THE 2015 NETWORK PROFILE OF THE MEDICAL RESERVE CORPS

CONNECTING WITH COMMUNITIES

The MRC: A network of dedicated volunteers

medical reserve corps

NACCHO
National Association of County & City Health Officials
The National Connection for Local Public Health

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ABOUT THIS REPORT

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NACCHO is solely responsible for the accuracy of the statements and interpretations contained in this publication, and such interpretations do not necessarily reflect the views of the United States government.

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INTRODUCTION

The idea for a civilian medical and public health volunteer corps emerged after the 9/11 terrorist attacks, when local responders found themselves flooded with many spontaneous medical and public health volunteers.

These professionals were eager to support emergency relief activities but many were turned away as an organized approach to channel their efforts did not exist. In 2002, the Office of the Surgeon General, part of the Department of Health and Human Service's Office of the Assistant Secretary for Health, established the Medical Reserve Corps (MRC) as a demonstration project to create the mechanisms to identify, train, and track volunteers who could strengthen local public health and serve if another human-made or natural disaster occurred. The following year, the Surgeon General made the MRC a program, and directed staff to expand the MRC concept nationwide. Congress authorized the MRC in the 2006 Pandemic and All-Hazards Preparedness Act (PAHPA) and reauthorized it in the Pandemic and All-Hazards Preparedness Reauthorization Act of 2013 (PAHPRA). The PAHPRA legislation assigned authority over and responsibility for the MRC to the Assistant Secretary for Preparedness and Response (ASPR). Since its inception, the MRC Network has grown dramatically, currently supporting nearly 1,000 units and over 205,000 local volunteers.

In 2006, the MRC Program Office engaged with the National Association of County and City Health Officials (NACCHO) through a cooperative agreement to promote, support, and build capacity within the MRC network. As the voice for local health departments (LHDs), NACCHO established and expanded strong partnerships between MRC units and LHD leadership.

In 2013, NACCHO conducted a comprehensive survey of the MRC network and in 2014 released the first Network Profile of the Medical Reserve Corps report about the MRC network's unit composition, administration, and community impact. Data from that initial report were invaluable, informing decision-makers, shaping future program goals, and sharing the impact the MRC has on the nation's health and safety. This document builds upon that original MRC Network Profile.

METHODOLOGY

In 2015, NACCHO again examined how the MRC network was changing over time, how new programs were affecting unit characteristics, and how the MRC program was contributing to the nation's state of preparedness on a national scale. NACCHO updated the questionnaire based on prior results and input from unit leaders and sent it to all 998 active unit leaders in January 2015.

Data were collected from January to March 2015. Overall, 801 MRC unit leaders completed the survey, yielding a response rate of 80%. When possible, NACCHO compared data from the 2015 survey with data from 2013 and included only those comparisons that represented meaningful differences between data from the two surveys. Some variations in the data reported between 2015 and 2013 may be due to survey refinement.

The 2015 Network Profile Survey data are nationally representative of the MRC network. Descriptive statistics presented are weighted for nonresponse. Nonresponse bias assessment compared the distribution of respondents and nonrespondents from the same survey with respect to jurisdiction size. Jurisdiction size from the survey responders was self-reported, while jurisdiction size for nonrespondents was obtained from each unit's profile indicating zip code catchment via the MRC government website. The U.S. Census data were used for accurate zip code population estimates. Some survey questions presented within this report are stratified by jurisdiction size. Doing so offered the greatest variability across categories.

To provide a richer picture, the report also presents two other data sources—NACCHO's 2014–2015 MRC Stakeholder Study and the 2013–2014 MRC Challenge Award survey. Both data sources provide additional insight into the MRC network but do not represent the entire network. Due to rounding, numbers in pie charts may not always add up to 100%.

