/covid19/. Accessed 1 April 2024.

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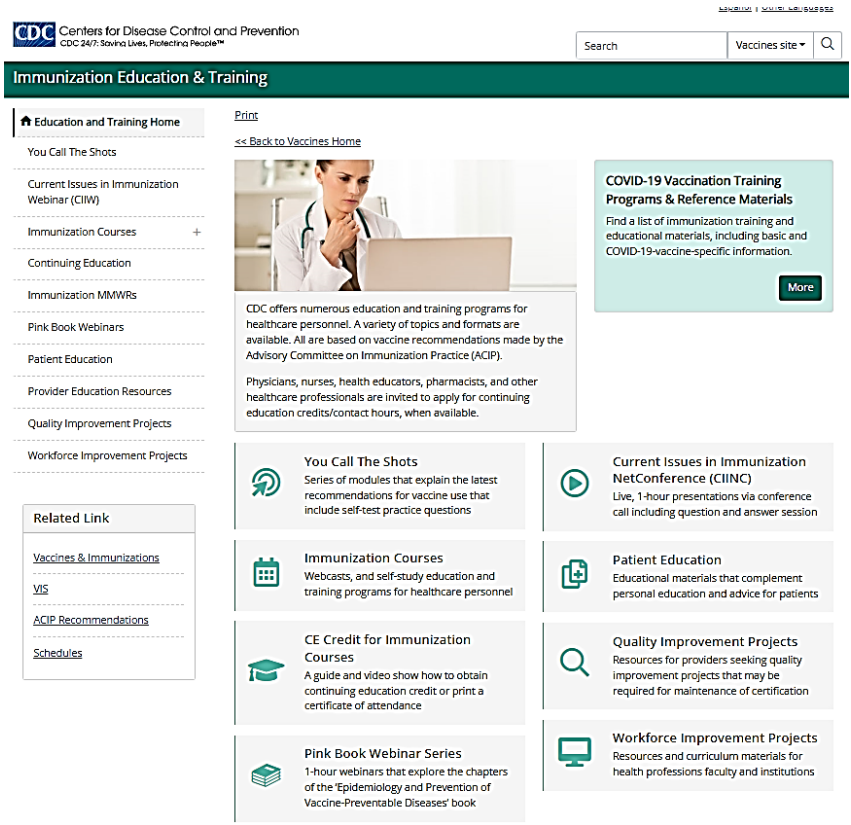

Figure 4.11. Immunization education and training from the CDC.[104]

4.3.9. MRC Operations

During COVID, there were (i) different ways to distribute the vaccine, (ii) recommended needles to be used in the protocol for different in-need populations, and (iii) identification of who was eligible for the vaccine. This critical data was shared continually using our the *LISTSRV* with all the

[104] Online: https://www.cdc.gov/vaccines/ed/index.html. Accessed 1 April 2024.

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volunteers, so they understood the most recent recommendations. We found that *YouTube* videos, printed materials, onsite supplies, and onsite just-in-time training were most often used to deal with these needs.

We would have used these information-sharing methods during H1N1,[105] but at that time we did not have the current technology to communicate with volunteers. At that time, training had to be conducted in live onsite sessions, and that delayed our response. We now conduct annual flu clinics or other public health events to practice operation of point distribution centers. We report our findings to the Commonwealth as well as our response partners. In this way, we identify gaps identified during the point-of-distribution drill and educate our volunteers on what to expect.

Each community has its own point-of-distribution site or sites that have been identified as the place where they would hold public clinics. During the COVID pandemic, there was a need for multiple sites. Given this stress on establish distribution points, we improvised "outside the box" by establishing clinics at churches, in hospital parking lots, and drive-through Department of Public Works (DPW) buildings. It was inspiring witness the innovation that evolved to manage the situation and minimize the infection risk, while performing extensive testing and accessibility to vaccine.

The Commonwealth supplied our MRC with needles, band aids, and trucks; everything we might need to establish a vaccine point-of-distribution site. We used all those supplies during COVID, and most of the PPE purchased by many local health departments with Commonwealth or federal funding at these point-of-distribution sites. Prior to the COVID pandemic, PPE supplies had been spurred by the H1N1 outbreak. The problem with our protocol at the time was that it disposed of any expired supplies, and unfortunately, expired supplies could still be used, particularly if there was nothing else to use during an infectious disease outbreak or vaccination. Much of the expired supplies had been thrown away during inventories, although they were still mostly usable. Again, this waste made us change protocols to better equip ourselves for the next disaster.

[105] Online: https://en.wikipedia.org/wiki/Influenza_A_virus_subtype_H1N1. Accessed 27 December 2023.

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4.3.10. Pandemic Response Clinics

The pandemic-response clinic, such as the MRC, supports or staffed for COVID-19. Establishing a pandemic-response vaccination clinic requires a variety of resources, including:

- *Vaccines:* The most important resource needed for a vaccination clinic is the COVID-19 vaccine itself. The vaccine should be obtained from authorized suppliers.
- *Trained healthcare personnel:* Healthcare personnel, such as doctors, nurses, pharmacists, and other trained professionals, are needed to administer the vaccine, monitor patients after vaccination, and handle any adverse reactions.
- *Location:* A suitable location is needed to set up the vaccination clinic. Ideally, the location should be accessible and have adequate space to accommodate the staff and patients.
- *Equipment:* Equipment such as syringes, needles, alcohol swabs, gloves, and other medical supplies are needed to administer the vaccine and maintain safety protocols.
- *IT infrastructure:* An electronic health record (EHR) system is needed to manage patient data, schedule appointments, and monitor vaccine inventory.
- *Communication materials:* Clear and concise communication materials, including posters, brochures, and other educational resources, are needed to inform patients about the vaccine, the vaccination process, and any potential side effects.
- *Transportation and storage:* An adequate transportation and storage system is needed to ensure the safe and timely delivery of the vaccine to the clinic and proper storage of the vaccine according to the manufacturer's instructions.

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Figure 4.12. MRC immunization training options.[106]

Overall, setting up a pandemic-response vaccination clinic requires careful planning, coordination, and allocation of material and equipment resources to ensure the safe and effective administration of the vaccine to the community.

4.4. Partnerships

The MRC is comprised of medical professionals and other community volunteers who are trained to respond to public health emergencies and provide support during disasters. The MRC operates at the national, state, and local levels, and partnerships with various organizations are essential for their success.

- *Public Health Departments:* The MRC often collaborates closely with local and state public health departments to support public health

[106] Online: https://www.mrcvolunteer.org/eds-pod-.html. Accessed 1 April 2024.

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initiatives and emergency response efforts. This partnership involves coordinating volunteer activities, training, and resource sharing.

- *Hospitals and Healthcare Facilities:* Many MRC units partner with hospitals, clinics, and other healthcare facilities to recruit medical professionals and other volunteers, as well as to provide training and support for emergency response activities.
- *Community Organizations:* The MRC often partners with local community organizations, such as faith-based groups, non-profits, and community centers, to engage and mobilize volunteers and to reach diverse populations within the community.
- *Emergency Management Agencies:* Collaboration with local and state emergency management agencies is essential for the MRC's involvement in disaster response and preparedness. These partnerships often involve joint planning, training, and coordination of resources.
- *Educational Institutions:* Partnerships with universities, colleges, and schools can provide the MRC with access to volunteers, training facilities, and resources for community outreach and education.
- *Non-Governmental Organizations (NGOs):* The MRC may form partnerships with NGOs that have a focus on public health, disaster relief, or community service to leverage resources and expertise.
- *Corporate Partners:* Some MRC units may engage in partnerships with local businesses and corporations to secure in-kind donations, sponsorships, or volunteer support.

Formal partnerships are often established through MOUs or similar agreements that outline the terms of collaboration, while informal partnerships may involve ongoing coordination and collaboration without a formal agreement.

4.4.1. The Importance and Establishment of Partnerships

Exercises, drills, deployments, leadership planning meetings, and any situation that gives you an opportunity to partner with another organizations,

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either by sharing resources or volunteers, is advantageous. In one of our day-to-day activities, we work with homeless shelters, hospitals, nursing homes, battered women's shelters, suicide prevention centers, and opiate programs. All these community resources need volunteers, which is our major source of valuable talent.

By working together with our response partners, and having our volunteers become integrated into the emergency response system, our communities across the Commonwealth are best prepared for all facets of both expected and unanticipated disasters. For this reason, it is continuously important to propose/attend meetings and build partnerships, particularly because the one-to-one trust relationships built with other organizations are at risk when their individuals—engaged in our cross-organization relationship—advance, retire, or otherwise leave their positions.

For this reason, the MRC leadership is always reaching out to potential, or verifying activities of existing, partners. Our outreach describes the resources available from the MRC and explains how they would be of value to the municipality or any entity requesting resources during disasters. No request is too small if we can provide it. We will issue a request for whatever is needed, and our volunteers continue to "step up" and deliver, devoting their time and expertise during either major disaster or community day-to-day health initiatives.

Often, there are informal partnerships that develop due to the needs of a disaster deployment. In these cases, it is best to already have an MOU in place with your partner organization. The MOU—established and signed by leadership before the disaster—ensures both the MRC and partnering organization have a good understanding of what each partner can and will seek to provide. It is therefore important to have that trusted collaboration between response partners before an actual disaster. Such pre-disaster partnerships give the MRC and organization's leadership more time to develop and deepen the relationship, learn from each other's organization, train volunteers in possible activities to help the partnering organization, and to learn their mutual protocols.

Over the years, these partnerships have been effective resources during times of need. During day-to-day operations, the MRC is integrated with many common community resources. In this way, they understand "how it works" and "what resources are needed, and when." We also learn what resources can be provided, because during disaster there remain (and occur) substance abuse, health, battered women, and safety issues as well as typical day-to-day issues

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that are often pushed aside during a disaster or deployment. For this reason, it is imperative that we understand partner-agency systems and our volunteers are prepared for working within these systems.

The MRC leadership saves many hours while increasing their virtual capabilities if these partnerships are built prior to a disaster. The resulting trust and understanding of MRC capabilities and resources means they need not be explained and evaluated at the time of a disaster, when time is often of the essence. In this regard, it is important to have the current, verified contact information of the organizations or response partners. We perform this verification during call-down drills involving multiple organizations, greatly improving our collective continuity of operations, and updating our protocol documents.

4.4.2. Established MRC Partnerships in Massachusetts

There are multiple established partnerships that are formal and informal across Massachusetts. For example, we have been working with the American Red Cross[107] and the Salvation Army[108] and other nongovernmental organizations (NGOs). Over time, each of us has proven capable of providing needed resources during a disaster as well as day-to-day activities. It is important to understand the capabilities of each organization and what resources it can provide. This understanding before the disaster saves valuable leadership time and streamlines the response process during disaster. There are informal partnerships with local grocery stores, pharmacies, and other businesses outside of deployments. Each year, we strive to build more such partnerships, both so we are not providing overlapping (unless needed) or conflicting services when there is no time to waste.

4.4.3. Health and Medical Coordinating Coalition

The MRC and the HMCC in Massachusetts have a partnership that is focused on enhancing emergency preparedness and response capabilities in the state. The HMCC is a coalition of healthcare organizations, public health agencies,

[107] Online: https://www.redcross.org/. Accessed 27 December 2023.
[108] Online: https://www.salvationarmyusa.org/usn/. Accessed 27 December 2023.

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and emergency management agencies that work together to coordinate healthcare and public health response during emergencies and disasters.

The partnership between the MRC and HMCC in Massachusetts involves a range of pre-planned activities, including joint training and education programs, collaborative volunteer deployments during emergencies and disasters, and support for public health initiatives such as vaccination clinics. MRC volunteers and HMCC members may work together to provide medical care and triage services, support public health outreach efforts, and coordinate emergency response efforts across different agencies and organizations.

In addition, the MRC and HMCC collaborate on emergency planning and preparedness activities, such as conducting drills and exercises to test emergency response plans and identify areas for improvement. The partnership also includes efforts to recruit and retain volunteers who are interested in serving their communities in times of need.

Overall, the partnership between the MRC and HMCC in Massachusetts helps ensure that communities are better prepared to respond to emergencies and disasters of all types, particularly those that impact public health and healthcare systems. By working together, the two organizations can leverage their respective strengths and resources to provide more effective and efficient services to those in need.

4.4.4. American Red Cross

The American Red Cross and the MRC in Massachusetts have a partnership that enhances emergency preparedness and response capabilities across the state. The Red Cross is a humanitarian organization that provides emergency assistance, disaster relief, and education across the US, including in Massachusetts. Of course, the MRC is a network of volunteers who support public health and emergency preparedness efforts in their communities.

The partnership between the Red Cross and the MRC in Massachusetts involves a range of activities, including joint training and education programs, collaborative volunteer deployments during emergencies and disasters, and support for public health initiatives such as vaccination clinics. The Red Cross and MRC also work together to recruit and retain volunteers who are interested in serving their communities in times of need.

During major emergencies and disasters, the Red Cross and MRC may collaborate to provide shelter, food, and other essential services to affected

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individuals and families. MRC volunteers may assist with medical care and triage, while Red Cross volunteers may provide disaster relief services such as sheltering, feeding, and distributing supplies.

Overall, the partnership between the Red Cross and MRC in Massachusetts helps ensure that communities are better prepared to respond to emergencies and disasters of all types. By working together, the two organizations can leverage their strengths and resources to provide more effective and efficient services to those in need.

4.4.5. Emergency Management Agencies

The MRC in Massachusetts works closely with local emergency management agencies to enhance emergency preparedness and response capabilities. MEMA is the state agency responsible for coordinating emergency management activities across the state, and the MRC works with MEMA and local emergency management agencies to support their efforts.

MRC units in Massachusetts provide volunteer support to emergency management agencies during emergencies and disasters, including public health emergencies such as infectious disease outbreaks and mass casualty incidents. MRC volunteers can assist with a variety of tasks, such as staffing emergency shelters, providing medical care and triage, and supporting public health initiatives such as vaccination clinics.

In addition to providing direct support during emergencies, MRC units in Massachusetts also engage in ongoing training and education to enhance their skills and knowledge. MRC volunteers receive training in emergency preparedness, disaster response, and public health, and they participate in regular drills and exercises to ensure they are ready to respond in times of need.

Overall, the partnership between the MRC and local emergency management agencies in Massachusetts is a critical component of the state's emergency preparedness and response capabilities, and it helps ensure that communities can respond effectively to emergencies and disasters of all types.

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4.4.6. Northeast Homeland Security Regional Advisory Council

Often, these partnerships are of great value to our MRC unit as well as the in-need communities. These partnerships teach our volunteers what we may not have provided them. Deployments give our MRC volunteers opportunities to engage real-life deployment practice. MRC leadership has determined through the years that more partnerships are built with each disaster. For example, we had an opportunity during COVID in which the Northeast Homeland Security Regional Advisory Council[109] (NERAC) provided the MRC with a call line, and our volunteers staffed that call line 12 hours a day, 7 AM to 7 PM, for almost six months.

This opportunity took the burden of answering the many community questions from the 85 NERAC municipalities and trained the engaged volunteers in managing a call center. That partnership came out of a disaster, but continues to be strong example of effective partnerships. MRC leadership believes we "are all in the same boat" when disaster strikes, and it does not matter who does the work or donates the time if the job gets done and the mission is achieved.

[109] Online: https://nerac.us/. Accessed 27 December 2023.

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Chapter 5

Training Our Volunteers

Abstract

The training of MRC volunteers is critical to the effectiveness of their deployments as well as providing them with the confidence to perform their often-critical responsibilities. The training required to be taken by a volunteer has increased over the years, as the roles and importance of the MRC has increased due to the onset of pandemic and the effects of climate change. This chapter describes the training performed by the Massachusetts MRC and their leadership to meet the increasing needs. It not only identifies the types of training we do, but also shows the nuanced way in which we improve the training to adapt to the need as well as benefit from the willingness of our volunteers to always learn to improve their services.

5.1. Introduction

The MRC is a national network of volunteers who assist their communities during public health emergencies and other times of need. The MRC core competencies[110] are a set of skills and knowledge areas that MRC volunteers should possess to effectively contribute to their communities during a public health emergency.

The MRC core competencies are as follows:

- *Emergency Management:* MRC volunteers should understand the emergency management process, including incident command, and should be able to work effectively within the ICS.
- *Public Health:* MRC volunteers should have knowledge of public health principles, disease prevention, and health promotion.

[110] Online: https://www.naccho.org/uploads/downloadable-resources/2019-MRC-Core-Competencies-and-Training-Plan.pdf. Accessed 8 January 2024.

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- *Emergency Medical Services:* MRC volunteers should have a basic understanding of emergency medical services, including First Aid and CPR.
- *Community Preparedness and Response:* MRC volunteers should be knowledgeable about community preparedness and response, including risk communication, community engagement, and volunteer management.
- *Healthcare System:* MRC volunteers should understand the Commonwealth healthcare system, including healthcare delivery, healthcare facilities, and healthcare providers.
- *Mental and Behavioral Health:* MRC volunteers should understand mental and behavioral health issues that may arise during a public health emergency.
- *Cultural Competency:* MRC volunteers should understand cultural competency and the ability to work effectively with diverse populations.
- *Information Management:* MRC volunteers should understand information management, including data collection, analysis, and dissemination.
- *Legal and Ethical Issues:* MRC volunteers should have knowledge of legal and ethical issues related to emergency response, including confidentiality, liability, and informed consent.
- *Personal Preparedness:* MRC volunteers should have a personal emergency preparedness plan in place, including a family communication plan, and should be prepared to respond to an emergency at a moment's notice.

These core competencies provide a framework for MRC volunteers to understand their roles and responsibilities during a public health emergency and to effectively contribute to their communities' response efforts. Our training covers the skills they need in these preparedness domains. The chapter addendum contains our training and drill options as shown on our website.

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5.2. Importance and Need for Training

5.2.1. The Need for Training

The MRC is founded on a core of highly trained volunteers from many different professional and medical backgrounds. Our volunteer training begins with the volunteer's own family and personal preparedness, including care for sheltered family pets as well as their workplace. We train them to understand how to ensure they and their families are safe in a disaster, particularly when they are deployed. This precautional training ensures that if a volunteer deploys to a disaster, they have confidence their own families are safe while they serve as volunteer at a shelter, an emergency dispensing site,[111] or a family reunification center[112] along with other potential deployments. This training not only makes it possible for them to concentrate on their deployment service—not worrying about their family's plight—but also is a benefit to them and their family's security. Moreover, this preparedness in their personal life enables them and their family to be better prepared at home and therefore will not likely need assistance from the community responders as well.

We encourage our volunteers to share our preparedness training with their friends, family, and coworkers. The overall goal is to have a better prepared community as a whole. So, in the event of a disaster, our volunteers are just taking care of those affected by the disaster who cannot care for themselves. In disaster shelter operations, warming centers or cooling centers, we get those with cultural and educational obstacles. They are often financially disadvantaged and have language barriers. It is this day-to-day culturally challenged population that we seek to support—in addition to the senior and already health-challenged population—because they are among the most vulnerable people during a disaster.

[111] Online: https://www.mass.gov/doc/emergency-dispensing-sites-eds/download. Accessed 5 January 2024.
[112] Online: https://www.fema.gov/fact-sheet/reunification-support. Accessed 5 January 2024.

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Another foundational training is incident management.[113] This incident-management training is intertwined throughout the training that we offer MRC volunteers. Once rained, our volunteers have a basic understanding of how a disaster is managed, which includes who is in command as well as the role that they should play in the disaster. Over the years, we have developed "strike teams"[114] for shelter operations, emergency dispensing sites, and other deployments they would likely experience, which would have incident-management leadership from the community, region, or Commonwealth.

