



**NAVAL
POSTGRADUATE
SCHOOL**

MONTEREY, CALIFORNIA

THESIS

**STANDARDIZED TRAINING TO IMPROVE READINESS
OF THE MEDICAL RESERVE CORPS:
A DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROGRAM UNDER THE DIRECTION OF THE OFFICE
OF THE SURGEON GENERAL**

by

Cynthia A. Cox

September, 2006

Thesis Advisor:

Lauren Wollman

Co-Advisor:

Kathleen Toomey

Approved for public release; distribution is unlimited

THIS PAGE INTENTIONALLY LEFT BLANK

REPORT DOCUMENTATION PAGE			<i>Form Approved OMB No. 0704-0188</i>
Public reporting burden for this collection of information is estimated to average 1 hour per response, including the time for reviewing instruction, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to Washington headquarters Services, Directorate for Information Operations and Reports, 1215 Jefferson Davis Highway, Suite 1204, Arlington, VA 22202-4302, and to the Office of Management and Budget, Paperwork Reduction Project (0704-0188) Washington DC 20503.			
1. AGENCY USE ONLY (Leave blank)	2. REPORT DATE September 2006	3. REPORT TYPE AND DATES COVERED Master's Thesis	
4. TITLE AND SUBTITLE Standardized Training for the Medical Reserve Corps: A Citizen Corps Program Under the Direction of the Office of the Surgeon General			5. FUNDING NUMBERS
6. AUTHOR(S) Cynthia Cox			
7. PERFORMING ORGANIZATION NAME(S) AND ADDRESS(ES) Naval Postgraduate School Monterey, CA 93943-5000			8. PERFORMING ORGANIZATION REPORT NUMBER
9. SPONSORING /MONITORING AGENCY NAME(S) AND ADDRESS(ES) N/A			10. SPONSORING/MONITORING AGENCY REPORT NUMBER
11. SUPPLEMENTARY NOTES The views expressed in this thesis are those of the author and do not reflect the official policy or position of the Department of Defense or the U.S. Government.			
12a. DISTRIBUTION / AVAILABILITY STATEMENT Approved for public release: distribution is unlimited			12b. DISTRIBUTION CODE A
13. ABSTRACT (maximum 200 words) The Medical Reserve Corps (MRC) was formed to provide a cadre of trained medical volunteers to support and strengthen the public health infrastructure and improve its' emergency preparedness level. Training policies and standards are left to the discretion of the local MRC coordinator so the program maintains its flexibility to meet community needs. Training varies from unit to unit, and there are no protocols in place to measure or evaluate the effectiveness of that training. According to recent studies and surveys, disaster operations are an unfamiliar role for most MRC volunteers and the public health workforce in general. Evidence also suggests that few medical and public health workers receive this important preparedness training. In 2005, MRC working group members developed a list of core competency recommendations to provide training guidance, but specific educational content to satisfy those competencies were not defined. This thesis offers specific training content guidelines and strategies for achieving competency. The MRC must be able to integrate into the disaster environment while working safely, effectively and efficiently. Standards will set the mark for success, enabling the MRC to respond in a coordinated manner and at a consistently higher level to any public health emergency.			
14. SUBJECT TERMS Medical Reserve Corps, Citizen Corps, public health preparedness, training			15. NUMBER OF PAGES 107
			16. PRICE CODE
17. SECURITY CLASSIFICATION OF REPORT Unclassified	18. SECURITY CLASSIFICATION OF THIS PAGE Unclassified	19. SECURITY CLASSIFICATION OF ABSTRACT Unclassified	20. LIMITATION OF ABSTRACT UL

THIS PAGE INTENTIONALLY LEFT BLANK

Approved for public release; distribution is unlimited

**STANDARDIZED TRAINING TO IMPROVE
READINESS OF THE MEDICAL RESERVE CORPS:
A DEPARTMENT OF HEALTH AND HUMAN SERVICES PROGRAM
UNDER THE DIRECTION OF THE OFFICE OF THE SURGEON GENERAL**

Cynthia A. Cox
Captain, Texas State Guard-Medical Rangers
B.S., Texas Tech University Health Science Center, 2003

Submitted in partial fulfillment of the
requirements for the degree of

**MASTER OF ARTS IN SECURITY STUDIES
(HOMELAND SECURITY AND DEFENSE)**

**NAVAL POSTGRADUATE SCHOOL
September 2006**

Author: Cynthia A. Cox

Approved by: Kathleen Toomey
Thesis Advisor

Lauren Wollman
Thesis Advisor

Douglas Porch
Chairman, Department of National Security Affairs

THIS PAGE INTENTIONALLY LEFT BLANK

ABSTRACT

The Medical Reserve Corps (MRC) was formed to provide a cadre of trained medical volunteers to support and strengthen the public health infrastructure and improve its' emergency preparedness level. Training policies and standards are left to the discretion of the local MRC coordinator so the program maintains its flexibility to meet community needs. Training varies from unit to unit, and metrics do not exist to measure or evaluate the training effectiveness. According to recent studies and surveys, disaster operations are an unfamiliar role for most MRC volunteers and the public health workforce in general, and few volunteers receive this important preparedness training. In 2005, MRC working group members developed a list of core competency recommendations to provide training guidance, but specific educational content to satisfy those competencies was not defined. This thesis offers specific training content guidelines and strategies for achieving the MRC preparedness goals. Establishing interim training standards will set the benchmark for future assessments and enable the MRC to respond at a consistently higher level to public health emergencies.

THIS PAGE INTENTIONALLY LEFT BLANK

TABLE OF CONTENTS

I.	INTRODUCTION.....	1
A.	BACKGROUND AND PROBLEM STATEMENT	1
B.	SPECIFIC RESEARCH OBJECTIVES	4
C.	SIGNIFICANCE OF RESEARCH	5
D.	LITERATURE REVIEW	7
E.	RECOMMENDATIONS.....	9
F.	METHODOLOGY AND STRUCTURE	10
II.	EVALUATION OF CURRENT TRAINING STATUS	13
A.	LIMITATIONS TO RESEARCH.....	13
B.	REVIEW OF DATA	13
1.	MRC NACCHO Survey	14
2.	MRC Hurricane Response Final Report	16
C.	CORE COMPETENCY PROJECT	18
1.	Overview and Background	18
2.	Assessment.....	19
III.	THE TEXAS STATE GUARD — MEDICAL RANGERS	21
A.	INTRODUCTION.....	21
B.	THE TEXAS STATE GUARD-TEXAS MEDICAL RANGERS	21
1.	Role in State Homeland Security.....	21
2.	Training Policies and Standards.....	23
C.	SUMMARY	26
IV.	CONTENT.....	29
A.	CONTENT AREA I: INCIDENT COMMAND SYSTEM AND THE NATIONAL INCIDENT MANAGEMENT SYSTEM	31
B.	CONTENT AREA II: PERSONAL PREPAREDNESS	32
C.	CONTENT AREA III: HEALTH AND SAFETY.....	34
D.	CONTENT AREA IV: COMMUNICATIONS.....	37
E.	CONTENT AREA V: ROLE AND RESPONSIBILITY	38
F.	CONTENT AREA VI: DISASTER BASICS	40
G.	CONTENT AREA VII: MRC POLICY AND PROCEDURES.....	40
V.	ISSUES AND RECOMMENDATIONS FOR PLANNING, IMPLEMENTING AND SUSTAINING TRAINING.....	43
VI.	CONCLUSION	53
	APPENDIX A: SUGGESTED TRAINING RESOURCES BY CONTENT AREA.....	57
	APPENDIX B: CONTENT AREA SUMMARY	61
	APPENDIX C: MEMS STUDENT HANDBOOK	63
	LIST OF REFERENCES.....	87
	INITIAL DISTRIBUTION LIST	93

THIS PAGE INTENTIONALLY LEFT BLANK

LIST OF ABBREVIATIONS AND ACRONYMS

AMA	American Medical Association
APHA	American Public Health Association
ARC	American Red Cross
BDLS	Basic Disaster Life Support
CDC	Centers for Disease Control and Prevention
CDLS	Core Disaster Life Support
CERT	Community Emergency Response Team
CISD	Critical Incident Stress De-briefing
CISM	Critical Incident Stress Management
COG	Councils of Government
CPR	Cardio Pulmonary Resuscitation
DHS	Department of Homeland Security
DHHS	Department of Health and Human Services
EMC	Emergency Management Coordinator
EMI	Emergency Management Institute
EMS	Emergency Medical Services
EOC	Emergency Operations Center
ESAR-VHP	Emergency System for the Advanced Registration of Volunteer Health Professionals
HRSA	Health Resources Services Administration
ICS	Incident Command System
MEMS	Military Emergency Management Specialist
MRC	Medical Reserve Corps
MRC NPO	Medical Reserve Corps National Program Office
NACCHO	National Association of County and City Health Officials
NDLS	National Disaster Life Support
NFA	National Fire Academy
NIH	National Institutes of Health

NIMH	National Institute of Mental Health
NIMS	National Incident Management System
NRP	National Response Plan
ODP	Office of Domestic Preparedness
PFA	Psychological First Aid
PTSD	Post- traumatic stress disorder
SFA	Standard First Aid
SGAUS	State Guard Association of the United States
TCL	Target Capabilities List
TMR	Texas Medical Rangers
TRAIN	Training Finder Real-Time Affiliate Integrated Network
TXSG	Texas State Guard
USFA	United States Fire Administration
USPHS	United States Public Health Service
USSG	United States Surgeon General
VA	Veterans Administration
VOAD	Volunteer Organizations Active in Disaster
WMD	Weapons of Mass Destruction

ACKNOWLEDGMENTS

Over the past eighteen months I have had the incredible opportunity to experience an education like no other and participate in shaping the future of our nation's homeland security in ways I never could have imagined. I am deeply honored to have been a part of the program at Naval Postgraduate School and the Center for Homeland Defense and Security. Throughout this process I have been continually amazed at the people I get to share this experience with; my fellow cohort members and peers in this profession have become such great friends and their expertise and dedication is always inspiring. When I need an expert- I'll know who to call! The awesome staff at CHDS can make anything happen and get anything done, and I mean anything. The faculty has the sincerest desire to make Homeland Security and our success in it a reality by continually striving to make the program better, more challenging and more relevant.

My advisors Kathleen Toomey and Lauren Wollman were invaluable in the thesis process, and I regret not seeking them out sooner. Fortunately for me they always had just the right thought provoking or rage evoking comment to pull me through a major rut and get me on the right track again. I have learned the value of solid data, proper research methods and sound analysis the hard way. Thanks also for allowing me to speak out about the issues that I was concerned about and helping me put them in the right context for this work.

During the past 18 months I had the opportunity to meet and work with MRC leaders in Texas and across the country. This topic was not always a popular one and had its share of obstacles from the start, but many of them encouraged me to continue my pursuit. It has been a worthwhile endeavor and at the very least, I hope it encourages the MRC to continually work toward preparedness.

I owe heartfelt thanks to those who had the faith in my abilities to recommend me for this program: Texas Adjutant General-MG Charles Rodriguez and Cappy, MG

Christopher Powers of the Texas State Guard, MG Harold Timboe and LTC Jim Solomon of the Texas Medical Rangers, and Mr. Mark Davis who continued his support long after our Red Cross days had passed.

This process has been difficult at best and my time here was not without some serious personal trials and tribulations. I am grateful for the support and encouragement of my colleagues in 501/502. You kept me going and coming back for more when it would have been easier to quit. My friends and family held me up and pulled me through the rough stuff. Each of you has my love and undying gratitude. To my daughters, Gloria and Shelley – you are MY heroes. Thanks for your love and patience-I am now available to take your calls! Mickey, I wouldn't have made it without you. I am so happy to say that *NOW we are done!*

I. INTRODUCTION

A. BACKGROUND AND PROBLEM STATEMENT

Following the traumatic events of September 2001, the United States experienced an overwhelming response from citizens who wanted to help but did not know who to contact or where to go, or how they could be of value. The Citizens Corps (CC) was created to take advantage of this potential volunteer resource. Through local Citizen Corps Councils, interested citizen volunteers receive information and resources needed to support their local community efforts on public outreach, education, training and volunteer service opportunities. Citizens are engaged to support local community preparedness efforts by participating in CC programs: Volunteers in Police Service (VIPS), Fire Watch (FWP), Neighborhood Watch Program (NWP), and Community Emergency Response Teams (CERT). Providing an organizational structure helps to alleviate many of the problems emergency managers face when overwhelmed with multitudes of unsolicited volunteers at the disaster site.¹

In 2003, a medical component was created to coordinate, train and credential medical volunteers. The Medical Reserve Corps program is administered by the Department of Health and Human Services and the Office of the Surgeon General. The local Medical Reserve Corps (MRC) unit is an organized cadre of medical volunteers that can augment and strengthen the public health infrastructure and improve emergency preparedness in the event of an act of terrorism, natural or manmade disaster, or public health emergency.² There are an estimated sixty thousand MRC volunteers in four hundred and thirty MRC units and forty three states, Puerto Rico and the U. S. Virgin Islands.³ In addition to disaster response, they support everyday public health activities

¹ Citizen Corps Program website, <http://www.citizenscorps.gov>. [Accessed 12/04].

² The Medical Reserve Corps (MRC) Program strengthens communities by helping medical, public health and other volunteers offer their expertise throughout the year as well as during local emergencies and other times of community need. MRC volunteers work in coordination with existing local emergency response programs and also supplement existing community public health initiatives, such as outreach and prevention, immunization programs, blood drives, case management, care planning, and other efforts. The MRC program is administered by HHS. Information on-line. Available from <http://www.citizenscorps.gov/programs>. [Accessed 12//04].

³ M. L. Hoard and R. J. Tosatto, "Medical Reserve Corps: Strengthening Public Health and Improving Preparedness," *Disaster Management and Response* 3, no. 2 (Emergency Nurses Association, 2005).

including those of the Public Health Service, health education, disease prevention, vaccination programs, and increase health system surge capacity in other times of community need. ⁴

Former Surgeon General VADM Richard H. Carmona identified the public health infrastructure as critical to our nation's public health and medical preparedness.⁵ Analogous to the healthy body that is more resistant to disease, a strong public health system makes a much less attractive terrorist target. Americans count on a strong public health system; when they are strong, healthy and safe they are much more resilient.⁶

Responder preparedness in any public health emergency requires familiarity with basic emergency management principles and practices, including familiarity with the incident command system, procedures and protocols for requesting resources, proper communications methods and more. All responders must be able to integrate in a coordinated manner with other organizations and response agencies, often working in unfamiliar environments and roles. They must also be aware of hazards and safety precautions. Working in the emergency environment can have serious long-term psychological and/or physical impacts on the responder, the victim and the public. Awareness and the confidence to act under these circumstances can be gained through appropriate training. ⁷

These challenges are familiar to responders who are veterans of disaster operations. However, they are not a part of the regular training and education process for many healthcare providers or the public health workforce. The MRC is a cadre of

⁴ Hoard and Tosatto, "Medical Reserve Corps."

⁵Richard H. Carmona, "Prevention and Preparedness: Medical Reserve Corps Serving America." Presentation in Nashville Surgical Society Meeting (Nashville, TN, 7 October 2003). Presentation on-line; available from <http://www.surgeongeneral.gov>. [Accessed 09/05].

⁶ Richard H. Carmona, *Surgeon General Priorities for Public Health Preparedness* (Washington, D.C.: Department of Health and Human Services, 2004). Website; available from <http://www.surgeongeneral.gov>. [Accessed 5/05]; Trust for America's Health, *Ready or Not? Protecting the Public's Health from Diseases, Disaster and Bioterrorism* (Washington, D.C.: Trust for America's Health, 2005). Report on-line; available from <http://healthyamericans.org/reports/bioterror05>. [Accessed 04/06].

⁷ Joint Commission Resources, "Disseminating Lessons Learned from a Terrorist Attack: Responding Effectively in the Midst of a Natural Emergency," *Joint Commission Perspectives Special Issue* (Oakbrook Terrace: Joint Commission Resources, 2001).

personnel with a wide variety of practical medical experience and expertise, but limited actual hands-on emergency preparedness, response, or mass casualty experience or training.

MRC training and education programs vary from one unit to another.⁸ Although we know MRC units require training, the specifics are vague. The lack of standardization poses some significant challenges for the MRC:

- Evaluating and measuring the current preparedness level is difficult.
- Health and safety of the volunteer and general public is placed at risk.
- Response partners will be reluctant to utilize them if they are unable to integrate into the system.
- Recruitment and retention may suffer if volunteers are not prepared for the challenges they will face in a complex and chaotic environment.

Standards are imperative to establish goals, evaluate, and plan strategies to improve readiness of the MRC.

A young organization, the MRC has not progressed to a level that it can provide consistently well-trained and prepared personnel to assist public health authorities. This lack of preparation can lead to serious health consequences, both mental and physical, for the emergency responder and patient.⁹ These psychological and physical impacts of a disaster have been extensively documented by a plethora of researchers, academia and response organizations. A 2003 RAND report on responder safety analyzed over 800 of these published sources in its efforts to improve the safety of responders involved at all phases of response and recovery. The study provides irrefutable evidence of the dangers responders are exposed to during disaster operations, and the role that proper preparation

⁸ Emily Cohen, "MRC Survey: Medical Reserve Corps Current Practices for Recruitment, Credentialing, Training and Screening," Presentation in Medical Reserve Corps Advisory Committee Working Group, Washington, D. C., 13-14 December 2005.

⁹ Adrienne S. Butler, Allison M. Panzer and Lewis R. Goldfrank, *Preparing for the Psychological Consequences of Terrorism: A Public Health Strategy* (Washington, D.C.: The National Academies Press, 2003).

can play in mitigating their occurrence.¹⁰ For example, five years after 9/11 an estimated 70% of the Ground Zero recovery workers and rescue personnel are suffering from chronic illness as a direct result of working in the toxic environment without appropriate protective gear.¹¹

Incompetent and poorly trained healthcare workers can also lead to a serious loss of public trust. Medical workers in any environment have an implicit connotation of capability and competence associated with it. The public expects them to behave, react and be prepared to provide care in a professional manner and under any circumstance. The public has an expectation of essential health protection in times of disaster as evidenced in the Trust for America's Health annual report. As fundamental as this element is, public health preparedness is poor; according to the report, we must improve our basic response capabilities and preparedness. For the general public health preparedness level to improve, all stakeholders, including MRC, must work diligently to increase their individual and organizational preparedness levels through appropriate planning and training.¹²

B. SPECIFIC RESEARCH OBJECTIVES

The goal of this research is to provide MRC coordinators and leaders meaningful, achievable and sustainable policy guidelines and recommendations for a standard training program across all units of the MRC. In late 2005, MRC working group members developed a list of core competency recommendations in an effort to direct MRC

¹⁰ Brian Jackson, John C. Baker, M. Susan Ridgely, James T. Bartis, and Herbert I. Linn, *Protecting Emergency Responders: Safety Management in Disaster and Terrorism Response: Volume 3* (Santa Monica, CA: RAND Science and Technology, 2004). Document on-line; available from http://www.rand.org/RAND_MG170 <http://www.rand.org>. [Accessed 3/06].

