



# MRC of SOUTHWESTERN VERMONT NEWSLETTER

Volume 1 Issue 4

August 2008

## MRC Volunteers needed for Medical Triage and Treatment Tents

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The MRC will staff and operate medical triage and treatment tents for two community sporting events; The Hoosic River Ride on August 23rd and the Maple Leaf Marathon on September 6th.



Participants of these two events are at risk of dehydration, exhaustion, heat related emergencies and sports-related injuries. The MRC will provide shelter, minor medical care and stabilization.

One of the major objectives of the MRC is to be

able to deploy rapidly, set up and operate a mass care site in the event of a disaster. The medical tents will allow MRC members to

### Hoosic River Ride 2008

**(Bike race)  
Sat Aug 23rd**

**0800-1500  
&**

### Maple Leaf Marathon

**(13 mile run)  
Sat Sept 6th**

**0800-1300**

practice these procedures as well as become familiar with the equipment, supplies and protocols in a "non-stress" environment.

This is an excellent opportunity for the MRC to train for a Mass Medical event while helping a great community cause.

### MRC Roles Needed:

Members of every unit within the MRC can benefit from participating in these two events. We are in special need of Physician, Physician Assistants, RNs, EMS providers, clerical and general support personnel.

### To Register:

MRC Course Registration

[www.vtmrc.org](http://www.vtmrc.org)

Or

Email: [vtmrc@phin.org](mailto:vtmrc@phin.org)

## MRC at the BIG E

From September 12 to September 28th, the annual Big E fair will be in West Springfield, MA. Listed on their website are some pretty exciting events and concerts. Natasha Bedingfield will be performing Friday, September 12th at 8 pm, LeAnn Rimes on Friday, the 26th at 8 (this show is free), Sugarland on the 27th at 8pm and, Fergie will be performing on Sunday, the 28th.

Each day has a theme state; Vermont is September 20th and even though the fair is a month away, we are looking to recruit volunteers to man a booth. Admission is FREE when you do. There are three shifts (10a to 2p, 2p to 6p, 6p to 10p) in which we would like to have a least two people per shift. Kara Leonetti will be there from 10 a to 2p. Contact her at 447-5079 if interested. Visit [www.big.e.com](http://www.big.e.com)



### Medical Reserve Corps of Southwestern Vermont

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# MRC: Who we are...What we do...



Flu Clinic 2006



Basic Disaster Life Support Course



Basic Disaster Life Support Course



MCI Drill — Arlington, VT



Decon Hazmat Training



Advanced Burn Life Support Course

# Role of MRC in Community Disaster: Alternate Care Center

*Heavy winds, near-tornado weather, has hit Bennington and North Bennington; roofs at Hanaford and Price Chopper have collapsed. Rescue crews are digging people out of the rubble. Southwestern Vermont Medical Center was also hit with heavy winds; windows knocked out, power knocked out, the Emergency Dept destroyed. **Where are the sick and injured going to get emergency care in the community?***

Southwestern Vermont Medical Center (SVMC), like most hospitals in rural Vermont, is geographically isolated from other acute care facilities and lacks the resources and infrastructure found in more urban areas for managing large-scale disasters or public health incidents (i.e. pandemics). SVMC is the only acute care hospital within a 30-45 minute radius of Bennington capable of managing multiply ill or injured patients.

In the event of man-made or natural disasters which incapacitates the hospital (e.g. physical or structural damage to the facility) or which overwhelms the capacity of SVMC (e.g. exceeds surge capacity); the community would need an alternate location for the temporary provision of emergency medical treatment and stabilization of ill or injured patients.

Additionally, Bennington County has over twenty-five "special

needs" medical facilities (nursing homes, adult care/residential homes, mental health group homes, etc); not including a large population of home-bound, medically challenged patients. During a large-scale community disaster or public health incident a large number of residents from these facilities may be displaced. Many of these residents will seek care at the local hospital; further taxing an already overwhelmed system.

***The MRC would play a vital role in the establishment and operation of an Alternate Care Center (ACC).***

Southwestern Vermont Medical Center has been working collaboratively with the Vermont Department of Health (VDH), Vermont Emergency Management (VEM), Northern New England Metropolitan Medical Response (MMRS), the Local Emergency Planning Committee (LEPC) District VII, and the Medical Reserve Corps of Southwestern Vermont (MRC) to identify locations throughout the Bennington area which may be used as temporary sites to provide emergency medical care during disasters or large-scale public health emergencies. This task has been challenging for a rural community hospital with limited personnel and resources.