Many of our volunteers have had FEMA training to include Incident Command 400,[115] which gives the MRC volunteer the credentials to serve as a shelter manager or an emergency dispensing site manager, as this training includes specific instruction for both positions. This FEMA credential gives our Commonwealth municipalities affected by the disaster or public health emergency trained volunteers who both can and may manage a shelter or emergency dispensing site. While the MRC volunteer responds medically to the disaster or public health emergency, they then have more far-reaching capabilities and may be trusted to perform incident management leadership duties as well, beyond managing a shelter or an emergency dispensing site alone.

By having our volunteers trained to operate using such incident management roles, it enables First Responders to know that shelter or emergency dispensing site operations are managed properly without their support. In this way, they can focus instead on their life-saving and protection role in their communities. In this regard, we ask that municipalities have a sheltering drill annually, which necessarily includes MRC volunteers. This drill gives our MRC volunteers an opportunity to meet the municipal leadership and to understand the local shelter.

During these drills, we access all the sheltering equipment and associated supplies, mobilize them as follows: (1) Locate, verify, and validate equipment and material available at the shelter; (2) Identify gaps in the supplies; and (3) Build a cohesive team with municipal leadership, who can than utilize within their community when needed. Overall, for the last 20 years, the MRC has

[113] Online: https://www.ready.gov/business/resources/incident-management. Accessed 5 January 2024.

[114] Online: Page 6 of https://training.fema.gov/emiweb/is/icsresource/assets/ics%20forms%20descriptions.pdf. Accessed 5 January 2024.

[115] Online: https://apps.usfa.fema.gov/nfacourses/catalog/details/10621. Accessed 5 January 2024.

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become an integral part of disaster response. This integration is accomplished by fostering partnerships, training, drilling together and developing exercise plans.

5.2.2. Our Training Methodology

Over the years, our MRC training curriculum has been adapted to each community or region needs, depending on the demographics, potential hazards, and the composition of the community. This adaptation includes the identification of vulnerable populations in that community. During our drills, we integrate translation, mental health services, and other resources that would be needed to best serve the community's needs in a disaster. It is important that the MRC volunteers understand the local leadership and the resources they have available to them during a deployment. For this reason, the purpose of our annual drills maintains community relationships and preparedness to counter the natural attrition of volunteers and the presence of replacement volunteers available to each community.

We are focusing on leaders from the community that have local cultural capital, and therefore trust within the community that they serve. This focus includes non-English speaking populations that have local community leaders at various places, like markets. By informing and supporting the leaders from each different cultural community, we gain their trust before a disaster, vastly simplifying the willingness of their population to utilize our resources during healthcare emergencies and disasters.

Many non-English speaking populations are vulnerable for multiple reasons. They may not have family in the area, do not understand local response plans and procedures during disasters, and often lack awareness of—or trust in—local governmental agencies. It is for this reason that we train local community leaders whenever possible to communicate with the population they serve, because oftentimes the local population is transient and changes regularly. This situation has been evident with the Massachusetts response to the immigrants and refugees that have come to our state. Although they are new to the community or the area, having a local leader that understands their culture and language gives trust to whom we are trying to provide services as well as with job placement and housing.

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The next vulnerable population we know need help during disasters are the elderly and those with disabilities. We work with senior centers and other senior programs in each community to help identify those that would need additional care or "welfare check"[116] visits during a disaster, because they may not have family in the area or their communications may have failed. This same situation often arises with those with disabilities that are living at home. Within our training regimen, we teach our volunteers how to take care of those with physical access and other functional challenges. This vulnerable population is often most in need during disasters. Our services for them includes medical care, behavioral healthcare, and mobility care. We make sure to locally store and supply resources needed to properly care of these disadvantaged populations in a disaster situation, such as durable medical goods and supplies as well as special dietary needs.

We also work with our communities in pandemic or disaster situations, such as local flu clinics. We provide public health outreach, generally offered at sites such as senior housing or government-subsidized housing. This outreach enables us to gain trust in the community and for the community to understand what the MRC provides for them in a disaster. This hands-on approach builds a team of volunteers that work very closely with the local public health staff, and they become a trusted member of that public health team. Thus, our MRC volunteers will therefore generally deploy upon request of that community, because our volunteers then know the community leadership, what they (volunteers) will be asked to do, and what resources are available during shelter operations.

In this regard, the MRC is a community-based operation. Over the years, MRC leadership has found that those living in a community have both the willingness and need to serve the community in which they live. Thus, the close working relationship of our MRC volunteers with local and regional public health and emergency management personnel and leadership is imperative for overall disaster or response success. This relationship oftentimes gives us an opportunity to partner with local operations by offering training to their volunteers. We therefore offer to assist in community outreach performed by local response organizations, so we become known as a valuable free resource during a disaster or public health emergency. Our response partners often already maintain close connections with vulnerable populations

[116] Online: https://en.wikipedia.org/wiki/Wellness_check#:~:text=A%20wellness%20check%20may%20be,of%20an%20elderly%20loved%20one.. Accessed 5 January 2024.

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in the community, so trust in those responders can be quickly shared with our MRC volunteers.

5.3. Initial Training

To become an MRC volunteer, a potential candidate must complete our basic training, which may vary depending on the specific needs of the person's local MRC unit. However, the common training requirements for MRC volunteers are as follows:

- *Orientation:* All MRC volunteers must complete a general orientation that provides an overview of the MRC program, its mission, the roles and responsibilities of volunteers, and their own family's safety and security.
- *Personal safety:* MRC volunteers may be exposed to hazardous materials or infectious diseases, so they must receive training on PPE and other safety measures.
- *ICS:* MRC volunteers are often called upon to support emergency response efforts, so they must have a basic understanding of the ICS, which is a standardized framework for managing emergency incidents.
- *Basic First Aid:* MRC volunteers may be asked to provide basic First Aid to individuals who are injured or ill, so they should be trained in CPR, AED use, wound care, and other basic First Aid skills.
- *Emergency preparedness*: MRC volunteers should be familiar with emergency preparedness principles and practices, such as disaster planning, communication, and response.

In addition to these basic training requirements, MRC volunteers may also receive additional training in specific areas, such as mental health, behavioral health, or disaster response. The specific training requirements and opportunities for MRC volunteers may vary depending on the needs of the local community and the MRC unit.

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5.3.1. Orientation

During the initial recruitment of an MRC volunteer, we explain the core competencies, including family and personal preparedness, basic understanding of incident command and psychological First Aid. These competencies are the foundational training that we require of a volunteer. In the orientation, we use "MRC 101,"[117] a class that takes 45 mins and describes the volunteer's role we envision if they join.

5.3.2. Personal Safety

It is imperative that each of our volunteers first thinks about personal safety. MRC leadership will not deploy a volunteer unless we know they are safe. Their safety and preparedness are part of the interview process that we do with volunteers prior to deployment. If they are driving, we need to make sure that the car is safe for travel in the current deployment environment. A few times during past deployments, we have asked other volunteers to transport doctors and nurses to a shelter site, ensuring the safety of the volunteers. This preparedness includes any specific travel information that is needed to get to the site.

Many times, as in the 2007 ice storms, the roads were impossible to regular vehicle traffic. In this case, the National Guard has met the volunteers on the highway and transported them to the shelter. The MRC has also partnered with the Hummer Vehicle organization, and I have used them extensively to deploy volunteers when road conditions were not safe for regular vehicles. This partnership came out of volunteers supporting local drills that were part of this four-wheel-drive vehicle organization. We have developed an MOU with them for our volunteers' transport during a disaster.

We also provide our volunteers with site information, including what to expect at the site as well as where they are deploying. Many times, when a shelter is opened, they may be the first on site with the facilities manager, who would be opening the shelter. In this situation, we ask that two volunteers deploy together. Sometimes, there are police and emergency medical services (EMS) already at the shelter location, but at other times there are not. When

[117] Online: https://wmmrc.org/wp-content/uploads/2015/02/MRC-101-March-2014-3.pdf. Accessed 5 January 2024.

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MRC leadership describes the deployment environment to the volunteer, we ensure they are comfortable with their deployment as well as their travel and security onsite.

When deployed, the volunteers have (i) a list of what they should bring with them; (ii) the identity of their onsite contact, (iii) their deployment information about travel, and (iv) their planned role at the shelter. In addition, they are provided with a job action sheet to give them a "heads up" regarding their anticipated role at the site. Once onsite, volunteers must report any unusual situations or anything that would seem unsafe directly to MRC leadership or the onsite manager, so it can be addressed as soon as possible. Each specific situation needs to be addressed individually to ensure site leadership and management take the most appropriate action. The foundation of these checks all goes back to personal and family preparedness, so the volunteers can leave their homes to deploy knowing their family and homes are safe.

Some of the newest and best volunteers in the MRC had actually been shelter occupants at some point in the past. If volunteer is also an occupant of a shelter—as the disaster requires that they seek shelter there as well as, possibly, their families—they will take their normal shifts during shelter operation. If they are an occupant as well as MRC volunteer, they will assume their role as the volunteer after first visiting the shelter's volunteer reception center specifically for sheltering volunteers. This center will inform them where they are housed in the shelter.

We perform just-in-time training for MRC volunteers and do license checks or background information checks if needed. When we deploy volunteers, we also ask them if they feel safe deploying and address any concerns they have at that time. We also ask that when shift change occurs, they brief the replacement volunteer about the current situation and potential safety risks that they may have on site. It is imperative that this is done and reported back to MRC leadership so that we can mitigate any unsafe situations as they arise. We also tell the volunteers that if they are asked to do something that makes them uncomfortable, they should not perform that function and report to the MRC leadership about the situation. In these cases, MRC leadership will assign a volunteer that is able to perform the necessary task.

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5.3.3. The Incident Command System

FEMA has online classes taken as "independent study" (no classroom, remote learning) where anyone can take incident command classes within the NIMS farmwork. These classes were created for those that manage incidents or work within a municipality. Unless the MRC volunteer is already part of the local emergency management team, these classes might be confusing as their specific role in the course content is not addressed.

To this end, we developed the MRC !01 training class, which addresses incident (e.g., disaster) command system[118] structure, the expected activities of the MRC volunteer in a disaster, and their anticipated role. The NIMS training can be confusing for a volunteer, possibly making them believe we are preparing them for a role not within their expertise. The typical MRC volunteer who does not serve in leadership might not assume any of the roles listed in the FEMA Incident Command training. The reason we offer this NIMS training is that MRC operations are intertwined with incident command activities, so it is valuable for our volunteers to at least be aware of the terminology and command structure before deploying, if possible. It helps them to understand their MRC role as well as to whom they report when deployed within the incident command structure. Each local disaster and the appropriate incident command is specific to whom they must report.

Specifically, the MRC falls under the "Logistics Section"[119] of the local ICS when we engage in local drills, plans and organizational structure. When the volunteers participate in local training exercises[120] or the drills to educate them about shelter operations and emergency dispensing sites, they receive a greater understanding of how local leadership works under incident command. It is imperative that these lessons be drilled at least annually, so as attrition in local emergency staff or MRC volunteers occurs, we sustain this knowledge in our volunteers who would be responding locally.

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[118] Online: https://en.wikipedia.org/wiki/Incident_Command_System. Accessed 8 January 2024.

[119] Online: https://www.sfcdcp.org/wp-content/uploads/2018/01/ENTIRE-LOGISTICS-SECTION-id107.pdf. Accessed 8 January 2024.

[120] Online: https://www.fema.gov/emergency-managers/national-preparedness/exercises. Accessed 8 January 2024.

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5.3.4. Basic First Aid

We offer training in basic First Aid[121] throughout the year. We do this training locally, online, or at local fire departments and police stations. These local First Responder organizations often offer basic First Aid classes free to the community. This training gives the MRC volunteer a basic understanding of First Aid and the tasks they need to perform when administering basic First Aid. Many times, through grants or donations, we can provide First Aid kits to our MRC volunteers once their First Aid training is complete. If we do not have kits to give them, we give them a list of what supplies they need in a First Aid kit.

This preparedness training achieves two objectives: (1) provides our volunteers with life-saving skills in First Aid for friends, family, and co-workers, and (2) it provides them with essential skills during a real deployment. We also offer advanced First Aid classes, hands-only CPR,[122] regular CPR, and healthcare-provider CPR. We offer CPR training to our MRC volunteers for their service, particularly for those that need CPR certification for the MRC roles, and we offer it at no cost (other than their time) to the volunteers. It is one of several important benefits of serving as an MRC volunteer.

5.3.5. Emergency Preparedness

We provide training and resources to MRC volunteers on emergency preparedness. Prior to disasters, we share information and give resources on potential hazards that may affect them and how to prepare for them. This training includes how to prepare their home, car, and pets as well. This information is another MRC volunteer benefit.

When accepting new volunteers, we send them up-to-date information about ongoing and potential disasters, including hurricanes, power outages, and flooding. For each such disaster, we explain how they should prepare and direct them to resources from *Ready.gov*.[123] We also provide weather-

[121] Online: https://en.wikipedia.org/wiki/First_aid. Accessed 8 January 2024.

[122] Online https://en.wikipedia.org/wiki/Cardiopulmonary_resuscitation. Accessed 8 January 2024.

[123] Online: https://www.ready.gov/. Accessed 8 January 2024.

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awareness training from the NWS about all weather-related disasters. Part of their initial training is to learn about identified disasters in their local area. We also encourage them to know their own local evacuation routes, the location of designated shelter in their community, and how to access local information.

We promote National Preparedness Month,[124] held every September, and again, we distribute information about personal and family preparedness. This information is shared continuously to ensure that each MRC volunteer knows how to protect themselves and their families from a disaster. We also teach them that if they own a home or rent an apartment, how they may shut off electricity or natural gas, if they have it. We also perform training on travel preparedness, which teaches them what to do if they are at a hotel or airport and they need to evacuate. It shows them how to learn the evacuation routes at various places while traveling and how to prepare their vehicle for travel in different physical environmental conditions. This travel training includes a list of recommended supplies to have in their vehicle for safe travel.

In addition, we give them information on how to prepare their children if the volunteer is not at home with them in a disaster. We ask that they have a family contact card, which lists all the contacts of family members both in and out of state. We ask that their children memorize home and cellphone numbers of immediate family members that they may need. This preparation is part of the family communication plan. We also educate them about having enough medication if they must evacuate as well as pet preparedness for small and large animals, including exotic pets. We also offer volunteer opportunities to assist with animal sheltering during a disaster and the necessary training to do so.

5.4. Developing the Training Curriculum

Our MRC leadership uses the National MRC[125] training, which addresses the necessary leadership and volunteer competencies. Our MRC core

[124] Online: https://www.acf.hhs.gov/ohsepr/national-preparedness-month. Accessed 8 January 2024.
[125] Online: https://aspr.hhs.gov/MRC/Pages/index.aspx. Accessed 8 January 2024.

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competencies are aligned along four MRC Learning Paths, namely: Volunteer Preparedness, Volunteer Response, Volunteer Leadership, and Volunteer Support for Community Resiliency. An MRC core-competencies training plan is available for MRC unit leaders and volunteers to assist them in meeting their respective training requirements.

In this regard, we offer over 200 training and drill opportunities annually. These opportunities can be cross-jurisdictional, working with various response partners and other MRC units. By partnering with other agencies, there are additional training and drill opportunities we can offer to our MRC volunteers, such as hospital drills,[126] decontamination drills,[127] active-shooter drills,[128] mass-casualty drills,[129] and evacuation drills.[130] Most hospitals perform these drills annually.

Our MRC leadership has developed partnerships with hospitals to provide volunteers as "actors," including serving as "victims," for their drills. These drills are popular with the MRC volunteers. We do moulage[131] to simulate injuries that our Massachusetts National Guard and other public and private entities need to drill their response plans. We give "patient cards" that provide a fake name, medical history, age, and medical symptoms to give to receiving hospital staff or other medical partners that need to test their capabilities during a mass casualty event. Participating a simulated "victims" ensures that volunteers have a good understanding of the local area response, local response capabilities, incident command, and a greater understanding of the potential MRC role in mass-casualty drills.

[126] Online: https://www.calhospitalprepare.org/post/what-are-required-drills-and-exercises-hospitals. Accessed 8 January 2024.

[127] Online: https://files.asprtracie.hhs.gov/documents/aspr-tracie-ta-decontamination-exercises-081816-508.pdf. Accessed 8 January 2024.

[128] Online: https://www.dhs.gov/xlibrary/assets/active_shooter_booklet.pdf. Accessed 8 January 2024.

[129] Online: https://cdp.dhs.gov/training/course/PER-902. Accessed 8 January 2024.

[130] Online: https://www.ready.gov/evacuation. Accessed 8 January 2024.

[131] Online: https://en.wikipedia.org/wiki/Moulage. Accessed 8 January 2024.

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5.5. Performing a Typical Training Session

The MRC leadership identifies training sessions that will meet least one of the MRC Core competencies, which are sent to our volunteers through *Massachusetts Responds*. We do this in concert with the Commonwealth when they specify the course. At this point, MRC leadership reviews the intended primary course discipline, our volunteer interests, and then customizes the course to meet their specific volunteer needs. Since the MRC is a local asset, the leadership accesses the local community in which they live, including that local information in their individualized training.

In this regard, the volunteers gain a greater understanding of how our MRC training and drilling applies to their community in which they live and serve. Also, as the MRC leadership posts training online through *Massachusetts Responds* and our partnering organizations, our Massachusetts volunteers can clearly see (i) who they would be working with in a disaster; (ii) the role they would play in a disaster; and (iii) the resources they can and may provide. It is imperative that they understand the resources and the roles of partnering entities with whom they will respond together so there is an integrated response.

Each training provided by the MRC leadership has a list of objectives and how they are applied specifically to each volunteer. Our volunteers offer do their best when they understand the MRC's role in response to a disaster. This role may differ greatly in each response, and it is assessed as MRC leadership develops the course material. As we offer courses, we have an open discussion, in which the volunteers can ask questions at any time during the course. This open training helps MRC leadership better understand what volunteers need to know in the event of a deployment.

Every course or drill offered to the volunteers is also a learning opportunity for the MRC leadership, which has proven to gain as much from the volunteers as they learn from the leadership. Of course, this experience enables the leadership to have a better understanding of volunteer needs, so that we can adapt future courses and drills to better meet those needs. Overall, it is important that volunteers are comfortable, confident, and value their contribution to public health and disaster response.

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During a disaster, it is the local leadership and MRC leadership that is responsible for mitigating any unplanned issues that arise. Overall, this adaptability makes us a better resource and creates a more effective unified response. After a course drill, we always conduct a "posttest,"[132] or a "debrief[133]/hot wash[134]," the MRC leadership asks questions that the volunteers would have had to specifically address in their deployment. The resulting discussion prompts the volunteers to think about what they learned from the deployment and provide feedback we can use to improve the relevant training courses and drills. This feedback helps give the volunteers a greater understanding of their role and it helps them absorb the information they really need. In this way, MRC leadership can integrate real-life incidents into subsequent training.

We also ask our volunteers how they were directed, or managed, during a recent deployment to collect suggestions as to how they would have themselves better managed that situation. This line of questioning allows them to apply their personal knowledge and expertise as if they themselves oversaw the situation. This approach changes the learning environment; instead of being "talked down to," the volunteers have an open line of communication with leadership during the engagement. The resulting improvements to training and practice gives them more confidence in, and "buy in" for, our guidance during their deployments.

Within a course or drill, the MRC leadership will divide volunteers into groups according to their discipline and have them play out specific scenarios. In this way, they can experience both what they could encounter in a real deployment, particularly what it is like to be engaged themselves by an MRC volunteer. Again, these scenarios further enhance the skills and abilities of each MRC volunteer. Those groups then report to each other and describe to whom who they would report the information.