¹¹ Mt. Sinai Press Office, "Large Study of WTC Responders Finds Significant Health Problems in Many: 60% Still Respiratory Problems from Exposure to Environment at Site," (New York: Mt. Sinai School of Medicine Press Office, 2006). Press release on-line; available from <http://www.fusion.mssm.edu/media/content.cfm>. [Accessed 9/06]; Jackson, et al, *Protecting Emergency Responders*; Butler, et al, *Preparing for the Psychological Consequences of Terrorism*; Occupational Safety and Health Administration, "Keeping Workers Safe During Clean Up and Recovery Operations," U.S. Department of Labor website. Fact Sheets online; available from <http://www.osha.gov/> [Accessed 5/06].

¹² Shelley A. Hearne, Laura M. Segal, Michael J. Earls, and Patti J. Unruh, *Ready or Not? Protecting the Public's Health in the Age of Bioterrorism* (Washington, D.C.: Trust for America's Health, 2004); available from <http://healthyamericans.org>. [Accessed 7/05]; Trust for America's Health, *Ready or Not?*

coordinators toward a more consistent training program.¹³ This thesis builds upon those competencies and offers specific training content guidelines and strategies for achieving those goals. Standards set the mark for success, enabling the MRC to respond in a coordinated, reliable and consistent manner in any public health emergency.

A robust training program with a policy in place to implement it will provide MRC volunteers with the knowledge, skills and abilities necessary to respond in a coordinated, consistent and reliable manner to any emergency. This will lead to a consistently higher level of preparedness and response. The MRC can provide the well-trained, well-prepared cadre to support public health preparedness. A well prepared MRC will strengthen the nation's public health infrastructure.

C. SIGNIFICANCE OF RESEARCH

There is a national requirement and mandate for the MRC to support and augment public health systems and functions. Homeland Security Presidential Directive 8 establishes a prevention and preparedness policy for Federal, state and local entities responding to a threatened or actual terrorist threat, that includes all first responders and members of the public health community. The National Preparedness Goal emphasizes the fact that preparedness is a shared responsibility and stresses the importance of developing common frameworks across jurisdictions and disciplines, both public and private, to achieve those goals.¹⁴

The general public places a great amount of trust on the community public health system. The MRC program was designed to be a community public health asset, available to citizens in everyday prevention activities and in times of emergency such as infectious disease outbreaks or natural disaster. As such, the impetus has been placed on the local MRC to determine training requirements.

¹³ Emily Cohen, "Medical Reserve Corps (MRC) Project in Brief," Presentation in Medical Reserve Corps Advisory Committee Working Group meeting, (Washington, D.C., 13-14 December 2005).

¹⁴ George W. Bush, *Homeland Security Presidential Directive/HSPD-8*, (Washington: Office of the Press Secretary, 2003). News release on-line; available from <http://www.whitehouse.gov/news/releases/2003/12/20031217-6.html>. [Accessed 12/04].

This research proposes a standard training policy necessary to prepare the MRC for its public health support mission and to help close the gaps that exist between expectations and current capabilities. Integration with other community partners is critical during all phases of disaster operations. Through a series of technical reports, MRC has provided unit leaders with tools necessary to build and coordinate their programs; however, they stop short of providing specific training guidance.¹⁵

Response standards and protocols are commonplace among agencies such as fire, EMS, and law enforcement responders who have had years of practical experience in the dynamics and necessities of a coordinated disaster response effort. Each of these groups has a specific function within the incident response system, to which training standards and common expectations are essential. But a nationwide, standardized approach to training for healthcare workers has been practically non-existent.¹⁶ In 2003, the American Medical Association (AMA) partnered with major medical centers and national health organizations to establish the National Disaster Life Support (NDLS) training program recognizing that the public health systems' ability to respond effectively during disasters depended on a well-trained workforce.¹⁷

While each MRC is considered a local community asset, the 2005 hurricane season resulted in many MRCs providing assistance to other cities, regions, and states and organizations. Although a full federal activation is not within the scope of the MRC, many MRC volunteers supported Health and Human Services (HHS) and Disaster Medical Assistance Team (DMAT) operations during the 2005 hurricane season as temporary federal employees. Some response outside of the unit's jurisdiction can also occur in areas where Emergency Management Assistance Compacts or mutual aid

¹⁵ Medical Reserve Corps Technical Assistance Team, *Organizing an MRC Unit: Operational Components and the Coordinators Role, Technical Assistance Series 11* (Rockville: Medical Reserve Corps Program Office, 2004); *Coordinating with your Local Response Partners, Technical Assistance Series 22*, (Rockville: Medical Reserve Corps Program Office, 2004); *Developing Volunteer Relationships and Capabilities, Technical Assistance Series 33*, (Rockville: Medical Reserve Corps Program Office, 2004). Series on-line; available from [http:// www.medicalreservecorps.gov/resources](http://www.medicalreservecorps.gov/resources). [Accessed 7/05].

¹⁶ David C. Landguth, "Public Health Specializations and Education Needs to Support Homeland Security," (M. A. Thesis, Naval Postgraduate School, 2005), 14.

¹⁷ Center for Public Health Preparedness and Disaster Response, *National Disaster Life Support*, (Chicago: American Medical Association, 2003). Document on-line; available from <http://www.ama-assn.org/ama/pub/category/12606.html>. [Accessed 5/05].

agreements are used to request resources. This makes it extremely important for the resource (or MRC) to have an expected level of competency to fulfill the needs of the community.¹⁸

D. LITERATURE REVIEW

The MRC has made admirable progress since it began. The initial focus of MRC units has been building its base of credentialed, trained, and prepared volunteers and there has been notable progress doing so. The volunteer base has grown to some sixty thousand volunteers.¹⁹ The MRC is also collaborating with the Health Resource Service Administration (HRSA) to credential and register MRC members through the Emergency System for Advanced Registration of Volunteer Health Professionals.²⁰ ESAR-VHP is a state based system to register and credential healthcare volunteers prior to a disaster. While this offers tangible evidence of recruiting and credentialing progress, the exact status of training and preparedness is uncertain.

Evidence used to develop the policy recommendations presented in this thesis was collected from a variety of sources, including informal discussions and interviews with MRC leaders, MRC Advisory Group members and public health officials who participated in the Competency development project. In addition, findings from the 2005 MRC Hurricane Response Final Report were considered. In 2005, National Association of County and City Health Officials (NACCHO) surveyed 154 MRC coordinators to assess the current training, credentialing and recruiting practices in an effort to facilitate the core competency project. The survey design limits its usefulness to provide any conclusive evidence of current training status of the MRC. The first significant research, a nationwide assessment of the MRC program under private contract, began in 2006. At the time of this thesis, results of that assessment had not been published.

¹⁸ Medical Reserve Corps Program, *Medical Reserve Corps 2005 Hurricane Response Final Report* (Rockville, MD: Medical Reserve Corps, 2006). Document on-line; available from <http://www.medicalreservecorps.gov/Hurricane/2005Report> [Accessed 04/06].

¹⁹ Hoard and Tosatto, *Medical Reserve Corps: Strengthening Public Health and Improving Preparedness*.

²⁰ Health Resources and Services Administration, *Interim Technical and Policy Guidelines, Standards and Recommendations, Version 2, June 2005* (Washington, D.C.: DHHS, 2005); Document online, available from <http://www.hrsa.gov/esarvhp/guidelines/default.htm> [Accessed 7/12/06].

Due consideration is given to the Surgeon General's vision for the MRC to remain a local public health asset. MRC volunteers represent a wide cross-section of the medical and public health profession. Consideration of current public health efforts to improve its' workforce preparedness level provides a foundation to base standard training content and policy recommendations.²¹

The MRC Core Competency project is also an integral part of the work to develop a standard training program. Core competencies are commonplace in the medical and healthcare professions and provide a baseline for content development. In December 2005, the MRC Advisory Group recognized the need for core competencies that would be applicable to any MRC volunteer deploying to an emergency. Final recommendations for competencies were announced in April 2006 at the National Leadership Conference. The intent of the project was to facilitate the development of standards across the MRC. The core competencies proposed would apply to all MRC volunteers whether they are licensed medical providers or support staff, and are representative of the basic knowledge, skills and abilities every MRC volunteer should possess before deploying.²²

Issues raised in the MRC Hurricane Response Final Report suggest that additional training would be welcomed by MRC unit volunteers and leader. However, the selection of training material for the medical professional and the MRC volunteer can be challenging. A plethora of materials is available from longstanding, reputable sources such as the American Red Cross (ARC), the Federal Emergency Management Agency (FEMA), the Centers for Disease Control (CDC), and private sector vendors. The selection process is further complicated by a confusing mix of core competency recommendations that attempt to define the knowledge, skills and abilities needed to prepare the medical worker for disaster response operations.²³

²¹ Joint Commission Resources, *Disseminating Lessons Learned*, 13-15.

²² Medical Reserve Corps Advisory Committee Working Group, *Core Competencies for the Medical Reserve Corps Volunteer* (Washington, D.C.: National Association of County and City Health Officials, 2006). Brochure on-line; available from <http://www.naccho.org/topics/emergency/documents>. [Accessed 4/06].

²³ Edbert B. Hsu, Tamara L. Thomas, Eric B. Bass, Dianne Whyne, Gabor D. Kelen, and Gary B. Green, "Healthcare Worker Competencies for Disaster Training." *BioMed Central* 6, no. 19.: BMC Medical Education, 2006. Document on-line; available from <http://www.biomedcentral.com/1472-6920/6/19> [Accessed 4/06].

The CDC, in cooperation with the Columbia University School of Nursing Center for Health Policy, published a paper on Bioterrorism and Emergency Readiness for public health personnel in November 2002.²⁴ The commonly cited report is one of many published in recent years in an effort to provide greater insight into the requirements of the public health worker in the emergency environment. The 2006 report *Healthcare Worker Competencies for Disaster Training* analyzes the core competency recommendations from several sources including Columbia University and John Hopkins, to develop a list of seven cross cutting competencies.²⁵

E. RECOMMENDATIONS

The policy recommendations proposed in this thesis outline specific guidelines for establishing training standards to help close the gap that exists between expectations and capabilities of the MRC. In lieu of a comprehensive evaluation of current MRC training status that does not exist, they are based upon what is known about the current preparedness level of the MRC volunteer, what is known about public health preparedness in general, common concerns revealed in the hurricane report and the training resources available to address them. MRC coordinators must be able to identify who should complete training, select the type of training needed, the instructional setting, and structure teaching and evaluation methods to ensure competency compliance and preparedness of all MRC personnel. The standard training policy addresses the issues and challenges to developing and sustaining a successful training program - standards are designed to be flexible to meet the basic training needs of the local MRC and other response partners. It does not mandate extensive training in public health disaster response; however, it does provide a baseline in emergency preparedness to familiarize those without prior disaster experience with the objectives, roles and functions of the MRC within a public health emergency, while leaving room for more training as it is

²⁴ Columbia University School of Nursing Center for Public Health Policy, *Bioterrorism and Emergency Readiness: Competencies for all Public Health Workers* (New York: Center for Public Health Policy, 2002); Cindy L. Parker, Daniel J. Barnett, Ayanna L. Fewes, David Blodgett, and Jonathan M. Links, "The Road Map to Preparedness: A Competency Based Approach to all-Hazards Emergency Readiness Training for the Public Health Workforce," *Public Health Report*, no. 120 (Sep-Oct 2005), (Baltimore: John Hopkins Center for Public Health Preparedness, John Hopkins Bloomberg School of Public Health, 2005).

²⁵ Hsu, et al., *Healthcare Workers Competencies for Disaster Training*.

applicable to individual community circumstances. The standards will establish a baseline to benchmark against in future evaluations of the program.

F. METHODOLOGY AND STRUCTURE

In this thesis, policy recommendations are based upon careful consideration of interviews and informal conversations conducted with MRC national leadership and coordinators, various public health officials and MRC leadership. Additionally, literature and interviews by subject matter experts in the field of emergency management, public health, academia, and homeland security provide the focus on current public health preparedness issues and prevention measures necessary to ensure a safe and healthy community and a healthy public health infrastructure that is responsive to homeland security needs.

The first section contains an evaluation of the NACCHO Medical Reserve Corps survey, and the 2005 MRC Hurricane Response Final Report. They provide insight into the current training practices and preparedness levels of the MRC. Additionally, they highlight recent response experiences and are helpful to validate inconsistencies of training in lieu of a formal evaluation. In spite this deficiency, lessons learned do point out issues that have a direct relationship to response capability, capacity and the impact upon the fundamental mission requirements of the MRC.

The Texas State Guard's (TXSG) - Texas Medical Rangers (TMR) is one of the original "demonstration project" MRC units in the country and the first MRC placed within a state military force. Over the past six years the TXSG has worked to make emergency preparedness training a priority to prepare its members for the homeland security and response mission. The TXSG and TMR have been successful in developing and implementing some training policy and guidelines for both its medical and civil support groups. This chapter reviews their model for disaster preparedness training. It is important to remember that like the regular MRC program, formal assessments and evaluations of its training practices have not been made. They should be included in any future evaluation efforts.²⁶

²⁶ Headquarters 4th Air Wing, *About the Texas State Guard* (Austin: Adjutant Generals Department, 2002), from old website; No longer available.

The next section presents training content in seven topic areas based on synthesis of the core competency guidelines developed by the MRC working group, training practices of the TXSG-TMR, lessons learned from the 2005 activations, and widely recognized preparedness training programs. Included in the appendix to this document is a suggested resource list for specific courses and a summary of the content.

There are issues and challenges to implementing a standard training program. Unless they are addressed in the planning effort, they can undermine any attempt of success. Issues, discussions and recommendations are presented in the final chapter. Some issues will be more or less significant to the MRC leader and many of them may already have been addressed or otherwise mitigated by the local unit. They are also dependent upon the local coordinators leadership, motivation and commitment to ensure program success.

The MRC program is ready to move to the next level as evidenced by the efforts to increase preparedness with the development of competencies. Just as they did on September 11, volunteers responded in overwhelming numbers to the hurricanes of 2005. The MRC came forward and demonstrated its value as a worthy partner in disaster and emergency response operations. The MRC increases the nation's medical readiness for a disaster by supporting and providing additional capacity and capabilities for our public health system. The policy recommendations proposed in this thesis offer MRC leaders the content and course guidance to meet competency, and increase the readiness of their volunteers.

THIS PAGE INTENTIONALLY LEFT BLANK

II. EVALUATION OF CURRENT TRAINING STATUS

A. LIMITATIONS TO RESEARCH

It is a bold statement to say that the MRC is unprepared or inadequately prepared for disaster response when we do know from survey results that some MRC members do receive some preparedness training. However, many unknown factors contribute to this statement; the number of courses conducted, number of volunteers receiving training, topics covered, delivery and evaluation methods, and resources used are all ambiguous. There are no metrics or general guidelines in place to evaluate training, measure performance, or gauge the impact of training on knowledge or competency. A comprehensive assessment of the MRC, including training practices and effectiveness, must be conducted before benchmarks can be set, but until such assessment is completed an accurate evaluation cannot be made. With these limitations considered, the evaluations, assumptions and recommendations proposed in this thesis are evidence-based utilizing what are considered common practice and core elements of disaster response and preparedness, and established training resources.

B. REVIEW OF DATA

Throughout the preparation of this thesis, numerous studies and reports on preparedness were found. One study, completed in 2005, evaluated competency based public health preparedness training. Researchers designed the study to determine if training did in fact improve knowledge and increase preparedness and competency levels of the workers. They were able to demonstrate conclusively that training did improve preparedness and increase competency levels of the participants. This helps to validate assertions made here that training has a direct correlation to preparedness of the MRC. Conversely, it is assumed that if training does not occur, the MRC may not be adequately prepared.²⁷

The paucity of concrete data makes it difficult to accurately evaluate of the preparedness level of MRC volunteers. However, inferences can be made by evaluating the two recent reports; the NACCHO Current Practices Survey, and the MRC Hurricane

²⁷ T.M. Reischl and A.N. Buss, *Responsive evaluation of competency based public health preparedness training programs*, Abstract from *JPMH*, November: S100-5, (Ann Arbor: University of Michigan Center for Public Health Preparedness, 2005),1.

Response Final Report (a compilation of After Action reports from unit coordinators, surveys and recommendations to improve future response efforts) and comparing them to the most commonly recognized guidelines for disaster preparedness.

1. MRC NACCHO Survey

In late 2005, the NACCHO conducted a survey of current MRC practices for credentialing, recruiting, screening and training. The small 14 question survey was presented online and invited 331 MRC unit coordinators to participate. Of those only 154 responded. In this survey only three training specific questions were asked:

- Do you require training for your volunteers?
- Do you provide training to your volunteers?
- What resources do you use for these trainings?

The survey highlights the need for a well constructed and more comprehensive evaluation before any accurate determinations of training status can be made.²⁸

Most MRC units require certain skill sets such as certification and licensure in the individual's professional field (physician, nurse, EMT), and some amount of training for volunteers in order to join. 97% of the units stated they provide training for volunteers. Sample responses to the skill and training requirement included: current medical licensure, current first aid and CPR training, Incident Command, and National Response Plan, as well as CERT, hazardous materials operations, Disaster Life Support and various FEMA courses. Some units include an orientation to the local disaster response system, and most use a variety of resources for training from existing programming including the American Red Cross, Disaster Medical Assistance Team training (no longer available), Strategic National Stockpile point of distribution, and some form of basic orientation. While the number of units requiring training is encouraging, nothing else is known about the specifics of that training and how it compares from one individual or unit to another.²⁹

²⁸ Cohen, *MRC Survey*, 1.

²⁹ *Ibid*, passim.

This survey does not provide an accurate view of current training status and highlights the need for a more thorough evaluation. The survey certainly raises more questions than it answers; it does not indicate frequency of training or whether every MRC unit is using the same resource to conduct classes (for example, Basic Incident Command System by FEMA is the recognized standard for incident management).³⁰ Other concerns are raised by the survey as well. The survey also does not indicate the context in which training takes place or who participates in training. We do not know what or if courses are presented as informational only, used as a prerequisite for membership or disaster deployment or whether they were used to meet a specific competency. The concern raised here is that some of the training may be used out of context.