SVMC has contractual agreements with Grace Christian School (former Ramada Inn) and

Southern Vermont College for use of their facilities as Alternate Care Sites during disasters. Through a combination of MRC and Health Resources Services Administration (HRSA) grants, SVMC has acquired enough equipment, supplies and resources to manage a 100-bed Alternate Care Site; including specialty medical cots, trauma and medical supplies, personal protective equipment (PPE) and IV fluids.

The one thing we don't have enough of is human resources. During a disaster or major public health event, most, if not all, hospital staff will be committed. Who will operate the Alternate Care Site.

The MRC would play a vital role in the establishment and operation of an Alternate Care Center (ACC). Community medical professionals would be able to provide the immediate care and treatment of the less seriously ill or injured; allowing the hospitals to care for the more critically ill or injured.

The MRC will be using community-based Mass Gathering events (i.e Race for the Cure, Maple Leaf Marathon, etc.) as opportunities for MRC members to remain proficient in their MRC roles and to become more familiar with the equipment and resources needed during a disaster.

# Dr. Polifka's Journal: Medical Mission in Liberia

Monrovia, Liberia  
March, 2008

Our Project HOPE team of 12 was transported from Ghana to Liberia on the stealth-looking U.S. Navy ship, appropriately named the Swift (actually it's a modified inter-coastal ferry). The rusted, gutted, semi-sunken ship at the wharf in Monrovia that prevented us from docking was premonitory of the difference in the condition between the two countries.

The drive to the city from the dock area made it absolutely clear. The four lane thoroughfare was more pot hole than road and managed to fit seemingly three lanes of traffic in each direction, a large majority of which were aged yellow taxis. At each window a passenger hung out head and arm trying to get a bit of relief from the 95 degree heat. The snail's pace traffic allowed me to see that each taxi typically had seven to eight passengers within, and occasionally with two more sitting in the back, legs covered with the partially closed trunk as if it was a lap blanket.

The shops along this commercial street selling hardware and building materials were open, but the hand painted signs suggested that this relatively recent. But the real commerce was on the sidewalk in front. Small tables with local vegetables shaded by bright colored crooked umbrellas, women in colorful patterned lapas with matching head scarves squatting next to the fish they are selling while fanning away the flies, a rusty wire mesh hangs shirts and pants dusty from the

road's proximity, there are wheelbarrows filled with brassieres, a wood plank is lined with shoes all are but minimal obstacles to the hundreds of people, bundles in their arms baskets on their heads, weaving about them in their own pursuit of the day's buying or selling.

As we enter the city center the fact that civil war ended but three years ago is even more apparent. The ground floor storefronts with hand painted signs suggest the short duration of the current enterprise, but hanging laundry and small cooking fires in the bombed out charred concrete shell in the second and third floors open to the sky tell the real story of the chaos just ending.



The following day we go to our work site, the John F Kennedy Medical Center, for orientation and a tour. Literally and figuratively a shadow of its former self, once the medical state-of-the-art, shining star of Western Africa, a third of the buildings on the campus are more bombed out concrete remnants from senseless destruction during the fourteen year civil war. The rest are all in bad need of lots more than cosmetic repair. Poorly lit, at times

dark, hallways lined with over filled benches served as waiting areas for various outpatient departments.

As typical for the third world, patients came very early in the morning and waited all day for the possibly of being seen. Some areas of the hospital seemed adequately supplied and staffed. The physical therapy department was staffed with well trained therapists who had adequate equipment, either older things in good repair or ingeniously things made for locally available material, as well as supplies for their very busy prosthetic limb clinic.

The emergency room, the intensive care unit and the general medical floor were quite the opposite. Typically out of daily supplies like gloves, and with medical equipment both in short supply and often non-functional, the quality of care was certainly affected.

I didn't see one heart monitor in the six bed open ward optimistically called the ICU; of the two oxygen concentrators in the entire place, the one I witnessed didn't function when needed; there are but two ECG machines; the lab results were often delayed for lack of reagents; the one x-ray machine in the hospital was a portable one and gave poor quality films, and on and on.

I then met with the Chief Medical Officer of the hospital to find out how we could best help. Dr. Robert Dennis, a plastic surgeon practicing in the U.S. for the

*(Continued on page 5)*

# Journal: Liberia

Continued from page 4

past 20 years had been recruited by Mde. Sirlief, the country's recently elected president, to return to country of birth and head up the hospital's effort to return to its former state of prestige.

I told him that with medicine we had with us, I was prepared to supplement the hospital's general outpatient clinic by seeing patients as we had done in Ghana or help in anyway else. "Education" is what his professional staff of interns, medical students and physician assistants most needed he said. Therefore, I would spend my time running teaching rounds on the medical floor in the mornings and mentoring them as they attend patients in the outpatient clinic in the afternoons.