[132] Online: https://trainingindustry.com/glossary/post-test/. Accessed 9 January 2024.
[133] Online: https://en.wikipedia.org/wiki/Debriefing. Accessed 9 January 2024.
[134] Online: https://en.wikipedia.org/wiki/Hotwash. Accessed 9 January 2024.

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For example, if it were a medical situation, the clinicians would follow their JAS and refer to other disciplines during deployment as needed, such as behavioral health, for their expertise. If the referenced volunteer or partnering entity personnel referenced cannot mitigate the situation, then it needs to go to the shelter and site manager. Once discussed at that level, and once it goes beyond the shelter manager, then it is addressed by the MRC leader or local emergency manager. This example demonstrates how incident command works to the volunteers. By engaging them as a collaborative group to solve the specific scenarios, (i) it gives them a greater understanding of their own deployment responsibilities, and (ii) if it goes beyond their response ability, then who they should involve for guidance.

The MRC leadership also does anonymous course evaluations, so the volunteers can give honest feedback. This anonymous feedback ensures they are unencumbered when identifying issues, they may be reluctant to mention during a course or drill. To this end, we use three approaches when offering courses or drills. Some volunteers learn better by seeing text and writing down what they are learning; while others learn better by discussing the situation, responding best to the "give and take" of a dialogue. Others best "learn by doing," that is, performing the physical activities needed during a response. Overall, this training triad provides multiple ways for the volunteer to learn and understand the courses and drills provided by the MRC leadership.

Addendum: Annotated List of MRC Training and Drill Sessions

This addendum contains the current (March 2024) Training & Drills offered by our MRC unit as displayed on our website. The Home Page appears as follows and offers several page options. Selecting "Training and Drills" leads to https://www.mrcvolunteer.org/training---drills.html and the following menu options. The figures in this addendum have been redrawn—and the text enlarged— from the original website html images to improve readability in this book.

Complimentary Copy

- MRC101 Training Video
- FEMA Independent Study Program
- Red Cross Family Preparedness
- Annual Disaster Preparedness
- Hands-Only CPR
- Basic First Aid
- Mosquito Control Video
- FEMA Personal Preparedness Video
- New England Public Health Courses
- Until-Help-Arrives Web-based Course

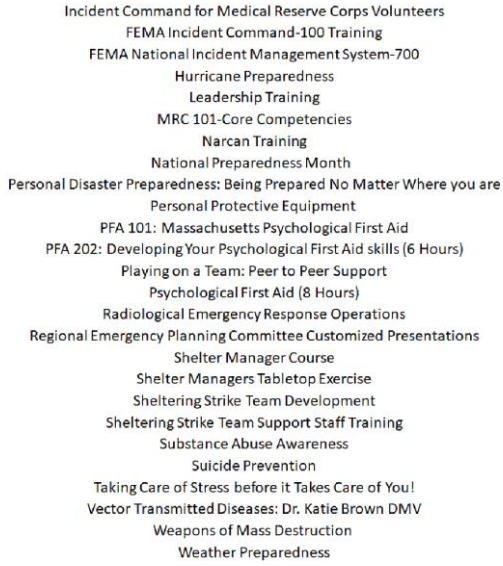
- MEMA's role in a Disaster
- Emergency Infectious Disease–password Salem
- Until-Help-Arrives Slides
- Opiate's History and Effects
- Merrimack Valley Gas Explosion
- CDC Field Triage Guidelines
- Active Shooter Drill
- Trailer Mobilization-Demobilization Drill
- Hurricane Preparedness Presentation
- Cold Weather Safety
- MRC Incident Command System (ICS)
- Zombie Field Triage
- Disaster Ready-Just-in-Time Training
- Anthrax Full-Scale Drill

- The Physiology of Addiction
- Mass Dispensing Sites
- FEMA Point of Distribution Online Training
- Psychological First Aid
- MRC TRAIN
- Community Emergency Response Teams
- Emergency Dispensing Site Video
- Nasal Narcan Administration
- Del Valle Courses
- Norton Vigle

*EDS – Emergency Dispensing Site
**POD – Point of Distribution

Immediately below the Home Page options “Training and Drills” selection are the training courses and drills offered to MRC volunteers as follows (as they appear on the website):

Active Shooter Drills
(BART) Basic Animal Rescue Training
Blood Borne Pathogens with Scene Safety
Business Preparedness and Evacuation Planning
Communications-Call Down Drills
CODE Pink Drill (Hospitals)
Cultural Competency
DECON-Mass Decontamination Drill
Disaster Behavioral Health 1 & 2
Drive Through Emergency Dispensing Site Drills
Great American Shake Out Drill
Earthquake Preparedness
Emergency Dispensing Sites 1 & 2
Emergency Pet Sheltering for Massachusetts Volunteers Level 1 & 2
Emergency Preparedness & Local Public Health
Emergency Preparedness for Massachusetts Volunteers Level 1 & 2
Emotional Resilience for First Responders
Family and Personal Preparedness
Flu Clinics run as an Emergency Dispensing Site
Disaster Field Triage Part 1
Disaster Field Triage Part 2
Home and Sheltering in Place Preparedness
Hot Topics with Dr. Al DeMaria
HSEEP Compliant Emergency Dispensing Site Full Scale Exercise
HSEEP Compliant Emergency Dispensing Site Functional Exercise
HSEEP Compliant Sheltering Tabletop Exercise



Given the importance of sheltering and the key roles played by MRC volunteers in sheltering operations, we select the "Sheltering" tab immediately following the "Training and Drills" tab, and we see the following training courses and drill provided for that option at <https://www.mrcvolunteer.org/sheltering-.html>. We also show below the options for Emergency Distribution Service (EDS) Point of Distribution (POD), Well Check, "Stop the Bleed." and COVID-19 training options from the MRC website as well. We have recreated the website images for improved print clarity and book physical layout requirements, but the options shown and presentation have been preserved to the extent possible. Visit the actual website to explore these options.

- MRC 101 Training Video
- FEMA Independent Study Program
- Red Cross Family Preparedness
- Annual Disaster Preparedness
- Hands-Only CPR
- Basic First Aid
- Mosquito Control Video
- FEMA Personal Preparedness Video
- New England Public Health Courses
- Until-Help-Arrives Web-based Course

- MEMA's role in a Disaster
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- Opiate's History and Effects
- Merrimack Valley Gas Explosion
- CDC Field Triage Guidelines
- Active Shooter Drill
- Trailer Mobilization-Demobilization Drill
- Hurricane Preparedness Presentation
- Cold Weather Safety
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- Zombie Field Triage
- Disaster Ready-Just-in-Time Training
- Anthrax Full-Scale Drill

- The Physiology of Addiction
- Mass Dispensing Sites
- FEMA Point of Distribution Online Training
- Psychological First Aid
- MRC TRAIN
- Community Emergency Response Teams
- Emergency Dispensing Site Video
- Nasal Narcan Administration
- Del Valle Courses
- Norton Vigle

*EDS – Emergency Dispensing Site
**POD – Point of Distribution

REGISTRATION GO KIT

- Registration Station Supply and Staffing List
- Registration Team Leader Job Action Sheet
- Registration Staff Job Action Sheet
- Just-in-Time Radio Training
- Shelter Occupant Intake Form
- Big Sign Shelter Rules
- Client Health Record
- Shelter Disclosure Form
- Multilingual Communication Sheet

MEDICAL GO KIT

- Medical Station Supplies and Staffing
- Medical Director Job Action Sheet
- Clinical Unit Leader Job Action Sheet
- Triage Staff Job Action Sheet
- Just-in-Time Radio Training
- Health Services Registration Form
- OSC*-CMIST** Worksheet
- Level-of-Care Triage
- Client Health Record

DORMITORY GO KIT

- Dormitory Station Supplies and Staffing
- Dormitory Job Action Sheet
- Just-in-Time Radio Training
- Big Sign Shelter Rules
- Dormitory Guidance
- Infection Control
- Multilingual Communication Sheet

*OSC – Operations Service Center

**CMIST - Communication, Maintaining Health, Independence, Support and Safety, and Transportation

SHELTER MANAGER'S GO KIT

- Sheltering Opening and Closing Checklist
- Sheltering Warming and Cooling Stations
- Comprehensive Shelter Supply List
- Just-in-Time Radio Training
- Shelter Inventory
- Daily Shelter Report
- Shelter Log
- Sheltering (SOG*)
- Multilingual Communication Sheet

BEHAVIORAL HEALTH GO KIT

- Behavioral Health Counselor
- Just-in-Time Radio Training
- Behavioral Health Assessment Tool
- OSC-CMIST Worksheet
- Self Care for First Responders
- Just-in-Time Psychological First Aid
- CERT** Disaster Psychology
- Psychological First Aid Field Guide

FOOD SERVICES GO KIT

- Food Service Supplies
- Food Establishment Inspection
- Guidance for Emergency Food Planning
- FDA Food Handling Guidance
- Just-in-Time Radio Training
- Food Services Job Action Sheet
- Hand Washing in 24 Languages
- Hand Washing English
- Serve Safe Presentation

*SOG – Standard Operating Guide
**CERT- Community Emergency Response Team

PET SHELTERING GO KIT

- Shelter Job Action Sheets
- Just-in-Time Radio Training
- Pet Shelter Survey
- Pet Shelter Supply List
- Animal Intake Form
- Pet Preparedness
- SMART* Sheltering Plan

MRC RECRUITMENT RESOURCES

- MRC Press Release for Recruitment
- Notice to Recruit MRC Volunteers
- Welcome Letter to New Volunteers
- MRC Letter to Community Groups

OTHER RESOURCES

- Mega Shelter Planning Guide
- Shelter Field Guide
- Radio Training PP**
- Show-Me Communication Tool
- FEMA Access Functional Needs
- emPower^ Mapping for Disasters
- ICS and Job Action Sheets
- Hand Washing English
- National Mass Care – Red Cross Forms

*SMART – State of Massachusetts Animal Response Team
** PP – PowerPoint
^ - See https://empowerprogram.hhs.gov/empowermap

Self-Guided Community Immunization Training

- Emergency Dispensing Site Template
- Emergency Dispensing Site Job Action Sheets
- EDS-POD Corrective Action Template
- Measles Info
- Closed POD
- CDC Closed POD Liability Protection
- Closed POD Plan
- EDS-POD Trainer's Notes
- Drive-Through COVID-19 Testing Sites
- Drive-Through EDS-POD Protocol
- EDS-POD Table Top Exercise
- Emergency Dispensing Site Intro
- EDS-POD Review Questions
- Measles Table Top Exercise
- CDC POD Fact Sheet
- Closed POD Commitment Letter
- EDS-POD Just-in-Time Training
- How to Set U a Closed EDS-POD
- Town Drive-Through Testing Site Protocol
- Drive-Through EDS-POD Supply List

MRC Well Check Program

The Medical Reserve Corps Well Check Team can provide a service the supports existing community organizations and city departments with a daily well check for at risk residents. The Medical Reserve Corps Well Check Trained volunteers are HIPAA^ compliant and have been CORIed** and SORIed^.

Key Activities

- Daily Well Check Communications
- Tracking the patient status with their care provider or emergency contact
- Reporting to patients care provider or emergency contact if there is a reason to follow up with the patient to identify additional services if needed.

Distribution Channels

Direct Phone Calls

Email, Text, Audio File or social media

Patient Relationships

- Continuity of service
- Continuity of Health Check Specialists

Health Care Providers will have the information that they need to be able to mitigate health or cognitive issues prior to a hospitalization due to a worsening health or cognitive problem or noncompliance to care plan.

By using this service in community health it is safe to say it will increase patient compliance and provided an opportunity for early intervention for new or worsening health issues.

This program can improve the overall health of patients in the program.

- Well Check Flyer
- MRC Well Check Program SOP*
- MRC Well Check Training Presentation
- Sample Daily Well Check for Sick Participants
- Sample Daily Well Check for Youth Participants
- Sample Well Check for Addiction Participants
- Sample Well Check Intake Form for Hoarding
- Hoarding-Cluttering Workshop Presentation
- Homeless Shelter Staff Job Action Sheets
- Homeless Sheltering Training Manual
- Information on the Substance Abuse Program
- Volunteer for the Well Check Program
- HIPAA Training

*CORI - Criminal Offender Record Information
**SORI - Sex Offender Registry Information
^HIPAA - Health Insurance Portability and Accountability Act

HOME | MRC FAQ's | ABOUT | TRAINING & DRILLS | SHELTERING | CONTACT | LOCAL MRC CONTACTS | EDS-POD | WELL CHECK PROGRAM | CALENDER | STOP THE BLEED | COVID-19

STOP THE BLEED-UNTIL HELP ARRIVES-FIELD TRIAGE

- Stop the Bleed Until Help Arrives
- Town Presentation
- Stop the Bleed Video
- Field Triage
- Start Field Triage Diagram
- Stop the Bleed Web-based Training

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COVID-19 Resources

- COVID-19 Vaccination Training Link
- Pfizer-Biotech Vaccine Prep and Admin
- Drive-Through EDS-POD Protocol
- COVID-19 Testing Site Images
- COVID-19 Testing Site Job Action Sheets
- Fact Sheet for preventing infectious disease in Homeless
- MA* Call Lines and Text Updates
- Reopening MA
- About COVID-19
- diet help
- Affected Government Services
- COVID-19 Clinical and Training
- Moderna Vaccine Prep and Admin
- Drive-Through Test Site Inventory
- LEO** Call Center guidance
- Call Center Script
- NASCSP^ Call Center Guidance
- COVID-19 Daily Updates
- What should you do during COVID-19
- Regulations and Guidance
- How can you help
- COVID-19 Response and Reporting

*MA – Massachusetts
**LEO – See https://leoinc.org/.
^NASCSP – National Association for State Community Services Programs

COVID-19 Resources (Continued)

- How to sew a Mask
- Personal Protective Equipment protocol
- Social Distancing
- Stop the Spread of Germs
- Best Practices for Outdoor and Open Spaces
- High School Graduation Guidelines
- COVID-19 Order Enforcement Primer
- Lodging Checklist
- COVID-19 Testing Site Map
- MOU^-Hospitals for COVID-19 Vaccine Distribution
- How to make a simple mask – no sewing
- Personal Protective Equipment Sequence
- Quarantine and Isolation
- Well Being of Health Care Professionals
- Guide for Industries for Reopening
- Legionella Guidance May 21, 2020
- Building Psychological Resilience
- Restaurant Checklist
- MA Reopening Phases
- Hospital Capacity and Surge

COVID-19 Resources (Continued)

Vaccine Questions?	Brazilian-Portuguese COVID-19 Questions	Spanish COVID-19 Questions
English COVID-19 Questions	Cape Verdean COVID-19 Questions	Chinese COVID-19 Questions
Arabic COVID-19 Questions	Haitian-Creole COVID-19 Questions	Swahili COVID-19 Questions
Black-African COVID-19 Questions	Khmer COVID-19 Questions	Vietnamese COVID-19 Questions
Facebook post-vaccine confidence	You don't know if you're going to be OK	Let's get their PSAs
Wait and See is getting old - Video	I'm gonna (FILL IN THE BLANK)	Let's get their playlist
	Is it a plot - video	

Chapter 6

Preparedness

Abstract

Preparedness is a state of readiness for the fullest range of incidents or disasters our communities might face that will quickly overwhelm day-to-day area hospital and clinic facilities. It represents the integration of all aspects of MRC activities, including operations, materials and equipment, training, and more. Sustainment of the necessary level of Preparedness directly both reflects and impacts volunteer confidence in themselves, their leadership, and the mission they must perform under time and life stress. No matter what, Preparedness can always be improved, particularly in an age of political upheaval, mass shootings, and climate change, and renewed nuclear-power and multi-national military and terrorist threats. In the end, preparedness perhaps most of all incorporates adaptability to different people, places, and threats to life and wellbeing. This chapter describes the many and varied measures and methods to sustain MRC Preparedness.

6.1. Scope

The scope of MRC preparedness is broad, and it involves a wide range of activities aimed at enhancing the nation's ability to respond to public health emergencies and disasters. Here are several keys—often interrelated—that define the scope of our MRC preparedness:

- *Emergency response:* MRC volunteers are often called upon to support emergency response efforts, such as providing medical care and triage, distributing medications and vaccines, and supporting emergency shelters.
- *Public health crises:* MRC volunteers also support public health initiatives, such as immunization campaigns, health screenings, and health education programs.

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- *Disaster preparedness:* MRC volunteers help communities prepare for disasters by participating in planning and training activities, conducting community outreach and education, and supporting local emergency management agencies.
- *Surge capacity (adaptability):* MRC volunteers provide surge capacity during public health emergencies and disasters, helping to supplement the existing healthcare workforce and support the response effort.
- *Special events:* MRC volunteers provide medical and public health support during large-scale special events, such as concerts, festivals, and sporting events.

The scope of MRC preparedness is continually evolving to meet the changing needs of communities and respond to emerging threats. MRC units work closely with local public health agencies, emergency management agencies, and healthcare providers to identify and address the most pressing public health and emergency preparedness needs of their communities.

6.2. Integrating MRC and Emergency Preparedness Plans

Integrating the MRC into local emergency preparedness (EP) plans involves a collaborative effort among local emergency management agencies, public health agencies, and MRC unit leaders. Here are some steps that can be taken to integrate the MRC into local emergency plans:

- *Identify local emergency management partners:* MRC unit leaders should identify and establish relationships with key local emergency management agencies, such as the local emergency management office and the local health department.
- *Assess local emergency plans:* MRC unit leaders can review the local emergency plans to identify opportunities to integrate MRC volunteers and resources into the response effort.
- *Identify MRC capabilities:* MRC unit leaders should work with their volunteers to identify the skills and resources that they can provide

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during an emergency, such as medical expertise, public health education, and logistical support.

- *Develop MRC activation protocols:* MRC unit leaders should work with local emergency management agencies to develop protocols for activating MRC volunteers and resources during an emergency.
- *Conduct joint training and exercises:* MRC units and local emergency management agencies should conduct joint training and exercises to test and refine the integration of MRC volunteers and resources into local emergency plans.
- *Establish communication protocols:* MRC unit leaders should establish communication protocols with local emergency management agencies to ensure that MRC volunteers are aware of emergency events and activation procedures.
- *Evaluate and update plans:* MRC integration into local emergency plans should be evaluated regularly and updated as needed to ensure that the MRC remains an effective partner in emergency response efforts.

By integrating the MRC into local emergency plans, communities can enhance their preparedness and response capabilities and ensure that they have access to additional resources and expertise during emergencies and disasters.

In the communities benefitted by the MRC, our MRC leadership "makes a point" of meeting with the local emergency management director in each town or city in our jurisdiction (which may be worldwide if the need persists) and develop a relationship with them so they understand the value of the MRC. Once they understand the value, it is often straightforward to review their local emergency plans.

Oftentimes the local fire department has multiple trainings throughout the year, and they will generally share their trainings with our MRC. That sharing gives them the opportunity to get to know the volunteers in their community. Sometimes, the involved volunteers become volunteers for the fire department as well, which further helps integrate the MRC into the fabric of the community's emergency plan. Local emergency management may have an

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active Community Emergency Response Team[135] (CERT), but we have found over the years is that many CERTs are inactive, so we ask the emergency management people to contact those CERT volunteers. We ask them if they are still available to volunteer, we recommend that they integrate the MRC into the CERT because they are under the same government jurisdiction.

6.3. Cross Training and Drills with Response Partners

MRC provides support for public health initiatives and community events. One way that the MRC prepares for emergencies is by participating in disaster drills. These drills allow MRC volunteers to practice their emergency response skills and interoperate with other responders, such as local emergency management agencies, hospitals, and public health departments. During these disaster drills, MRC volunteers may be involved in a variety of activities, such as:

- Setting up and staffing emergency shelters
- Providing medical assessments and treatment to simulated victims
- Coordinating with local EMS and other medical personnel
- Conducting epidemiological investigations[136] and disease surveillance
- Providing public health education and outreach
- Serving as realistic victims in the disaster.