One such example, although it cannot be confirmed, is the use of CERT training as a basic disaster preparedness course. This course was listed in sample responses to resource used for training, skill or competency required to join the MRC and required training questions. CERT is a team concept to be used in a localized area of a community, such as a group of neighbors on a city block, co-workers in the same office who could care for each other until help arrives. The training teaches basic rescue and recovery techniques that may be necessary for survival in the first 72 hours after an event when other resources are unavailable. CERT training is not useful unless all responders receiving training are in close proximity and able to respond as a team. It is not a general preparedness course. Yet this very specialized program is reported to have been used as a disaster preparedness training tool. Because the survey does not indicate the context in which training has occurred, this cannot be confirmed. The fear is that volunteers may use the skills learned in the course inappropriately or that it is being used as a replacement for basic disaster awareness training.³¹

³⁰ Federal Emergency Management Agency, "NIMS, NRP and ICS Training in FY06: Who Needs to Take the Courses?" (Washington: Federal Emergency Management Agency, 2006). Document on-line; available from <http://www.training.fema.gov/emi>. [Accessed 2/05].

³¹ Citizen Corps, program information available at <http://www.citizen corps.gov/programs/cert.shtm>. [Accessed 8/05].

2. MRC Hurricane Response Final Report

During response to mass casualty events, all healthcare workers must understand the importance of cooperation and coordination across local, state, and federal emergency response efforts. They must be able to function within the system. Additionally, workers must know how to protect themselves and others from further harm; be able to communicate with other emergency response partners and the media; and be able to recognize and address the unique psychological impacts and social disruptions they may encounter.³²

The 2005 hurricane season proved to be the largest test of the MRC program to date. An estimated six thousand MRC volunteers supported response and recovery efforts in their local communities. An additional fifteen hundred MRC members deployed with state or federal agencies outside of their jurisdiction, the ARC and the United States Department of Health and Human Services (HHS). Vice Admiral Richard Carmona commended the MRC for its dedication and willingness to respond. But as in all disaster response, there is room for improvement, and many of the lessons learned can be applied to future efforts.³³

Volunteers will encounter many extremes and hazards from the environment to the psychological of patients and other responders. They must be able to integrate with countless other response organizations, each with different expectations, roles and responsibilities within the same event. Often, these roles differ substantially from those encountered in the daily work environment. After action reports and comments made by both MRC leaders and volunteers indicated the emergency operations environment was not familiar to many MRC volunteers. Some volunteers were asked to perform duties that were either unfamiliar or uncomfortable to them, or they were not able to assist in a medical capacity whatsoever. Some felt they were under-utilized because they were not able to provide care at their licensure or certification level. This concern was predominant among those medical corps volunteers who provided support in shelters managed by the

³² Center for Public Health Preparedness and Disaster Response, *National Disaster Life Support* (Chicago: American Medical Association, 2003), online. Available from <http://www.ama-assn.org/ama/pub/category/12606.html>. [Accessed May 1, 2005].

³³ Medical Reserve Corps Program, *Medical Reserve Corps 2005 Hurricane Response Final Report*.

Red Cross, which has very strict protocols for providing medical care in a shelter regardless of the proficiency or certification level of the medical worker onsite.³⁴

Working in a disaster environment requires specific knowledge, skills and abilities that responders in other agencies such as the Red Cross, FEMA and Disaster Medical Assistance Teams have long recognized and addressed in their policies and practices. The workers in these agencies undergo training specifically in disaster operations prior to any field deployment and also have strict guidelines regarding procedures and provision of care in the field. However, this is often not the case with the majority of MRC volunteers who may find themselves working side by side in a shelter with these other partners, rendering aid at a level of care they are unaccustomed to, or performing tasks unrelated to medical care altogether.

According to the MRC Hurricane Response Final Report, 73% of the MRC volunteers responding indicated it was their first disaster deployment. Of that number only 51% felt they had been well trained for their experience. Leaders had an even lower impression of volunteer preparedness levels (32%). While the numbers may seem acceptable, an overwhelming majority indicated they would seek additional courses on their own (87%) and 96% said they would participate in training courses offered by their local MRC unit.³⁵

The MRC National Program Office (MRC-NPO) conducted two post deployment surveys to obtain feedback on hurricane response efforts. One survey was distributed to MRC leaders, and the other to volunteers who deployed outside of their local jurisdiction. The purpose of the surveys was to collect information to improve future response activities of the MRC. In both instances, leaders and volunteers identified key issues impacting the response and effectiveness of the MRC. Key recommendations to enhance future efforts include:

³⁴ Medical Reserve Corps Program, *Medical Reserve Corps 2005 Hurricane Response Final Report*, 21-22.

³⁵ *Ibid*, 24-25.

- Joint training with the American Red Cross to clarify roles and responsibilities.
- Establish clearly defined scope of practice, roles and responsibilities of the MRC volunteer.
- Incident Command System training.
- Effective integration and collaboration with other response and volunteer organizations.
- Establish clear deployment protocols, guidelines and criteria.
- Personal disaster preparedness.
- Communication mechanisms.

An event of national significance will quickly overwhelm and exceed any single jurisdictions capacity to respond. With the impetus placed on prevention and preparedness efforts across the country, homeland security and response professionals agree that preparedness for such a major catastrophic event involves the cooperation and coordination of many organizations. The responsibility belongs to everyone; every agency, community, home, responder and critical infrastructure. MRC must not be negligent of or excluded from its responsibility in preparedness efforts.³⁶

C. CORE COMPETENCY PROJECT

1. Overview and Background

Training has long been recognized as an integral part of preparedness, yet standards for such training are still a rarity in the health and medical environment.³⁷ In recent years many organizations such as the Columbia School of Nursing have adopted different approaches to competency based education in an effort to develop and issue competencies for the workforce.³⁸ While the competencies have been well defined, defining the education requirements necessary to meet those competencies has not been done.³⁹

³⁶ National Association of County and City Health Officials, "Assessment of Local Bioterrorism and Emergency Preparedness," *National Association of County and City Health Officials Research Brief 5: October* (Washington: NACCHO, 2001). Document on-line; available from <http://www.naccho.org/topics/emergency/documents> [Accessed 12/03].

³⁷ Landguth, "Public Health Specializations and Education," 14.

³⁸ Columbia University School of Nursing, *Bioterrorism and Emergency Readiness*.

³⁹ Hsu et al., *Healthcare Worker Competencies for Disaster Training*, 3.

In 2005, NACCHO partnered with the MRC program to facilitate the development of standards for MRC volunteers. The core competency recommendations were developed by a working group of 29 experts including MRC unit coordinators representing 10 MRC regions, public health, and education experts under the guidance of the MRC Program Office leadership. The core competencies are the recommended minimum knowledge, skills, attitudes and abilities every MRC volunteer needs to fulfill their role the community or public health emergency environment.

- Describe the procedures and steps necessary for the MRC member to protect health, safety, and overall well being of themselves, their families, the team and the community.
- Document that the MRC member has a personal and family preparedness plan in place.
- Describe the chain of command (e.g., Emergency Management Systems, ICS, NIMS), the integration of the MRC, and its application to a given incident.
- Describe the role of the local MRC unit in public health and/or emergency response and its application to a given incident.
- Describe the MRC member's communication role(s) and processes with response partners, media, general public and others.
- Describe the impact of an event on the mental health of the MRC member, responder and others.
- Demonstrate the MRC member's ability to follow procedures for assignment, activation, reporting and deactivation.
- Identify limits to own skills, knowledge and abilities as they pertain to MRC role(s).⁴⁰

2. Assessment

The overarching goal of the competency project was to lay the groundwork for future training and development activities of the program. Units would be able to better prepare volunteers for disaster response. Additionally, it proposed to assist local MRC units in their recruiting efforts. It proposed that various benefits would be gained from competency adoption and these are:

- To define a standard set of activities each volunteer can perform.
- Provide a framework for the programs training component.

⁴⁰ Medical Reserve Corps Program Office, *Special Topics: MRC Training and Core Competencies*, 4.

- Assist in describing what communities can expect from their MRC.⁴¹

Participants in the competency development project met with a clear goal to develop a tool to increase the capabilities of the MRC. But the language being used by each group was very different, as was clear in the early meetings; the local MRC representative/coordinators sought detailed specific achievable training targets, and competency experts sought proper form, definition and phraseology of competencies. The resulting document is a step in the right direction, but still inadequately addresses training guidance that MRC coordinators expected from the exercise.⁴²

The core competencies are broad statements that do not provide clear training direction to the coordinator, they are essentially end-goals; a point on the map without directions to get there (as is commonly the case with competency statements).⁴³ They do not state clear measurable objectives necessary to conduct a competency based training program. As is, they are subject to very broad interpretation. Take for example the following competency statement:

- Describe the procedures and steps necessary for the MRC member to protect health, safety, and overall well-being of themselves, their families, the team, and the community.

This statement leaves the options wide open; under which circumstances are we speaking of exactly? Does this mean taking a first aid course, are they referring to individual healthcare, and how is one expected to safeguard the community? These examples highlight the need for additional clarification. With the exception to specific references to chain of command and incident management systems competency, the remaining statements are broad as well. As a stand alone tool- the core competencies do not completely address the specific course content needs of the MRC.

⁴¹ Cohen, *Medical Reserve Corps (MRC) Project in Brief*.

⁴² During the first sessions, MRC coordinators expressed their need for a “shopping list” of courses that would prepare their volunteers to participate in disaster response and accordingly developed a list of specific courses they felt every MRC volunteer should take before deploying to a disaster. This “list” was then re-written into a series of broad statements that would reflect the desired knowledge, skills and abilities of the MRC volunteer. Core competencies lack the detailed guidance MRC coordinators need to prescribe specific emergency preparedness training.

⁴³ Hsu et al., *Healthcare Worker Competencies for Disaster Training*, 1.

III. THE TEXAS STATE GUARD — MEDICAL RANGERS

A. INTRODUCTION

This section reviews the practices and policies for training within the Texas State Guard (TXSG) and in particular, its medical component, the Texas Medical Rangers (TMR). The TXSG is a third component of the state military forces under command of the Texas Adjutant General and activated at the pleasure of the governor who is Commander in Chief. The separate medical reserve corps component, the TMR, is one of the original Office of the Surgeon General demonstration project units for the Medical Reserve Corps concept. Although a registered MRC organization, the TMR primary responsibility is to the state of Texas to augment public health preparedness and disaster operations at the request of the governor.⁴⁴

B. THE TEXAS STATE GUARD-TEXAS MEDICAL RANGERS

1. Role in State Homeland Security

With the increasing deployments of National Guard troops overseas to support the war on terror, the Governor placed increasing responsibility on the TXSG to support the community homeland security efforts. In the past six years the TXSG has grown from an unknown commodity with inconsistently trained personnel, to a reliable and valued response partner. They did so by establishing training policies, standards and guidelines ensuring a consistent response whether to a large festival in San Antonio or a disaster on the Gulf Coast. The new role and mission emphasis on homeland security, disaster response and community service placed the all-volunteer TXSG in a unique position. Working side by side with civilian authorities, they support community organizations including the Red Cross during emergencies and disasters, provide training, coordinate CERT, and other spontaneous (or non affiliated) volunteers. These tasks require TXSG personnel to be familiar with all phases of the emergency management process and their operational response partners in the field from Federal to local levels. TXSG personnel are also active participants in the communities in which they serve; this is in direct response to their increasing homeland security role in the community and the state.

⁴⁴ Hoard and Tosatto, *Medical Reserve Corps*; Adjutant General's Department, "Texas State Guard Medical Reserve Corps," Regulation 10-1, Appendix E. (Austin: Adjutant General's Department, 2002).

TXSG knowledge of the state and local emergency management procedures and policies allows it to function optimally in conjunction with those partners in any situation. The initial training required for all TXSG members is comprehensive, cost effective (free), convenient, and consistent with the organizational values of the Texas State Guard: integrity, leadership, professionalism, service, and volunteerism and its mission to provide support to the National Guard and the community during times of need. The training also addresses the needs of the entire organization: senior level leadership, brigade commands, and front line personnel and all other stakeholders including the community and its assistance to other volunteer organizations such as the ARC.

In September 2005, the TXSG experienced its largest activation since WWI when the entire state force was called to active duty to support the hurricane evacuation and relief efforts. Approximately 1000 TXSG and TMR volunteers participated in shelter operations, evacuation assistance, disaster medical evacuation operations, regional medical operations, logistics, communications, counseling and facility security. Other members traveled with the 149th Air Medical group support operations in the New Orleans Convention Center. These volunteers provided thousands of man-hours between September and November of 2005. The TXSG and TMR could not have fulfilled these duties and worked effectively in the dynamic environment without the training its members had received prior to the event. TXSG and TMR personnel were regularly called upon to assist in other areas of the operations because they had knowledge of disaster functions and operations, including the command and control structure during a disaster and shelter operations, and could also provide on-the-job training to non-affiliated volunteer workers. Of note, the TXSG and TMR forces had no reports of injury during the long activation. Numerous personnel in the TXSG and MRC received commendations for their efforts in the hurricane relief efforts, including the Humanitarian Service Award from the Governor. TXSG and TMR are valued partners in Texas' disaster planning efforts due to its capacity to function in the environment, knowledge of disaster operations, the reliability of the troops and the safe and professional manner in which they conduct themselves. The Texas State Guard is also recognized as the lead shelter management organization in the state. Training in emergency operations undoubtedly contributed to the enormous success of the mission.

2. Training Policies and Standards

The TXSG and the successes it has had during actual emergency operations serves as an excellent reference for training practices for other MRC units to follow. The TXSG homeland security training program began in 2002, with the first course of study in emergency management offered to personnel attending a one week annual training camp. 368 soldiers participated in a two hour course including modules on state and local disaster response and recovery activities, and the role of the TXSG in disaster response and recovery operations. This was an overwhelming success by all accounts with many individuals requesting additional training and some even implementing ad hoc programs within their home units. Since that time, homeland security and emergency operations have become the primary focus of all TXSG training.

In 2003, Governor Rick Perry placed the first designated MRC unit in the country, the TMR, under the command of the State Adjutant General as an element of the TXSG, the third component of the state military forces.⁴⁵ Due to its military affiliation and a mandate to provide support to the state during an emergency, the TXSG has built a strong program over the past few years incorporating emergency management and disaster training into regular drills for all personnel, including the TMR. Aside from the initial training held during 2002, the TXSG and TMR made additional efforts to define and refine the training requirements for the organization based on mission and community needs. This represented a marked departure from old mission and response efforts where TXSG functioned in its own stovepipe, often disregarding emergency management policy and procedure, and alienating partners along the way. As early as November 2002, initial recommendations for standardized training applicable to its functional area were made after a study of various training courses available from FEMA, the American Red Cross, and Texas Division of Emergency Management courses was presented to senior leadership at the request of the brigade commander. Later in 2004, course recommendations were refined and have now expanded to include varying levels of awareness, technical, and operational training. Additional training is left up to the individual unit training officers and considers group interests keeping in mind future roles in community prevention, preparedness, response and recovery operations, and

⁴⁵ Adjutant General's Department., "Texas State Guard Medical Reserve Corps."

support to the local National Guard and other response agencies. Current training requirements all evolved from original efforts to define core competencies and the educational content guides to meet them. TMR conducted a series of meetings in 2004 to develop core competencies for the medical volunteers. In addition to the basic program advised by the TXSG, additional course recommendations for TMR volunteers include disaster mental health, disaster life support, mass care, and Strategic National Stockpile distribution.⁴⁶

The TXSG has a headquarters Training Command and each unit has a designated training officer. TXSG member volunteers participate in eight hours of training drills per month, including topics such as Red Cross shelter management, Incident Command System, National Incident Management System, Emergency Management, and first aid and CPR. All instruction is completed utilizing courses available from FEMA, including several independent study courses that can be completed as a group study or individually, other DHS approved training programs, and the American Red Cross. TXSG personnel have responded well and many have pursued additional training including advanced level certifications and instructor designations in several homeland security areas.

As of 2006, all TXSG and TMR personnel are encouraged to complete the Military Emergency Management Specialist (MEMS) qualification program delivered and sponsored by the State Guard Association of the United States (SGAUS). In February 2006 SGAUS MEMS Academy officially opened its doors for applications.⁴⁷ At the present time, approximately 75 TMR members are enrolled in the Texas MEMS program and interest is gaining momentum as leaders recognize the benefits. This number does not reflect the number of personnel pursuing the MEMS qualification who have not submitted official enrollment applications. Approximately four to five new qualifications are awarded each month. It is estimated that approximately 200 personnel have completed

⁴⁶ Texas Medical Rangers, "Core Competency Recommendations for all TXSG- Medical Reserve Corps Provider and Support Personnel," Transcript from TMR-HQ staff meetings (San Antonio, December 2004); Cynthia A. Cox, "FEMA Training Course Recommendations," prepared for the Commander, 2004.

⁴⁷ State Guard Association of the United States Military Emergency Management Specialist Academy, website <http://www.sgaus.org/MEMS>, [Accessed 2/06]; George Heart, *MEMS Student Handbook* (Nashville: State Guard Association of the United States, 2006). Document on-line; available from <http://www.sgaus.org/MEMS>. [Accessed 9/06].

at least the Basic level of the MEMS program. In addition, four TXSG members hold positions as MEMS Academy staff.⁴⁸

In 1999, the SGAUS Education Committee Chair, LTC George Heart, was tasked to develop a training program with an associated award to bring new members into the organization after similar success developing a SGAUS training program for Chaplains. The information presented in this section is from a personal interview with him. Ideally, the new program would increase membership and help with retention efforts as well. Considering the many ideas, recommendations, and advice from state defense force leaders and SGAUS members, a need for emergency management training was identified. The original Military Emergency Management Specialist program was established and offered a ribbon award for successful completion of five FEMA Independent Study (FEMA-IS) courses and a short narrative. Members could attain awards at three levels: Basic, Senior, and Master, after satisfying FEMA-IS course requirements and SGAUS membership for a designated time period. The initial MEMS program was highly successful according to Heart, and underwent an extensive revision in 2005. In February 2006, the expanded comprehensive curriculum went on-line. The current program staff is comprised of the Academy Commandant, an Eastern and Western Regional Director, an Academy State Director within each state and Academy Instructors (AI) within each state to proctor students throughout the program.⁴⁹

Thus far, there has been minimal opposition to the strict standards of the program. The few negative comments questioned requirements for practical assignments, waivers of course requirements for those with/without actual experience, and questioned the ability of some personnel with limited literacy levels to complete the courses. Current interest and enrollment in the program suggests these initial concerns were unwarranted.