DATA LIMITATIONS

Data in this report were self-reported and not independently verified. The time estimates to complete this survey, based on the pilot, averaged 45 minutes. With unit leaders typically dedicating 10 hours per week to MRC activities, time constraints can certainly affect the richness of the data supplied. The data from some questions changed little from 2013 to 2015. NACCHO will consider adjusting the frequency of some demographic and funding questions for future surveys. As with the 2013 survey, the text responses provided in the "other" field will inform possible answer options for questions in subsequent surveys.

MESSAGE FROM CAPT TOSATTO

“Making communities stronger…”

Dear Medical Reserve Corps Network, Colleagues, and Partners,

We are pleased to support the efforts of the National Association of County and City Health Officials (NACCHO) and its work to produce this second edition of the Network Profile of the Medical Reserve Corps. Founded in 2002 as a way for medical and public health professionals and others to volunteer in their communities, the Medical Reserve Corps (MRC) has since served to improve the health, safety, and resilience of the nation. The Office of the Assistant Secretary for Preparedness and Response (ASPR) and the MRC Program work to build greater awareness of the MRC network through a variety of reports, presentations, and briefings.

To build resilience and reduce disaster risk, MRC volunteers are fully engaged in improving the overall wellness of individuals and their communities. Through their service, gaps in public health are filled, emergency preparedness capabilities are strengthened, responses are quicker, and recovery is smoother. By reducing vulnerabilities locally, the MRC network is lessening the need for federal level involvement while making their community healthier and stronger.

Building on the success of the first edition of this publication, the latest Network Profile highlights the efforts of the MRC network and the impact it is making across the country at this point in time. The Profile also takes into consideration where the network was in 2013 and clearly illustrates the areas of growth and evolution. The graphics, stories, and images showcase a diverse network connected by a common mission with more than a decade of success.

This profile would be incomplete and less well-rounded if not for the input of the MRC unit leaders and their willingness to share information and stories. Additionally, the tremendous work of the NACCHO staff in collecting, analyzing and sharing the information in a compelling way is to be commended. This publication will serve as a great way to tell the MRC story, increase awareness, and shed much deserved light on the efforts of these wonderful and dedicated volunteers.

With warm regards,
Robert J. Tosatto, RPh, MPH, MBA
CAPT, USPHS
Director,
Medical Reserve Corps Program

MESSAGE FROM DON BOYCE

“MRC contributes significantly…”

Dear MRC Network,

As the Director of the Office of Emergency Management (OEM) in the Office of the Assistant Secretary for Preparedness and Response (ASPR), I value what the Medical Reserve Corps Program (MRC) has brought to preparedness and response since its transfer from the Office of the Assistant Secretary for Health to ASPR in 2013. The emergency management cycle relies on prepared and resilient communities and, as witnessed during a number of recent incidents, MRC contributes significantly to efforts at the local and community level.

The MRC network has made great strides in building resilience, a key part of the ASPR and OEM mission, as well as one of the priorities of the National Health Security Strategy. Your efforts to reduce vulnerabilities, prevent disease, and educate your communities strengthen the entire nation’s ability to withstand disasters. When people have the information they need to protect themselves, whatever the vectored source, they feel empowered and capable to respond and react efficiently. MRC leaders and volunteers are making a hands-on impact in building resilience and OEM and ASPR values its contributions.

This profile of the MRC national network brings the efforts of the leaders and volunteers to light and draws attention to the areas where you have grown stronger and improved your impact on the health and safety of your communities.

While adversity remains, MRC continues to evolve.

Sincerely,
Don Boyce, J.D.
Director,
Office of
Emergency Management

MRC unit snapshot

Each MRC unit brings individuals from all backgrounds, skills, and experiences together to strengthen local public health, prepare communities for emergencies, and respond to natural and human-made disasters. Collectively the MRC network works everyday to build a healthier and more resilient nation.

VOLUNTEERS

211 IS THE AVERAGE NUMBER OF VOLUNTEERS PER UNIT

- **61** CITIES < 100,000
- **170** 100,000–250,000
- **476** CITIES >250,000

The average varies widely from small towns to large cities.