By participating in disaster drills, the MRC in Massachusetts is better prepared to respond to real emergencies when they occur – and we know they will occur, if not now, then eventually. Performing this type of exercise or drill

[135] Online: https://www.fema.gov/emergency-managers/individuals-communities/preparedness-activities-webinars/community-emergency-response-team. Accessed 8 February 2024.

[136] Online: https://www.ncbi.nlm.nih.gov/books/NBK100248/. Accessed 11 August 2023.

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is one of the best methods of minimizing or eliminating one or more of the infamous Pearl Harbor communication failures.[137]

These drills allow MRC volunteers to practice their skills and build relationships with other responders, which can be critical during a real emergency, particularly those unexpected (no warning) incidents, like the gas explosions described in Chapter 2. Performing drills on these no-warning scenarios is critical in establishing and sustaining preparedness in these incidents by practicing our response in realistic (i.e., historic) disasters. These drills help our volunteers experience the unexpected, particularly possible, probable, and historic, disaster scenarios.

6.3.1. Mass Decontamination Drills

The Massachusetts MRC plays an important role in supporting disaster preparedness and response by participating in drills and other training exercises. One of the important roles of MRC volunteers is to participate in mass decontamination drills. These drills simulate a scenario in which individuals have been exposed to a hazardous substance and need to be decontaminated before receiving medical treatment. The purpose of the drills is to test the preparedness and response capabilities of local emergency responders and healthcare providers, including the MRC.

During a mass decontamination drill, MRC volunteers may be responsible for assisting with the setup and operation of decontamination stations, providing medical screening and triage, and assisting with the decontamination process itself. Volunteers may also be responsible for providing education and information to the public about the decontamination process and the importance of taking appropriate precautions in the event of a hazardous substance exposure. Overall, the participation of MRC volunteers in mass decontamination drills is an important part of ensuring that local communities are prepared to respond to emergencies and disasters that may pose a risk to public health and safety.

[137] Robert Irving Desourdis, "Déjà Vu All Over Again," *The COVID-19 Disaster Volume I: The Historic Lessons Learned and Human Collaboration Failures*. Robert I Desourdis (ed.). New York: NOVA Science Publishers, 2021.

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Figure 6.1. Hospital Mass Decontamination (Decon) Drill (1) Pre-drill staging; (2) PPE; (3) Decon Drill actors; (4) Emergency Medical Services; (5) Decon tent entrance; (6) Inside Decon tent; (7) triage; (8) Emergency Department intake.

6.3.2. Train Derailment Drill

The Massachusetts Department of Transportation[138] (MassDOT) needed volunteers to help with a train derailment drill, which was scheduled to take place in just a few days. The MRC volunteers moved forward without hesitation to "answer the call" because of their mental preparedness from experience and confidence in their training. On the day of the drill, the volunteers arrived at the train derailment site, where they were briefed on the scenario for the day. The scenario started with a train having derailed, and there were multiple passengers with varying degrees of injuries. The MRC volunteers were to play the role of injured passengers and provide support to the medical staff.

As the drill began, the volunteers were scattered throughout the wreckage, "acting out" by moaning and groaning in pain. The medical staff quickly assessed the injuries of each passenger, and the MRC volunteers provided feedback on the severity of their injuries. The volunteers worked closely with the medical staff, providing support and assistance wherever it was needed. Some volunteers were tasked with helping to move injured passengers to the triage area,[139] while others provided First Aid to those with more severe

[138] Online: https://www.mass.gov/orgs/massachusetts-department-of-transportation. Accessed 11 August 2023.
[139] Online: https://www.ncbi.nlm.nih.gov/books/NBK557583/. Accessed 11 August 2023.

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injuries. The drill was intense, and the volunteers found themselves in challenging situations as they worked to help the injured passengers. Our volunteers exhibited focus and commitment, providing critical support to the medical staff, and ensuring that all the passengers were properly treated.

As the drill came to an end, the volunteers were exhausted but satisfied with their work. They had demonstrated their commitment to their community and their willingness to step up and help in times of crisis. They had proven again that the MRC was an essential part of the emergency response system, providing critical support to the medical staff and ensuring that all those in need received the best possible care.

In the end, the train derailment drill was a success, thanks in large part to the dedication and hard work of the MRC volunteers. They had shown that, no matter the scenario, they were ready and willing to provide the necessary support to ensure the safety and well-being of their community. The drill provided an important test of MRC Preparedness for the possible, yet improbable and all-to-often, unexpected, disasters.

6.3.3. Aircraft Crash Drill

MRC volunteers were preparing for their annual aviation crash scenario drill at Logan International Airport.[140] As they arrived at the airport, they were briefed on the scenario for the day. A plane carrying dozens of passengers had crashed on the runway, and the MRC volunteers were to play the role of injured passengers. As they donned their fake injuries and boarded the mock plane, they could feel the excitement and anticipation building. They had trained for this scenario many times, but the adrenaline still coursed through their veins as they took their seats.

Suddenly, the sound of an explosion shattered the calm. Smoke billowed from the plane's engines, and the volunteers were thrown forward in their seats. The cabin filled with screams and chaos as the passengers struggled to escape the wreckage. The MRC volunteers responded quickly, assessing their injuries, and providing aid to those around them. They used their training to triage the injured and provide First Aid to those in need. They worked continuously to help transport the injured passengers to the triage area, where they were treated by the medical staff.

[140] Online: https://www.massport.com/logan-airport/. Accessed 11 August 2023.

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As the drill progressed, the volunteers found themselves in increasingly challenging situations. They had to navigate their way through the smoke and debris, help passengers escape the wreckage, and provide aid to those with more severe injuries. Despite the chaos and confusion, the MRC volunteers remained calm and focused, providing critical support to the medical staff, and ensuring that all injured passengers were properly treated.

When the drill was finally over, the volunteers were exhausted, but proud of their work. They had demonstrated their commitment to their community and their dedication to helping those in need. They had proven that the MRC serves as an essential part of the emergency response system, providing critical support in times of crisis.

As they left the airport, the volunteers knew that they had made a difference. They had helped to ensure that Logan Airport was prepared for the worst-case scenario and that the medical staff were ready to handle any emergency that might arise. They had shown that, in times of crisis, the MRC was ready and willing to step up and help those in need.

6.3.4. Local Mass Casualty Drill

Once a year, the MRC in the small town of Oakville, Massachusetts, would receive a call from the local hospital. It was time for their annual mass-casualty drill, and they needed volunteers to play the role of injured patients. The MRC always meets this need. On the day of the drill, the MRC volunteers arrived at the hospital, ready to put their training into action. They were greeted by the hospital staff, who explained the scenario for the drill. In this scenario, there had been a gas explosion at a nearby factory, and numerous patients had been rushed to the hospital. The MRC volunteers themselves were assigned different injuries, from broken bones to severe burns, and were given instructions on how to act out their injuries realistically.

The volunteers were then taken to different parts of the hospital, where they were placed in various positions to simulate the chaos of a real disaster. Some were lying on gurneys in the emergency room, while others were placed in the hospital's cafeteria or outside on the lawn, waiting for triage.

The hospital staff then began the simulated response, running through their emergency protocols as if it were a real disaster. They quickly assessed each patient's injuries and determined the appropriate course of action. Some patients were sent to surgery, while others were treated in the emergency room

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or admitted to the hospital. Throughout the drill, the MRC volunteers remained in character, moaning and groaning in pain, and providing realistic feedback to the medical staff. They were impressed by the professionalism and skill of the hospital staff, who worked quickly and efficiently to treat the mock patients.

After several hours, the drill ended, and the volunteers were debriefed by the hospital staff. They were thanked for their help and given feedback on how they could improve their performance in future drills. The MRC volunteers left the hospital feeling proud of their contribution and grateful for the opportunity to help their community.

In the end, the annual mass casualty drill was a success, thanks in large part to the dedication and commitment of the MRC volunteers. By providing realistic simulations of injured patients, they helped the hospital staff prepare for the worst-case scenario and ensure that they were ready to handle any emergency that might come their way.

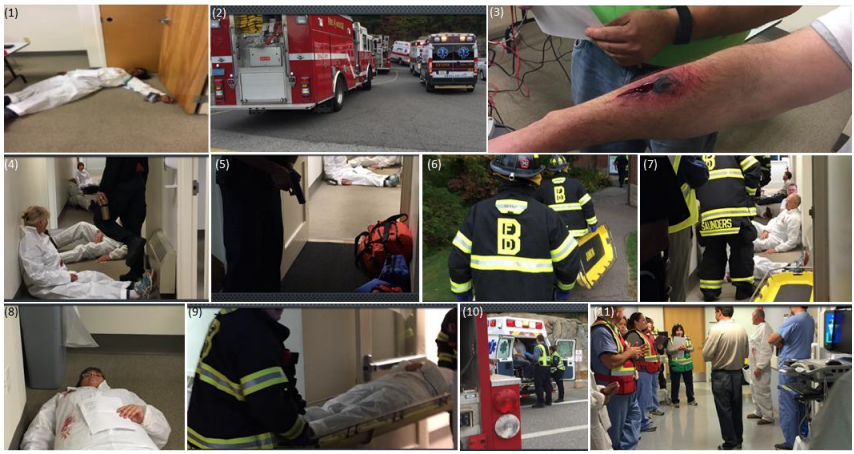

Figure 6.2. Mass casualty (shooter) drill: (1) Victims and alerting; (2) Police, fire and EMS staged outside drill site; (3) Fake moulage wound on actor; (4) Actors with faked wounds and symptoms in position; (5) Securing the scene; (6) Rescue operations; (7) Triage; (8) Victim to be transported; (9) Evacuating team rescue; (10) Triage; (11) End of drill at emergency department.

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6.3.5. Benefits of Cross Training

Cross-training with partners is an important service of the MRC program. Cross-training allows MRC volunteers to gain new skills and knowledge, share expertise with other organizations, and build stronger partnerships with other agencies involved in emergency preparedness and response. Important examples of cross-training opportunities for MRC volunteers includes:

- *Joint training exercises:* MRC units can participate in joint training exercises with other local emergency management agencies, such as fire departments, law enforcement agencies, and hospitals. These exercises can simulate emergency scenarios and allow MRC volunteers to practice their response skills alongside other emergency responders.
- *Collaborative training sessions:* MRC units can also organize collaborative training sessions with other organizations involved in emergency preparedness and response, such as the American Red Cross, local public health agencies, and community-based organizations. These training sessions can cover a wide range of topics, such as disaster planning, emergency communication, and incident command.
- *Specialized training opportunities:* MRC volunteers can participate in specialized training opportunities offered by other organizations, such as the FEMA, the CDC, and the NIH. These training opportunities can provide MRC volunteers with advanced skills and knowledge in specific areas, such as disaster mental health, infectious disease control, and emergency management.

By participating in cross-training opportunities with other organizations, MRC volunteers broaden their skills and expertise, strengthen partnerships with other agencies, and enhance their ability to respond effectively to emergencies and disasters in their communities.

Mass Casualty Drills offer a good opportunity for the MRC volunteers as well as the leadership meet our local response partners and provide much needed victim volunteers for the drill. The volunteers appreciate these drills

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and they have always given positive feedback for each of them we have supported.

6.3.6. MRC Leadership Roles in Sheltering and Points of Distribution

The MRC is a national network of volunteers, organized locally to improve the health and safety of their communities. MRC units are made up of medical and non-medical volunteers who are trained to respond to public health emergencies and disasters. In this regard, MRC leadership play a critical role in ensuring the safety and well-being of their communities during emergencies and disasters. In the context of sheltering and points of distribution (POD)[141], MRC leaders may play several roles, such as:

- *Shelter Management:* MRC volunteers can assist with managing and staffing emergency shelters during disasters. They can help with registration, triage, and medical treatment of evacuees.
- *Medical Support:* MRC volunteers can provide medical support at POD, which are locations where essential supplies such as food, water, and medication are distributed to the public during emergencies. They can help with screening and triage of individuals seeking assistance, and provide basic medical care if needed.
- *Logistics:* MRC leaders can also play a key role in the logistics of sheltering and POD operations. They can help with the setup and maintenance of these sites, as well as the distribution of supplies and equipment.

In terms of leadership roles, MRC leaders can serve as coordinators, trainers, and supervisors of volunteers. They can help with recruitment, training, and deployment of volunteers during emergencies. They can also work with community partners and stakeholders to ensure effective communication and collaboration during disaster-response efforts. MRC volunteers within our units take shelter operations and shelter management

[141] Online: https://www.fema.gov/glossary/points-distribution-pod. Accessed 11 August 2023.

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courses. Many times, our volunteers can manage the shelter, which gives the local response teams the opportunity to go out and do their varied missions in their community rather than staying in the shelters.

We like to drill using the local sheltering plans at least annually, and in doing so, also perform an inventory of the tools and materials available within their shelter. These drills are further benefit to our local response teambuilding experience. Many times, we open the drill to the public and let them walk through the shelter stations so they can learn about what their local shelter provides. It is important to drill these sheltering plans every year, because it helps us identify the gaps in these sheltering plans, check on shelter inventory, and then take corrective actions.

Our local strike teams are made up of someone who understands shelter management, registration, medical station, and behavioral health, and how to manage the kitchen (usually, schools have two extra weeks of food supplies). In dormitories, our volunteers understand how to place people in our shelter, configuring separate spaces for single men, single women, families, and the medical section. They are ware that each of those population types have needs access to different things when developing the floor plan for the dormitory area. Other shelter we work in are refugee shelters, we provide medical and vaccinations for the folks that are in the shelter. We work with homeless shelters throughout the year as well as food kitchens, battered women's shelters, and "warming and cooling" enters during extreme heat or extreme cold. Our volunteers are well versed in all these types of sheltering, and they understand the supply inventory and how to establish them.

In our Emergency Dispensing Sites (EDS), we use our flu/COVID clinics, general health clinics, and other vaccination clinics, as an opportunity to drill the EDS plan in that opportunity, so, in essence the EDS are real-life drills. This gives the volunteers an opportunity to meet the public health director, nurses, and any other staff to develop a unified team for pandemic response. During our COVID-19 response, we did over 2000 clinics and 500 testing site clinics as a drive-through model of the EDS. We also use hazardous waste days as an opportunity to test our drive through clinic capabilities. This capability was instrumental during our COVID-19 response because we had already performed the needed services many times locally. Initially, all the clinics operated as drive- thru facilities.

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Figure 6.3. MRC Covid-19 testing images: (1) Setting up right medical tent for swabbing; (2) Setting up left medical tent for swabbing; (3) Greeter station; (4) Registration, giving vial, bag, and instructions; (5) Traffic direction to swabbing station; (6) Lane control; (7) Swabbing nose from tissue used to blow patients nose.

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Chapter 7

Historic Deployments

Abstract

This chapter provides further detail on our major MRC deployments during historic incidents and events in the Commonwealth. In each subsection, we have described the incident or event to which the MRC responded and how our operational steps (see Chapter 2) were applied for each deployment. In addition, we describe the lessons learned from these deployments and how they were used to improve MRC performance. It is this cycle of deployment and improvement that is optimizing the MRC as an important health-care asset of the Commonwealth, the country, and beyond.

7.1. Scope

The MRC has been deployed for many incidents and events that take and threaten the lives and well-being of the visitors to the Commonwealth as well as its citizens. In this chapter, we describe specific natural and manmade disasters that caused MRC deployments. We describe how our operational steps defined in Chapter 2 pace our MRC operations for each deployment. We have also included the specific lessons-learned and MRC improvements made as a result. We have organized our description of these deployments in the order of most-to-least warning and pre-deployment situational awareness.

7.2. Pandemic

7.2.1. H1N1

7.2.1.1. Background

In the spring of 2009, a new strain of influenza known as H1N1 began to spread rapidly around the world. The virus caused widespread panic, with

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people fearing that it could lead to a global pandemic, like the deadly Spanish Flu outbreak of 1918.[142] In response, public health officials around the world began to act. In the US, the CDC quickly mobilized to develop a coordinated response plan. The CDC worked closely with state and local health departments to monitor the spread of the virus and develop strategies for containing its spread. They advised people to practice good hygiene, such as washing their hands frequently and covering their mouths when coughing or sneezing. See Figure 7.1.

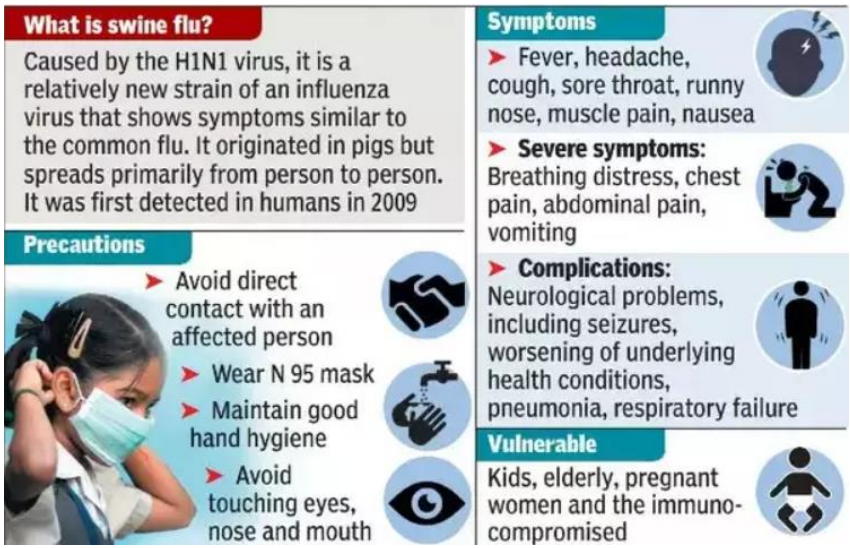

Figure 7.1. CDC H1N1 publication on H1N1.

As the virus continued to spread, public health officials began to implement more aggressive measures. Schools were closed, public gatherings were canceled, and travel restrictions were put in place to try to slow the spread of the virus. Healthcare workers were also mobilized to provide care to those who had been infected. Hospitals and clinics set up special triage areas to screen patients for symptoms of the virus, and healthcare workers were trained to use personal protective equipment to prevent the spread of the virus.

Despite these efforts, the virus continued to spread, and by the fall of 2009, it had reached pandemic levels. But thanks to the coordinated efforts of

[142] Online: https://en.wikipedia.org/wiki/Spanish_flu. Accessed 14 March 2024.

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public health officials and healthcare workers, the impact of the pandemic was less severe than many had feared. Millions of people had become infected with the virus, and thousands died, but the rapid public health response helped to slow the spread of the virus and minimize its impact.

The H1N1 pandemic (well before the emergence of COVID-19) served as a reminder of the importance of public health preparedness, and it highlighted the critical role that public health officials, healthcare workers, and everyday citizens play in responding to public health emergencies.

7.2.1.2. MRC Operations

The sequence of MRC operations for the H1N1 pandemic are described below. The last subsubsection describing MRC operations presents the specific lessons learned and their application to improve MRC performance.

7.2.1.2.1. Preparedness and Situational Awareness

For years prior to that H1N1 outbreak, we had been planning and drilling our emergency dispensing-site plans in preparation for a potential pandemic. This preparation included training for municipal departments to give them an understanding of what their role would be in a pandemic, given that the local public health departments would lead the response. In fact, this work was challenging because not everyone understood that their local department of public health (historically the least-funded public safety agency despite the massive societal impact of pandemics on the population) would be the primary lead on the local response. For this reason, our MRC determined there needed to be an educational program for many town departments as well as local public health departments on what they were expected to do during a pandemic.