The medical ward had about seventy beds divided up into six bed wards. It was but 75% filled, not for lack of patients in the country but rather because of lack of any public funding or health insurance. With the profound lack of virtually all standard daily medical supplies the hospital had to resort to having most patients pay an upfront deposit for medicine before they could be admitted and then pay for every lab or x-ray test prior to it being done.

Some of the patients lived in or near the capital but many of the patients had been to other medical facilities in the country recently and had come to 'the JFK' for more advanced treatment; all were very sick. In one ward were mostly patients in their 40s and 50s, too young for the significant stroke, kidney disease or heart failure they had resulting from severe uncontrolled hyper-

The next was a room with older patients often with cancer presenting too late for effective treatment even if there were oncologists or surgeons available; there weren't. The one starkly furnished room where there was up to date treatment available (from international sources) was the female AIDS ward; it was always full.

The afternoon outpatient clinics were more of the same illnesses, severe hypertension, heart disease, pneumonia, and diabetes along with the more common intestinal parasites, typhoid fever and malaria (lots and lots of malaria). There are remarkably few patients with just aches and pains. My days are always full and satisfying, feeling that I have added a bit to the care of the patients being that day and to seen in the future.

Yesterday was eye opening to say the least. A 16 year old girl who had slipped into a coma the previous night was presented to me on morning hospital rounds. She had been slowly deteriorating for the past five days (she had walked into the hospital) and the cause unrecognized by all the nurses, med students, and interns that had seen her over that time. As I was about to begin a Socratic questioning of the medical students about the causes of coma, I noticed the IV fluid the patient was obtaining was dextrose water, apparently only that since admission and was certainly the cause of her condition. My comments were direct but restrained, aimed at education during the last

minute change in treatment that of course did nothing to change the expected outcome. She died in front of us.

Through the day I found myself perseverating about the case, trying to grasp the magnitude of the problem. Where do you start? The immediate lesson to be taught about the IV fluid management was easy to present, but what about the bigger picture? Certainly being accusatory is use-



less at best; for the med students have all taken nine years to get to the 4<sup>th</sup> year of med school, with little in the way of textbooks, school closed every couple of months for undetermined amounts of time and no real clinical training. The interns all in their 40s have taken even more time to get to where they are, trying to learn without even the most basic clinical equipment to support them, and with few attending physicians to supervise and teach them. And there are but 52 physicians in the entire country, many of whom are elderly, hanging on hoping there will be someone soon to replace them.

Worldwide it is increasingly being recognized that real improvement in the 3<sup>rd</sup> world comes not from large grandiose plans (more often than not from those outside) but from those working locally. The task of returning this medical center to its prestigious level of two decades ago is a very large barrel to fill. Dr. Dennis and his small attending staff certainly have made major contributions in the past two years adding to the barrel, but there is still so much to do.

# Education & Training

## *Planning for and Responding to a Terrorism / WMD Incident*



September 23 - 25, 2008  
8:00AM to 4:00PM daily

Bennington Fire Dept,  
River Street  
Bennington, Vermont



Hosted by the **Bennington Police Department** and the **Local Emergency Planning Committee of Bennington County**, in conjunction with the **Department of Homeland Security** and **Texas Engineering Extension Service, Texas A&M University**

This course provides a unique opportunity for individuals to acquire the knowledge, skills, and attitudes necessary to help them protect public safety and infrastructure from the ***threat of a terrorism incident or a natural disaster***. Course participants, using their extensive professional experience, work together in multi-discipline teams to apply the information presented during the course in a variety of hands-on, small-group activities as well as realistic, multi-media scenarios.

**RSVP by September 12:**

**Lissa Stark at 442-0438 or [lstark@bcrcvt.org](mailto:lstark@bcrcvt.org)**

*Early registration is suggested – seating is limited*

## **CORE Disaster Life Support (CDLS)**

### **—Free Online course**

The American Medical Association Center for Public Health Preparedness & Disaster Response and the National Disaster Life Support Foundation are offering an online Core Disaster Life Support® (CDLS®) training course FREE to members of the Medical Reserve Corps.

**Core Disaster Life Support® (CDLS®)** is a nationally recognized all-hazards course designed to increase emergency responder awareness of basic skills, competencies, knowledge, and resources that are critical for a coordinated and effective local emergency response effort.