> "Our MRC is managed exceptionally well by an individual who has wonderful skills working with and engaging volunteers. The MRC coordinator is the glue that makes our MRC a value-added resource." —*Stakeholder survey respondent*

THE MRC NETWORK COVERS **91%** OF THE U.S. POPULATION.[1]

LEADERS

22% OF UNIT LEADERS SERVE IN THEIR ROLE AS VOLUNTEERS.

35% OF UNIT LEADERS HAVE AN ADVANCED DEGREE.

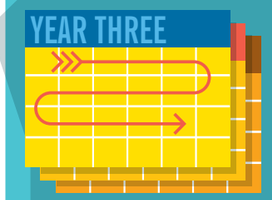
48 IS THE AVERAGE AGE OF UNIT LEADERS.

AFFILIATION

67% OF UNITS ARE HOUSED WITHIN A LOCAL HEALTH DEPARTMENT.

LEADER TENURE

THE AVERAGE TENURE OF A UNIT LEADER IS 3.9 YEARS, UP FROM 3.6 YEARS IN 2013.



More than a third of unit leaders were part of an MRC prior to becoming the leader, up from 28% in 2013.

DEDICATION

UNIT LEADERS REPORT THAT THEY CAN COUNT ON AT LEAST 25% OF THEIR VOLUNTEER POOL TO PARTICIPATE IN A GIVEN ACTIVITY.

JURISDICTION SIZES

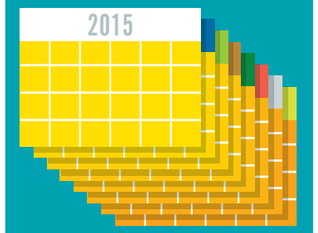
- **31%** COVER OVER 250,000 PEOPLE OR MORE.
- **20%** COVER FROM 100,000 TO 249,999 PEOPLE.
- **49%** COVER LESS THAN 100,000 PEOPLE.

COMMITMENT

ON AVERAGE, UNIT LEADERS REPORT DEVOTING 10 HOURS PER WEEK TO MRC ACTIVITIES.

COMMUNITY SUPPORT

MORE THAN A THIRD OF UNITS HAVE BEEN WITH THEIR HOUSING ORGANIZATION FOR MORE THAN 8 YEARS.



Atlanta, Georgia
2015 Preparedness Summit attendee discusses the 2013 Network Profile at the MRC booth.

PART 2

MRC connects with the community

KEY FINDINGS:

More units are using social media. In 2013, 49% of units reported using social media; in 2015, that number increased to 60%.

Text messaging increased between unit leaders and volunteers from 34% in 2013 to 53% in 2015.

On average, the volunteer composition of units is a third nurses, a third other medical professionals, and a third non-medical professionals.

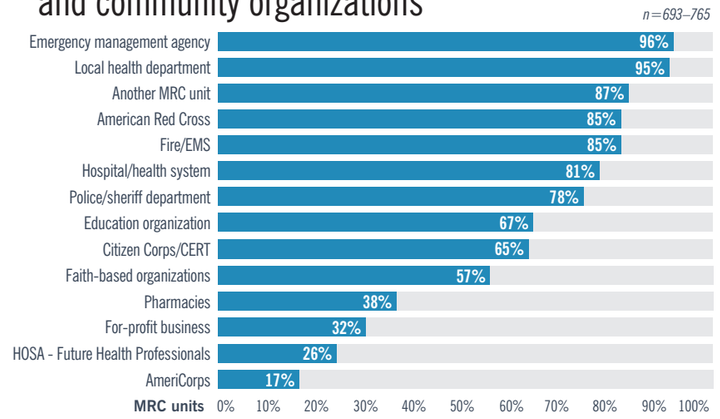
LOCAL CONNECTIONS

The MRC connects and partners with local communities in varied ways across the country. Units are immersed within LHDs, emergency management agencies, and healthcare facilities. They partner with police and fire departments to strengthen existing capabilities and serve alongside fellow first responders. Local connections are essential in providing reliable, committed volunteers for day-to-day and emergency public health events. Such connections also convey the value of the MRC in communities across the country.