We developed plans and protocols for each health department that were specific to their local needs. We recruited MRC volunteers to staff potential emergency dispensing sites, which included medical and non-medical staffing. We also trained our volunteers and how to staff an emergency dispensing site. During that time, we developed our JAS (see Chapter 2) for online training through video and viewgraph presentations that could be shared locally to train the volunteers. We had a significant response from community members to join the MRC prior to a response. Within that MRC volunteer list, we developed our deployment leadership, which included doctors as the medical director and leadership staff for all the stations that would be at emergency dispensing sites.

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7.2.1.2.2. Activation

When we were alerted of the potential H1N1 outbreak, we began performing informational briefing sessions on (i) what we knew of the H1N1 virus, (ii) how it was transmitted, and (iii) what the public could do to protect themselves. This alert also initiated training for our volunteers to staff an emergency dispensing site prior to getting the vaccine themselves. Many of our volunteers already understood the concepts of an emergency dispensing site and we produced new training that was specific to H1N1.

During that Activation, we used our website (http://www.mrcvolunteer.org/) to have volunteers register for their shifts. Prior to that time, we had done it all by hand, which at times led to administrative errors. Setting up the interface to have volunteers register themselves caused us to identify many gaps and needs for the system. Thus, we adapted its operation as needed during that response. It was then obvious that the Internet and mobile application technology was greatly improving the deployment of our volunteers.

The H1N1 Activation also provided an opportunity to educate our healthcare and public safety/service partners and town departments on how we could best respond to the H1N1 outbreak. It took over a year to get the vaccine, and that was particularly challenging because many people wanted to understand how to protect themselves and what to expect once we received the vaccine. All we could do during this time was to work to minimize the spread through prevention education of our volunteers, our response partners, and the public.

7.2.1.2.3. Notification

Over the years, we had used several types of Notifications. When we started our MRC operation in 2004, we primarily used e-mail, "snail mail" (written hard copy correspondence and manual mailings), and phone calls to communicate with our volunteers and response partners. As time went on, we built a notification system within our website developed first during this H1N1 activation. It helped us prevent deployment errors and ensured that we had adequate information distributed to both our volunteers *and* the municipal employee partners collaborating with us in the response.

7.2.1.2.4. Deployment

We received the vaccine a year after the pandemic was announced, and with that, we started to plan to activate our emergency dispensing sites. At the

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beginning, we worked with municipal departments and then backfilled staffing gaps with our local MRC volunteers. The response was beneficial, and our clinics were well staffed, so much so that we were able to dispense the vaccine almost immediately upon receiving it. Again, it was an important response from the municipality's stakeholders and our motivated and well-trained MRC volunteers.

7.2.1.2.5. Debriefing

Shift debriefing during our H1N1 Deployment was done often, generally once each shift had completed. There is a debrief when volunteer shift changes occur with a half-hour overlap. This overlap enables a proper debriefing from volunteers that had covered the previous shift, allowing the incoming volunteers to ask questions. Once on their shift, if there is something that they need, they know to contact MRC leadership or the onsite contact to get more information.

Shift debriefing is important because it covers information specific to the ongoing Deployment not given with the initial deployment Notification. Moreover, those who have been onsite have a better awareness of what is happening at that time. In this way, MRC volunteers who have just completed their shift can best prepare the next shift on what to expect and how best to mitigate any potential issues. For example, identifying a difficult shelter occupant or alerting on other situations needing immediate attention.

The shift debriefing is also a particularly suitable time to identify any support a volunteer determined they needed as well as to address any issues or stress that the volunteer may have during their deployment shift. It is important we monitor this stress level to make sure our volunteers are not "burnt out," so they are able to continue to perform their assigned duties on their next shift. By understanding the mental state of the volunteers, MRC leadership determines when the volunteer will be deployed again or not at all. With the debrief, MRC leadership can share information with the incoming-shift volunteer crew as they function as leadership's "eyes and ears" onsite.

Deployment Debrief or "hotwash," is conducted immediately once our MRC Deployment is completed. In this way, many issues and their recommended resolution can be reviewed and concise improvement recommendations provided. Not only can we address persistent issues identified in the shift debriefings, but we can also identify systemic issues with protocols, training, logistics, and supply. These issues and associated recommendations are documented in the After-Action Report.

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Figure 7.2. (1) Author presents dispensing drill results; (2) Mobilization in 12 minutes; (3) Drill explanatory briefing; (4-5) Volunteer registration; (6) Clinician provided psychological First Aid; (7-8) Medical stations; (9) Patient actor with anthrax exposure; (10) Actor playing threat to staff and patients; (11) Medical triage surge; (12) Event debrief with press.

7.2.1.2.6. Lessons Learned and Applied: Improvements

There is always an after-action report after each deployment or drill. This report gives us an opportunity to (i) "dig deep" into any issues that had arisen, (ii) if and how they are resolved, and (iii) how to better prevent or mitigate such issues in the future. Once identified in the After-Action Report from a Deployment, the MRC leadership can then take corrective actions, such as addressing protocol improvements, training improvements, and improvements to equipment/material supply or other logistics problems as well as failures or inadequacies experienced with provisioned equipment.

Within an after-action report, we list recommended corrective actions and the timeline for them to be resolved. If there is a funding issue, we search for grants to provide the funding we need and/or seek donations. The corrective recommendations in the after-action reports are arguably the most important information coming from our Deployment activities. They help us prepare and mitigate similar potential issues during future deployments.

After the H1N1 pandemic, for example, the Commonwealth rolled out a system called *Massachusetts Responds,* which mimicked what we had done on our website, and to more capabilities have been added over time. There had been delay in getting our MRC volunteers into the *Massachusetts Responds* system. Although we could communicate with them, it was challenging because the volunteer had to fill out a profile and learn how to use the new

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system. Once we implemented *Massachusetts Responds* for our volunteers, it proved invaluable and the MRC leadership now uses it on an almost daily basis.

Despite availability of *Massachusetts Responds*, we nonetheless practice other communication protocols in case the Internet fails, telephone lines and cellular communications goes down. We have even "dug down" deep enough to set up neighborhood groups that would go out and knock on doors to get volunteers if there was a need for a public health response. This activity presented a good opportunity to build our MRC teams and prepare them for all the deployments we have since done over the subsequent years.

7.2.2. COVID-19

The MRC's capabilities extend well beyond responding to natural disasters. In the event of a public health emergency, such as a pandemic, the MRC was ready and equipped to respond. In early 2020, the world suffered the start of a pandemic caused by the novel coronavirus, COVID-19. The virus quickly spread across the globe, infecting millions of people, and overwhelming healthcare systems everywhere. When the COVID-19 pandemic emerged, MRC units across the country were activated. During the COVID-19 pandemic,[143] the MRC played a critical role in supporting the Commonwealth's response efforts. Volunteers helped with testing, vaccination, and contact tracing. We also worked alongside healthcare professionals to ensure that everyone had access to the care and support they needed.

7.2.2.1. MRC Operations

The sequence of MRC Operations for the COVID-19 pandemic is described below. The last subsubsection describing MRC operations presents the specific lessons learned and their application to improve MRC performance when multiple simultaneous disasters occur. Fortunately, we were able to meet all the needs and assistance requests we received. During COVID, which was a unique disaster, most workers in our supported communities were sent home or worked from home. This home working requirement provided a perfect environment for volunteers to be able to support the COVID-19 response.

[143] Online: https://en.wikipedia.org/wiki/COVID-19_pandemic. Accessed 14 March 2024.

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7.2.2.1.1. Activation

When we were alerted to the COVID-19 virus, we had little information about its characteristics. Our Commonwealth Activation occurred immediately following the Federal Government's announcement that a COVID-19 pandemic was underway. This Activation was done through *Massachusetts Responds*, which put our MRC volunteers on "standby."

7.2.2.1.2. Notification

Using *Massachusetts Responds*, we notified our volunteers of potential deployment and often communicated with them daily. We set up teams that could be sent specific information describing our volunteers roles in supporting the public health response. The most efficient way to track volunteer support was through the *Massachusetts Responds* system. We were able to download an MS Excel spreadsheet that could be shared with local health and other response partners we were supporting.

7.2.2.1.3. Volunteer Response

Upon Notification, our volunteers began immediately staffing local health departments to share public information about the available pandemic guidance for citizens and businesses. Our MRC volunteers staffed a call center to support local health departments. We shared our latest information about public health regulations and policies, plans, and procedures that businesses could execute under current pandemic guidance. We were also able to already provide conventional hygiene guidance to citizens about how best protect themselves from the virus, even though COVID-19 specifics were not yet available.

7.2.2.1.4. Deployment

7.2.2.1.4.1. Initial Response

Our MRC volunteer deployment was done using *Massachusetts Responds* and was tracked through the capabilities of this system. As assistance requests were received by the MRC leadership, we sent out these requests immediately and built a volunteer staff roster to support each specific request. If needed, we would quicky develop focused training for our volunteers and write job action sheets for them to streamline the process of for their support of local health departments, hospitals, and clinics.

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In the week following the Government's pandemic announcement, we trained volunteers to staff phone lines at local health departments. Their role was to provide surge capacity for those local departments, who were also responsible for enforcement. We also helped free their staff from answering phone calls.

The MRC leadership sent out notifications to our volunteer corps as we received guidance from the MDPH and the CDC. Our volunteers quickly developed expertise using the most current CDC guidance. We were thus able to effectively provide surge capacity to healthcare facilities, hospitals, public health departments, and many other organizations that needed volunteer support. Next, we expanded our call handling capability to 200 lines staffed by our volunteers, who then staffed these lines from 7:00 AM to 7:00 PM each day for six months, initially providing this guidance to businesses and citizens about developing their own CDC-driven COVID protocols.

Our MRC leadership handled a wide range of small and large required-MRC-response requests. We told our supported agencies and partners to send requests to us, and then we would send them to the volunteers. The MRC did things as limited as cleaning a church bathroom once a week to staffing entire clinics. We helped hospitals do screening for patients as they were coming to the hospital for COVID. This support was prior to getting the COVID-19 test kits. After we received the kits, we staffed thousands of testing sites, many on a daily basis. We had an incredible response from the volunteers and many of the testing sites were outside during extremely hot or very freezing weather situations.

7.2.2.1.4.2. Long-Term Response

The volunteers were indefatigable, and so we were able to fulfill all agency requests for which the leadership had developed specific response protocols. Often, the leadership would have the roster available within an hour of a request receipt, then it was it was uploaded as a spreadsheet. We then submitted a meeting request within *MS Outlook*[144] that included all the volunteers supporting that specific response. The meeting request included any necessary training protocols for volunteer on-site work, contact information, location address, and any other pertinent information. This was a

[144] Online: https://support.microsoft.com/en-us/office/create-or-schedule-an-online-meeting-in-outlook-for-windows-b8305620-d16e-4667-989d-4a977aad6556. Accessed 18 March 2024.

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valuable tool for us because everyone involved in that specific response had all the information, they needed in the meeting invitation and anybody could comment and share information within that alert notification. This benefit was discovered as we expanded our roles in supporting public health and our response partners and proved to be an incredible asset that was easily accessed.

At this point, our role was expanded, so that we helped register folks without Internet, and we coordinated transportation to distribute vaccines as well as staffing clinics. Again, this was an important activation that has been ongoing (as of this writing) for two years, now incorporating COVID-booster clinics. Our volunteers adapted to these changing requirements as the COVID response guidance evolved, and as our MRC training expanded to support local health, hospitals, and other public health support functions. Our volunteers became experts in the COVID-19 response, optimized for their individual community's needs, becoming a much-needed asset during the COVID response. For the most part, this need occurred because health departments were historically minimally funded. As a result, they lacked the staff needed for the massive operations required in a pandemic response.

It was for this reason that our thousands of volunteers we were able to provide the support when and where needed. The dedication of the volunteers was evident in that many of them supported the COVID-19 response efforts for 8 to 12 hours daily. The healthcare facilities and their public health staff became sick or unable to help due to underlying healthcare conditions before more was known about the virus spread mechanisms, so our and the volunteers were able to backfill their staffing.

In one Commonwealth city, a group of MRC volunteers helped set up a testing site for COVID-19. They worked alongside healthcare professionals to swab patients for the virus, collect samples, and ensure that everyone followed safety procedures. For weeks, they worked long hours, testing hundreds of people each day. In another location, MRC volunteers helped staff at a hospital that was overwhelmed with COVID-19 patients. They assisted with tasks like taking vitals, delivering meals, and transporting patients around the hospital. They provided essential support to the overworked healthcare workers, who had been on the frontlines of the pandemic.

Once the vaccine arrived at the states our volunteers staffed hospital clinics to vaccinate the forward-facing staff for COVID-19. After that we set up first responder's clinics all over the state and then the clinics were set up by highest risk, we staffed thousands of clinics during 2020 to 2022 and still

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are staffing clinics for flu and COVID. Overall, our volunteers achieved the following benefits to their communities:

- Staffed thousands of COVID-19 clinics
- Staffed thousands of COVID-19 testing sites
- Performed over 60,000 COVID-19 tests
- Administered over 225,000 vaccines
- Distributed PPE to 72 communities
- Staffed call lines and registered over 20,000 people without Internet access for vaccine appointments
- Delivered over 20,000 meals
- Helped perform contact tracing for local health departments
- Staffed COVID-19 pool testing in schools
- Staffed COVID-19 help lines with 19 different languages spoken.

MRC volunteers helped run vaccination clinics during the entire response. They helped people check in, fill out paperwork, and receive their shots. They answered questions and provided information about the vaccine to anyone who was hesitant or unsure.

Throughout the pandemic, MRC volunteers worked tirelessly to help their communities. They risked their own health to support others, and their efforts played a critical role in the fight against COVID-19. While the pandemic is still far from over, the dedication and selflessness of the MRC volunteers have provided many lifesaving benefits to their communities.

7.2.2.1.5. Debriefing

Shift debriefings of deployed volunteers were done in multiple ways through Zoom calls after a COVID-19-related activation, via e-mail follow up, through texts, and on site. The debriefings gave us an opportunity to adapt to the needs of each type of pandemic activation, develop job action sheets, improve protocols, and streamline the information that was given to the volunteers and our response partners. Throughout the debriefing process, we were able to help volunteers better prepare to support any activation—certainly our many local

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COVID-19 activations—and to provide specific types of support for each activation. Because the staff of our response partners and public health departments were stretched thin, we were able to do the coordination training and provide volunteer support with minimal effort from those public health or response partners.

7.2.2.1.6. After-Action Report

With the COVID 19 as with each Deployment, we learn from the volunteers when they report back. This allows the MRC leadership to take corrective actions regarding our plans and procedures to ensure a better response on the next deployment. Again, the keys to effective volunteer response are the trust in their MRC leadership as well as the knowledge that leadership "has their back" no matter what situation occurs. In this regard, the MRC leadership exists to support the volunteers, to make sure they are assigned activities that they want—and feel confidant—to support through the necessary training that prepares them for any type of deployment or public health need. The MRC leadership works *for* them.

There were many lessons learned from our MRC COVID 19 After Action Report as we had to adapt to each situation, whether a new Activation or the result of changing situations in a specific Activation. We provided technical support, training, and protocols. These experiences helped the leadership further streamline our MRC internal and external (e.g., response partner) communications, so we were able to provide short messages, yet were able to provide all the information needed for any specific activation.

We have a committed group of volunteers, such that when something happens that may require an MRC activation, they will text MRC leadership to see if their help is needed. Our volunteers are continually active, which may be why we have such a capable corps of volunteers. This trust with the volunteers has developed over many years. Thus, it has been important to be consistent, communicate directly with them, and mitigate any issues that arise. As the MRC leadership, we must build trust, have continuity, clear communication, and detailed training so the volunteers feel comfortable being deployed.

7.2.2.2. Lessons Learned and Improvements

In this regard, there were a few new capabilities that we identified, tailored, and implemented during the COVID pandemic. We found some new tools describing how to organize testing and vaccine clinics while reducing

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confusion. The best IT tool has been—as described earlier—the *MS Outlook* meetings capability, which allowed our MRC leadership to not only schedule meetings, but also push to our volunteers at a specific clinic (i) all the information that was known about what they are going to be requested to do; and (ii) any other materials, such as JAS, that would be needed to specifically support clinics.

The COVID-19 disaster truly increased our MRC response capacity, and it offered as such an important opportunity to develop specialized teams with the integrated skills needed to respond to specific Activation or Deployment requests. The volunteers were given leadership roles and provided expertise that was perhaps the most valuable asset during the COVID-19 response.

Moving forward beyond COVID-19, we will have dedicated volunteers that work either directly with their local health departments, supporting all their MRC needs and providing specialized support in multiple capacities in concert with our response partners. It was principally through this public health support that our response partners realized the value of our MRC, and so they continue to utilize the volunteers in multiple ongoing local responses. As a result, we have extended our capabilities into new roles that support public health disaster response and healthcare capabilities. This evolution of MRC volunteer value continues to keep volunteers active and dedicated to supporting their communities, and will help us further prepare for disasters and other public health threats inevitable in the future.

7.3. Major Storms

7.3.1. Introduction

Winters in Massachusetts can be harsh, with snow, ice, and freezing temperatures making life challenging for Commonwealth residents. One winter, a powerful snowstorm hit the region, causing widespread power outages that left many people without heat or electricity. MRC volunteers were quickly deployed, responding to calls for help from the community. They knew that the cold temperatures could be life-threatening for some, and they were determined to do all they could to help.

The MRC establishes emergency shelters in local schools and community centers, providing a warm and safe place for people to stay. They also went door-to-door, checking on the elderly and vulnerable, making sure they had

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enough blankets and supplies to stay warm. As the days passed, the MRC volunteers continued their work, providing hot meals, medical care, and emotional support to those in need. They worked alongside other emergency responders, such as the National Guard and local police and fire departments, to ensure that everyone was safe and received the necessary care.

At one point, the MRC received a call from a local nursing home. The facility had lost power, and their backup generator had failed. The residents were cold and frightened, and the staff was overwhelmed. The MRC volunteers responded immediately, bringing in generators, blankets, and medical supplies. They worked to keep the residents warm and comfortable, reassuring them that they were not alone.

As the storm subsided and power was gradually restored, the MRC volunteers continued to provide support to the community. They helped clear snow from sidewalks and driveways, delivered groceries to those who could not leave their homes, and even provided counseling services to those who were struggling emotionally.

In the end, the MRC's response to the winter storm was a testament to the power of community and compassion. Despite the challenges they faced, the volunteers never wavered in their commitment to helping others. They worked tirelessly, selflessly, and with unwavering dedication, making a significant difference in the lives of those affected by the storm.

7.3.2. Winter Storm Nemo

7.3.2.1. Background

The February 2013 North American blizzard, also known as Winter Storm *Nemo*[145] and the Blizzard of 2013, was a powerful blizzard that developed from the combination of two areas of low pressure, primarily affecting the Northeastern US and parts of Canada, causing heavy snowfall and hurricane-force winds. The storm crossed the Atlantic Ocean, affecting Ireland and the United Kingdom. The nor'easter's effects in the US received a Category 3 rank on the Northeast Snowfall Impact Scale,[146] classifying it as a "Major" winter storm.

[145] Online: https://en.wikipedia.org/wiki/February_2013_North_American_blizzard. Accessed 30 March 2024.

[146] Online: https://en.wikipedia.org/wiki/Nor%27easter. Accessed 6 April 2024.

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The first low-pressure system, originating from the Northern Plains of the US, produced moderate amounts of snow across the Great Lakes region of the US and Canada. The second low, originating across the State of Texas, produced heavy rains and flooding across much of the southeast and mid-Atlantic parts of the US. As the two systems merged off the northeast coast on February 8, 2013, they produced heavy snowfall over a large region from northern New Jersey and inland from New York City through eastern New England up to coastal Maine and inland to Ontario.