The current MEMS curriculum is comprised of three parts completed independently by the individual candidates: FEMA-Independent Study courses, a course narrative assigned by the Academy Instructor (proctor), and a practical assignment. As in the original program there are three qualification levels, with the curriculum for each

⁴⁸ Heart, *MEMS Student Handbook*; SGAUS MEMS Academy Commandant, Interview by the author, Washington, 6 June 2006, phone conversation.

⁴⁹ Ibid.

involving increasingly advanced FEMA-IS or in-residence courses, additional narrative assignments, and practicum. Successful completion of the program is rewarded with a unique skills badge and certificate of qualification. Additionally, MEMS badge recipients can apply for a special flash to be worn on uniforms to designate actual active duty service during a disaster or other significant homeland security event. To date, more than 700 MEMS qualifications have been awarded to State Defense Force (SDF) volunteers, federal active duty military, Army and Air National Guard and reservists in all branches of the military. The student handbook for MEMS is included in Appendix C.⁵⁰

Success of the MEMS program is best indicated by the reported improved performance of SDFs during emergency activations. As in the MRC and the TXSG-TMR, the 2005 Hurricane season validates the preliminary success of the program. In unofficial reports, over 2700 state defense force volunteers were activated during Katrina and Rita operations. Comments and briefs from unit commanders, emergency management personnel, government leaders and other agencies across the country indicate that personnel who completed the training were much more confident in the environment, familiar with the functions, processes and command structure utilized during such operations, and overall provided outstanding support during the activations.

The SGAUS-MEMS Academy program has been very well received and has garnered favorable reviews from participants across the country. Texas and Maryland SDFs are recommending policies to add the MEMS program to existing training requirements for all personnel. Local National Guard and Reserve units have expressed interest in the program and have authorized personnel to wear the badge on uniforms. The Civil Air Patrol and Coast Guard Auxiliary are considering the qualification for their members. In Texas initial plans are underway to pilot test MEMS training in a select number of high school Junior ROTC programs.

C. SUMMARY

The Texas State Guard TMR has policy establishing guidelines for training all personnel. MRC units within the TXSG do not have designated training funds, have limited staff, and similar time constraints as do other MRCs in the country. Training policy and standards has increased participation of volunteers who want to serve and has

⁵⁰ Heart, *MEMS Student Handbook*, passim.

increased opportunities to serve in the community. The flexible training program adds value to the organization both in the eyes of the individual member, the guard, the community and the state. The successes shown in TXSG and TMR highlight the fact that training can be done in an efficient way. The success of the policy is evidenced by the highly successful participation during the 2005 hurricane season and increasing homeland security role in the state and the training itself continues to prove a worthy undertaking for all involved.⁵¹ Preparedness levels of members have increased allowing them to function more effectively, efficiently, confidently and safely in the emergency environment. As with the MRC, time and resources to conduct training can be problematic. Ways were found to eliminate and reduce those obstacles by using existing courses such as FEMA and Red Cross, encouraging members to serve as instructors and support staff, and utilizing independent study resources. Oppositions to the programs were overcome as participants and leaders saw improvement and increases in participation, rather than a decline. The policy and standards resulted in increased opportunities to serve in the local community and state, increasing their visibility, and proving value as an integral part of homeland security and emergency response efforts.

⁵¹ There are numerous news releases from state resources and private newspaper accounts of the State Guard participation in hurricane response efforts. They are available on the Texas National Guard Public Affairs Office website: <http://www.agd.state.tx.us/pao>.

THIS PAGE INTENTIONALLY LEFT BLANK

IV. CONTENT

As mentioned in previous sections of this thesis, a comprehensive assessment of MRC current training status is necessary to determine gaps and requirements for training. The content recommendations made here could change as a result of that assessment. In the interim they establish a baseline to address current expressed needs of the MRC volunteer and serve as a benchmark for future training evaluations.

For the seasoned disaster veteran, much of the content would seem to be common sense and perhaps they would question why it even needs to be addressed. But research tell us emergency preparedness and disaster training are not common knowledge for the majority of public health and medical workers, and are not addressed in most medical academic curricula. A survey done by Landguth in 2005 is evidence that emergency preparedness is still uncommon, regardless of specialization.⁵² MRC volunteers represent the broad spectrum of health and medical fields - from nurse and pharmacist to dentist and veterinarian. They are the target audience for this content.

There is no single resource providing training material to address each competency area. As an example, the American Red Cross (ARC) focuses on first aid and CPR training and provides family preparedness educational materials. In its Disaster Services division, training is directed to its ARC disaster volunteers including shelter management, emergency response vehicle operation, and family assistance. It does not offer courses in Incident Command or Disaster Basics as FEMA does, and FEMA does not offer health and safety courses. So it takes some work to search out what training is available where and perhaps it has impeded efforts to standardize MRC training in the past.⁵³

Every MRC unit is unique and will ultimately serve in ways that are most beneficial to the individual community's overall preparedness for a public health crisis. For some MRC units this may mean supporting everyday public health priorities such as

⁵² Landguth, "Public Health Specializations and Education."

⁵³ American Red Cross Health and Safety and disaster training course information; available on the website <http://www.redcross.org>. [Accessed 10/30/05]; FEMA Independent Study course information; available on the website http://www.fema.gov/tab_education. [Accessed 10/30/05].

vaccination clinics and health education. For others, it may mean participating in training exercises with local response agencies or setting up point of distribution sites for the strategic national stockpile. MRC units across the country cover the realm of disaster life cycle from mitigation and preparedness to response and recovery.⁵⁴ With the variety of potential roles for the MRC volunteer, there have been concerns that standardization of training would be either impractical or impossible to achieve.

Training and education of the public health and medical workforce is an integral part of disaster preparedness. Leading researchers at universities, associations and schools of public health have published varying models of competency based preparedness education for the healthcare worker. Competency based training and education to improve preparedness efforts is a new, yet familiar concept, as evidenced by the many public health preparedness competency documents published in recent years. In the BioMed paper “Healthcare Worker Competencies for Disaster Training,” the authors synthesized six of the most commonly referenced competency research documents and condensed them into seven competency areas. Although this is a step toward a more comprehensive and inclusive approach, they are quick to point out that content, objectives, and evaluation measures for preparedness training have yet to be refined.⁵⁵

Training that is useful, practical and applicable in any circumstance in which the MRC volunteer could be involved is, however, possible. Some common themes emerge from the data available from the MRC After Action Reports, core competency recommendations, commonly accessed preparedness training programs (such as FEMA, Red Cross, etc.) and Lessons Learned resources.

The core content areas suggested here are directly related to each competency recommendation made by the MRC Core Competency working group, considering as well the most commonly recognized competencies for public health preparedness and recognized standards in the emergency management of disasters. They also correlate with the issues discussed in the Lessons Learned from the 2005 MRC Hurricane Response Final Report. The content areas are: Incident Command System and the National Incident

⁵⁴ Medical Reserve Corps, *Pandemic Influenza Planning Guidance*. Document on-line; available from <http://www.medicalreservecorps.gov/POUupdates/PandemicFluGuidance>. [Accessed 8/06].

⁵⁵ Hsu et al., *Healthcare Worker Competencies for Disaster Training*, 2.

Management System, personal preparedness, health and safety, roles and responsibilities, communications, concepts of basic disaster response, and policy/procedures. The content areas are representative of the basic information that any citizen, disaster worker and MRC volunteer should have to better prepare themselves for disaster. This knowledge is essential to protect health and general well being of the responder and the public, and facilitates the coordinated and integrated response of all partner agencies during a disaster. The content areas are non-specific: they are equally applicable to the role of the non-medical support staff and the physician in the field, and encompass any type of catastrophic event, consistent with the all-hazards approach to planning and training as recommended by FEMA and the Department of Homeland Security. In the following sections each of the content areas are explained greater detail and a course resource section is included in the annex to this document.

A. CONTENT AREA I: INCIDENT COMMAND SYSTEM AND THE NATIONAL INCIDENT MANAGEMENT SYSTEM

MRC volunteers should be able to recognize and describe the chain of command, structure, functions and terminology of the Incident Command System and the National Incident Management System, and identify their role in that system.

Seasoned emergency managers and responders alike agree that the cornerstone of any disaster operation is the ability of all agencies to collaborate and coordinate many resources and functions in the most effective and efficient way possible. Everyone must be able to communicate in common terms, follow chain of command, and use standard protocols and procedures. Failure to do so can result in chaos.

Following activations of the 2005 hurricane season, many MRC coordinators and volunteers noted that following and understanding the Incident Command System (ICS) was critical to mission success. Both groups felt that setting up and following a well organized incident command structure was critical to coordination efforts, and both groups suggested that future preparedness training should include the ICS and the National Incident Management System (NIMS).⁵⁶ The NIMS is the national framework for standardized sets of processes, procedures and terminology that should be used by any

⁵⁶ *Medical Reserve Corps Hurricane Response Final Report*, passim.

agency involved in incident response. The ICS is the combination of facilities, equipment, personnel, procedures, and communications operating within a common organizational structure, designed to aid in domestic incident management activities.⁵⁷

Perhaps no group was more keenly aware of the implications of failure to follow ICS than the MRC and public health agencies involved in the Texas shelter operations. During one incident, medical supplies were ordered outside of usual ICS protocols. This became problematic when the shelter was inundated with supplies it had no space for and could not be reimbursed for because appropriate documentation was not kept. This problem could have been avoided altogether had the chain of command been followed and supplies ordered through the proper channels which is identified within the ICS. There were also reports of personnel mismanagement resulting in critical staffing shortages in the shelters and security concerns after personnel were released, turned away or reassigned without command knowledge. These were problems that could have been mitigated successfully by following recognized protocols for resource requests and deployments within the ICS. The immediate solution to the problem was to conduct Just-in-Time (JIT) ICS training with each shift change. Although some amount of JIT training is expected during emergency operations, training prior to the event is more practical and makes the process much easier.⁵⁸

FEMA recommends that all volunteers and CERT members receive ICS/NIMS training at the basic introductory level which includes FEMA IS-700: NIMS, An Introduction, and ICS-100: Introduction to ICS or its equivalent. NIMS/ICS training is required for all regular response personnel from federal, state, local, tribal, private sector and non governmental agencies, and all entry responders and disaster workers.⁵⁹

B. CONTENT AREA II: PERSONAL PREPAREDNESS

The MRC volunteer should be able to describe the steps and plans necessary to prepare for personal deployment to a disaster, and measures taken to prepare their family for disaster including a preparation of a family disaster plan and kit.

⁵⁷ Federal Emergency Management Agency, "NIMS, NRP and ICS Training in FY06."

⁵⁸ Texas Medical Rangers, *Katrina: Regional Medical Operations After Action Briefings* (San Antonio, Texas, 2005).

⁵⁹ FEMA, "NIMS, NRP and ICS Training in FY06."

Organizational readiness for disaster response is important, but individual preparedness was rarely a topic of training plans prior to 9/11. For citizens, being prepared can be a key factor in surviving and managing those first critical hours following an event. As the first anniversary of Katrina nears, an alarming number of citizens still do not have an emergency plan in place for themselves or their families, and few have any sort of emergency kit on hand in the event of another disaster.⁶⁰ For workers who have never been part of an actual disaster operation, the physical and mental challenges can be daunting; what they see, hear and experience first hand can have a lasting impact. Those experiences can influence the individual's willingness to participate in future efforts; so a positive experience is critical and being prepared is key. Disaster workers should practice personal and family preparedness so that they are less likely to become victims themselves.

MRC volunteers felt that personal and family preparedness was an important element in preparing for deployment during the 2005 hurricane season. The MRC Core competency working group also felt that personal and family preparedness are essential to the MRC volunteer. Because the majority MRC volunteers had not previously been activated many had questions, issues and concerns that could have been eliminated or lessened with some advance preparation. MRC volunteers needed to know where they would eat or sleep, how long would they be away from home, what they should pack, how they could communicate to family, etc. For those with family in the disaster impact areas, it became important to know that their loved ones were safe and out of harm's way. In circumstances such as these, it is every bit as important for the disaster worker to be prepared as it is for the community at large. For the worker to be most effective at his job,

⁶⁰The National Hurricane Survival Initiative, "New Mason Dixon Poll Shows Coastal Residents Still Unprepared for Hurricane Season," *National Hurricane Survival Initiative Online*. Available from <http://www.hurricanesafety.org/newpoll.html>. [Accessed August 26,2006]; Katherine Hobson, "Are we Ready?" *U. S. News and World Report* 01 May 2006, in USNews.com. Article on-line; available from <http://www.usnews.com/health/articles/060501/1disaster.htm> [Accessed 8/06].

he needs the assurances that his and his family's needs for food, clothing and shelter will be met.⁶¹ Some key elements of personal and family preparedness are:

- Deployment schedule including when, where and for how long deployment is expected.
- Plans for communicating with loved ones.
- “Go Bag”-Having gear ready to go prior to deployment including appropriate work clothing, sleeping gear, medications, toiletries, cash, etc. Prepared food and bottled water. For the family this would mean making sure a family disaster kit is stocked and ready at all times.
- Up to date vaccination and medical records available.
- Make sure the family has a plan; knows where to meet and has a plan for communications with family and friends and alternative living locations.
- Participate in preparedness training whenever possible including first aid and CPR, exercises with other response groups, etc.

Additional personal and family preparedness information is available from the American Red Cross and is included in the annex to this document.

C. CONTENT AREA III: HEALTH AND SAFETY

The MRC volunteer should be able to recognize and describe the various hazards that may be encountered in an emergency environment and the steps, procedures and/or equipment necessary to protect the health, safety, and mental well being of themselves and others in that environment including first aid, CPR and PFA.

Disasters are chaotic events and each comes with a variety of hazards. Faced with overwhelming demands and urgency of the situation demands emergency workers often push themselves to mental and physical limits, risking their personal health and safety in the process. Countless dozens of worker illness and injury (both physical and mental) reports from events such as the World Trade Center collapse, the Murrah Building bombing and environmental issues such as those associated with Katrina cleanup have highlighted the need for more robust worker safety training. Recent findings suggest as many as 50% of the workers involved in the WTC clean-up are suffering from long term

⁶¹*MRC Hurricane Response Final Report*, passim.; Medical Reserve Corps Advisory Committee Working Group, “Core Competencies for the Medical Reserve Corps Volunteer,”; Texas Medical Rangers, *Katrina: Regional Medical Operations Brief*; American Red Cross, *Together We Prepare* (Washington, D.C.: American Red Cross, 2003).

health effects. A recent RAND report conducted in cooperation with the CDC and the National Institute for Occupational Safety and Health (NIOSH) reviewed many of these reports and suggested that a safety function integrated into the current ICS structure would allow safety managers to better manage disaster worker safety and health risks. For it to be even mentioned as an added function to the ICS system is evidence that responder safety should take a much higher priority than it has in the past.⁶²

There are no statistics or reports available on MRC volunteer injuries suffered during any activation, although it is safe to assume that any disaster worker risks exposure to injury and illness unless proper precautions are taken; MRC is certainly included in that group. The RAND/NIOSH study, MRC Hurricane Report and competency findings share common concerns when it comes to worker health and safety issues including all-hazard awareness (which is a common element of most basic disaster courses), use of personal protective equipment, procedures for reporting injuries, disaster mental health, and first aid and CPR.

Many areas of health and safety content overlap with personal preparedness issues, such as first aid and CPR, and disaster mental health. First Aid and CPR training is currently a part of some MRC units' active training programs. Although personal health and safety was considered a core competency, some MRC members have been reluctant to require or recommend First Aid and CPR for volunteers for fear it would obligate non-medical volunteers to provide care, expose them to liability, or even prevent members from joining the organization.⁶³

Good Samaritan or volunteer statutes in many states offer protection for those (including disaster workers) who provide care in good faith during times of emergency, do not intentionally cause harm and do not provide care beyond the level at which they are trained. Laws vary from state to state, and a review of relevant laws as a part of the health and safety training content will help lessen these fears. For those volunteers who

⁶² Mt. Sinai Press Office, "Large Study of WTC Responders;" Jackson et al., "Protecting Emergency Responders," 36.; Occupational Safety and Health Administration, "Keeping Workers Safe During Clean Up and Recovery Operations," U. S. Department of Labor website. Fact Sheets online; available from <http://www.osha.gov/> [Accessed 5/06].

⁶³ Nonprofit Risk Management Center, *State Liability Laws for Charitable Organizations and Volunteers* (Washington, D.C.: Nonprofit Risk Management Center, 2004. Available from <http://www.sfcad.org/goodsamaritanlaws.pdf> [Accessed 20 May 2005].

are uncomfortable providing care, first aid and CPR training can still be valuable. Being able to recognize a medical emergency and call for assistance is as important as the care itself, according to the American Red Cross and American Heart Association training materials.⁶⁴

Basic First Aid and CPR can be particularly helpful for MRC volunteers who work in ARC shelters. As many as 80% of the MRC supported either the ARC national mission or ARC operated shelters during the 2005 hurricane operations. Because of ARC protocol and liability issues, their disaster volunteers are only allowed to provide the most basic level of medical care to shelter residents and are trained to identify those that require more urgent care so help can be summoned. While this can be particularly frustrating for the highly trained medical professional, some awareness of the conditions under which care may be provided in shelters is helpful, in particular ARC protocols.⁶⁵

Another critical issue is that of disaster mental health and psychological first aid. No one who endures, witnesses, or responds to a disaster is immune from the emotional response; it is felt by the victim, the worker, and the community alike. Workers may experience uncomfortable reactions to the sights, sounds and human suffering, and may not know how to cope. The psychological reactions to disaster experiences include:

- Emotional reactions: temporary (i.e., for several days or a couple of weeks) feelings of shock, fear, grief, anger, resentment, guilt, shame, helplessness, hopelessness, or emotional numbness (difficulty feeling love and intimacy or difficulty taking interest and pleasure in day-to-day activities)
- Cognitive reactions: confusion, disorientation, indecisiveness, worry, shortened attention span, difficulty concentrating, memory loss, unwanted memories, self-blame
- Physical reactions: tension, fatigue, edginess, difficulty sleeping, bodily aches or pain, startling easily, racing heartbeat, nausea, change in appetite, change in sex drive
- Interpersonal reactions in relationships at school, work, in friendships, in marriage, or as a parent: distrust; irritability; conflict; withdrawal; isolation; feeling rejected or abandoned; being distant, judgmental, or over-controlling

Another aspect of disaster mental health preparedness is cultural competence. The typical mental health response to disaster was usually generic until recently when leading

⁶⁴ American Red Cross, *Standard First Aid and CPR* (Washington, D.C.: ARC, n.d.).

