



# *The Newsletter*

## *'HEARING AND UNDERSTANDING ARE NOT THE SAME THING' - UNDERSTANDING THE NEEDS OF THE DEAF*

### Special points of interest:

Page 3  
Pictures-2009

Page 4  
H1N1- summary of our activities this fall/winter

Page 6  
Public health initiatives

Page 8  
Haiti- there in the moment

Page 9  
announcements

At the Regional MRC meeting in November 2009, Jonathan O'Dell was the special guest speaker for the program. When Jonathan was a child, an illness caused profound deafness which forced him to live in two worlds, the world that can hear and the world that cannot. With his wonderful sense of humor he was able to give the audience insight into how interactions between the two worlds can and cannot blend in the scenario of an emergency.

Start with the basics. The deaf and the hard of hearing (HOH) cannot hear television and radio so are very likely to miss announcements of an emergency and instructions that relate to that emergency. Newer technologies have given the deaf additional communication tools but if the electricity is down, these technologies are of limited use if at all. Batteries for hearing aids or communication devices need to be recharged and if there is no electricity, there is no way to recharge the batteries, leaving the person without hearing or a way to communicate effectively. Many of the deaf cannot read or read at a primary school level, grade 4 at best because sign language is a language of its own and does not translate well into a readable language. To read a language requires the combination of learned sounds and recognized symbols for the sounds. If you cannot hear the sounds to match to the symbols, then it makes reading hard to master. If you can hear some sounds with the help of a hearing aid, there may be a lot of 'white noise' interference or sounds if not articulated very clearly, they remain indistinct. Hearing and understanding are not necessarily the same thing.

The most common cause of HOH and deafness is due to nerve damage and so making sounds louder with amplification support of a hearing aid is not helpful. By age 65, 1 of 3 people will be HOH and by 85, 50% of the elderly will be HOH. It is not just those born deaf or those who have lost their hearing because of illness or injury that emergency responders need to be aware of, but of a much larger population that may have special communication needs. This is why deafness is considered an invisible disability.

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If you are assisting a person who is deaf and is dependent on other forms of communication, there are a few things to know. American sign language (ASL) has dialects. What may be signed in New England may be a little different from what is signed in the Midwest or the South. This difference is more pronounced as you travel from country to country. Just as German or French are different from English and require study to communicate comfortably, sign languages in Germany or France are also quite different from ASL. Deaf people are 'shockingly blunt' because ASL is a direct language not subject to descriptive or idiomatic phrases that softens or rephrases a statement to what general society considers acceptable and/or polite. ASL is also a simpler form of English using facial expressions or gestures to take the place of adjectives or inflections that are heard in a voice.

Mouthing words in hopes that the person can read lips is the least helpful form of communication. Jonathan demonstrated by saying the following sentences: 'I'll have two' ; 'I love you' ; and 'orange juice'. They are very similar in the way the mouth forms to say the words so the person trying to read the lips may only get 30% of the sentence. One of the best forms of communication has come to be because of 'text messaging'. As technology has developed and society has become crazed over text messaging, this has given the deaf community a dependable tool of communication as English can remain simple and to the point, the cell phone or pager vibrates as a signal, it bridges easily between the two worlds and can be supplemented with pictures or maps as well.

For the deaf community, there is no central registry of the deaf and HOH like there is for the blind so they continue to remain that invisible population. Planning for special needs populations during an emergency needs to consider this and other hidden disabilities. We cannot meet the needs of everyone in an emergency but there are some populations that need to be accommodated and planning put in place. Understand that in the early moments of an emergency that there will probably not be an ASL interpreter, there will be no definitive way to identify the deaf from the general population, and a lack of communication will lead to lack of ability to follow a direction or a misdiagnosis of a person's need or anxiety.

When working with a deaf individual, consider the lighting, the visual distractions, the acoustics and the way you choose to communicate. Is the lighting sufficient or too strong? Are there a lot of distractions that can add to miscommunication or anxiety? Are there echoes or vibrations that would be misinterpreted to cause worry? If you have an I-Phone or other similar device, there are apps with ASL symbols and having that downloaded ahead can be very helpful in the urgency of the moment. When communicating maintain eye contact, touch the person to get their attention, use mime, keep your face unobstructed with sufficient light on your face and don't read to them.

The best way to help the HOH and the deaf is to educate yourself on deafness via websites, getting a Cliff book on ASL, or spending time with those that work in the field of audiology. Then reach out to the community of the HOH and deaf working as a partner with local agencies to identify first and then teach emergency preparedness. And finally, be part of a response team that plans for the deaf community from the small items such as knowing resources for hearing aid batteries to the larger such as knowing who can speak in the language of ASL in your community.