PARTNERSHIPS AND SUPPORT

Staying connected to the community through partnerships integrates an MRC into the local preparedness and public health sectors. NACCHO incorporated new questions into the 2015 questionnaire to look closer at the types of partnerships in which MRC units participate and the resulting support they garner from these partnerships. The questionnaire defined "partnership" as exchanging ideas and information, sharing resources, and enhancing the capacity of a partner for mutual benefit and a common purpose. The top three partnerships MRC units reported were with local emergency management agencies (96%), LHDs (95%), and other MRC units (87%) (*). While a majority of units have traditional partners, such as LHDs and emergency management agencies, fewer units reported relationships with non-traditional partners (e.g., pharmacies, for-profit organizations). Seeking out less traditional relationships could build sustainability within a unit's program, possibly resulting in opportunities for alternative funding or resource sharing.

* Types of partnerships among MRC units and community organizations



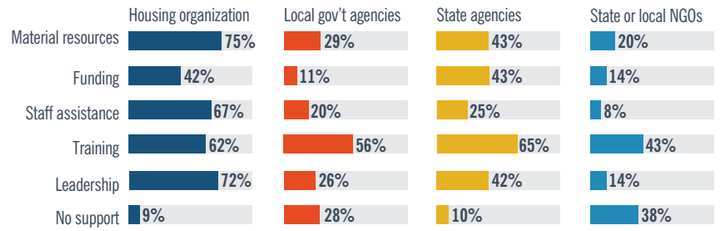
"The unique partnerships created through our MRC Challenge Award project [have] allowed for the pooling of materials, resources, best practices, and MRC person power to enact wide-reaching community change."

-Erin McDonough, RI MRC unit leader

MRC units described the type of support (i.e., material resources, funding, staff assistance, training, leadership, or none) their unit received from different entities including their housing organization, local and state government organization, and non-governmental organizations (❇). Seventy-five percent of units reported receiving material resources, 67% received staff assistance, and 72% received leadership support from their housing organization. Training support was highly reported across all partner types. Further, only 9% of MRC units reported not receiving support of any type from their housing organization, and 10% reported receiving no support of any type from state agencies. The data did not reveal how a lack of support affects an MRC unit; NACCHO may consider conducting future research on the sustainability of those units that received no support from their housing organization.

❇ Support from local and state entities

n=469–707



COMMUNICATIONS

Connectivity among MRC units helps spread innovative ideas, share lessons learned from experienced unit leaders, provide encouragement during emergency responses, and much more. Unit leaders have long cited in-person networking as a great benefit. When asked how they connect with other units around the country, 80% of units reported using state or regional meetings. Only 22% of units reported participating in formal or informal mentorships with other units (✻). Facilitating connections between units with similar characteristics (e.g., rural or frontier jurisdictions) through a formal mentorship program could help new units learn from more experienced ones.

NACCHO asked MRC units about their use of social media (e.g., Facebook, Twitter, LinkedIn, MRC Connect) (✣). The units that reported using some type of social media platform increased from 49% in 2013 to 60% in 2015. One interpretation of the data is that the increase is at least partially due to the fact that unit leaders were able to select additional options in the 2015 questionnaire (e.g., MRC Connect and Podcasts). Facebook and Twitter saw the largest increases in use from 2013 to 2015 (data not shown).