⁶⁵ *MRC Hurricane Response Final Report*, 27-28.

psychology researchers determined that culture was important to the society and individuals' mental response to the traumatic events faced in disaster. Issues such as race, gender, socioeconomic status, education, disability, special needs and language are but a few areas that shape victim or responder reactions to the dramatic circumstances such as those witnessed on 9/11 or during Katrina. Accordingly, the response to each of the phases will be different depending on individual circumstances or cultural differences of those affected.⁶⁶

In August 2006 the MRC issued the Psychological First Aid (PFA) Field Operations Guide for the MRC volunteer in recognition of the critical need for mental health support for victims and responders to disaster. This document was adapted from the original guide developed by the National Child Traumatic Stress Network and the National Center for PTSD.⁶⁷ All MRC units are advised to reference this document to address disaster mental health issues.

D. CONTENT AREA IV: COMMUNICATIONS

The MRC volunteer should be able to describe internal and external communications policy and procedures for communicating with their unit, chain of command, the general public and media. In addition, they should be aware that communications equipment will vary from incident to incident and agency to agency in their community.

Communications in the disaster environment are very complex and difficult. There are technical challenges due to the wide variety of equipment in use, many agencies are trying to communicate with different equipment and overloading every channels. The volume alone is often enough to overload the system and render it useless. Despite the best made plans, communications in such extraordinary circumstances will be challenging. Still, planning and preparation must take place if it is to be effective at all.

⁶⁶ Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, "Developing Cultural Competence in Disaster Mental Health Programs: Guiding Principles and Recommendations," SMA 3828:3 (Washington: DHHS, 2003). Document on-line; available from <http://www.mentalhealth.samhsa.gov/disasterrelief/publications/allpubs/SMA03-3828>. [Accessed 3/06]; Bruce H. Young, Julian D. Ford, and Patricia J. Watson, "Disaster Response and Recovery Workers: A National Center for PTSD Fact Sheet" (Washington: U. S. Department of Veterans Affairs, n.d.). Document on-line; available from http://www.ncptsd.va.gov/facts/disasters/fs_rescue_workers_html. [Accessed 5/06].

⁶⁷ Medical Reserve Corps, *Psychological First Aid Field Operations Guide for the MRC Volunteer*, (Washington, D.C.: MRC, 2006), 1. Available from <http://www.medicalreservecorps.gov>. [Accessed 8/06].

All workers must be aware of the barriers to communication and be advised of any alternate means and methods that can be utilized to overcome them. Above all, they should practice patience. The technical issues of communications are best addressed by the MRC local emergency management team. They can provide information specific to their operations. With so many agencies involved it is often difficult to know whom need to report to, what to report and when and how to do it. Some agencies use software programs or special forms to issue communications up the channels. Others schedule regular conference calls for updates. Regardless of the methods used or procedures, MRC volunteers must be aware of communications channels and reporting methods they are to use in their community and within their unit. Again, this can be addressed by the local emergency management team and the MRC coordinator.⁶⁸

The public's need to know presents other challenges to the communication process. Most inquiries are out of curiosity and concern but it is a nuisance and even problematic if communications are not handled correctly. Rumors are commonplace and the media are hungry to get a story out on the next broadcast. Some information is sensitive due to security issues involved or to protect privacy of families and individuals. A public affairs officer is usually in charge of handling all communications with the public and the media so that these issues are managed correctly. Volunteers should be advised of any restrictions on communicating with the press or the public including types of information that can or cannot be discussed, and processes to follow before granting interviews or making any statements with the press or public. In some cases, particularly those involving medical care of individuals, discussions even within the ranks of workers is restricted. Individual privacy must be respected at all times.

E. CONTENT AREA V: ROLE AND RESPONSIBILITY

The MRC volunteer should be able to describe the local, state and national role of the MRC in public health emergency preparedness and be able to describe their possible individual role and expected scope of practice within any emergency operation.

The MRC mission is to provide a cadre of trained, credentialed and prepared volunteers to support and augment the public health system in times of crisis. Beyond this

⁶⁸ Joint Commission Resources, *Disseminating Lessons Learned from a Terrorist Attack*, 16-17.

national mission, each MRC has a local mission defined by the community it serves, based on local need. For example, the Texas State Guard MRC primary mission is to support state homeland security efforts as a component of the state military forces, other MRC unit missions are directed by local health departments or emergency management. Each circumstance will be different and MRC volunteers must be familiar with the mission of the MRC at the national, state and community level.

MRC volunteers fill different positions, different roles and have varied responsibilities depending on the local mission and the event they are responding to. They staff call-centers, assist in special care shelters, support community vaccination clinics and support medical missions. Some may provide actual medical care while others serve in administrative functions such as logistics and registration activities. During the Hurricane operations, many MRC volunteers supported the American Red Cross in shelter operations. Many volunteers expressed frustration at being asked to do work they were not qualified for, or to perform menial tasks instead of medical care. This was most evident in shelter operations where strict Red Cross protocols restrict all but the most basic of medical care. Regardless of the mission, MRC volunteers should be apprised of potential roles they will fill in times of disaster, although many of those will not be determined until the actual event occurs.⁶⁹

When working with the local health department, hospital or in areas outside of the local jurisdiction, it is extremely important that the volunteer knows the level of care they can provide and under what circumstances (or scope of practice). As in ARC shelter operations, medical professionals may not be able to practice at their usual certification or licensing level. To many, this can be frustrating and disappointing. This became especially critical in the Katrina shelter operations in San Antonio.⁷⁰ Although staffed by many capable medical professionals, policy and procedures were in place through the local emergency management plan to integrate all shelter residents into the community health system as quickly as possible. This way issues such as patient privacy (which can

⁶⁹ Medical Reserve Corps Program, *Medical Reserve Corps 2005 Hurricane Response Final Report*, 24.

⁷⁰ Texas Medical Rangers, *Katrina: Regional Medical Operations After Action Briefings*.

be challenging in a shelter), pharmacy operations and treatment of chronic conditions are more effectively managed and reduce the burden on recovery.

F. CONTENT AREA VI: DISASTER BASICS

The MRC volunteer should be able to recognize and describe the phases of emergency management, the local plan to deal with an emergency, and the agencies involved in response to that incident at the local, state and federal level.

MRC members should be familiar with the fundamentals of this integrated emergency management system. The local government bears primary responsibility for the efficient management of a disaster. As is often heard, the first response is always going to be a local one. This response involves participants from all government levels and across the public/private sector. The effectiveness of the emergency management system relies upon a strong collaboration between these partners. Many resources and capabilities across all functional areas must network together in all phases of the emergency management cycle including mitigation, preparedness, response and recovery.

MRC volunteer should be familiar with the basic emergency management principles and practices that include the phases of management, roles and responsibilities of the different agencies involved in emergency management and some basics of all-hazards planning. This will increase understanding of the principles of emergency management and introduce them to the various partner agencies and their responsibilities in the process. These partners include local, state and fed government, non-profit, private, and other volunteer organizations. Many of the responsibilities and functions of disaster management are established through local emergency management plans and policies.⁷¹

G. CONTENT AREA VII: MRC POLICY AND PROCEDURES

MRC volunteers should be able to describe local unit policy and procedures for attendance, licensing and certification, training, personal conduct, dress code, reporting and deployment.

Finally, all MRC volunteers should know the policy and procedures of their local unit. This content area is locally developed and is ideally a part of basic entry level training. Some will overlap with roles and responsibilities content. Just as a new

⁷¹ Joint Commission Resources, *Disseminating Lessons Learned from a Terrorist Attack*.

company hire receives an employee handbook, the MRC volunteer must be familiar with policy and procedures specific to their unit in both day to day operations and during activations.

As is true in many volunteer organizations, some volunteers will join but not participate or otherwise interact with the group until an event occurs. In the case of the MRC volunteer, they run the risk of being a hindrance and no more useful than the hundreds of other spontaneous volunteers who show up unsolicited once disaster strikes. It becomes extremely important that policies and procedures are in place to limit this occurrence. Policy should include any requirements for registering, credentialing and updating license or certification records. They must include meeting, training and attendance expectations especially if there are requirements to meet before they can serve in the field. If there is a dress code for attending training or for duty assignments it should be included as well. Policy and procedures are also necessary for deployments and activations.

MRC volunteers need to know the time commitment expected of them, including reporting and call up roster procedures specifying when, where and to whom they must report. This was a common concern of many MRC volunteers during the 2005 activations and has been reported in other agencies in the past. Disasters are such chaotic events that even the best made plans can fail. Policy and procedures cannot be developed on the fly as the situation warrants though and must be carefully thought out ahead of time to eliminate some of the confusion that is inherent to a crisis event.

THIS PAGE INTENTIONALLY LEFT BLANK

V. ISSUES AND RECOMMENDATIONS FOR PLANNING, IMPLEMENTING AND SUSTAINING TRAINING

MRC Units across the country are organized by the city or jurisdiction with support of the local Citizen Corps. Citizen Corps focuses on community preparedness issues such as the Community Emergency Response Teams that assist local residents until regular emergency services are available to respond, while the MRC function is to support the public health system response. Some MRC units have only limited training or funding support from the jurisdiction in which they are affiliated, and a few have grants to help with limited office staff or training costs. The local MRC volunteer coordinator often serves in multiple roles as recruiter, trainer, public relations manager, operational and logistics chief. In addition, little time or funding is available for training and much less time needed to coordinate and conduct a useful training program. In spite of the challenges, there are opportunities to overcome them while building and sustaining a successful training program.⁷²

Planning, implementing and sustaining a training program require commitment from the individual volunteer and the coordinator. For volunteers and coordinators who have other demands on their time and resources it can be an overwhelming undertaking. Fortunately, as noted in the recent surveys, the majority of volunteers are willing to participate in additional training opportunities. Making the task easier, the MRC leader has a variety of resources available to make the coordination and delivery of the program easier. The MRC must continue to support and encourage volunteer efforts to participate, and facilitate preparedness activities whenever possible prior to an event.

Planning is the key to the success of any program. A well-planned strategy is necessary to overcome any hurdles or challenges to build, maintain and sustain a successful program. Although a certain amount of just-in-time training will always occur and even be necessary to some extent in the field, it is not an adequate substitute for pre-event planning. Many factors can influence the content, success or sustainability of a training program. Some of these issues are addressed on the following sections.

⁷² Hoard and Tosatto, "Medical Reserve Corps: Strengthening Public Health and Improving Preparedness," *passim*.

ISSUE 1:

Beyond its national mission to support and improve public health preparedness, the MRC local role must be clearly defined before an effective training program can be implemented.

DISCUSSION:

Local need will drive the MRC mission, thus training beyond the basic level will depend upon the role and function of the local MRC in its community. As an example: Does the MRC assist the local Red Cross with shelter operations, staff special needs shelters, work at SNS distribution points, or provide logistical or communications support to the public health department? These are relevant missions and must be clearly identified before they can be addressed in training.

RECOMMENDATION:

The MRC should establish and work to build collaborative relationships with local stakeholders and emergency management partners including public health and medical, special needs groups, local government, non-profit and private organizations such as the Red Cross, Salvation Army and faith based groups, community leaders, and emergency response organizations. Many MRC coordinators and volunteers expressed disappointment that other agencies in their communities did not recognize them or know their capabilities during the hurricane response. Seeking stakeholder input on preparedness training is one solution to finding gaps that exist in community emergency preparedness where MRC can be of value and increases the visibility of the MRC unit. It also provides additional opportunities to participate in local community public health preparedness. It is not expected that every MRC volunteer will know every single agency and every person in the community. MRC should take advantage of relationships that may already be established with these agencies by their own MRC volunteers. Some MRC volunteers may serve with local public health, on hospital boards, local medical societies, neighborhood associations, etc.

These relationships will enable the MRC to be an active participant in the community and help to define its role and function in times of emergency. Building

positive community relationships prior to a response increase the effectiveness of that response and help to mitigate some of the issues of recognition that many MRC members discussed following the hurricane response efforts.

ISSUE 2:

Volunteers come into the MRC with different training needs and expectations.

DISCUSSION:

The basic goals of a training program should support the minimum levels of competency recommended by the MRC so volunteers can work effectively and safely in the field. Types of volunteers and their individual preferences and experiences will determine when they are ready for deployment and to what extent they will serve. Basic training in disaster preparedness does not obligate the MRC volunteer to participate in emergency operations, nor will every MRC volunteer want to participate at the same level. It does, however, prepare those who may volunteer to participate in future response efforts. There is also value in the personal and family preparedness knowledge that is gained. Individual preparedness increases the confidence of the individual and contributes to the overall preparedness of the community.

RECOMMENDATION:

Specific training guidance should be established for different levels or tiers of volunteers. Suggested levels or designations of volunteers might include:

- Individuals ready to deploy to the “front lines” (readiness status) in support of a public health or other emergency. These individuals have direct contact with other response agencies, victims, the community, media, etc. They are also familiar with all phases of emergency management response either from experience or extensive training.
- Individuals with no prior training in emergency or disaster response. These individuals may require additional training and exercises before being “cleared” to participate in the actual response efforts.

- Individuals who wish to provide support but in a non-medical position only with no direct role in the actual operations.

This guidance should specify timelines for completing training at each level (i. e, new volunteers with no prior training or experience will complete basic emergency preparedness training within 6 months) before volunteers are eligible to deploy.

ISSUE 3:

Not all training meets the objectives and needs of the MRC.

DISCUSSION:

Because of the large number of courses available from many resources, it is challenging to select appropriate training materials.

RECOMMENDATION:

Courses should be consistent with standard emergency response practices and with those of the National Incident Management System. Courses at the basic level and beyond should be selected from academically sound, reliable, and commonly accepted sources. The majority of training courses come from American Red Cross, the Federal Emergency Management Agency-Emergency Management Institute, United States Fire Administration, Office of Domestic Preparedness, and Centers for Disease Control. Many of these are listed on TRAIN by public health competency or subject. The MRC Program Office recently announced its participation in the Training Finder Real-Time Affiliate Integrated Network (TRAIN). This was first introduced at the 2006 MRC National Leadership and Training Conference and is now available free of charge to any registered MRC coordinator and volunteer.⁷³ TRAIN is a database of public health learning resources divided into subject areas. Courses are listed and available from a variety of sources; a few have a small cost but the majority is free. TRAIN is an excellent learning management tool for the MRC coordinator to use, allowing them to coordinate training events, track training progress and monitor current status of the individual and

⁷³ *Special Topics: MRC Training and Core Competencies, Technical Assistance Series* (Rockville: Medical Reserve Corps Program Office, 2006). Series online; available from <http://www.medicalreservecorps.gov/resources>. [Accessed 8/06].

the unit's training plan. This is not to say that other resources should not be used when selecting course materials, but care should be taken and a little research done beforehand.

Be aware of the fact that some training practices are controversial and may not be widely accepted by the response community. It is advisable for MRC to consult their local medical community and health department before offering training that may pose a risk to either the volunteer or victim. One such example is the practice of Critical Incident Stress Debriefing (CISD). This popular technique (used as an intervention for those who have experienced a significant critical incident) has come under scrutiny in recent years. As in other interventions to treat acute stress reactions its value or potential for harm has not been validated. The consensus among the MRC mental health working group is that PFA is a more practical and useful tool and at the very least will cause no harm.⁷⁴

Another recent trend in training is private companies offering online certifications in practical, hands-on skills such as first aid and CPR. They are not adequate replacements for in class training and skills practice. Most of these certifications are not recognized or accepted by the health profession. The American Red Cross does offer blended learning courses in first aid and CPR, but following the online didactic portion participants must take a practical skills examination with a qualified ARC instructor before being certified. ARC and AHA CPR courses are the two most commonly recognized life support certifications. A listing of some of the most commonly used training resources by content area is included in Appendix A.⁷⁵

ISSUE 4:

In order to improve performance and increase the preparedness level of the MRC volunteer, we must be able to accurately assess the program and set benchmarks for improvement.

DISCUSSION:

The MRC has made great strides recruiting, credentialing and providing an organizational structure for volunteer medical professionals. However, the current

⁷⁴ Butler et al., *Preparing for the Psychological Consequences of Terrorism*, Ch 4.

⁷⁵ American Red Cross, *Standard First Aid and CPR: Update 2006* (Washington, D.C.: American Red Cross, 2006). Document Online; available from <http://www.redcross.org>. [Accessed 7/06].

training program status and effectiveness to prepare the MRC volunteer for work in the field is unknown. Current practices do not include performance measures or reliable methods to determine effectiveness or status of training.

RECOMMENDATION:

MRC should conduct a formal evaluation of preparedness to include a comprehensive assessment of training. Before this evaluation can take place, measures must be taken at the local level to collect and record training data once standards have been established. At the minimum, data collected should include the following:

- Number of classes
- Class type (Shelter operations, First Aid CPR, ICS, Trainer, etc.)
- Course provider (FEMA, ARC, CDC, local agency)
- Number of Instructors per class
- Course length
- Participation with other agencies
- Media used (video, independent study, classroom lecture, group exercise, etc.)
- Number of participants enrolled per class
- Number of pass/fails per class
- New vs. repeat students
- Percentage of volunteer roster ready for active duty (successful course completion)
- Pre and Post course survey regarding previous subject area training, previous functional role in disaster ops, preparation for future disaster duties, course relevance to potential future activations, instructional method critique, etc.
- Pre and post disaster activation surveys to determine usefulness in preparation for duties.

ISSUE 5:

Limited resources adversely affect the ability of the MRC coordinator to develop, conduct and coordinate a viable training program.

DISCUSSION:

MRC grant funding unfortunately ended this year, before many MRC units were able to complete the most basic organizational activities such as credentialing, training and preparing their volunteers for possible activations.

RECOMMENDATION:

Fortunately, most of the training recommendations made here can be met using readily available instructional materials that require minimal time, are low or no cost, use a variety of media types, and can be conducted in group settings, such as regularly scheduled MRC meetings. In addition, MRCs may find that local agencies such as Fire, EMS and Red Cross provide many of the courses, or instructors may be available within the ranks of the MRC. Many also offer train-the-trainer courses for to those interested.

In many instances, as a part of the emergency response system, MRC volunteers can qualify to participate in training courses offered through state or local emergency management divisions, the Office of Domestic Preparedness or universities. Check with local emergency management or responders on the availability of such courses.

Managing student training records, accessing courses, and keeping updated on latest revisions and requirements is made easier for the coordinator by taking advantage of the TRAIN learning management system mentioned in Issue 3.

ISSUE 6:

As a community resource, the MRC must remain flexible and sensitive to the unique needs of that community while remaining prepared for its role to support the public health emergency response.

DISCUSSION:

MRC NPO is reluctant to impose training standards, arguing that community needs must take precedence in determining the missions the local MRC must prepare for. However, the original goal and intent of the MRC program is moot if it does not prepare itself for its primary mission: to support public health in times of crisis.