# Pictures...2009 in Review



Princeton, August 2009

National Conference, Dallas, Texas, April 2009



Westminster, First Aid Tent, in the rain, September 2009



Home Day  
Petersham, August 2009



WHACK the Flu program



Templeton, December 2009  
Flu vaccine clinic



## *Lessons Learned...Flu Clinics*

It has been a busy six months for our volunteer unit. Starting in September, and going to November, volunteers in groups of two and three persons went to twelve schools to present the WHACK the flu program. The program is designed to supplement health teaching that may have already been presented by teachers or school nurses on preventing the spread of disease. It includes a fun cheer using the letters WHACK to help the children remember basic health practices. Overall it was well received by children, teachers and school nurses alike. A lesson learned was that even though you may have members that have done the program before and are familiar with the script, if those members have not worked together it is important to have a half hour of practice time made available so that you get as seamless a presentation as possible. Another lesson learned was to relax and go with the flow of the conversation keeping the goals of the presentation in mind rather than trying to stay with the script in its original form. In other words, be open to ad lib as then it is a lot more fun. The third and final lesson we learned was when you have a team that clicks, then try to keep that team together as much as possible as they get better and better with time.

Starting in October and going to February, our MRC was able to provide assistance and support to several clinics. There was such a willingness of all volunteers called, whether they were available or not, to help that there was never a worry about getting volunteers. An effort was made to get as many volunteers involved as possible, but still there were a number of folks who were not called because we were able to meet the needs easily. A couple of Boards of Health also asked us to help them plan for the clinics and that gave us an opportunity to see some of the responsibilities that they had in addition to our responsibilities to provide volunteers and have sufficient information about the vaccine for our nurses. Each clinic was run slightly different not only with the general set up but with different paperwork that was provided to the boards from Massachusetts DPH. An MRC or its volunteers do not have any control over these factors and we were able to flex easily to accommodate the different approaches and the different paperwork although a lesson learned could be to have more uniformity of the paperwork.

The Just-in-Time booklet was helpful for some but the 8 x 11 inch paper with the summary chart seemed to be more helpful for most. No Board of Health can sponsor a vaccine clinic without physician orders but having a set of physician orders to see at each table was also helpful for some. There were a couple of medication errors. One was that a Novartis vaccine was given to a child under 4 years instead of the Sanofi vaccine. There is no difference between the two medications. The difference was the FDA approval. Novartis clinical trials did not include children under age 4 years and Sanofi did. FDA approved based on safety, efficacy and ages involved in the clinical trial. This just served as a good reminder to all to pay attention to packaging instructions. The second was when a family unit came through and a nurse took flu-mist for the children, the family then went to the flu-mist table and the children were given a second dose of the same medication. This one generated a lot of discussion behind the scenes...Would it be better to have both flu-mist and injectable vaccine at each table to accommodate families as a unit or would it be better to keep one vaccine type per table. The nurses at that clinic were unanimous to keep one type of vaccine at each table but to be more forceful about seeing paperwork and questioning before any vaccine is administered. Also to make it clear to those receiving the vaccine, that paperwork must be presented to nurses before any vaccine will be given.

## Articles About Other MRC Units...

### Local Medical Reserve Corps volunteers visit Senior Centers, teach seniors about fall prevention



Local Medical Reserve Corps members have been visiting Senior Citizen Centers, teaching about fall prevention. Falls are not just the result of getting older. Many

falls can be prevented. By making changes, chances of falling are lowered. Four things are suggested to prevent falls. 1. Begin a regular exercise program. 2. Make your home safer. 3. Have your health care provider review your medicines. 4. Have your vision checked. Unintentional home injury is the fifth leading cause

of death, and 2.5 times more likely to cause injury than car crashes.

The Southeastern Medical Reserve Corps is happy to have two new volunteers, Jason and Korene Merrell of Cleveland. Anyone interested in donating their time and expertise to prepare and respond to emergencies contact Camille Huntsman at 435-653-2120.

Emery County News

December 15, 2009

### Medical Reserve Corps volunteers join shelter effort

Local volunteers with the Medical Reserve Corps answered a call to assist the Red Cross in opening a second shelter in response to the Wenden flood.

As evacuees entered the second shelter the MRC volunteers assisted the families in registration and provided comfort to the children. "These ladies came prepared to help, with their emergency go-kit and can do attitude," said Mindy Christman, Medical Reserve Corps Coordinator.