Total snowfall in Boston, Massachusetts, reached 24.9 inches (63 cm), the fifth-highest total ever recorded in the city. Many surrounding cities picked up at least 1 foot (30 cm). In addition to the significant snowfall totals, hurricane-force wind gusts were recorded, reaching 102 mph (164 km/h) in Nova Scotia, 89 mph (143 km/h) at Mount Desert Rock, Maine, and 84 mph (135 km/h) off the coast of Cuttyhunk, Massachusetts. Boston experienced a storm surge of 4.2 ft (1.3 m), its fourth-highest. The storm affected Atlantic Canada after hitting the northeastern US.

Watches and warnings were issued in preparation for the storm, and state governors declared states of emergency throughout New England and New York. Flights at many major airports across the region were canceled, and travel bans were put into place on February 8 in several states. People in their hundreds ended up stranded on Long Island late on February 8 as a result of the rapidly accumulating snowfall. A combination of strong winds and heavy, wet snow left 700,000 customers without electricity at the height of the storm. At least 18 deaths were attributed to the storm.

As temperatures plunged, many residents found themselves without heat or shelter. In response, a network of volunteers, including the MRC, with emergency responders provided aid and comfort to those in need. The storm hit on a Friday night, and within hours, shelters began to open across the state. A combination of paid professionals and volunteers staffed these shelters, many of whom had experience working in emergency response. They provided food, water, and warm shelter to anyone who needed it. As the storm continued to rage, increased numbers of people sought refuge in the shelters. Families with young children, elderly residents, and those with medical conditions were all particularly vulnerable to the freezing temperatures, and the volunteers did everything they could to ensure that everyone was safe and comfortable.

In some cities, volunteers went door-to-door, checking on residents who had not yet made it to a shelter. They helped people dig their cars out of the

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snow, and they provided transportation to those who were unable to travel on their own. The shelters themselves were often filled to capacity, but the volunteers never turned anyone away. They worked to create makeshift accommodations wherever they could, using blankets, sleeping bags, and other supplies to keep people warm and comfortable.

As the storm finally began to subside, the volunteers continued their work. They helped residents dig out their homes and cars, and they provided hot meals and coffee to those who were still without power. They also worked to coordinate with other organizations and agencies to ensure that everyone who needed assistance was able to receive it.

In the end, the response to *Nemo* in Massachusetts was a testament to the resilience and compassion of the state's residents. Despite the challenges of the storm, volunteers and emergency responders came together to provide aid and comfort to those in need. Their selflessness and dedication will be remembered for years to come, as an example of the power of community and the strength of the human spirit.

7.3.2.2. MRC Operations, Response, and Deployment

During *Nemo*, we were able to support our regions and regions outside of our "catchment area."[147] Again, our volunteers were dedicated to their missions and able to fulfill all their requests. During that time, we supported local shelters that housed citizens with access and functional needs and helped identify gaps in shelter plans, training, and equipment that is needed for shelter operations. We also did well-checks for people that were isolated via phone calls and, if they were unable to shelter, in place provided transportation if needed to a local shelter.

Past deployments had helped us identify gaps in our training, planning, and sheltering drills that we provided to volunteers prior to the storm. We had provided training and supported local shelter drills to help volunteers prepare to support a sheltering operation. Activation was done through *Massachusetts Responds*. By this time, we were using spreadsheets to share information with the local shelters that could be downloaded by our volunteers from *Massachusetts Responds*, which we then that we shared with local shelter managers.

[147] Online: https://en.wikipedia.org/wiki/Catchment_area. Accessed 30 March 2024.

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7.3.2.3. Lessons Learned and Applied

Our *Nemo* response helped better prepare for the types of populations that would access local shelters. We had done minimal training on access and functional needs, and we realized that our capabilities in this regard had to be expanded to support who would access the shelter. As stated in the previous sections, there were many lessons learned that helped us adapt our training, such as the protocol we used for our local shelter drills and to verify we had the needed equipment to support the population that would need our shelters during this storm. Prior to *Nemo*, the plans and protocols were only tailored to general populations and had not addressed the functional needs of human access. This realization changed our plans and protocols and helped us improve the list of needed supplies to support the shelters. See Chapter 2.

In addition, we realized (i) that there was a primary need was for medical staffing that could support people with ambulatory issues; and (ii) that the on-site shelter supplies were not appropriate for that population. There was a need for hospital beds, not cots, and durable medical goods, such as walkers, wheelchairs, oxygen concentrators, commodes, and other durable medical goods. We found we needed these devices, but they were not available at the shelter.

Thus, we contacted the local representatives of the National Council on Aging,[148] who had donated durable medical goods that could be transported over to the shelter. Many of the shelters were at schools, and some elementary schools had small toilets and low sinks that made it particularly difficult for the aging population to effectively utilize bathrooms. We also realized we needed to find funding for bariatric[149] equipment costs and other aging medical costs to better serve this population, so moving forward, we looked for funding to develop a cache of this type of equipment.

[148] Online: https://www.ncoa.org/. Accessed 18 March 2024.

[149] Online: https://en.wikipedia.org/wiki/Bariatrics. Accessed 18 March 2024.

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Figure 7.3. (1) Author presented sheltering drill results; (2) shelter supply trailer – inventory done during drill; (3) Activation of EOC; (4) Communications check; (5) Shelter set up in 23 minutes; (6) Pre-rill briefing; (7) Registration team; (8) Behavioral health; (9) Pet shelter staff; (10) Medical; (11) Dormitory with Medical, Single, and Family; (12) Post-drill "hotwash."

7.3.3. Hurricanes Triggering MRC Stand-by and Deployment

7.3.3.1. Background

In Massachusetts, hurricanes have become a common occurrence during the late summer months.[150] While people were used to the occasional storms, the severity of the hurricanes hitting the region in recent years had been increasing, which increased concern among the local authorities. As the hurricane season approaches, MRC volunteers are put on alert and began to prepare for any potential emergencies. They review their emergency protocols, build up their supplies, and make sure their equipment is in good working order.

When Hurricane *Irene* made landfall in Massachusetts in August 2011, it had weakened to a tropical storm, but that did not stop the damage. *Irene* ultimately became one of the worst storms in the region's history. In western and central Massachusetts and Vermont, the storm brought high winds, heavy

[150] Online: List of US tornadoes from July to September 2021 - Wikipedia. Accessed 31 March 2024.

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rains, and flash flooding. At least 16 people died throughout the region, including 10 in Connecticut.

Parts of the coastlines in Connecticut and Rhode Island were devastated by Hurricane *Sandy*, which made landfall in New Jersey on Oct. 29, 2012, and became one of the costliest hurricanes to impact the US. When the storm was over, property damage was estimated at approximately $71.4 billion, and five people had been killed in New England. Around 600,000 people in Connecticut were without power, and the region saw wind gusts over 70 mph.

Hurricane *Henri*, was a tropical storm by the time it came ashore around 12:15 PM on an August day in Rhode Island. The eye of the storm made landfall near Westerly, then brought significant rain and wind to western Massachusetts. *Henri* also triggered three tornadoes that uprooted trees and caused localized power outages.

When Hurricane *Alice* made landfall, the MRC volunteers were activated. They set up emergency shelters and provided medical care to those who had been injured or displaced by the storm. They worked around the clock, checking on patients, administering medication, and providing emotional support to those who had been affected by the disaster.

As the days passed, MRC volunteers continued to provide their services, even as the storm's aftermath began to take its toll. They were tireless in their efforts, always ready to help those in need, and their dedication did not go unnoticed. They became a beacon of hope for the community, a symbol of resilience and compassion in the face of adversity.

In the end, the MRC volunteers were able to help thousands of people affected by the hurricane. They had worked tirelessly, selflessly, and without complaint, and their efforts had made a real difference in people's lives. As the storm subsided and the recovery process began, the people of Massachusetts knew that they could always count on the MRC to be there in their time of need.

7.3.3.2. MRC Operations

The sequence of MRC Operations following these historic events are described below. The last sub-subsection in each event or incident recounting MRC operations describes the specific lessons learned and their application to improve MRC performance. The response we had prepared included (i) support for shelter operations, (ii) delivery services to those that were homebound, and (iii) wellness checks to those folks that were unable to evacuate and we are sheltering in place.

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Our Activation had been done through *Massachusetts Responds* as requests came in for day shelters, overnight shelters, and support for many other diverse requests. The Notification for shelter support and other needs came from our response partners and local health departments. It was sent to our volunteers through *Massachusetts Responds*, including volunteer site-specific rosters sent to the requesting entity as well as with job action sheets and any information about that specific deployment.

Our volunteer Deployment was also done through *Massachusetts Responds*. Rosters were sent to the requesting entity and the volunteers adapted to the local situation. They reported to MRC leadership recommending corrective actions and provided us with valuable information about that Deployment. Again, the volunteers were able to support all the requests that came to our MRC and again strengthened our response capabilities. Thus, the MRC volunteers continued to support and expand their expertise and response capacity through this event.

Shift debriefing was done via phone calls post shift, on site with the volunteers that were changing shifts, and that information was shared with me and the local requesting agencies this helped us adapt to the current needs and provide better information to our volunteers that were deployed.

7.3.3.3. Lessons Learned and Applied

As with any deployment there were lessons learned. Generally, these lessons learned pertained to supporting documentation for the volunteers and how to adapt our communications to each unique situation. We learned that we needed to provide specific JAS for each local request. It served as an opportunity for us to continue to team build and develop leadership within our MRC units.

7.3.4. Flooding Events

7.3.4.1. Background

In Massachusetts, we have multiple incidents of flash flooding due to heavy rains. Severe flooding events have been increasing in frequency over the past several years. The MRC has deployed to assist with warming shelters and temporary shelters for people displaced from their homes. We have also assisted with cleanup after flooding events, which has become common when severe storms arrive, often causing widespread flooding and power outages.

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The MRC volunteers are immediately called into action, working alongside emergency responders to provide critical support to affected communities.

Figure 7.4. Local flash flooding.

MRC volunteers quickly set up makeshift shelters for those who had been displaced by the storm, providing food, water, and medical care to those in need. They worked to ensure that everyone was safe and comfortable, even as the storm continued to rage outside. As the floodwaters receded, the MRC shifted its focus to helping with the recovery effort. Volunteers worked to clean up debris and damage, aiding those who had lost their homes or suffered other losses.

7.3.4.2. MRC Operations

To be prepared for potential storm-related deployments, the MRC leadership monitors available power-outage maps as shown in Figure 7.5. As part of our preparedness for floods, we shared information about flood safety and safe travel during a flooding event. We also train volunteers to support evacuation as well as clean up after the flooding. In this way, our volunteers help local public health departments and protect citizens from flood damage. Again, this experience expanded our capacity beyond shelter operation alone, adding evacuation support to our community support.

Activation has been done upon request from local health and other response partners using *Massachusetts Responds*. Again, this Activation expanded our capabilities as an MRC unit and prepared volunteers for what they could expect during the expected deployment requests. Subsequent MRC

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volunteer Notification was done through e-mail, text message, or phone call from local health departments or response partners. The Notification included the needs they had for volunteer support. The notification to the volunteers was provided through *Massachusetts Responds* with all the pertinent information needed for the specific requests sent forward to our volunteers.

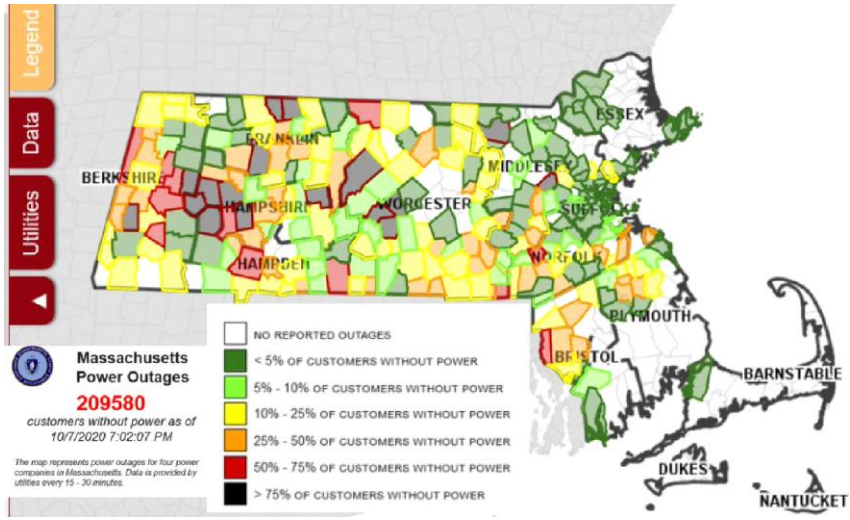

Figure 7.5. Massachusetts power outage maps used by the MRC to predict their potential Activation locations, provided by the MRC with changes, Fair Use.

The volunteer response fulfilled the needs of our health departments and response partners. Again, our flooding responses have better prepared volunteers for future responses and have provided opportunities to develop leadership within the volunteers and expand our response capabilities.

Each volunteer Deployment was done upon request. We identified the needed volunteers, then e-mailed them and our response partners with the necessary information to support each shift and Activation. With each Deployment, we expanded our response capabilities and increased the knowledge of our volunteers and response partners regarding MRC capabilities.

Debriefing was done through (i) phone calls post shift, (ii) onsite with the volunteers that were covering specific stations, and (iii) using text and e-mail. The debriefings were used as opportunities to provide information to the

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volunteers and local response partners about potential needs and changes that were needed for the upcoming shifts.

7.3.4.3. Lessons Learned and Applied

The lessons learned that we have applied helped us expand our response capabilities and expand the information that is shared to the volunteers and response partners. Each deployment has given us an opportunity to learn, adapt and better prepare our volunteers for future deployments as well as educate our response partners and public health about our MRC capabilities.

7.3.5. Mass Casualty Incident: The Boston Marathon Bombing

Starting in 2007, the MRC supported the Boston Marathon. Before the terrorist bombing, we had recruited MRC volunteers to staff the medical sweep teams at the Boston Marathon finish line. These teams were put together so medical staff assess runners after they complete the course and transport runners needing medical assistance to one of the medical tents. The MRC volunteers had become Boston Athletic Association volunteers, so they had the liability coverage and all the resources provided by the Boston Athletic Association. There are also local First Aid booths set up in all the cities and towns along the marathon route many times these are staffed with local MRC volunteers to First Aid two runners along the course.

7.3.5.1. Background

The MRC in Massachusetts provides medical support and assistance during the Boston Marathon, one of the world's most famous road races. The Boston Marathon[151] is a major event that draws thousands of runners and spectators each year, and the MRC is an essential part of the event's medical response team.

MRC volunteers with medical training are typically stationed along the course and at the finish line to provide medical assistance to runners and spectators who may experience injuries or medical emergencies. They work closely with local EMS and other medical personnel to provide critical care to those in need.

[151] Online: https://en.wikipedia.org/wiki/Boston_Marathon. Accessed 30 March 2024.

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Some specific ways that MRC volunteers assist with the Boston Marathon include:

- Providing medical assessments and treatment to runners and spectators who experience injuries or medical emergencies.
- Administering medications and treatments as needed
- Coordinating with local EMS to transport patients to hospitals if necessary.
- Providing support to runners with pre-existing medical conditions, such as diabetes or asthma
- Providing education about injury prevention and other health topics to race participants and attendees.

On April 15, 2013, the City of Boston was shaken by a horrific act of terrorism: two bombs went off near the finish line of the Boston Marathon, killing three people and injuring hundreds more. In the aftermath of the attack, a group of volunteers stepped forward to help the victims and their families. MRC volunteers included medical professionals, First Responders, and ordinary citizens who wanted to do whatever they could to assist in the recovery effort. They worked tirelessly, often putting their own safety on the line, to provide aid and comfort to those affected by the bombing.

Some of the volunteers were runners who had just crossed the finish line when the bombs went off. They immediately went to work, using their own clothing as tourniquets and helping to carry injured people to safety. Others were medical professionals who had come to the marathon to provide support to runners. They quickly transformed their medical tents into triage centers, treating the wounded and helping to transport them to hospitals.

As news of the bombing spread, increased numbers of volunteers arrived on the scene. They brought food, water, and blankets to those who had been displaced from their homes or were waiting for news about their loved ones. They offered emotional support to those who were traumatized by the attack, and they worked to ensure that everyone who needed help received it.

In the weeks and months that followed the bombing, these volunteers continued to provide support to the victims and their families. They raised money, organized blood drives, and helped to coordinate medical care and rehabilitation for those who had been injured. They also offered a listening

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"ear" and a "shoulder to cry on," as many people struggled to come to terms from the trauma of the attack.

The Boston Marathon bombing was a dark moment in the city's history, but the response of these volunteers showed the world the best of humanity. Their selflessness, kindness, and dedication inspired countless others to step forward and do what they could to help those in need. Their actions will be remembered for years to come as a testament to the power of community and compassion.

7.3.5.2. MRC Operations

The sequence of MRC Operations for the Marathon Bombing is described in what follows.

7.3.5.2.1. Preparedness and Situational Awareness

Each year, prior to the Boston Marathon, our volunteers attend training for a mass casualty event, which included medical protocols and other potential situations provided by the Boston Athletic Association[152] (BAA) to our volunteers. Our volunteers then effectively become Boston athletic association volunteers, which provide liability coverage and specific support from the BAA. This practice is common with support from our response partners, and it is best served for our volunteers to become part of their volunteer corps, providing all the benefits they would receive from the requesting organization.

7.3.5.2.2. Activation

Activation was done initially by recruiting volunteers to support the medical sweep teams,[153] with MRC volunteers prior to that the sweep teams were lay volunteers that really transferred volunteers to medical tents as needed at the finish line. This expanded the capabilities of the BAA to provide medical teams that would triage and transport injured runners or spectators specific to their situation.

7.3.5.2.3. Notification

Initial Notification was done through e-mail *listservs* that included MRC volunteers from across the state. We provided those volunteer lists to the BAA, so they could contact the volunteers directly, provide training, and resources

[152] Online: https://www.baa.org/. Accessed 18 March 2024.

[153] Online: https://www.baa.org/races/boston-marathon/plan/medical. Accessed 18 March 2024.

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to the volunteers that supported the medical sweep teams, and to prepare them to support the sweep teams at the finish time. It proved to be a successful partnership between the MRC and the BAA.

7.3.5.2.4. Volunteer Response

The volunteer response was effective initially and prepared volunteers to support the medical sweep teams, which provided a platform for MRC support of the Boston Marathon and enable volunteers to become part of their medical sweep teams.

7.3.5.2.5. Deployment

The initial Deployment was done in partnership with the BAA and continues to be a great partnership with them. As stated above, the volunteers became BAA volunteers, so they were provided with their resources, volunteer protection and needed training to support the medical sweep teams.

7.3.5.2.6. Debriefing

Every year there is a debriefing provided by the BAA to the event's volunteers that is very extensive. After the Boston Marathon bombing, mental health support that was provided to all the volunteers that responded to that event. It helped the MRC volunteers that supported the medical sweep teams to recover and take care of themselves after the human horrors witnessed immediately after the bombing.

7.3.5.2.7. Lessons Learned and Applied

We expanded and modified our protocols and the associated training provided to the BAA medical sweep team volunteers. Again, this expands the MRC volunteer capabilities, which will help in other deployments and other mass casualty events. Our volunteers continue to support the Boston Marathon every year and their training prior to the Boston Marathon bombing prepared the volunteers for that type of response despite the unexpected nature of the event.