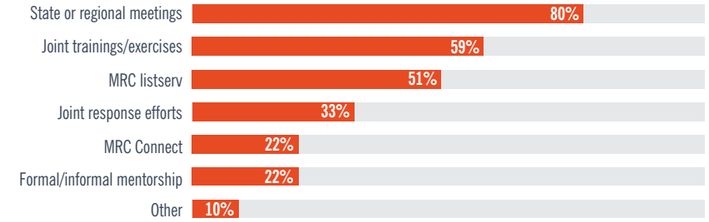
Unit leaders who did not use social media for their MRC units cited the following reasons: More than half (53%) cited time constraints; 44% reported that their housing department limited the use of social media sites; and 3% reported that they saw no value in using these sites (❇).

Unit leaders often turn to online technology to connect to volunteers, potential volunteers, or other unit leaders. The method of exchanging information between an MRC unit leader and volunteers depends on the type of situation and the volunteer pool. Different methods may be appropriate for day-to-day activities versus an emergency situation, depending on the technological savviness of volunteers. When MRC unit leaders exchange information with volunteers during an emergency, the telephone and an e-mail distribution list remain the top reported methods used. However, looking closer at less traditional methods revealed use of social media and text messaging increased substantially in 2015.

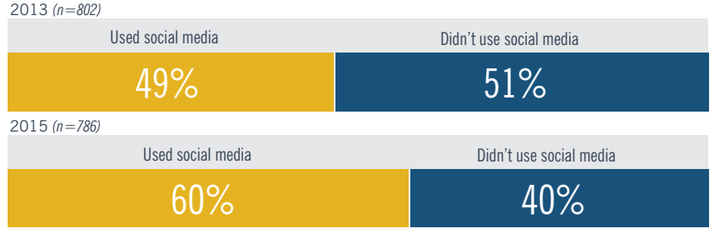
Social media use reported by unit leaders as a method of information exchange jumped from 7% in 2013 to 24% in 2015, while text

✻ How MRC units connect with each other

n=776

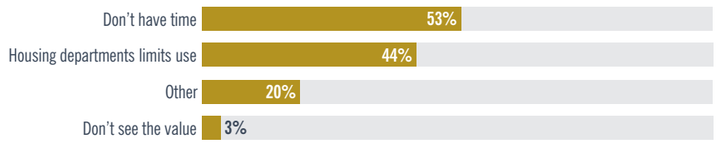


✣ More MRC units are using social media



❇ Reasons for not using social media

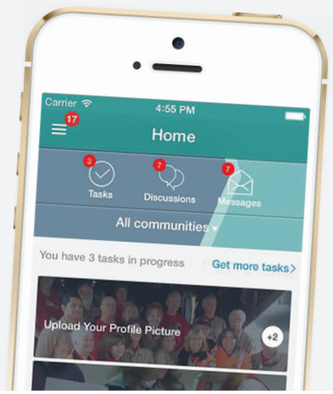
n=306



MRC CONNECT

One resource unit leaders use to connect with their peers within the network is MRC Connect, the first mobile application for the MRC.

Released in 2014, MRC Connect simplifies the sharing of best practices and critical knowledge that strengthens the preparedness and public health system nationwide.



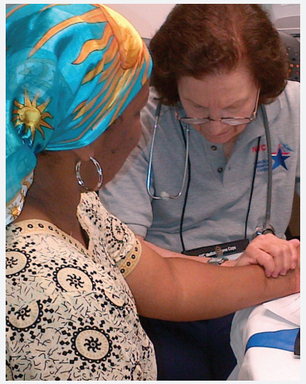
HEALTHCARE COALITIONS: MAINE RESPONDS

Healthcare coalitions are partnerships among healthcare organizations, public safety, and public health agencies to create a comprehensive, resilient response to catastrophic health events in support of Emergency Support Function #8.[2] Because the healthcare industry is broadly represented, healthcare coalitions are a natural partner for the MRC. In Maine, the state health department is using healthcare coalitions to expand the MRC network's reach. Maine has only two MRC units, so the health department is diligently expanding the statewide, volunteer capabilities needed for an emergency. Jared McCannell, the MRC state coordinator, is using the coalitions to network with healthcare workers across the state to form MRC units in rural areas that may have limited access to emergency resources. The coalitions help the MRC target appropriate community partners who can provide invaluable support to units. McCannell sums up the relationship: "There's a benefit for both sides: the MRC gets a place at the table, and the local healthcare coalitions are able to plan on support from MRC volunteers in the event of a medical surge emergency."