La Paz County Medical Reserve Corps is a volunteer pro-

gram under the La Paz County Health Department whose mission is to provide assistance to the public health system during emergencies. Medical Reserve



Corps is a nationwide volunteer program under the office of the Surgeon General. La Paz County

Medical Reserve Corps is one of 873 chapters across America.

La Paz County Medical Reserve Corps is actively seeking volunteers with medical and non-medical backgrounds. Volunteers receive training in personal preparedness, community preparedness, and emergency response. To find more information on joining MRC contact Mindy Christman at 928-669-9364 or go to [www.medicalreservecops.gov](http://www.medicalreservecops.gov)

Parker Live, a news website in La Paz County, owned and operated by [KLPZ.1380am](http://KLPZ.1380am).

## Public Health...

### HHS Secretary and Surgeon General Join First Lady to Announce Plans to Combat Overweight and Obesity and Support Healthy Choices

First Lady Michelle Obama, U.S. Department of Health and Human Services (HHS) Secretary Kathleen Sebelius and U.S. Surgeon General Regina Benjamin announced plans on January 28, 2010 to help Americans lead healthier lives through better nutrition, regular physical activity, and by encouraging communities to support healthy choices. In her first release to the nation, *The Surgeon General's Vision for a Healthy and Fit Nation*, Dr. Benjamin highlights the alarming trend of overweight and obese Americans, and asks them to join her in a grassroots effort to commit to changes that promote the health and wellness of our families and communities.

The prevalence of obesity has more than doubled among adults and has tripled among children and adolescents from 1980 to 2004. Currently, two-thirds of adults and nearly one in three children are overweight or obese. Increased food intake, a sedentary lifestyle, and environments that make it difficult for people to make healthy choices but easy to consume extra calories, all contribute to the epidemic of overweight and obesity. This epidemic threatens the progress we have made in increasing Americans' quality and years of healthy life.

Additionally, many racial and ethnic groups and geographic regions of the United States are disproportionately affected. For instance, African American girls and Hispanic boys are more likely to be obese compared to non-Hispanic whites. Among adults, American Indian and Alaskan native adults have the highest rates of obesity. The sobering impact of these numbers is reflected in the nation's concurrent epidemics of diabetes, heart disease and other chronic diseases.

"Americans will be more likely to change their behavior if they have a meaningful reward - something more than just reaching a certain weight or dress size," said Dr. Benjamin. "The real reward is invigorating, energizing, joyous health. It is a level of health that allows people to embrace each day and live their lives to the fullest without disease or disability."

The Medical Reserve Corps can play a great role *The Surgeon General's Vision for a Healthy and Fit Nation* by supporting activities and initiatives at the local level. As MRC units and volunteers have a direct link to, and impact on, the health of communities, we look forward to hearing reports of the work you do to negate, prevent, and drive down the numbers of overweight and obese Americans. In fact, several MRC units are already doing work in support of this mission, including:

- The Wachusett (MA) MRC participated in a Home Day Fair, where volunteers presented on nutrition, providing information to adults and plastic food items to children, in order to teach them which to choose for a healthy lifestyle.
- The Detroit (MI) MRC partnered with community organizations to sponsor the "Look Good! Feel Good! The Presidential Way" National Health Care Day of Service, where volunteers taught community members how to start a community garden, shop healthy with reasonable prices, and the benefits of eating healthy. Health care professionals, along with nutritionists, educated the public on how to take care of their health with fun activities, such as aerobic exercising, face painting and other activities.
- The Twenty First Century Youth (Birmingham, AL) MRC educated legislators and their staff on the impact of obesity on the health of the state of Alabama and its correlation to hypertension by providing them with blood pressure, BMI, and visual acuity screenings.
- The Union County (OH) MRC held a "Super Teen Party", where local teens were educated on healthy living and choices through a fun and interactive approach.

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The East Central Health District (GA) MRC volunteers supported a local health fair, where blood pressure, blood glucose and AIDS screenings were provided, as well as education on obesity, diabetes, and healthy living.

You may wish to review *The Surgeon General's Vision for a Healthy and Fit Nation* to see how your MRC can get involved. The recommendations include:

Improving our communities – Neighborhoods and communities should become actively involved in creating healthier environments. The availability of supermarkets, outdoor recreational facilities and the limitation of advertisements of less healthy foods and beverages are all examples of ways to create a healthier living environment.

Healthy Choices and Healthy Home Environments – Change starts with the individual choices Americans make each day for themselves, their families and those around them. Reducing the consumption of sodas and juices with added sugars; eating more fruits, vegetables and whole grains; limiting television time; and being more physically active help us achieve and maintain a healthy lifestyle.

Creating Healthy Child Care Settings – It is estimated that more than 12 million children ages 0-6 receive some form of child care on a regular basis from someone other than their parents. Parents should talk with their child care providers about changes to promote their children's health.