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7.4. MRC Improvements

The broad scope of MRC preparedness involves a wide range of activities aimed at enhancing the nation's ability to respond to public health emergencies and disasters. Several key examples of the scope of the MRC preparedness are as follows:

- *Emergency response:* MRC volunteers are often called upon to support emergency response efforts, such as providing medical care and triage, distributing medications and vaccines, and supporting emergency shelters.
- *Public health initiatives:* MRC volunteers also support public health initiatives, such as immunization campaigns, health screenings, and health education programs.
- *Disaster preparedness:* MRC volunteers help communities prepare for disasters by participating in planning and training activities, conducting community outreach and education, and supporting local emergency management agencies.
- *Surge capacity (adaptability):* MRC volunteers provide surge capacity during public health emergencies and disasters, helping to supplement the existing healthcare workforce and support the response effort.
- *Unique events:* MRC volunteers provide medical and public health support during large-scale extraordinary events, such as concerts, festivals, and sporting events.

The scope of MRC preparedness is continually evolving to meet the changing needs of communities and respond to emerging threats. MRC units work closely with local public health agencies, emergency management agencies, and healthcare providers to identify and address the most pressing public health and emergency preparedness needs of their communities.

We have also used our Notifications for multiple differing deployments, including clinics, shelters, warming centers, cooling centers, and any other public health request we have had for our volunteers. Over the years, we have expanded our capabilities to "wellness checks" for seniors, support of local

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opiate programs, suicide prevention, hoarding, and support of any community need that is requested. The volunteers are regularly active and always want to provide their support and expertise for all the requests we, the MRC leadership, have sent out.

7.4.1. Improvements in Notification

We realized it was important to adapt our methods of volunteer communications for Notification on an ongoing basis. Our volunteers know our Notification will be easy to understand and will provide all the information they need to deploy when contacted. We drill this system four times a year to educate new volunteers as well as volunteers who have not yet deployed. In this way, they know what to expect when we notify them to deploy, Again, we constantly adapt to the current situation and latest technology.

Beyond pandemic, we have also used our notification capabilities for many different deployment types, including MRC staffing of clinics, shelters, warming and cooling centers, as well as any other public health request we may have of our volunteers. Over the years, we have expanded our capabilities to "well checks" for seniors, support for local opiate programs, suicide prevention, and even hoarding. We support any community healthcare need that is requested, and apply lessons learned from every such experience. The volunteers are highly active and always want to provide their support and expertise to all the requests we have sent out. We are grateful for their service.

7.4.2. Integrating MRC Plans into Emergency Preparedness Plans

Integrating the MRC into local emergency preparedness (EP) plans involves a collaborative effort among local emergency management agencies, public health agencies, and MRC unit leaders. Here are some steps that can be taken to integrate the MRC into local emergency plans:

- *Identify local emergency management partners:* MRC unit leaders should identify and establish relationships with key local emergency management agencies, such as the local emergency management office and the local health department.

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- *Assess local emergency plans:* MRC unit leaders can review the local emergency plans to identify opportunities to integrate MRC volunteers and resources into the response effort.
- *Identify MRC capabilities:* MRC unit leaders should collaborate with their volunteers to identify the skills and resources that they can provide during an emergency, such as medical expertise, public health education, and logistical support.
- *Develop MRC activation protocols:* MRC unit leaders should work with local emergency management agencies to develop protocols for activating MRC volunteers and resources during an emergency.
- *Conduct joint training and exercises:* MRC units and local emergency management agencies should conduct joint training and exercises to evaluate and refine the integration of MRC volunteers and resources into local emergency plans.
- *Establish communication protocols:* MRC unit leaders should establish communication protocols with local emergency management agencies to ensure that MRC volunteers are aware of emergency events and activation procedures.
- *Evaluate and update plans:* MRC integration into local emergency plans should be evaluated regularly and updated as needed to ensure that the MRC remains an effective partner in emergency response efforts.

By integrating the MRC into local emergency plans, communities can enhance their preparedness and response capabilities and ensure that they have access to additional resources and expertise during emergencies and disasters.

7.4.3. Developing New Partnerships

Our partnerships with the BAA were one of our most extensive arrangements we had developed, which helped us look for other partnerships and expand MRC capabilities to further support public health, disaster response, and any other day-to-day needs of our communities. These partnerships include homeless shelters, hoarding situations, wellness checks, opiate prevention

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programs, suicide prevention, youth services, hospital support, long-term care support, and community health support. Our response scope upon Activation and level of expertise continues to expand because of our MRC volunteers. These improvements are continuing as well for our relationships response-partner organizations.

When the MRC leadership communicates with our response partners, we tell them that in the worst case, we would not have volunteers to meet their needs. Thus far, no request has been too small or too large, and to date, our volunteers have been able to meet the needs of the requesting communities. In this regard, it is particularly important to expand MRC capabilities to support day-to-day needs for public health incentives and to educate our response partners about the potential use of volunteers.

The scope of our MRC role with response partners is expanding every year. This expansion occurs in part because MRC leadership takes every opportunity to offer MRC volunteers to support their efforts. Many times, this expansion is effectively done through our current response partners, including public health agencies and others like the BAA. They share information about the MRC and how we have historically supported any need with our volunteers. This aspect of our work is a particularly important aspect of our MRC units. It helps to integrate our volunteers into current programs before the incident or event occurs, which again expands our volunteer training, education, and capabilities for their communities.

7.4.4. Continuous Improvement

The MRC is always developing new partnerships, which gives other response organizations a motivation to share their training and resources with our volunteers. Doing so provides our MRC unit with opportunities to support any public health incentive and disaster response support within the communities we cover. We also expand outside of our catchment (i.e., covered communities) to support other organizations with volunteers for training development. MRC leadership believes that any use of our volunteers is valuable if it could be helpful to the community in disaster response and public health.

The MRC continues to expand our capabilities. This expansion helps grow our MRC volunteer capabilities and expand our reach into the community. This effort represents an education campaign about how our

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volunteers can support anything that is needed within our communities. Therefore, MRC leadership supports any potential partnerships that our volunteers can be used to achieve. Our goal is to provide support as needed and to integrate the MRC into all aspects of community support, disaster response, and any public health initiative.

Often, the MRC leadership reaches out to our volunteers, asking them if they know of any local incentives that would benefit from MRC involvement. In this way, the MRC is a community-support entity in which volunteers can share their expertise in any capacity that is needed. This environment is especially important for a volunteer organization, that is, keeping the volunteers active in providing the volunteer with opportunities in which they want to be engaged.

In this regard, the MRC leadership works for our volunteers, providing the necessary resources, training, protocols, and other support needed for them to be confident about their community contribution. This work requires seeking new partnerships and supporting any request to MRC leadership with training resources, policies and protocols, and community outreach.

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Chapter 8

Improvements

Abstract

This chapter provides examples of improvements that were identified in MRC After-Action Reports from the COVID-19 Pandemic Deployment. The purpose of presenting this information is to show how a review of MRC deployment actions identified perceived shortfalls in one or more aspects of a deployment and how those shortfalls became objects for improvement in the organization. After-action Reports are crested for every deployment of the MRC, but the long-term COVID-19 deployment was noteworthy in the shortfalls identified and the actions taken to address them. Here, we draw from After Action report from the MRC COVID-19 deployment to present an example of the improvement process, beginning with volunteer reports of issues or difficulties during the deployment. It addresses the problems found during the deployment and the actions taken to minimize or eliminate their impact in future deployments.

8.1. MRC COVID-19 Responsibilities and Challenges

8.1.1. Background

The Massachusetts MRC mobilized over 3,000 volunteers from across the state to support the COVID-19 response effort. The MRC worked in collaboration with state and local public health agencies, hospitals, and other healthcare providers to support a range of response activities. MRC provided support in several key areas:

- *Testing:* MRC volunteers assisted with COVID-19 testing at drive-through testing sites and other locations across the state. They helped with registration, screening, and sample collection.

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- *Contact Tracing:* MRC volunteers served as contact tracers, helping to identify and notify individuals who had been exposed to COVID-19.
- *Vaccine Administration:* MRC volunteers supported COVID-19 vaccine administration efforts, helping to staff vaccination clinics and assist with registration, screening, and vaccine administration.
- *Public Education:* MRC volunteers helped to educate the public about COVID-19 prevention measures and provided information about testing, contact tracing, and vaccine administration.

8.1.2. Challenges

The MRC faced the following challenges during the COVID-19 response:

- *Limited PPE:* At the beginning of the response, there was a shortage of PPE, which made it difficult for MRC volunteers to safely provide support. Our solution was adapted around current PPE usage changes, N95 and cloth masks were reused several time, not recommended. MRC volunteers sewed, assembled, and delivered over 10,000 cloth masks and 3-D printed face shields across the state. We received pallets of PPE and then set up a staging area in Topsfield and delivered equal quantity to health departments across the Commonwealth.
- *Limited Training:* Some MRC volunteers felt that they were not adequately trained to perform certain tasks, such as contact tracing and vaccine administration. Training was developed as the response progressed and was done prior to deployment, and just-in-time training was provided onsite. The guidance changed frequently and had to be adapted as the conditions evolved. We used in-person, Zoom video teleconferencing and JAS to provide the training on demand for volunteers. This approach was successful and enabled collaborative among state, regional, and local response partners, and their staff.

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- *Volunteer Burnout:* The response effort was prolonged, which led to volunteer burnout and a need for additional volunteers. We benefitted from the Commonwealth and Governor Charlie Baker[154] effectively performing did MRC volunteer recruitment when they provided updates. In many cases, our volunteer pool doubled during COVID, and many remained on our roster.
- *Communications:* Initial communication needs were challenged and we adapted our methods, eventually finding many ways to communicate effectively.

8.1.3. Lessons Learned

The Massachusetts MRC identified several key lessons learned from their COVID-19 response:

- *The importance of PPE:* The need for adequate PPE to ensure the safety of volunteers cannot be overstated, we had prior to COVID threw away expired PPE but realized that that practice needed to be changed, expired PPE is better than no PPE, of course it is the last resort but would have made a difference if we had expired PPE to give to Health Care workers.
- *The importance of training:* Volunteers need to be adequately trained to perform their assigned tasks. As with any response the training is adapted to encompass gaps in prior training protocols. Just in time training was developed but does not replace foundational training.
- *The need for flexibility:* Response efforts can be unpredictable, and volunteers need to be flexible and adaptable to changing circumstances. We had included that in our training protocol but realized it needed to become a culture in the MRC.
- *The importance of community partnerships:* Collaboration with community partners is critical to a successful response effort. We had many partners prior to COVID and developed many more during

[154] Online: https://en.wikipedia.org/wiki/Charlie_Baker. Accessed 19 March 2024.

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COVID, overall, it was an effective collaborative effort throughout state and local public health and emergency management domains.

Overall, the Massachusetts COVID-19 response demonstrated the important role that MRC volunteers play in supporting public health emergency response efforts. The MRC provided a much-needed human resource, which most often is the limiting factor in disaster and pandemic response. Most healthcare settings are "maxed out" under normal operations, which are greatly exacerbated during a major disaster response or pandemic.

8.2. Critical Components of Preparedness

8.2.1. Volunteer Preparedness

The Massachusetts MRC identified several corrective actions from their COVID-19 response, as detailed in their After-Action Report. These actions were designed to address the challenges and lessons learned during the response and improve the MRC's readiness for future emergencies. Several of our key corrective actions were as follows:

- *PPE Supply Chain:* The Massachusetts MRC is working to establish a reliable supply chain for PPE to ensure that volunteers have access to the necessary equipment during emergencies.
- *Training and Credentialing:* The MRC is developing additional training and credentialing opportunities for volunteers to ensure that they are adequately trained to perform their assigned tasks. They are also exploring ways to provide ongoing training and professional development opportunities for volunteers.
- *Volunteer Recruitment and Retention:* To address volunteer burnout and the need for additional volunteers, the MRC is working to expand its volunteer recruitment efforts and establish a volunteer retention plan that includes recognition and appreciation programs.
- *Standard Operating Procedures:* The MRC is developing and implementing standard operating procedures (SOPs) for various response activities, such as testing, contact tracing, and vaccine

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administration. These SOPs will help ensure consistency and quality in MRC response efforts.

- *Community Partnerships:* The MRC is continuing to build and strengthen partnerships with community organizations and stakeholders to ensure effective communication and collaboration during emergencies.

Overall, the corrective actions identified by the Massachusetts MRC aim to improve the organization's readiness and capacity to respond to public health emergencies, particularly pandemics.

8.2.2. Communication Protocols

The COVID-19 pandemic highlighted the importance of effective communication during public health emergencies. Here are some communication protocols that could be improved after the COVID-19 response:

- *Clear and Consistent Messaging:* Communication during an emergency should be clear, concise, and consistent across all channels. Messaging should be tailored to the target audience and delivered through multiple channels, such as social media, email, and text messaging.
- *Rapid Response:* Communication during an emergency should be timely and responsive. There should be protocols in place for responding to inquiries and concerns from the public and for providing updates on the situation.
- *Multilingual Communications:* In diverse communities, communication should be provided in multiple languages to ensure that everyone has access to important information.
- *Coordination among Agencies:* Communication protocols should be established among all agencies involved in the emergency response effort to ensure that all information is accurate, consistent, and up-to-date.

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- *Use of Technology:* Technology can be used to improve communication during emergencies, such as by providing real-time updates on social media, creating mobile apps for information and resources, and using telehealth services to provide medical care remotely.
- *Emergency Communication Plan:* Each organization involved in the emergency response effort should have an emergency communication plan in place that outlines the roles and responsibilities of key stakeholders, identifies communication channels, and establishes a process for monitoring and updating information.

Improving communication protocols during emergencies is crucial to ensuring that accurate information is disseminated in a timely and effective manner, and that the public is able to access the resources and support they need to stay safe and healthy.

8.2.3. Communication Alternatives

During a disaster, traditional communication channels such as phone lines, Internet, and TV broadcasts may become unavailable due to infrastructure damage or overload. In such situations, it is important to have alternative means of communication to stay connected and receive critical information. Here are some communication alternatives during a disaster:

- *Walkie-talkies or two-way radios:* These can be effective for short-range communication, especially if you are in a group or team that needs to coordinate.
- *Satellite phones*[155]*:* These phones can work even in areas where traditional phone lines and cellular networks are down. However, they can be expensive to acquire and use.

[155] Online: https://en.wikipedia.org/wiki/Satellite_phone. Accessed 30 March 2024.

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- *Amateur radio (HAM[156] radio):* This form of radio communication uses high-frequency radio waves and can work over long distances and has long been a pre-satellite staple of emergency communication. However, it requires specialized equipment and training to use, though many HAM operators are willing to support emergency communications for their communities as embodied in the Amateur Radio Emergency Service.[157]
- *Social media and messaging apps:* These can be useful for sharing information and updates among friends and family. However, they may not be reliable in all situations and may require internet connectivity.
- *Emergency alert systems:* These backup systems are government-run systems that can send alerts and notifications to mobile phones or other devices in case of an emergency. Examples include the Emergency Alert System (EAS)[158] and Wireless Emergency Alerts (WEA)[159] in the US.
- *Loudspeakers or sirens:* These can be used to broadcast messages to a large area and alert people to evacuate or take other necessary actions.

It is important to have a plan in place for alternative communication methods before a disaster strikes, as well as to stay informed about which methods are working during the disaster.

[156] Online: https://en.wikipedia.org/wiki/Etymology_of_ham_radio, accessed 30 March 2024.

[157] Online: https://en.wikipedia.org/wiki/Amateur_Radio_Emergency_Service. Accessed 30 March 2024.

[158] Online: https://en.wikipedia.org/wiki/Emergency_Alert_System. Accessed 30 March 2024.

[159] Online: https://en.wikipedia.org/wiki/Wireless_Emergency_Alerts. Accessed 30 March 2024.

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Addendum: Sample after-Action Report[160]

Exercise Overview

Exercise Name	Emergency Dispensing Site (EDS) Drill
Exercise Dates	February 9-10, 2017
Scope	Emergency Dispensing Site activation drilling our EDS Plan focusing on EDS facility activation, EDS call down and activation and MRC volunteer call down and activation. Mobilization-demobilization of EDS, following SNS protocols, volunteer management, information sharing and onsite Incident Command.
Mission Area(s)	Emergency Dispensing Site Activation drilling EDS Plan focusing on-community preparedness, Medical Counter Measures, Volunteer management, mobilization-demobilization of EDS, SNS protocols, Onsite Incident Command, EDS facility activation call down and volunteer call down drill.
Core Capabilities	#1 Community Preparedness; #3 Emergency Operations Coordination; #6 Information Sharing; # 8 Medical Counter Measures; #10 Medical Surge; #14 Staff Safety and Health; #15 Volunteer Management Mobilization-Demobilization of EDS, SNS protocols, Onsite Incident Command, EDS facility activation call down drill and volunteer call down drill.
Objectives	To evaluate the EDS throughput utilizing Holyoke War Memorial Building as an EDS facility, develop strong partnerships between response partners, identify gaps in current plans and procedures, to make corrective actions and to train EDS staff and volunteers.
Threat or Hazard	Anthrax exposure-Dispensing Antibiotics-Medical Triage-Psychological First Aid
Scenario	The scenario was Emergency Dispensing Site throughput drill activating the County and City EDS staff and volunteers to respond to an Anthrax exposure on February 9th of 2017. The purpose was to drill EDS Plan was to prepare and train the EDS staff and volunteers to meet the needs of the public in the event of an EDS activation, to triage patients and dispense antibiotics.
Sponsor	County Health Coalition, Valley Planning Commission, County MRCs and City. The drill was funded by allocation from MDPH. Drill support: City DPW, Fire, EMS, CERT, City Community College.
Participating Organizations	Planning Commission, County Boards of Health, City Department of Public Works, City Fire-Emergency Management, Action Ambulance-City EMS, County MRC's, City CERT, City Aux Police, City Community College, City Health Center and other response partners.
Point of Contact	Liisa Jackson, President of Preparedness Specialty Services: HSEEP Drill Designer, Planner and Facilitator, et al.

Improvement Plan (IP)

This IP has been developed specifically for the Health Coalition because of the Real Opt Throughput Drill conducted on January 2017.

[160] Online: https://preptoolkit.fema.gov/web/hseep-resources/improvement-planning, Accessed 1 April 2024.

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Core Capability	Issue/Area for Improvement	Corrective Action	Capability Element	Primary Responsible Organization	Organization POC	Start Date	Completion Date
#1 Community Preparedness		Community Education about EDS	Outreach	City	Board of Health	March 2017	March 2018
#3 Emergency Operations Coordination		Annual Drill	EOC	Emergency Management	EMD	March 2017	March 2018
#3 Emergency Operations Coordination		Add communication protocol for contacting HMCC to request assets during activation	EDS plan updates and drill communication protocol shared with all County Health Departments	Coordinator Board of Health		March 2017	March 2018
#14 staff Safety and Health		Training	EDS Staffing	County Health Coalition	Executive Committee	March 2017	March 2018
#6 Information Sharing		Interoperability between response partners	Communications	County Health Coalition	County Executive Committee	March 2017	March 2018
#15 Volunteer management		Annual Drill	Training and Coordination	County MRCs	County MRCs	March 2017	March 2018
#15 Volunteer management		Improvement on Just in Time Training	Training and Coordination	County Health Coalition	County MRCs	March 2017	March 2018
#8 Medical Countermeasure Dispensing		Annual Regional EDS Drill	SNS Protocol	County Health Coalition	County Executive Committee	March 2017	March 2018

[161] Capability Elements are: Planning, Organization, Equipment, Training, or Exercise.