RECOMMENDATION:

View standards as a part of the overall process. Concerns that standards will somehow limit or inhibit the MRC capacity as a community resource are unwarranted. Preparing MRC volunteers at the most basic level builds the solid foundation and discipline necessary to function effectively in a disaster, regardless of the role they will eventually fulfill. Without this baseline knowledge, they are limited in their ability to perform more complex tasks in the future. This is analogous to the new physician who must first master knowledge of the body before he can specialize in surgery, or the home builder who must pour the foundation before putting up walls. A solid base lays the groundwork necessary for future efforts.

Building community relationships is also integral to success of the MRC and the community's overall perception of its value as a resource. Use newly learned preparedness skills as a way to build community relationships. Trained volunteers can assist community outreach efforts in many ways. Teaching families how to put together disaster supply kits, practicing ICS skills to set up and coordinate a community health fair or conduct physicals for the local volunteer fire department are just a few examples. The MRC can help foster positive community relationships by increasing its interaction with other agencies and by participating in activities outside those of disaster response.

MRC should pursue opportunities to fulfill needs in the community where gaps currently exist. However, it must not neglect its primary mission to support public health preparedness. The MRC has to work within an established system when disaster strikes. That system is complex, and regardless of the role or function the MRC plays, its ability to integrate and function appropriately within it is necessary to a successful outcome for all partners involved.

ISSUE 7:

Regular and active participation in training activities is necessary to sustain and increase preparedness levels.

DISCUSSION:

Volunteers in any disaster response organization frequently face long periods of inactivity waiting for the next opportunity to respond. If volunteers lose interest in unit activities they may be less likely to respond when called upon, or respond without the skills necessary to fulfill their role(s).⁷⁶ This is particularly true in the MRC when an actual disaster response may be the only time a volunteer is actively involved in the organization.

RECOMMENDATIONS:

Training should be an ongoing effort in all MRC units. Few organizations can sustain a consistent level of participation and depend upon personnel to respond when needed if they do not aggressively seek regular opportunities to involve their members outside of emergency response. Training is also necessary to refresh seldom used skills and update standards, protocol and procedures. With the field of disaster response constantly evolving, staying abreast of current practices is essential.

A regular training schedule is advisable. Set up training times on the same day and time each week or month, and publishing the schedule as far in advance as possible. Advance scheduling allows volunteers to plan accordingly. A published schedule also increases opportunities to include other response agencies when appropriate.

A variety of training methods should be used to maintain interest. Many emergency management training programs use self study as the primary delivery method and they are a great bonus for volunteers and responders with other demands on their time. Some courses, such as FEMA Independent Study, work well in a group setting, may include video or other job aids, and offer another way to increase participation and interest. Training scheduled in advance of a field exercise or that include practical hands on demonstrations, video or online content offer benefits as well.

⁷⁶ National Leadership Forum on Disaster Volunteerism, *Preventing a Disaster within the Disaster: The Effective Use and Management of Unaffiliated Volunteers* (Washington, D.C.: Points of Light Foundation & Volunteer Center National Network, 2002). Document on-line; available from <http://www.pointsoflight.org/disaster/disaster.cfm>. [Accessed 12/05].

Recognize volunteer participation and dedication to the MRC program. Set training and attendance goals and acknowledge those who have reached them even if it is just with a phone call or card. A pat on the back to signify their worth and value to an organization, and appreciation for completing a task is a very strong incentive for most volunteers to participate in the future. This is true for all volunteers, regardless of the organization they are affiliated with.

VI. CONCLUSION

The sheer size and complexity of our society make it impossible for any single individual, agency, organization or community to shoulder the burden for future catastrophic events. When catastrophic events occur, our nation's healthcare system will depend upon the availability of trained and prepared medical care providers and support personnel to meet the demands on the system. Protecting the public health infrastructure is a national priority, but our hospitals, public health and other medical facilities are neither designed nor staffed to meet surge capacity. In addition, the healthcare system itself is experiencing crisis level shortages in personnel. The value of a trained cadre of medical volunteers ready to assist becomes abundantly clear. The MRC must prepare for this important mission.⁷⁷

The very nature of the disaster life cycle is complex, requiring an intense coordinated effort at every stage of the process and at all levels. Volunteers are important and an invaluable resource but unless they are organized and trained for the mission they can actually become a part of the problem. The MRC must be able to function safely, effectively, and efficiently in this environment yet remain flexible and responsive to community needs. There are hazards that pose risks, complicated communications processes, command and control challenges, infinite resources to manage, and as many people and agencies to interact with. Fortunately, there are common recognized systems and mechanisms in place to manage them, and training resources available so the emergency worker can respond to them appropriately. A lot of this may seem common sense and is second nature to veteran emergency responders, but it is not as familiar to public health and medical workers.

This thesis has attempted to synthesize common practices in emergency management with competency recommendations, MRC training surveys, lessons learned and current training resources into a standard training content that is useful and practical. The content areas are ICS/NIMS, health and safety, personal preparedness, disaster

⁷⁷ Thomas A. Glass and Monica Schoch-Spana, "Bioterrorism and the People: How to Vaccinate a City Against Panic," *Clinical Infectious Diseases* 34 (2002): 220.; Health Resources and Services Administration, "Public Health Workforce Study," (Washington: HRSA, 2005). Document on-line; available from <http://bhpr.hrsa.gov/healthworkforce/reports/publichealth/default.htm>. [Accessed 7/06].

basics, communications, roles and responsibility, and policy and procedure. Regardless of individual role or mission of the MRC they should be a pre-requisite to any activation or deployment.

The TXSG and its medical corps play an active role in their state homeland security and community preparedness activities. They have faced challenges similar to other MRCs such as limited time and resources, and they have a diverse, scattered volunteer base. However they have been able to set standards and start building a consistent training program. Their training practices and policies provide a smart practice model for comparison.

There are a variety of emergency preparedness training materials available but there is no single source that can offer the entire curriculum. MRC coordinators must be cognizant of the fact that not all training is alike and some may conflict with standard practices. The ARC, FEMA, NFA and CDC are the most well known and reliable resources for preparedness training materials and the majority of them are offered at no cost. They also offer flexible options for training delivery including independent study, online and classroom.

The MRC must be able to integrate into the disaster environment while working safely, effectively and efficiently. Standards will set the mark for success, enabling the MRC to respond in a coordinated manner and at a consistently higher level to any health emergency. Implementing a standard training policy will present challenges to the leader and those issues must be addressed during the planning process: a) evaluation and performance methods are needed to set goals and measure success, b) managing, coordinating and conducting training requires resources, c) volunteers must be motivated to participate in training, and d) training for the public health support mission must not supplant community need; engaging partners and stakeholders in their efforts and building relationships with partner agencies is critical to the success of the program and acceptance of the MRC.

The MRC faced its first real test during the 2005 hurricane season with a tremendous nationwide response. For such a young organization this was a worthy accomplishment. Its efforts to recruit and credential medical volunteers are progressing

well, and with the new focus on public health preparedness their value in augmenting those efforts is recognized. To strengthen the MRC and to fully realize its potential as a disaster response partner, it must increase its readiness to respond and integrate into an established system. This can be accomplished by establishing a standard training program that is meaningful, achievable and sustainable for all.

THIS PAGE INTENTIONALLY LEFT BLANK

APPENDIX A: SUGGESTED TRAINING RESOURCES BY CONTENT AREA

The resources here represent the most commonly accessed and readily available sources for basic disaster and emergency preparedness training. This list is not exhaustive; MRC volunteers and coordinators are encouraged to seek out other resources and pursue training opportunities that are offered through their state and local emergency management offices, public health departments and first responder organizations. Some content areas do not have formal course listings associated but provide a resource listing for more information. Content area responsibility is specific to the local MRC unit in many instances and is not included here.

CONTENT AREA I: ICS and NIMS

Federal Emergency Management Agency- Emergency Management Institute

Website: <http://www.training.fema.gov/emiweb/IS>

Course(s): IS 100 An Introduction to Incident Command System

IS 195 Basic Incident Command System

IS 700 National Incident Management System, (NIMS), An
Introduction

CONTENT AREA II: Personal and Family Preparedness

American Red Cross

Website: <http://www.redcross.org>

Resources(s): Community Disaster Education, Health and Safety courses

Federal Emergency Management Agency- Emergency Management Institute

Website: <http://www.training.fema.gov/emiweb/IS>

Course(s): IS 22 Are You Ready? An In-depth Guide to Citizen Preparedness

CONTENT AREA III: Health and Safety

American Red Cross

Website: <http://www.redcross.org> (or the local Red Cross office)

Course(s): Community First Aid
 Standard First Aid
 CPR (Adult, Child and Infant)
 CPR for the Professional Rescuer
 Emergency Response
 Preventing Disease Transmission

American Heart Association

Website: <http://www.americanheart.org>

Substance Abuse and Mental Health Services Administration

Website: <http://www.samhsa.gov>

CONTENT AREA IV: Communications

Federal Emergency Management Agency- Emergency Management Institute

Website: <http://www.training.fema.gov/emiweb/IS>

Course(s): IS 242 Effective Communications

CONTENT AREA V: Roles and Responsibilities

Federal Emergency Management Agency- Emergency Management Institute

Website: <http://www.training.fema.gov/emiweb/IS>

Course(s): IS 288 The Role of Voluntary Agencies in Emergency
 Management

CONTENT AREA VI: Disaster Basics

FEMA- EMI

Website: <http://www.training.fema.gov/emiweb/IS>

Course(s): IS 292 Disaster Basics

IS 800 The National Response Plan, An Introduction

IS 208 State Disaster Management

THIS PAGE INTENTIONALLY LEFT BLANK

APPENDIX B: CONTENT AREA SUMMARY

- Content Area I: Incident Command System and National Incident Management System (Required for all regular response personnel)
- Chain of command
 - System structure and functions
 - Terminology
- Content Area II: Personal Preparedness
- Preparing for deployment
 - Family disaster plan
 - Family disaster kit
- Content Area III: Health and Safety
- First Aid and CPR
 - Hazard and situational awareness
 - Personal protective equipment
 - Disaster mental health
- Content Area IV: Communications
- Internal:
 - External: Media and public
- Content Area V: Role and Responsibility
- National, state and local MRC mission
 - Scope of practice including expectations and limitations
 - Medical and support staff functional roles in disaster
- Content Area VI: Disaster Basics
- The emergency management cycle
 - Introduction to the local emergency management plan
 - Introduction to local response partners including local health authority, emergency management, fire, EMS, law enforcement and other volunteer and community response partners
 - Introduction to federal and state partners including state emergency management and homeland security, FEMA, DHS, DHHS and national VOADs (ARC, Salvation Army, etc)
- Content Area VII: Unit Policy and Procedures
- Attendance
 - Licensing and certification
 - Training
 - Deployment process
 - Reporting
 - Dress code

THIS PAGE INTENTIONALLY LEFT BLANK

APPENDIX C: MEMS STUDENT HANDBOOK

State Guard Association of the United States

Military Emergency Management Specialist Academy

Qualification Standards and Procedures

Student Handbook

Revision of September 11th, 2006

The credit belongs to the person who is actually in the arena; whose face is marred by dust and sweat and blood; who strives valiantly; who errs and comes up short again and again; who knows the great enthusiasms; the great devotions, and spends himself in a worth cause; who, at the best, knows in the end the triumph of high achievement; and who, at worst, if he fails, at least fails while daring greatly, so that his place shall never be with those cold and timid souls who know neither victory nor defeat.

— Teddy Roosevelt

S.G.A.U.S.

MEMS Academy

P.O. Box 1416

Fayetteville, GA 30214

www.sgaus.org

I. Welcome Remarks from the MEMS Academy Commandant

Welcome to the SGAUS MEMS Academy!

1. Congratulations - you have taken the first important step and are on the way to earn your qualification as a Military Emergency Management Specialist and earn the coveted MEMS Skills Badge! The MEMS Academy gives you the unique opportunity to earn the nation's only military emergency management specialist qualification.

2. The Academy qualification program fully complies with the Department of Homeland Security NIMS (HSPD-5), NRP and ICS requirements for emergency management personnel. However, your qualification process is way above and beyond and far exceeds this basic requirement!

3. The qualification process is not easy, will take time to complete, takes effort and perseverance, and will certainly challenge you! Most of the course work can be completed online, but a heavy emphasis is placed on actual experiential and practical field training. This means that you will be required to actually get your “boots dirty.”

4. This handbook is intended to help you through the process of obtaining your MEMS qualification and working with your MEMS Academy proctor. Again, I welcome you to the MEMS Academy and wish you all the best in your qualification process.

Yours in Service,

/s/

LTC (WA) GEORGE H. HEART, C.H.S.

Commandant

SGAUS MEMS Academy

II. Mission Statement

To promote and advance military emergency management skills among members of the U.S. Armed Forces, the various State Guards, and other approved military and civilian organizations, the State Guard Association of the United States (SGAUS) Board of Directors has instituted the Military Emergency Management Specialist Academy (MEMS Academy). SGAUS members may earn, through intensive training and testing, qualification as a Military Emergency Management Specialist (MEMS) and receive credentials issued through SGAUS and the MEMS Academy.

III. General Information on the MEMS Academy

1. Across the country, members of the U.S. Armed Forces and State Guards are increasingly being mobilized to respond to natural and man-made disasters. Military and civilian authorities now see an urgent need to provide additional and improved emergency management training for personnel deploying into disaster areas.

2. In response to these challenges, SGAUS developed a specialized Military Emergency Management qualification program for the U.S. Armed Forces and State Guards. The program specifically prepares military personnel to effectively operate and function in local- or state-wide military Emergency Management mobilizations.

3. The MEMS Academy offers qualification as a Basic, Senior and Master Military Emergency Management Specialist and confers the appropriate insignia.

4. Individuals with MEMS qualification will have the knowledge, skills and abilities to effectively work in and manage a comprehensive emergency management program and will have operational knowledge of all the basic tenets of emergency management, including mitigation, preparedness, emergency response and recovery.

5. Academy graduates will also get the added benefit to be able to network with other Academy graduates and emergency management and homeland security professionals across the nation.

6. Most courses can be completed online through an agreement with the State of Washington's Homeland Security Institute or otherwise through FEMA's Emergency Management Institute.

7. Since the program's inception in 1998, hundreds of professionals from the various U.S. military branches, state guards and other military and civilian organizations have earned the MEMS qualification!

8. The program was originally developed by SGAUS for members of the various State Guards (the state reserve components of the National Guards - also known as State Defense Forces and State Military Reserves) and now has been expanded to include all members of the U.S. Armed Forces and other approved military and civilian organizations.

9. MEMS Academy Qualification Programs and Standards:

a. Basic Program: Upon completing the Basic program, students will have a fundamental understanding of emergency management principles and be able to function in a federal, state or local Emergency Operations Center (EOC).

b. Senior Program: After completing the Senior program, students will be able to work under the National Incident Management System (NIMS) - Homeland Security Presidential Directive (HSPD-5), National Response Plan (NRP) and national Incident Command System (ICS). Students will also have completed special emergency response to terrorism courses and gained added advanced leadership practice working in a federal, state or local EOC or Joint Operations Center (JOC).

c. Master Program: The Master MEMS qualification is the "capstone" program of the MEMS Academy. Students will have completed advanced emergency management practical assignments, various Train-the-Trainer certifications and related advanced training programs. Students will also have attended a comprehensive MEMS Academy resident capstone exercise and actually taught several Emergency Management courses.

d. MEMS Flash: MEMS badge recipients who actually deploy into disaster areas can qualify for award of the MEMS flash.

10. All uniformed and civilian members of the U.S. Armed Forces, including the various State Guards, and other SGAUS approved military and civilian organizations are eligible to receive MEMS qualifications. Civilian organizations generally include law

enforcement agencies, emergency management divisions, fire departments, and other homeland security focused governmental organizations.

11. Potential students must be or become members of SGAUS to enroll in the MEMS qualification program.

12. The MEMS qualification program is offered free of charge to all SGAUS members. However, some resident Emergency Management courses may incur applicable expenses and fees. Academy student are responsible to pay these expenses. The MEMS Academy may in the future have funding available for students to cover these costs

IV. Basic MEMS Qualification

1. Requirement Synopsis:

1. Be a member in good standing with SGAUS, complete the online application and connect with the appropriate Academy proctor.

2. Complete Basic MEMS Course Curriculum.

3. Complete Basic MEMS Practicum.

4. Complete Basic MEMS Narrative.

5. Complete “graduation interview” with the appropriate Academy proctor.

6. Learning objectives:

a. Know NIMS, NRP, and ICS.

b. Introduction to Disasters and EOC.

c. Practical experience in an EOC and emergency management exercises.

2. All military and civilian members in good standing with SGAUS may enroll in the Basic MEMS qualification program.

3. Complete the online application and connect with a local Academy proctor. A listing of all Academy staff is found in the Appendix of the Student Handbook.

4. Complete the Basic MEMS Course Curriculum from Federal Emergency Management Agency (FEMA) Emergency Management Institute (EMI) Independent Study Program (ISP) course offerings. You can access courses at <http://training.fema.gov/EMIWeb/IS/>

a. You may also take most of the courses online through an agreement with the State of Washington's Homeland Security Institute (HSI). Go to www.hsi.wa.gov to enroll in the courses. There is no cost to take these courses.

b. You can either complete the courses online or in a classroom group setting (preferred). Talk to your Academy proctor about how to complete the courses in a classroom setting.

5. At a minimum, complete the following online (classroom preferred) EMI ISP courses (Basic MEMS Course Curriculum):

- a. IS100 Introduction to Incident Command System
- b. IS200 Basic Incident Command System
- c. IS275 Emergency Operations Center
- d. IS292 Disaster Basics
- e. IS700 National Incident Management System (NIMS)
- f. IS800 National Response Plan* (NRP)

* IS800 NRP specifically mentions State Guards/SDFs

6. If a required EMI ISP or classroom course is not available, another course may be substituted with the same Continuing Education Unit (CEU) credits, when approved by an Academy State Director. As DHS/FEMA qualification/certification requirements change, courses may be substituted (with MEMS academy approval) to complete the Basic MEMS qualification requirements.

7. Applicants must submit official FEMA EMI ISP or HIS transcripts to the Academy proctor showing completion of the Basic MEMS Course Curriculum.

8. Complete a Basic MEMS Practicum. Before enrolling in the Basic MEMS Practicum, you must receive approval from your Academy proctor and military commanding officer (CO)/agency supervisor. If you do not have a military CO or agency supervisor, contact your Academy proctor for guidance.

a. Complete a Basic MEMS Qualification and Training Exercise offered through or sponsored by the MEMS Academy.

or

b. Complete a practical assignment with a federal, state or local Emergency Operations Center (EOC) or other emergency management agency.

and

c. Complete an emergency management classroom training program with a state or federal emergency management agency, state or federal military school or other applicable educational institution.