Creating Healthy Schools – To help students develop life-long health habits, schools should provide appealing healthy food options including fresh fruit and vegetables, whole grains, water and low-fat beverages. School systems should also require nutrition standards and daily physical education for students.

Creating Healthy Work Sites – Employers can implement wellness programs that promote healthy eating in cafeterias, encourage physical activity through group classes and create incentives for employees to participate.

Mobilizing Medical Communities – Medical care providers must make it a priority to teach their patients about the importance of good health. Doctors and other health care providers are often the most trusted source of health information and are powerful role models for healthy lifestyle habits.

To view *The Surgeon General's Vision for a Healthy and Fit Nation* in its entirety, please visit [www.surgeongeneral.gov](http://www.surgeongeneral.gov).

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[www.fruitsandveggiesmatter.gov](http://www.fruitsandveggiesmatter.gov)

## Haiti...First moments

*Editor's note: I found this story on Doctors without Borders website: [www.doctorswithoutborders.org](http://www.doctorswithoutborders.org). It is a first hand account and gives you a good sense of the extreme urgency that the doctors and nurses felt in this devastating disaster as they pulled out their emergency supplies, drew on their disaster response training and used every piece of their medical training. Check out the video under Field News on their website as well: An MSF Surgeon in Haiti as well. judie*

*February 3, 2010 As medical assistance moves into a second phase, with conditions finally improving for the practice of surgery and medicine, three staff members describe how the teams treated patients in the ruins of the Delmas district in the immediate aftermath of the January 12 earthquake in Haiti.*

### The Earth Shakes

It was the end of the day in Haiti, and Pacot, the rehabilitation centre had closed its doors. The pharmacy was locked up for the night. Then the building shook. "We all had the same reflex: run for it, get out as quickly as possible" recalls Joseph Yogho Andona, logistics coordinator in Port-au-Prince. "It was only once we were outside, in the clouds of dust, that we realized it was an earthquake. It didn't last more than ten minutes, and we finally grasped what was happening when we saw the district go up in smoke."

Wounded patients started pouring in, and the team pulled out the emergency boxes. The most serious cases were swiftly delivered by car. Joseph left in search of other emergency boxes in the house. The doctors and nurses delivered first aid and sutured wounds while the logisticians set up areas for work. Some patients were too severely wounded to be saved, given the lack of resources at hand; in such cases, pain relief was all the teams could offer. The headlights on cars were the only source of light. For two entire days no one stopped, neither to eat nor sleep. The watchmen controlled the surging crowds while a member of the medical staff picked out the most urgent cases. On January 14, even though no reinforcements had arrived, the surgical team started operating in a theater cobbled together under plastic sheeting.

### Organizing Triage, Medicine and Surgery

The incoming support teams were stunned by the conditions at Trinité Hospital. The patients were everywhere, in front of the hospital ruins, in the streets, lying on boxes or spread out on the floor. Two surgical teams worked in makeshift operating theaters, one under plastic sheeting, the other in a container. A third cleaned the patients' wounds in another closed off area. Dr. Roberto Beccari, a surgeon, recalls using pallets stacked on top of each other as an operating table. "It was a race against time," he says. "There were so many open fractures and we had to get a handle on necrotic tissue infections." A fourth post was set up for triage, identifying serious cases and providing care for dressings and plasters. Off to one side, a doctor was busy suturing. The work took place in the heat and the noise, at times under the light of only headlamps. But at least the sterilization system worked, and the anaesthetists had the medicines they needed in the pharmacy. "I remember one young woman who had suffered very severe head injuries," recalls Dr. Philippe Touchard, an anesthetist. "It took three of us to administer the anaesthetic, as her airways for intubation were barely accessible." Her wounds were in awful shape, he says. "We operated on this 27-year-old woman several times," and managed to save her life. More than 110 procedures were carried out in ten days (without counting the dressings) at the Pacot and Trinité sites, including 27 amputations. Most of the wounded had a crushed limb, or markedly open and infected wounds. The teams tried to avoid amputating if at all possible, but there were cases where it was the only way to save the patient's life. Hard decisions had to be made. "My first operation was on a hand, which is my speciality," Roberto recounts. "It was a gaping open wound, really infected, I cleaned it. I couldn't amputate. It took me two days to resolve to cut off limbs. I ended up, three days after this first operation, amputating this hand. The infection had set in too deep, and was moving too quickly. The patient risked losing an arm or dying. It got easier to amputate. It's not because I got used to it, but I accepted that it was at times the only thing to do, the right decision." The team "still saved many others—legs, arms, hands," he adds. In the morning, at 7 am, without saying a word, each doctor would check if his patients were still alive, or had "passed on." That was the term the team used.