Core Capability	Issue/Area for Improvement	Corrective Action	Capability Element	Primary Responsible Organization	Organization POC	Start Date	Completion Date
#8 Medical Countermeasure Dispensing	Improved Signage-Easels-caution tape or crowd barriers	Request funding to purchase signs and Easels	Request funding for EDS Supplies	City Board of Health		March 2017	March 2018
	EDS Staff Identification	Vests, badges	Request funding for EDS Supplies	City Board of Health		March 2017	March 2018
	EDS Plan update	Add Runners and Flow control to EDS Plan	EDS Plan update	City Board of Health	Name, POC info	March 2017	March 2018
		Clipboards to speed up registration process	Request funding for EDS Supplies	City Board of Health	Name, POC info	March 2017	March 2018
	1.9 Anthrax Antibiotic information	Have in plan Medical Protocol Anthrax antibiotic list and dosage information	SNS/MDPH Decision Tree will be out from MDPH soon	City Board of Health	Name, POC info	March 2017	March 2018
	1.2 Improve Just in Time Training	Development of Just in Time Training	Training Development	City Board of Health	Name, POC info	February 2017	February 2018

[162] Capability Elements are: Planning, Organization, Equipment, Training, or Exercise.

Chapter 9

Funding the MRC

Abstract

This chapter describes MRC need and use of grant funding based on our Massachusetts experience. We have described how we identify grant funders, determining specific funding targets for grants, and describes how we have applied and been award grants for MRC work to date. We also highlight the typical content of a grant response that the MRC leadership must complete to access the available funds.

9.1. Identifying Grant Sources and Programs

Generally, grant funding sought by MRC units is to needed provide funding for staffing, MRC training events, and needed medical and non-medical supplies for disaster response. In Massachusetts, the Commonwealth's health department funds our MRC units, and we are encouraged to work will public health coalitions as well. Our policies and procedures (see Chapter 3) impacts our success in grant funding for as follows:

- *Grant applications:* Many grants require organizations to submit detailed proposals that outline their goals, objectives, and strategies for achieving them. Policies and procedures themselves help to demonstrate that the MRC has a clear plan for how it will use the grant funds to support its mission. For example, policies and procedures may describe how the MRC will recruit and train volunteers, how it will coordinate with other organizations during emergencies, and how it will use funds to purchase equipment and supplies.
- *Compliance:* Most grant programs have specific requirements for how the funds can be used and how the organization must report on its activities. Policies and procedures are designed in part to ensure

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the MRC complies with these requirements. This compliance helps to avoid potential penalties or loss of funding. For example, policies and procedures may describe how the MRC will (i) track volunteer hours, (ii) document its activities, and (iii) report on its progress toward meeting its goals.

- *Risk management:* Funders may be more likely to award grants to organizations that have policies and procedures in place to mitigate risk and ensure accountability. Policies and procedures can help to demonstrate that the MRC is taking steps to manage risks related to volunteer safety, data privacy, and financial management.
- *Performance evaluation*: Some grant programs require organizations to report on their performance and demonstrate the impact of their activities. Policies and procedures can help to establish clear performance metrics and evaluation processes, which can make it easier to demonstrate MRC effectiveness and value to funders.

Overall, policies and procedures can play a critical role in securing and managing funding and grants for the MRC in Massachusetts. By demonstrating strong organizational capacity and risk management practices, the MRC can increase its chances of securing funding and delivering effective services to its community.

Identifying grants for the MRC can be a challenging task, but there are several strategies that can help you find appropriate funding opportunities. Here are some tips on how to identify a grant for the MRC and identify the needs that the grant can address:

- *Assess the needs of your community:* Before applying for a grant, it is important to identify the specific needs of your community. This process helps MRC leadership to target their grant search to funding opportunities that specifically address those needs. For example, if a community is at high risk for natural disasters (e.g., a coastal or flood-prone community), we would want to focus on applying for grants that support disaster preparedness and response.
- *Research grant databases:* There are many online databases that list grant opportunities for nonprofit organizations and government

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agencies. Some popular databases include Grants.gov,[163] Foundation Directory Online,[164] and GrantStation.[165] You can search these databases using keywords related to emergency management, public health, and volunteerism to find grants that may be a good fit for the MRC.

- *Check with government agencies:* Federal, state, and local government agencies often offer grants to support emergency preparedness and response efforts. Check the websites of agencies like the Department of Homeland Security,[166] the Centers for Disease Control and Prevention,[167] and state emergency management agencies to see if they have any relevant grant opportunities.
- *Look for private foundation grants:* Private foundations can also be a good source of funding for the MRC. Look for foundations that have a focus on public health, emergency management, or volunteerism, and check their websites for information on grant opportunities.
- *Consider partnering with other organizations:* Partnering with other organizations can help you identify grant opportunities and strengthen your application. Look for organizations that have similar missions or serve the same community, and explore opportunities for collaboration.
- *National Association of County Health Officials (NACCHO):* We have also sought locally sourced grants, such as hospital grants from the NACCHO,[168] which has funded our MRC for many years. NACCHO provides funding to MRC units through their continued

[163] Online: https://www.grants.gov/. Accessed 17 August 2023.

[164] Online: CjwKCAjwivemBhBhEiwAJxNWN40BjRn9fg_MdAqw5m6MN617gtVeoHe1kjYOT1X57S5FPgU73lAA8RoCyfYQAvD_BwE. Accessed 17 August 2023.

[165] Online: https://grantstation.com/. Accessed 17 August 2023.

[166] Online: https://www.dhs.gov/. Accessed 17 August 2023.

[167] Online: https://www.cdc.gov/index.htm. Accessed 17 August 2023.

[168] Online: https://en.wikipedia.org/wiki/National_Association_of_County_and_City_Health_Officials. Accessed 30 March 2024. The National Association of County Health Officials was founded in 1965. In early 1984, the organization experienced remarkable growth in membership and the organization opened its own office. In 1994, it was renamed to National Association of County and City Health Officials (NACCHO). Since its inception, NACCHO has sought to improve the public's health while adhering to a set of core values: equity, excellence, participation, respect, integrity, leadership, science & innovation.

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partnership with the HHS ASPR Medical Reserve Corps Program Office.[169] Figure 9.1 shows past MRC grant funding opportunities from the NACCHO.

Figure 9.1. ASPR grants to MRC units nationwide.[170]

Overall, identifying a grant for the MRC requires careful research and a clear understanding of the needs of your community. By taking a strategic approach and leveraging partnerships, the MRC leadership can increase our chances of finding and securing funding to support this important community work. Recent awards to MRC units nationwide are shown in Figure 9.2.

9.2. Writing Grant Proposals for the MRC

Our leadership is always searching for new grant and award opportunities that can help support the mission of the MRC. Oftentimes, this search means acquiring medical durable goods, uniforms, badging, and any other supplies that are identified as gaps. Grants and awards are also used to supplement staff hours, to update plans, or to expand capabilities. We have done this expansion over the years, including many day-to-day operations beyond disaster response, such as: refugee support, hoarding program support, opiate prevention support, wellness checks, harm-reduction programs.[171]

[169] Online: https://aspr.hhs.gov/MRC/Pages/About-the-MRC.aspx. Accessed 31 March 2024.
[170] Online: https://aspr.hhs.gov/MRC/Pages/index.aspx. Accessed 31 March 2024.
[171] Online: https://hri.global/what-is-harm-reduction/. Accessed 22 March 2024.

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MRC Award	About this Award
MRC COVID-19 Response, Innovate, Sustain, and Equip (RISE) Awards Round 2	Through additional support from the Administration for Strategic Preparedness and Response (ASPR), NACCHO awarded 71 MRC RISE Awards totaling $3,783,750 million through $25,000, $50,000, and $75,000 award tiers.
2023 Operational Readiness Awards	NACCHO awarded more than $1.255 million to support 146 units in building (Tier 1) or strengthening MRC response capabilities (Tier 2). Learn more about the progress the awardees have made in the 2023 MRC ORA Interim Project Report.
MRC COVID-19 Response, Innovate, Sustain, and Equip (RISE) Awards - Round 1	Through additional support from the Administration for Strategic Preparedness and Response (ASPR), NACCHO awarded 188 MRC RISE Awards totaling $11,431,250 million through $25,00, $50,000, and $75,000 award tiers. The second round of funding is forthcoming.
2022 Operational Readiness Awards	Continuing the goals of the MRC Operational Readiness Awards (ORA), NACCHO awarded more than $1 million to support 129 units in building (Tier 1) or strengthening MRC response capabilities (Tier 2). Learn more about the progress the awardees have made in both the 2022 MRC ORA Interim Project Report and the 2022 MRC ORA Final Project Report.
2021 Operational Readiness Awards Round 1 and Round 2	The 2021 ORAs aimed to continue building the operational readiness capabilities of MRC units to meet the emergency preparedness and response needs of their local, regional, or statewide stakeholders. The awards were intended to be flexible to meet the needs of all MRC units, support efforts to build and strengthen MRC capabilities, raise stakeholder awareness of MRC capabilities, and identify or sustain the integration of the MRC into local, state, and/or regional emergency response plans. Learn more about the progress the 174 awardees have made in the 2021 MRC ORA Interim Project Report and in the 2021 MRC Operational Readiness Awards Final Report
2020 COVID-19 Operational Readiness Awards	This award funding supported 32 MRC units that were actively supporting or planning COVID-19 responses by building unit response capabilities through the development of response plans to support COVID-19 and providing resources to support their activities.
2020 Operational Readiness Awards	The 2020 ORAs were intended to build the operational readiness capabilities of MRC volunteers and units to meet the emergency preparedness and response needs of their local, regional, or statewide stakeholders. This award funding supported 202 MRC units to increase their volunteer capacity (Tier 1) or strengthen the unit's response capabilities as a whole (Tier 2). More information is available in the 2020 MRC ORA Final Report.
2018 Challenge Awards	The 2018 MRC Challenge Awards focused innovation towards projects that align with nationally recognized health initiatives, are significant at the local level, and demonstrate capability within the MRC network. Project proposals may draw from ASPR's National Health Security Strategy (NHSS), the six Surgeon General's Priorities which includes the National Prevention Strategy (NPS), the CDC's Winnable Battles, or the strategic plans of other partner organizations.

Figure 9.2. Recent national funding programs for MRC Units.

Preparing for these expanded capabilities includes developing training, protocols, and expansion of volunteer recruitment to meet the needs of these

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programs. Over time and as Commonwealth demographics change, we have also considered various ways to recruit more multilingual volunteers. This recruitment has been challenging, but doable, as we have developed partnerships with local community leaders and organizations that support communities of non-English speaking populations.

We have also received helpful donations from response organizations to support our MRC capabilities. Many times, we cannot use grant or award funding for volunteer identification, which includes hats, shirts, and jackets. We do have funding for badging and safety vests, but it has proven beneficial to have other types of identification for MRC volunteers that are supporting local health or are being deployed to public sites.

9.3. Our Grant Proposals

A typical grant proposal is aligned and written to meet the needs of the Grantor. Our grant application and management must ensure our MRC implements the grants, particularly including the capacity to complete the (often written) deliverables. Depending on the grantor, each set of grant requirements is unique and so our grant proposals must be modified to address these unique requirements. Our state grant funding comes from the MDPH. They must approve all aspects of the grant allocation, meaning in part that we must provide specified deliverables to be eligible for grant funding.

Once our MRC receives a grant award, we promise to specified written (and other) deliverables. We agree to periodic reporting to the grantors. This reporting includes specifying (i) how many volunteer hours were devoted to the funded work; (ii) how many staff hours were given to the project; and (iii) a list of supplies that were purchased to support the related MRC activities. With certain grants, we must agree to log our activities into national regional and local reporting systems to be eligible to receive grant awards. Figure 9.3 shows our grant funding reporting process monitored by the Massachusetts HMCC through the Department of Public Heath (DPH) contractor Regina Villa Associates (RVA).

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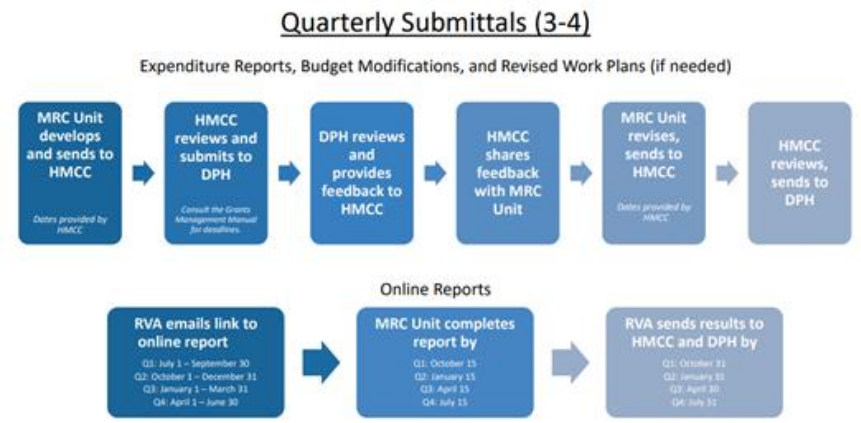

Figure 9.3. MRC Unit submissions required for MDPH funding.

Part of our grant applications often requires that we list our response partners as well as all the organizations supported by our MRC. This submission requirement is necessary to convince grantors of our proven capacity enhanced with strong partnerships for disaster response and public health programs. Over the years, we have actively engaged with potential response partners and other organizations involved in disaster response and public health deliverables. This grant requirement includes divulging the capabilities of the MRC and how they have historically supported partner missions or protocols.

Our MRC's most valuable assets are our trained volunteers with certified background checks. Since MRC inception, we have developed training and resources for volunteers that will be deployed in multiple situations (see Chapter 5). We would recruit volunteers available to respond when Notified (see Chapter 2) and set up the schedule for their Deployment. We provide the information needed for the volunteer to deploy safely and be able to work efficiently and effectively at the deployment site.

Over the years, these grants have been necessary to expand MRC capacity and to better prepare our volunteers for their deployments.

There are often opportunities given by our response partners due to MRC support of their programs and deliverables. At times, there has been funding given to our MRC, including donation of necessary supplies that have been

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donated to specific MRC units "in kind"[172] for their services. Moreover, our response partners will often include a broader scope of volunteer liability protection than other traditional local federal and state laws that protect responding volunteers.

In 2024, Massachusetts will award ASPR grant funds totaling $838,680 through the MDPH, which will use the funding to improve volunteer coordination and response capacity across the state by building a collaborative, comprehensive training program for both leaders and volunteers; developing recruitment and retention strategies and materials to strengthen MRC capacity. These activities will ensure that MRC units can meet the ongoing needs of the diverse communities, residents, and organizations across Massachusetts.

[172] Online: https://en.wikipedia.org/wiki/Gifts_in_kind. Accessed 30 March 2024.

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Epilogue

The MRC plays a vital role in the healthcare and wellbeing of the people in many Massachusetts communities as well as nationwide. Although closely coordinated with the hospital systems, clinics, firefighters and other First Responders, the MRC is an independent volunteer organization that often deploys trained people within their own communities. As has been shown, the MRC supplements the day-to-day healthcare system when disasters, pandemics, and other incidents outstrip the established "brick and mortar" medical facilities and their capacity. As we have shown, there are many success stories, and the testimonials at the front of the book bear witness to their success.

As described, the MRC leader is alerted by the state government if deployment of their volunteers is imminent or anticipated, followed by the leader reaching out to the volunteers to alert and deploy them when and where directed. All aspects of deployments are recorded and, when needed, improvements to MRC policies, procedures, and the associated volunteer training are made. The wealth of training courses, all available online as shown above, are at the heart of MRC success. These courses are constantly updated to reflect new information or improved methodology, including the benefits of locally improved as well as state and federal updates to their best available information.

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Our MRC Training Modules

Active Shooter Drill
(BART) Basic Animal Rescue Training
Blood Borne Pathogens with Scene Safety
Business Preparedness and Evacuation Planning
Communications-Call Down Drills
CODE Pink Drill (Hospitals)
Cultural Competency
DECON-Mass Decontamination Drill
Disaster Behavioral Health 1 & 2
Drive Through Emergency Dispensing Site Drills
Great American Shake Out Drill
Earthquake Preparedness
Emergency Dispensing Sites 1 & 2
Emergency Pet Sheltering for Massachusetts Volunteers Level 1 & 2
Emergency Preparedness & Local Public Health
Emergency Preparedness for Massachusetts Volunteers Level 1 & 2
Emotional Resilience for First Responders
Family and Personal Preparedness
Flu Clinics run as an Emergecy Dispensing Site
Disaster Field Triage Part 1
Disaster Field Triage Part 2
Home and Sheltering in Place Preparedness
Hot Topics with Dr. Al DeMaria
HSEEP Compliant Emergency Dispensing Site Full Scale Exercise
HSEEP Compliant Emergency Dispensing Site Functional Exercise
HSEEP Compliant Sheltering Table Top Exercise
Incident Command for Medical Reserve Corps Volunteers
FEMA Incident Command-100 Training
FEMA National Incident Management System-700
Hurricane Preparedness
Leadership Training
MRC 101-Core Competencies
Narcan Training
National Preparedness Month

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Personal Disaster Preparedness: Being Prepared No Matter Where you are
Personal Protective Equipment
PFA 101: Massachusetts Psychological First Aid
PFA 202: Developing Your Psychological First Aid skills (6 Hours)
Playing on a Team: Peer to Peer Support
Psychological First Aid (8 Hours)
Radiological Emergency Response Operations
Regional Emergency Planning Committee Customized Presentations
Shelter Manager Course
Shelter Managers Table Top Exercise
Sheltering Strike Team Development
Sheltering Strike Team Support Staff Training
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Suicide Prevention
Taking Care of Stress, before it Takes Care of You!
Vector Transmitted Diseases: Dr. Katie Brown DMV
Weapons of Mass Destruction
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I have known Liisa for seven years, but it seems like an eternity. I have worked with her on multiple occasions on Public Health emergency preparedness in the Town of Randolph, Massachusetts, in her capacity as the Medical Reserve Corps Director-Coordinator. Liisa has always been quick to respond to all our emergency needs and shelter training and to deploy volunteers wherever needed. I really valued her inventiveness and her willingness to consider any suggestions for enhancing emergency readiness. One day I asked Liisa if we might convert the recruitment brochures into multiple languages, especially Haitian Creole, as I am of Haitian origin, and she enthusiastically accepted. She plays a vital role in our public health emergency preparedness, and I am thankful and inspired by such a beautiful soul. Thank you for embracing me in the MRC family. I am so happy to work with you.

- Peggy Montlouis, MPH, MBA, SHAR (Stoughton, Holbrook, Avon, Randolph)
Community Health Educator, Medical Reserve Corps Unit Coordinator

Since the beginning of my Public Health career in 2015, the MRC volunteers led by Director Liisa Jackson have played an integral role in supporting and advancing public health programs in our communities. Whether it is assisting folks at the Council on Aging to complete their pre-vaccination paperwork or setting up a callbank of volunteers during COVID-19 to answer concerns in the native languages of our constituents, the MRC steps up when help is needed.

The trusting relationship established with Liisa Jackson and MRC volunteers long before the pandemic truly made a difference in saving many lives in our community. As soon as I started receiving COVID-19 positive cases, I immediately knew I needed Liisa's help to establish a call center for COVID-related questions and concerns from constituents and assistance with case investigation to mitigate the spread of disease.

The MRC volunteers and leadership represent the cultures, languages, diversity, and medical expertise of our communities, making them a sustainable and trustworthy organization that truly makes a lasting impact on our communities.

- Kelley Hiland, BSN, RN, Deputy Director of Public Health,
Health and Human Services, City of Somerville, Massachusetts

Liisa, you are a true inspiration to so many who have been privileged to work with you. Your energy, creativeness, personal strength, and drive made you one of the top public health leaders in Region 1 of the US. Congratulations on this wonderful undertaking and thank you for your unwavering passion to help those all around you with ongoing challenges or sudden life events they were not prepared for. I wish you God Speed and great success with this book and continued success in your future endeavors. I am humbled and truly honored that you asked me to contribute this small note.

- Michael R. Milner, DHSc, PA-C, Rear Admiral, US Public Health Service (retired)
Assistant US Surgeon General, Former Regional Health Administrator for US Region 1, New England

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