9. Complete a detailed Basic Narrative on the practicum option selected. Cover the following points in the Basic Narrative:

a. The title of your Basic Narrative.

b. Agencies names and addresses where you completed your Basic Practicum.

c. Contact name and title of agency POCs.

d. Rank, name, and contact information, including email, of your military CO/agency supervisor who approved this practicum.

e. How long did the practicum take?

f. Explain what you actually did and accomplished (detailed description).

g. How will the training and experiences of this practicum assist you in any future emergency management activation with your unit/organization?

- h. How will you use the MEMS qualification in your military/agency career?
 - i. What steps will you take to complete the Senior and Master MEMS Qualifications?
 - j. How will you let others know about the MEMS program?
 - k. What kind of suggestions and recommendations do you have for us to improve our programs?
 - l. Attach copies of all your class notes and any course curricula from the training.
 - m. Attach copies of any AARs you completed, orders you received and other relevant paperwork.
10. Once you have completed all of the assignments and submitted them, you will have a "graduation interview" debrief with your Academy proctor. Your Academy proctor will advise you once you have completed all the requirements and will send you a conditional statement of qualification via email.
11. Keep a personal file of all the work and training certificates you received completing your Basic MEMS qualification. To protect the student's privacy, the MEMS Academy does not maintain detailed files on its students. The MEMS Academy permanently records the student's name, rank, military/agency affiliation, contact information, date and level of MEMS qualification on official MEMS Academy completion rosters.
12. Upon acceptance and completion of training, the graduate is presented with a graduation certificate. Your name will be added to the official MEMS Academy Qualification Roster. See Section X. for more information about the MEMS Skills Badge.

V. Senior MEMS Qualification

1. Requirement Synopsis:

1. Be a member in good standing with SGAUS, complete online application and connect with the appropriate Academy proctor.
 2. Complete Senior MEMS Course Curriculum.
 3. Complete Senior MEMS Practicum.
 4. Complete Senior MEMS Narrative.
 5. Complete “graduation interview” with the appropriate Academy proctor.
 6. Learning objectives:
 - a. Know advanced ICS and Professional Leadership.
 - b. Introduction to Terrorism and WMD.
 - c. Practical experience in an EOC and emergency management exercises.
2. Before you can apply for the Senior MEMS Badge, you must have maintained Basic MEMS qualification for at least 90 days.
3. The Senior MEMS level qualification is open to any SGAUS member who is also a member of the U.S. Armed Forces, State Guards or other MEMS Academy approved military or civilian organizations. Contact your Academy proctor for qualification guidelines.
4. Complete the online application and connect with a local Academy proctor. A listing of all Academy staff is found in the Appendix of the Student Handbook.
5. Complete the Senior MEMS Course Curriculum. This includes the Federal Emergency Management Agency (FEMA) Emergency Management Institute (EMI) Independent Study Program (ISP) Professional Development Series (PDS). You can access the courses at <http://training.fema.gov/EMIWeb/IS/> There is no cost to take these courses. You can either complete the courses online or in a classroom group setting (preferred). Talk to your Academy proctor about how to complete the courses in a classroom setting.

6. At a minimum, complete the following online (classroom preferred) EMI ISP Professional Development Series (PDS) courses (Senior MEMS Course Curriculum):
 - a. IS139 Exercise Design (This course should be completed in a classroom setting!)
 - b. IS230 Principles of Emergency Management
 - c. IS235 Emergency Planning
 - d. IS240 Leadership and Influence
 - e. IS241 Decision Making and Problem Solving
 - f. IS242 Effective Communication
 - g. IS244 Developing and Managing Volunteers
7. In addition, the following Emergency Management classroom courses needs to be completed (Senior MEMS Course Curriculum):
 - a. G300 Intermediate Incident Command System (ICS 300)
 - b. G400 Advanced Incident Command System (ICS 400)
8. If the G300 or G400 courses are not available in your area, Academy proctor authorized substitute classroom courses may be temporarily completed in lieu of the G300 and G400 courses.
 - a. The G300 and G400 courses, or exact equivalent, must be completed prior to enrolling in the Master MEMS qualification program. The "G" designated courses are State sponsored/taught and a State Emergency Management Agency or another State sponsored Homeland Security Agency usually maintains a roster of certified instructors for these courses. Contact your MEMS Academy proctor for more information.
 - b. Students will be required to furnish official course certificates of completion.

9. If a required EMI ISP or classroom course is not available, another course may be substituted with the same Continuing Education Unit (CEU) credit when approved by an Academy State Director.

a. As DHS/FEMA qualification/certification requirements change, courses may be substituted (with MEMS academy approval) to complete the Senior MEMS qualification requirements.

b. Note: Students, who have completed the Basic and Senior qualification prior to the introduction of the IS100, IS200, IS700, and IS800 requirements, must complete these prerequisites prior to advancing to the Senior and Master levels, respectively to be in compliance with Homeland Security Presidential Directive (HSPD-5).

10. Applicants must submit an official FEMA EMI ISP transcript (not the Student Record) and an EMI ISP PDS completion certificate to the Academy proctor.

11. In addition, complete the following two online courses:

a. U.S. Fire Academy (USFA) "Emergency Response to Terrorism" (Q 534) course. This course is available online at www.usfa.fema.gov/training/nfa/independent/ There is no cost to take this course. Students must furnish an official certificate of completion for this course.

b. State of Washington Homeland Security Institute (HSI) "Weapons of Mass Destruction Awareness" (AWR-160) course. This course is available online at www.hsi.wa.gov There is no cost to take this course. Students must furnish an official certificate of completion for this course.

12. Complete a Senior MEMS Practicum. Before enrolling in the Senior MEMS Practicum, you must receive approval from your Academy proctor and military commanding officer (CO)/agency supervisor. If you do not have a military CO or agency supervisor, contact your Academy proctor for guidance.

a. Complete a Senior MEMS Qualification and Training Exercise offered through or sponsored by the MEMS Academy.

or

b. Complete an advanced practical assignment with a federal, state or local Emergency Operations Center (EOC) or other emergency management agency.

and

c. Complete an advanced emergency management classroom training program with a state or federal emergency management agency, state or federal military school or other applicable educational institution.

13. Equivalent experience in an actual Emergency Management activation or mobilization may be partially substituted (up to 50%) on a case-by-case basis for the practicum.

a. This activation or mobilization must have occurred within 12 months of applying for MEMS qualification.

b. Students must submit applicable detailed After Action Reports and an additional detailed narrative of your experiences during the mobilization addressing how the MEMS qualification has prepared you for this particular emergency management deployment.

14. Complete a detailed Senior Narrative on the practicum option selected. Cover the following points in the Senior Narrative:

a. The title of your Senior Narrative.

b. Agencies names and addresses where you completed your Senior Practicum.

c. Contact name and title of agency POCs.

d. Rank, name, and contact information, including email, of your military CO/agency supervisor who approved this practicum.

e. How long did the practicum take?

f. Explain what you actually did and accomplished (detailed description).

- g. How will the training and experiences of this practicum assist you in any future emergency management activation with your unit/organization?
- h. How will you use the MEMS qualification in your military/agency career?
- i. What steps will you take to complete the Master MEMS Qualifications?
- j. How will you let others know about the MEMS program?
- k. What kind of suggestions and recommendations do you have for us to improve our programs?
- l. Attach copies of all your class notes and any course curricula from the training.
- m. Attach copies of any AARs you completed, orders you received and other relevant paperwork.

15. Once you have completed all of the assignments and submitted them, you will have a "graduation interview" debrief with your Academy proctor. Your Academy proctor will advise you once you have completed all the requirements and will send you a conditional statement of qualification via email.

16. Keep a personal file of all the work and training certificates you received completing your Basic MEMS qualification. To protect the student's privacy, the MEMS Academy does not maintain detailed files on its students. The MEMS Academy permanently records the student's name, rank, military/agency affiliation, contact information, date and level of MEMS qualification on official MEMS Academy completion rosters.

17. Upon acceptance and completion of training, the graduate is presented with a graduation certificate Your name will be added to the official MEMS Academy Qualification Roster. See Section X. for more information about the MEMS Skills Badge.

VI. Master MEMS Qualification

1. Requirement Synopsis:

1. Be a member in good standing with SGAUS, complete online application and connect with Academy proctor.

2. Complete Master MEMS Advanced Course Requirements.

3. Complete Master MEMS Teaching Project.

4. Complete Master MEMS Narrative.

5. Complete Master MEMS Capstone Exercise

6. Attend a Master MEMS Graduation.

7. Learning objectives:

a. Become TTT certified in several categories.

b. Teach emergency management courses.

c. Advanced practical experience in an EOC.

d. Complete capstone emergency management exercise.

2. The Master MEMS qualification is the “capstone” program of the MEMS Academy. You must have maintained Senior MEMS qualification for at least 12 months before applying for Master qualification.

3. The Master MEMS level qualification is open to any SGAUS member who is also a member of the U.S. Armed Forces, State Guards or other MEMS Academy approved military or civilian organizations. Contact your Academy proctor for qualification guidelines.

4. Complete the online application and connect with a local Academy proctor. A listing of all Academy staff is found in the Appendix of the Student Handbook.

5. Select and complete advanced emergency management classroom training on a local or national level. Before enrolling in any advanced emergency management

training, student must receive approval from his/her Academy proctor and military CO/agency supervisor.

a. You may fulfill this requirement by being, or having recently become “Community Emergency Response Team” (CERT) certified through FEMA or equivalent emergency management program.

c. Applicants must furnish official training transcripts or letters of completion on all training completed.

d. Applicants must complete a detailed narrative on the training received. This narrative must address the following points: How the training will assist in any future emergency management mobilization and how the particular certification will augment with the MEMS qualification.

e. Students may have to complete additional EMI ISP online course depending on other courses previously taken. Contact your academy proctor for guidance. Students are encouraged to complete the remainder of all online EMI ISP courses available.

6. Complete a Master MEMS Teaching Project by teaching at least two basic Emergency Management courses. Before teaching any emergency management training courses, student must receive approval from his/her Academy proctor and military CO/agency supervisor.

a. Equivalent experience in an actual EM activation or mobilization can be partially substituted (up to 50%) for the teaching project on a case-by-case basis.

b. This activation or mobilization can have been accomplished within 12 months of applying for MEMS qualification.

c. Students must submit applicable detailed After Action Reports and an additional detailed narrative of your experiences during the mobilization addressing how the MEMS qualification has prepared you for this particular emergency management deployment.

7. Completing a Train-the-Trainer (TTT) certification program in NIMS, NRP, ICS, CERT or equivalent emergency management TTT program will also satisfy the Master MEMS Teaching Project.

8. Complete a detailed Master Narrative on the advanced training and teaching projects completed. The following points need to be covered in the Master Narrative:

- a. The title of your Master Narrative.
- b. Agencies names and address where you completed your training and teaching
- c. Contact name and title of applicable agency POCs and contact information.
- d. Rank, name, and contact information, including email, of your military CO/agency supervisor who approved the training and teaching projects.
- e. Explain what you actually did and accomplished (detailed description).
- f. How will the training and experiences of these assignments assist you in any future emergency management activation with your unit/organization?
- g. How will you use the MEMS qualification in your military career?
- h. What other Emergency Management training are you looking to complete in the future?
- i. How will you let others know about the MEMS program?
- j. What kind of suggestions and recommendations do you have for us to improve our programs?
- k. Attach copies of any AARs you completed, copies of all your class notes, copies of course curricula you wrote or obtained, orders you received, and other relevant paperwork.

9. Attend a resident Master MEMS Capstone Exercise offered through or sponsored by the MEMS Academy, usually held in conjunction with the annual SGAUS national convention. Contact your Academy proctor for more information.

10. Keep a personal file of all the work and training certificates you received completing your Basic MEMS qualification. To protect the student's privacy, the MEMS Academy does not maintain detailed files on its students. The MEMS Academy permanently records the student's name, rank, military/agency affiliation, contact information, date and level of MEMS qualification on official MEMS Academy completion rosters.

11. Upon acceptance and completion of the Master MEMS training, the graduate is highly encouraged to attend a MEMS Academy graduation exercise and awards ceremony at an annual SGAUS convention to be properly recognized for his/her achievements. Besides being presented with the Master MEMS graduation certificate and the Master MEMS Badge, the graduate will also receive the SGAUS Achievement Award (Ribbon) for completing all three modules of the MEMS qualification program. See Section X. for more information.

VII. MEMS Flash

1. Individuals who have earned at a minimum the Basic MEMS Qualification may also earn the MEMS Flash. The MEMS Flash denotes actual emergency management activation and mobilization in response to a state or local disaster or man made emergency.

2. To apply for the MEMS Flash, applicant shall contact the appropriate Academy State Director and submit appropriate documentation that records the recent emergency management activation. Documents include:

- a. Copies of competent military orders
- b. After Action Reports
- c. Other military papers, documenting such service.
- d. Newspaper and magazine articles/stories.

3. Applicant shall also complete a detailed narrative documenting his/her involvement in the activation and highlighting how the MEMS qualification helped him/her in the activation process.

4. Applicant shall also forward two (2) formal letters from military and/or governmental authorities attesting to the fact that the applicant actually served in an emergency management activation and mobilization.

5. Upon recommendation of the Academy Regional Director, the applicant will receive a certificate of award of the MEMS Flash. Your name will be added to the official MEMS Academy Qualification Roster as a MEMS Flash recipient. See Section X. for more information about the MEMS Flash.

VIII. College and Continuing Education Credit

1. Many FEMA, EMI and USFA online courses will qualify for college and Continuing Education Unit (CEU) credit. Various Emergency Management classroom courses may also qualify for credits. Contact either FEMA for more information at <http://www.training.fema.gov/emiweb/is/crslist.asp> or talk to your Academy proctor.

2. The MEMS Academy, in a cooperative agreement with Towson University in Baltimore, Maryland, may also grant college credit for the experiential practicum portions of the MEMS qualification process and other relevant classroom and academic work. Contact the Towson University Liaison for more information.

3. You may also check with your local community college if they offer college credit for EMI ISP courses. Contact your Academy State Director for more information.

IX. Waivers

1. Partial academic, time and practicum waivers may be considered from individuals with advanced professional training (e.g. Bachelor's Degree in Emergency Management) and work experience (e.g. Emergency Manager, past disaster response mobilization, etc) in emergency management for the Basic and Senior MEMS qualification. Waivers are not available for the Master MEMS qualification and are only

available to SGAUS members who are also members of the U.S. Armed Forces, State Guards or other MEMS Academy approved military or civilian organizations.

2. MEMS Academy State or Regional Directors, as applicable, approve or disapprove waiver requests. Denials cannot be appealed. Before applying for a waiver, students must connect with their Academy proctor and discuss the waiver option and if they qualify for a waiver.

a. If approved to proceed, students must write a formal letter to their Academy proctor requesting such waiver with full documentation attached.

b. Students who are cleared for a partial waiver must submit a detailed narrative on the subject matter waived, and how their advanced training and/or work experience covers and meets or exceeds these partial MEMS qualification requirements.

c. Waivers are not guaranteed, will be granted on a case-by-case basis and are only offered once per a student's request.

X. MEMS Skills Badges and Patches

1. The Military Emergency Management Specialist Skills Badge depicts the historic United States "Civil Defense" eagle of World War II rampant on a bound laurel wreath, signifying the ancient symbol for "victory."

2. The MEMS Skills badge is authorized in a Basic, Senior and Master version. The Senior MEMS Skills Badge has a five pointed star added to the top of the eagle. The Master MEMS Skills Badge has a five pointed star in a circular laurel wreath added to the top of the eagle.

3. The Basic, Senior and Maser MEMS skill badges are authorized in full and miniature silver high gloss polished metal finish, full size subdued black metal finish and as full size subdued black or white on OD green sew-on patches. MEMS skill badges are generally worn centered above or below military ribbons on the left side of military dress type uniform shirts or jackets. On combat type uniform shirts, the badge is worn on the left chest - either centered above the branch name tape or below on a pocket flap.

4. The MEMS Flash patch has a light blue background with a gray border, denoting the colors of the State Guard Association of the United States. The MEMS badge is centered on the flash and generally only worn on dress uniforms.

5. Official wear of all MEMS skill badges and patches is solely dependent on military or organizational authority and not SGAUS or the MEMS Academy! Please consult your military authority on official wearing guidelines.

6. For more information and places where to procure MEMS badges and patches, contact your Academy State Director or Academy Instructor.

7. Note: All SGUAS and/or MEMS Academy proprietary artwork and designs used as and in the various symbols, patches, badges, emblems, and insignias, altered or not, are proprietary to SGAUS and the MEMS Academy and may not be reproduced, used, manufactured or otherwise copied, duplicated, replicated and otherwise disseminated, distributed or circulated without the express authorization of the SGAUS Board of Directors and/or the MEMS Academy Executive Council. Violation of these regulations and policies are prosecutable by state and federal criminal and civil law!

XI. Suggestions for Practicum Assignments

1. The following is a partial list of agencies you can contact for practicum and/or training purposes:

1. Local emergency managers.
2. Local Fire and/or Police Departments – in many rural areas, emergency management falls to the police or fire departments.
3. County emergency managers.
4. County Sheriff or metropolitan police department – some states mandate the sheriff is responsible for emergency management.
5. State office of emergency management.
6. Large corporations – many large corporations have their own emergency management programs and officials.

7. FEMA regional headquarters – contact information is available on www.fema.gov

8. American Red Cross.

9. Your state Military Department.

10. Your State Guard.

11. Contact your Academy proctor for more suggestions...

2. The following is a partial list of practical assignment suggestions you may want to consider for your practicum:

1. Community Emergency Response Team (CERT) disaster exercises.

2. Department of Homeland Security disaster drills.

3. Federal Emergency Management Agency (FEMA) disaster drills.

4. State or Local Office of Emergency Preparedness (OEP) disaster exercises.

5. Fire Department disaster exercises.

6. Local Hospital disaster exercise.

7. Accredited University Level disaster or emergency exercises.

8. Participation in a civilian or military emergency management training exercises.

9. Multi Agency Exercise involving EOC or Incident Management Teams.

10. Participation at an EOC at a major planned event, i.e. major festival, concert, etc.

11. Contact your Academy proctor for more suggestions...

3. The following is a list of courses you may want to consider for your practicum and classroom training requirements:

1. City, county or state delivered resident emergency management courses.

2. FEMA/Emergency Management Institute classroom courses such as:

- a. B/E 132 – Exercise Design and Evaluation
- b. B/E 133 – Exercise Control/Simulation Program Management
- c. B/E 136 – Exercise Development
- d. E 900 Series – Integrated Emergency Management Curriculum
- e. E 388 – Advanced Public Information Officer
- f. E 449 – Incident Command System (ICS) Curricula Train-The-Trainer
- g. E 548 – COOP Program Manager Train-The-Trainer
- h. E 464 – Disaster Resistant Jobs’ Strategies for Community & Risk Management
- i. E 210 – Recovery from Disaster: The Local Government Role
- j. E 376 – State Public Assistance Operations
- k. R 317 – Command and General Staff Functions in ICS
- l. R 342 – Training Program Management
- m. R 810 – Leadership and Administration

4. There are other courses that may meet classroom course requirements. Contact your Academy proctor to determine if you have specific courses in mind. For additional listings of all state delivered emergency management courses, contact your state department of Emergency Management or go to:
www.training.fema.gov/emiweb/stcourses/nrcrs.asp.