Throughout the week, another team was busy preparing a site for a future hospital, in Saint-Louis. The supplies finally showed up, six days after the earthquake, with several days of delay due to the refusal of landing permission for the plane in Port-au-Prince. The medical staff organized the circuit and the pharmacy. The logisticians inflated tents and set up beds. One hundred patients hospitalized in Pacot and another 80 from Trinité were transferred to Saint-Louis. They found themselves installed on beds with mattresses and without what they feared most: a roof that could collapse on them.

## *Announcements...*

### **Our volunteer time:**

We have been doing some calculations and the results are pretty impressive. Between the H1N1 clinics that we participated in and the WHACK the Flu program, our unit had 75 members participate, logged in over 600 hours of volunteer time and provided close to \$20,000 worth of service to the smaller rural communities of north Worcester County.

***Thank you one and all!!***

### **Special needs:**

One of our newest members from Rutland, Allison Jones, (volunteered at the last clinic in Rutland) was on the way home from Connecticut and stopped to assist another motorist. While helping, another car hit the disabled car and caused it to roll over on top of her. Her injuries, although listed as not life threatening, are severe and will require some long term healing. If you would like to send her a card of support, her address is 45 Brintnal Drive, Rutland, 01543. Update: She was able to come home on Feb. 9th after 3 weeks in the hospital but still has many medical needs that require much care.

Our condolences to Sandy Stevens of Gardner, who was notified the day after she helped at a clinic that her niece died of H1N1 leaving a husband and two children.

### **Statewide meetings:**

Upcoming schedule for statewide MRC meetings:

March 10 (11AM - Noon): Statewide Call

April 14 (10AM - 2PM): Statewide Meeting

Interested in listening in on the statewide call or going to a quarterly meeting of the MRC leaders?

Call 978-928-3834 and details will be provided.

### **Reminder: Check the website.**

The website has been updated with a brighter design and new items. As events unfold, information will be added to keep you up to date as to what is being for-

ers. Additionally, there are CEU links and copies of various MRC newsletters including this one. Please take some time a couple of times each month and check it for new items.

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

### **A Public Health Opportunity...**

Gardner has for some time been screening the adolescents in the middle school for diabetes and other weight related issues. They have recently put together two committees to look at Youth and Alcohol and Youth and Obesity. If you would like to join one of these committees to help define and develop programs to address these issues, please give us a call at 978-928-3834.

### **Badges– Important Information**

If you have completed your paperwork for registration, i.e. the application, the CORI form, and the questionnaire, you should have received a badge. There are presently two forms of the badge. A temporary version with a medical symbol instead of a picture and a permanent version with your picture in place. If your badge does not have a picture, then you need to send me one *in color*. The picture can be on plain paper or regular photo paper or it can be an expired badge from an old job that happened to be a reasonable picture. We will scan it and the program will lighten or darken, trim or delete unwanted background.

As we work together at various activities, I will try to get pictures for badges. But it would be better for you to find a picture you like than take a chance on my photography skills. The badges are good for two years and expire on your birthday. We will check with you before re-issue to validate address and telephone numbers. You have been given two badges because if you respond in an emergency, you may be asked to leave one ID at the check-in as a way of knowing who is there or not there and who belongs to what unit or organization.

If you didn't get a badge and know you sent in the paperwork, please call me and I will check. A reminder to others, to please check that pile of papers on the desk and see if that application packet may be still there. *Then fill it out and send it in!! Thanks, judie*

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## Conference?

Spring is right around the corner, we hope. But in the light of being an optimist, we will think that the mud of spring will replace the frozen ice bringing warmer winds, longer days and first blooms of the crocus. Energy will return and creativity will rise to the surface. With renewed vigor it will be time to get up and go to various programs to collect those continuing education credits needed for renewal of your license.

Our goal this year is to try to have a couple of conferences that would be designed offer a variety of topics to choose from and flexible enough to allow you the freedom to come for one or two or three classes according to your schedule of the day. A late afternoon class or two for those who work nights or morning classes for those who have to go to work at 2pm for the evening shift? Saturday classes? CPR and First Aid would be available as well, a preference for day or night?. More ideas or suggestions?

We are looking for two things from everybody. Topics of interest (and if you have a guest speaker in mind, send along the name as well) and people to make it happen i.e. CPR instructors, folks willing to help set up, pass along a name of a good cook or caterer for lunch etc.

Please leave a message at 978-928-3834 or drop a note to us as all ideas will be considered.