LANGUAGE AND CULTURAL OUTREACH

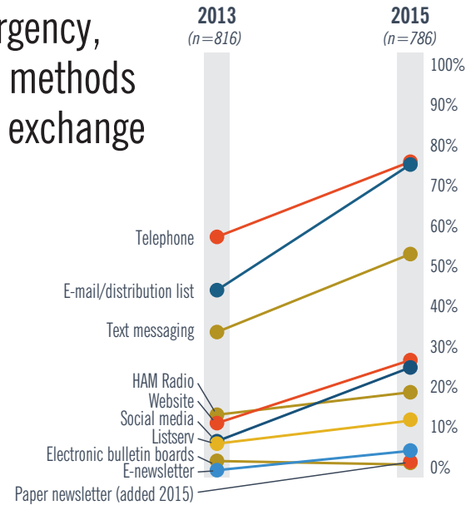
Many MRC units live and work in diverse communities. Some of the most underserved populations in these areas are residents who are new to the country and speak little or no English. These populations may not have the same access to healthcare or know the emergency preparedness services in their area. In the past year, using the skills within their own volunteer pool, MRC units in Colorado, New Orleans, and New York City reached out to these populations to create a more resilient community.

With a volunteer force that speaks 72 languages, the New York MRC collaborates with healthcare organizations to be translators during blood pressure screenings and pharmacist consultations. The Colorado Muslim Society MRC uses trusted religious leaders to educate recent immigrants and asylum seekers on emergency preparedness issues. In New Orleans, the MRC created hurricane readiness materials in Spanish, Vietnamese, and Braille and distributed 23,000 brochures, trained 103 community partners, and reached over 1,200 households. Across the country, MRC units are taking advantage of internal resources to make a difference for the most at-risk individuals in their community.



MRC volunteer participates in a blood pressure screening.

During an emergency, less traditional methods for information exchange is increasing

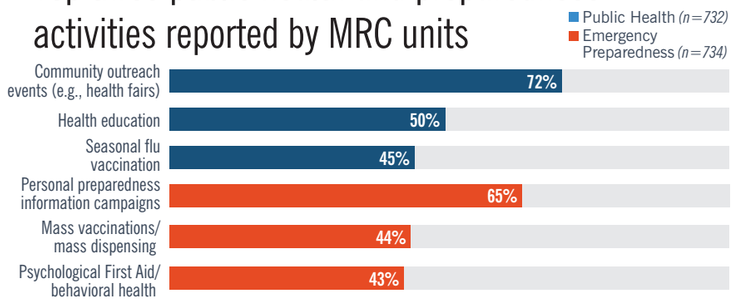


messaging increased by more than half, from 34% to 53% (❄).

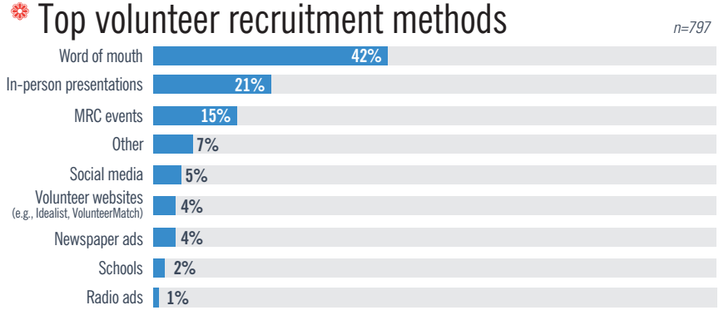
ACTIVITIES

MRC unit volunteers become familiar faces in their communities. Conducting screenings at health fairs, staffing flu clinics, educating the public on personal preparedness, or assisting during a local emergency are some ways volunteers make communities safer, healthier, and more resilient. MRC units commented on their participation in a number of public health and emergency preparedness community activities. Community outreach events (e.g., health fairs), health education, and seasonal flu vaccination clinics remain the top three public health activities MRC units reported participating in during the last year (❖). Under the umbrella of preparedness activities, MRC units reported personal preparedness information campaigns, mass vaccinations/mass dispensing, and psychological first aid and behavioral health activities as the top three reported activities.