This online course is targeted to address the issues of paramount importance across first responder disciplines: firefighters, law enforcement, emergency management, emergency medical services, public health, healthcare, public safety communications, governmental administrative, hazardous materials, and public works. They are covered at a level that is accessible and understandable across all levels of public health, health care, and safety. The course comprises nine modules, a pre-test, and a post-test.

The course is funded and approved through a grant from the DHS. eCDLS users who complete the free course by September 30, 2008 will receive a CDLS course manual, the AMA virtual library CD-ROM, *Responding to Public Health Emergencies*, and a CDLS wallet-card. You do not need these materials to complete the course.

The American Medical Association is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians. The American Medical Association designates this educational activity for a maximum of 4.0 *AMA PRA Category 1 Credits™*. Physicians should only claim credit commensurate with the extent of their participation in the activity. Non-physicians may request a certificate of participation indicating the *AMA PRA Category 1 Credits™*.

The course is available at: <https://www.mrc.train.org> - Course ID #1012300

# Incident Command System Training Required for MRC Members

As a disaster response volunteer, it is important that MRC members have a thorough understanding of the Incident Command System (ICS) and National Incident Command System (NIMS). ICS is the emergency management system which all first responders and local, state and federal agencies use during major events. The MRC National Office has recently distributed ICS/NIMS guidance for MRC units. Every MRC volunteer is required to complete training in ICS 100 and NIMS 700 courses.

If you have not already completed an ICS or NIMS course, please consider taking an ICS course offered this fall or an online course such as:

- o Yale New Haven "Introduction to Emergency Management with NIMS (EM 103 w/NIMS)" program at <http://ynhhs.emergencyeducation.org>
- o Introduction to the Incident Command System for Healthcare/Hospitals (IS 100-HC) at <http://training.fema.gov/EMIWeb/IS/is100HC.asp>
- o An Introduction to National Incident Management System (IS-700) at <http://training.fema.gov/EMIWeb/IS/is700.asp>

The MRC is required to maintain accurate records of our members' credentials and certifications; including ICS and NIMS. **Please submit copies of any ICS training you have received to the MRC of Southwestern Vermont office.** Also, please ensure your contact information is up-to-date on the MRC registration ([www.vtmrc.org](http://www.vtmrc.org)) or by contacting the MRC office at 802-440-4236 so we may notify you of course dates and times.

## National Preparedness Month September

September 2008 marks the 5th National Preparedness Month anniversary. The National Preparedness Month campaign is held each September and is designed to encourage Americans to take simple steps to prepare for emergencies in their homes, businesses and communities.

This year, the Ready Campaign and its DHS partner, Citizen Corps, are encouraging Americans to take simple steps to prepare including:

- Get a Kit;
- Make a Plan;
- Be Informed about the different types of emergencies and their appropriate responses;
- and Get Involved.

The MRC is planning display tables, public awareness articles and other activities to help our communities be better prepared in case of a disaster. YOU too can help spread the message and make members of the community prepared. **For more information about the Ready Campaign and National Preparedness Month, visit [www.ready.gov](http://www.ready.gov) or call 1-800-BE-READY**



# MRC of SOUTHWESTERN VERMONT

## Calendar of Events

### Schedule of Events

- ♦ **August 23, 2008**— MRC Medical Triage & Treatment Tent at Hoosic River Ride. 8 am—3 PM Bennington.
- ♦ **September 6, 2008**— MRC Medical Triage & Treatment Tent at Maple Leaf Marathon. 8 am– 3 PM Manchester
- ♦ **September 8, 2008**— MRC Advisory Council Meeting. 7 PM. SVMC Conference Dining Room.
- ♦ **September 23, 2008.** Hazmat Awareness Education. SVMC
- ♦ **September 23-25, 2008.** Planning for and Responding to a Terrorism/WMD Incident. Bennington Fire Dept.
- ♦

## August 2008

Sun	Mon	Tue	Wed	Thu	Fri	Sat
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

### OSHA Hazmat First Receiver Awareness Course.

September 23, 2008  
0800-1100 am  
Or  
1800-2100 PM

The Occupational Health And Safety Administration (OSHA) requires Hazardous Material (Hazmat) First Responder Awareness Level training for those who work in the contaminant-free, post-decontamination zone, but might be in a position to identify a contaminated victim who arrived unannounced.

Even though MRC members are secondary-responders and are not expected to provide hazardous material decontamination, the risk of accidental or unintentional exposure remains. Therefore, knowledge of the risks, roles and responsibilities in dealing with potentially contaminated patients and the proper usage of Personal Protective Equipment (PPE) is important.

## September 2008

Sun	Mon	Tue	Wed	Thu	Fri	Sat
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	1	2	3	4
31						