5. For FEMA and EMI resident emergency management courses held at Emmetsburg, MD, contact FEMA directly or log on to their website.

XII. Student Information

1. **STUDENT CONDUCT:** Every student admitted to the MEMS qualification process is expected to treat Academy staff, fellow students, outside instructors and others with proper respect, dignity and military courtesy. Violations of this rule may cause the student to be dismissed from the MEMS Academy.

2. **STUDENT ETHICS:** Students will adhere to the highest standards of personal and military ethics while enrolled in the MEMS Academy. Any academic cheating, falsification, student dishonesty, and other type of deception will result in immediate dismissal from the Academy. If it is learned that a student received a MEMS qualification under deceitful or dishonest conditions, s/he may have his/her qualification revoked at any time by the Academy Commandant.

3. **STUDENT ISSUES:** Students that encounter problems or concerns with their academy studies and/or assignments are encouraged to resolve any issues informally with their academy proctor. If this approach does not lead to resolution, the student may informally contact the Academy State Director to explicate the issue(s). If this does not resolve the problem, the student may write a formal request to the Academy Regional Director to address his/her issue(s). If the Regional Director is also not able to resolve the issue, the matter will be forwarded to the MEMS Academy Deputy Commandant and, if necessary, to the Academy Commandant for resolution. The Academy Commandant's decision is final.

XIII. Legal Disclaimer

1. All MEMS Academy students and participants, by their mere involvement in the qualification program and process, fully understand and have reviewed the requirements of the MEMS Academy training and are fully familiar with the hazards, the potential for injury, illness or damage, and have either previously participated in comparable training programs, have read or had the opportunity to read materials describing it, and have otherwise evaluated the potential for injury and resulting damages and understand that participation in the program can be a strenuous event.

2. SGAUS and the MEMS Academy require as a condition of participating in the MEMS qualification process, that all students, in consideration of permission to enter this activity, do hereby for SGAUS and the MEMS Academy, its heirs, executors, administrators, personal representatives, assigns, and anyone entitled to act on SGAUS and the MEMS Academy behalf, irrevocably release and forever discharge SGAUS, the MEMS Academy, its agents, servants, and employees, sponsors, the owners of the property on which it conducts its training, its promoters, managers, instructors,

inspectors, officials, volunteers, and any and every other person participating in any way, from any and all claims for damages or injury or liability of any kind, illnesses alleged to result from the training or damages of any and every kind suffered, as a result of participating in or travel to or from training exercises or courses and students further agree to indemnify and hold harmless those released for costs, attorneys fees, or other expenses should the student or any person for or on the student's behalf file a legal action against the United States of America, the various States, territories or commonwealths, SGAUS, the MEMS Academy or anyone else involved in the MEMS Academy qualification program.

3. For more information contact the MEMS Academy JAG.

LIST OF REFERENCES

- Adjutant General's Department. *Texas State Guard Medical Reserve Corps*. Regulation 10-1, Appendix E. Austin: Adjutant General's Department, 2002.
- American Red Cross. *Standard First Aid and CPR: Update 2006*. Washington, D.C.: American Red Cross, 2006. Document online. Available from <http://www.redcross.org>. [Accessed 7/06].
- Bernsten, Christine. "Training Volunteers for Field Operations...Just in Time." Presentation in Training Volunteers: Medical Reserve Corps National Leadership Conference. Los Angeles, CA, 07-09 July 2004. Presentation on-line. Available from <http://www.medicalreservecorps.gov/2004Conference/HTML/Christine%20Bernsten.html>. [Accessed 04/06].
- Bush, George W. *Homeland Security Presidential Directive-8*. Washington, D.C.: Office of the Press Secretary, 2003. News release on-line. Available from <http://www.whitehouse.gov/news/releases/2003/12/20031217-6.html>. [Accessed 12/04].
- Butler, Adrienne S., Allison M. Panzer and Lewis R. Goldfrank. *Preparing for the Psychological Consequences of Terrorism: A Public Health Strategy*. Washington, D.C.: The National Academies Press, 2003.
- Carmona, VADM Richard H. "Prevention and Preparedness: Medical Reserve Corps Serving America." Presentation in Nashville Surgical Society Meeting. Nashville, TN, 7 October 2003. Presentation on-line. Available from <http://www.surgeongeneral.gov>. [Accessed 09/05].
- . *Surgeon General Priorities for Public Health Preparedness*. Washington, D.C.: Department of Health and Human Services, 2004. Website. Available from <http://www.surgeongeneral.gov>. [Accessed 5/05].
- Centers for Disease Control and Prevention. "First Reports of Health Effects of World Trade Center Rescue and Recovery Workers Find High Rates of Respiratory and Mental Health Problems." Atlanta: CDC, 2004. Document on-line. Available from <http://www.cdc.gov/od/oc/media/pressrel/r040909.htm>. [Accessed 4/06].
- Center for Public Health Preparedness and Disaster Response. "National Disaster Life Support." Chicago: American Medical Association, 2003. Document on-line. Available from <http://www.ama-assn.org/ama/pub/category/12606.html>. [Accessed 5/05].

- Center for Mental Health Services, Substance Abuse and Mental Health Services Administration. "Developing Cultural Competence in Disaster Mental Health Programs; Guiding Principles and Recommendations." SMA 3828. Washington, D.C.: DHHS, 2003. Document on-line. Available from <http://www.mentalhealth.samhsa.gov/disasterrelief/publications/allpubs/SMA03-3828>. [Accessed 3/06].
- Columbia University School of Nursing Center for Public Health Policy. *Bioterrorism and Emergency Readiness: Competencies for all Public Health Workers*. New York: Center for Public Health Policy, 2002.
- Cohen, Emily. "MRC Survey: Medical Reserve Corps Current Practices for Recruitment, Credentialing, Training and Screening." Presentation in Medical Reserve Corps Advisory Committee Working Group. Washington, D. C., 13-14 December 2005.
- . "Medical Reserve Corps (MRC)- Project in Brief." Presentation in Medical Reserve Corps Advisory Committee Working Group meeting. Washington, D.C., 13-14 December 2005.
- Cox, Cynthia A. "Texas Medical Rangers Issue Brief: Medical Intelligence." Katrina Regional Medical Operations Center. San Antonio, Texas: 2006.
- Dalitsch, Megan. "Preparing Volunteers Through Training: The Virginia Beach Experience." Presentation in Training Volunteers: Medical Reserve Corps National Leadership Conference. Los Angeles, CA. 07-09 July 2004. Presentation on-line. Available from <http://www.medicalreservecorps.gov/2004Conference/HTML>. [Accessed 07/05].
- Edwards, Claudia. "Medical Reserve Corps Demonstration Project: Broome County Health Department." Presentation in Training Volunteers: Medical Reserve Corps National Leadership Conference. Los Angeles, CA. 07-09 July 2004. Presentation on-line. Available from <http://www.medicalreservecorps.gov/2004Conference/HTML>. [Accessed 7/05].
- Federal Emergency Management Agency. *NIMS, NRP and ICS Training in FY06: Who Needs to Take the Courses?* Washington, D.C.: Federal Emergency Management Agency, 2006. Document on-line. Available from <http://www.training.fema.gov/emi>. [Accessed 2/05].
- Gerberding, Julie. "Health Protection in the Time of Terror: Clinicians, Connectivity and Communication." Presentation in: A Call to Action: The National Perspective, National Congress on Public Health Readiness. Washington, D.C., 20-22 July 2004. Presentation on-line. Available from <http://www.bt.cdc.gov/training/ncphr>. [Accessed 7/05].

- Glass, Thomas A., and Monica Schoch-Spana. "Bioterrorism and People:How to Vaccinate a City Against Panic." *Clinical Infectious Diseases* 34 (2002).
- Headquarters 4th Air Wing. "About the Texas State Guard." Austin :Adjutant Generals Department, 2002.
- Heart, George. *MEMS Student Handbook*. Nashville: State Guard Association of the United States, 2006. Document on-line. Available from <http://www.sgaus.org/MEMS> [Accessed 9/06].
- Health Resources and Services Administration. *Public Health Workforce Study*. Washington, D.C.: HRSA, 2005. Document on-line. Available from <http://bhpr.hrsa.gov/healthworkforce/reports/publichealth/default.htm>. [Accessed 7/06].
- Hearne, Shelley A., Laura M. Segal, Michael J. Earls, and Patti J. Unruh. *Ready or Not? Protecting the Public's Health in the Age of Bioterrorism*. Washington, D.C.:Trust for America's Health, 2004. Available from <http://healthyamericans.org>. [Accessed 07/06].
- Hoard, M. L., and R. J. Tosatto. "Medical Reserve Corps: Strengthening Public Health and Improving Preparedness." *Disaster Management and Response* 3, no.2 (2005).
- Hobson, Katherine. "Are We Ready?" *U.S. News and World Report*, January 5, 2006. USNews.com. Document on-line. Available from <http://www.usnews.com/health/articles/060501/1disaster.htm> [Accessed 8/06].
- Hsu, Edbert B., Tamara L. Thomas, Eric B. Bass, Dianne Whyne, Gabor d. Kelen, and Gary B. Green. "Healthcare Worker Competencies for Disaster Training." *BioMed Central* 6, no. 19. (2006). Document on-line. Available from <http://www.biomedcentral.com/1472-6920/6/19> [Accessed 4/06].
- Jackson, Brian, John C. Baker, M. Susan Ridgely, James T. Bartis, and Herbert I. Linn. *Protecting Emergency Responders: Safety Management in Disaster and Terrorism Response, Volume 3*. Santa Monica, CA: RAND Science and Technology, 2004. Document on-line. Available from http://www.rand.org/RAND_MG170 <http://www.rand.org>. [Accessed 3/06].
- Joint Commission Resources. "Disseminating Lessons Learned from a Terrorist Attack: Caring for Your Own." *Joint Commission Perspectives, Special*. Oakbrook Terrace, Il.: Joint Commission Resources, 2001.
- . "Disseminating Lessons Learned from a Terrorist Attack: Managing People and Resources Effectively." *Joint Commission Perspectives, Special*. Oakbrook Terrace, Il.: Joint Commission Resources, 2001.

- . "Disseminating Lessons Learned from a Terrorist Attack: Responding Effectively in the Midst of a Natural Emergency." *Joint Commission Perspectives, Special*. Oakbrook Terrace, IL: Joint Commission Resources, 2001.
- . "Disseminating Lessons Learned from a Terrorist Attack: Talking to each Other in a Crisis." *Joint Commission Perspectives, Special*. Oakbrook Terrace, IL: Joint Commission Resources, 2001.
- . "Disseminating Lessons Learned from a Terrorist Attack: The Power of Preparation." *Joint Commission Perspectives, Special*. Oakbrook Terrace, IL: Joint Commission Resources, 2001.
- Lister, Sarah H. "The Pandemic and all-Hazards Preparedness Act (S.3678): Provisions and Comparison with Current Law and Related Proposals." RL33589 Washington, D.C.: Library of Congress, 2006. Document on-line. Available from <http://crsdocuments.com> [8/06].
- Medical Reserve Corps Advisory Committee Working Group. *Core Competencies for the Medical Reserve Corps Volunteer*. Washington, D.C.: National Association of County and City Health Officials, 2006. Brochure on-line. Available from <http://www.naccho.org/topics/emergency/documents>. [Accessed 4/06].
- Medical Reserve Corps Technical Assistance Team. *Organizing an MRC Unit: Operational Components and the Coordinators Role. Technical Assistance Series 11*. Rockville: Medical Reserve Corps Program Office, 2004. Series on-line. Available from <http://www.medicalreservecorps.gov/resources>. [Accessed 7/05].
- . *Coordinating With Your Local Response Partners. Technical Assistance Series 22*. Rockville: Medical Reserve Corps Program Office, 2004. Series on-line. Available from <http://www.medicalreservecorps.gov/resources>. [Accessed 7/05].
- . *Developing Volunteer Relationships and Capabilities. Technical Assistance Series 33*. Rockville: Medical Reserve Corps Program Office, 2004. Series on-line. Available from <http://www.medicalreservecorps.gov/resources>. [Accessed 7/05].
- Medical Reserve Corps Program. *Medical Reserve Corps 2005 Hurricane Response Final Report*. Rockville, MD: Medical Reserve Corps, 2006. Document on-line. Available from <http://www.medicalreservecorps.gov/Hurricane/2005Report> [Accessed 04/06].
- . *Pandemic Influenza Planning Guidance for Medical Reserve Corps Units*. Rockville, MD: Medical Reserve Corps National Program Office, 2006. Document on-line. Available from <http://www.medicalreservecorps.gov/POUupdates/PandemicFluGuidance> [Accessed 8/06].

- _____. *Psychological First Aid Field Operations Guide for the MRC Volunteer*. Washington, D.C.: MRC, 2006. Document online. Available from <http://www.medicalreservecorps.gov>. [Accessed 8/06].
- Mt. Sinai Press Office. "Large Study of WTC Responders Finds Significant Health Problems in Many: 60% Still Respiratory Problems from Exposure to Environment at Site." New York: Mt. Sinai School of Medicine Press Office, 2006. Document on-line. Available from <http://www.fusion.mssm.edu/media/content.cfm> [Accessed 9/06].
- National Association of County and City Health Officials. "Assessment of Local Bioterrorism and Emergency Preparedness." *National Association of County and City Health Officials Research Brief 5*, October 2001. Document on-line. Available from <http://www.naccho.org/topics/emergency/documents> [Accessed 12/03].
- National Hurricane Survival Initiative. "New Mason Dixon Poll shows Coastal Residents Still Unprepared for Hurricane Season." The National Hurricane Survival Initiative, 2006. Document on-line. Available from <http://www.hurricanesafety.org/newpoll.html>. [Accessed 08/06].
- National Leadership Forum on Disaster Volunteerism. *Preventing a Disaster within the Disaster: The Effective use and Management of Unaffiliated Volunteers*. Washington, D.C.: Points of Light Foundation & Volunteer Center National Network, 2002. Document on-line. Available from <http://www.pointsoflight.org/disaster/disaster.cfm> [Accessed 12/05].
- Nonprofit Risk Management Center. *State Liability Laws for Charitable Organizations and Volunteers*. Washington, D.C.: Nonprofit Risk Management Center, 2004. Document on-line. Available from <http://www.sfcard.org/goodsamaritanlaws.pdf>. [Accessed 5/05].
- Office of Homeland Security. *National Strategy for Homeland Security: Protecting Critical Infrastructures and Key Assets*. Washington, D.C.: Office of Homeland Security, 2002.
- Occupational Safety and Health Administration. "Keeping Workers Safe During Clean Up and Recovery Operations." U. S. Department of Labor website. Fact Sheets online. Available from <http://www.osha.gov/> [Accessed 5/06].
- Parker, Cindy L., Daniel J. Barnett, Ayanna L. Fews, David Blodgett, and Jonathan M. Links. "The Road Map to Preparedness: A Competency Based Approach to all-Hazards Emergency Readiness Training for the Public Health Workforce." *Public Health Report*, no. 120 (Sep-Oct 2005).

- Reischl, T.M. and A.N. Buss. "Responsive evaluation of competency based public health preparedness training programs." Abstract from *JPMH*, November 2005. S100-5. Ann Arbor: University of Michigan Center for Public Health Preparedness, 2005.
- Spear, Terri H. "Competency Based Training for Bioterrorism and Other Public Health Emergencies: Helpful Resources." Hand-out from MRC Advisory Committee Working Group meeting, Washington, 13-14 December 2005.
- Thomas, Richard. "Maricopa Medical Reserve Corps: A Pharmacy Training Program." Presentation in Training Volunteers: Medical Reserve Corps National Leadership Conference. Los Angeles, CA. 07-09 July 2004. Presentation on-line. Available from <http://www.medicalreservecorps.gov/2004Conference/HTML>. [Accessed 07/05].
- Timboe, Harold L. "Principles and Challenges of Training." Presentation in Training Volunteers: Medical Reserve Corps: National Leadership Conference. Los Angeles, CA. 07-09 July 2004. Presentation on-line. Available from <http://www.medicalreservecorps.gov/2004Conference/HTML>. [Accessed 07/05].
- Trust for America's Health. *Ready or Not? Protecting the Public's Health from Diseases, Disaster and Bioterrorism*. Washington, D.C.: Trust for America's Health, 2005. Report on-line. Available from <http://healthyamericans.org/reports/bioterror05>. [Accessed 04/06].
- USNews.com. "Progress for Tomorrow: Preparing for the Next Disaster." *U.S. News and World Report*, 2006. Document on-line. Available from http://www.usnews.com/usnews/health/articles/060420/20summit_panel3.htm. [Accessed 4/06].
- U.S. Department of Health and Human Services. *Developing Cultural Competence in Disaster Mental Health Programs: Guiding Principles and Recommendations*. No. SMA 3828. Document online. Available from <http://www.mentalhealth.samhsa.gov/disasterrelief/publications/allpubs/SMA03-3828/www.mentalhealth.samhsa.gov> [Accessed 9/06].
- Young, Bruce H., Julian D. Ford, and Patricia J. Watson. "Disaster Response and Recovery Workers: A National Center for PTSD Fact Sheet." Washington, D.C.: U.S. Department of Veterans Affairs, n.d. Document on-line. Available from http://www.ncptsd.va.gov/facts/disasters/fs_rescue_workers.html. [Accessed 5/06].

INITIAL DISTRIBUTION LIST

1. Defense Technical Information Center
Ft. Belvoir, Virginia
2. Dudley Knox Library
Naval Postgraduate School
Monterey, California
3. LTC George Heart
State Guard Association of the United States
Fayetteville, Georgia
4. MG Marshall Scantlin
Texas Medical Rangers
San Antonio, Texas
5. MG Christopher Powers
Texas State Guard
Austin, Texas
6. CDR Rob Tosatto
Medical Reserve Corps Program Office
Rockville, Maryland