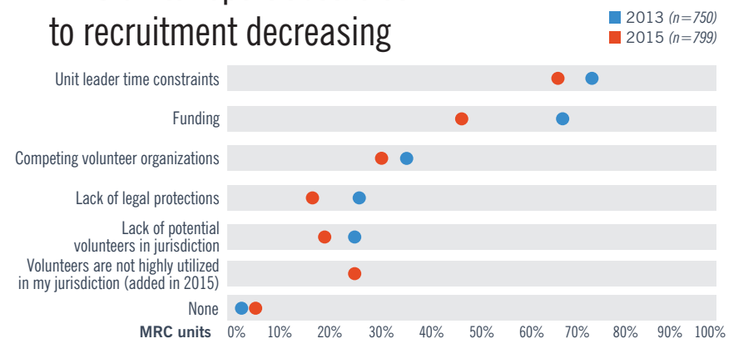
Top three public health and preparedness activities reported by MRC units



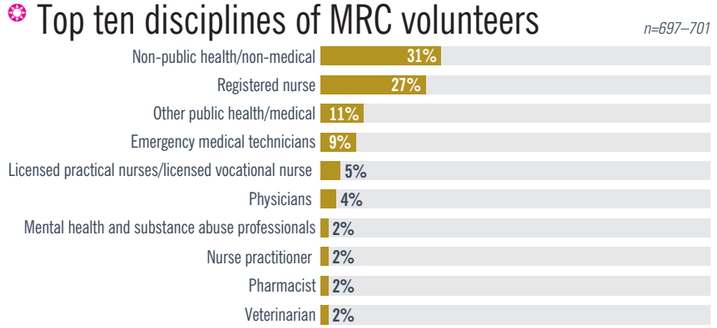
Top volunteer recruitment methods



MRC units report obstacles to recruitment decreasing



Top ten disciplines of MRC volunteers



VOLUNTEER RECRUITMENT

To participate effectively in community activities, an MRC unit needs a robust membership. Recruiting volunteers is an ongoing activity for unit leaders, as volunteer numbers ebb and flow over time. Many leaders count on word of mouth as the top recruitment strategy (42%) (❄). One in 5 cited in-person presentations as the top recruitment method. Unit leader time constraints (67%) was cited as the top obstacle to volunteer recruitment (❄). Funding decreased as an obstacle to recruitment for MRC units from 68% in 2013 to 48% in 2015. Lack of legal protections also decreased from 27% in 2013 to just 17% in 2015. Based on feedback in 2013, NACCHO added the option "volunteers are not highly utilized in my jurisdiction." More than one in four unit leaders selected this option as an obstacle to recruitment. Future research may investigate why some communities do not use volunteers.

MRC units collect demographics about volunteers' age, gender, race, education, and employment. The MRC network comprises both medical and non-medical volunteers. On average, a third of the volunteers reported in MRC units are non-medical support volunteers, a little less than a third (27%) are registered nurses, and the remaining third are other medical professionals (e.g., physicians, mental health professionals, pharmacists) (❂). As missions vary from unit to unit, the volunteer composition changes to reflect the types of activities each MRC unit is called upon to carry out.

MRC capabilities

The MRC is a national network of volunteers, organized locally to strengthen public health, improve emergency response capabilities, and build community resiliency. The MRC network comprises nearly 1,000 community-based units and over 205,000 volunteers located throughout the United States and its territories.

TRAINING

Community partners value proper training and continually look to local MRC units as a source of workforce multipliers.

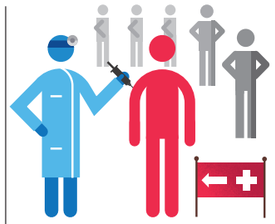
93%
of all MRC units offer in-person CPR/first aid/AED training.

91%
of units offer Introduction to the Incident Command System.

80%
of units also offer Psychological First Aid training.

TOP ACTIVITIES OF UNITS

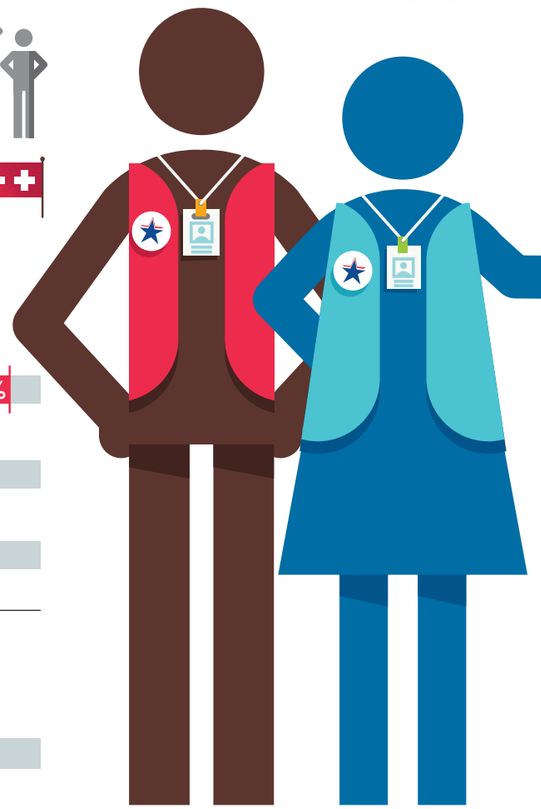
These are the top activities MRC units have the capabilities in which to participate:



PUBLIC HEALTH
Community outreach — 89%
Seasonal flu vaccination — 78%
Health education — 75%

EMERGENCY PREPAREDNESS
Personal preparedness and National Preparedness Month information campaigns — 90%
Mass vaccinations/ mass dispensing services — 85%
Emergency Operations Center support — 81%

INTEGRATION IN THE COMMUNITY
57% trained with four or more community partners in the last year.
57%



STRENGTH OF NETWORK

19% of units participated in an emergency response last year, responding to natural disasters, infectious disease outbreaks, hazardous materials spills, foodborne illness, and others.

NATURAL DISASTERS **64%**

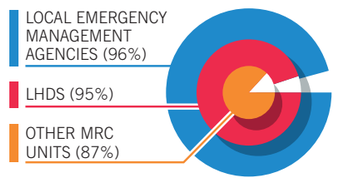
INFECTIOUS DISEASE OUTBREAKS **30%**

OTHER EMERGENCIES **26%**

FOODBORNE ILLNESS **1%**

HAZARDOUS MATERIALS SPILLS **5%**

TOP THREE PARTNERSHIPS
The top three partnerships MRC units reported were:



DEPENDABILITY

MRC volunteers are vetted and protected so they can keep communities healthy and safe.

96%
of units verify credentials of medical volunteers.

83%
of units have some type of liability coverage for their volunteers.

74%
of units perform criminal background checks on their volunteers.

PARTNER PERSPECTIVE

Our 2014-2015 MRC Stakeholder Survey gave us these insights.

HEALTH PROMOTION ACTIVITIES

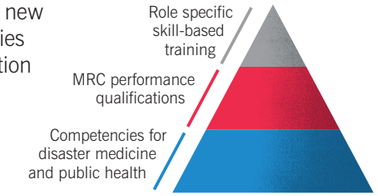
73% of respondents felt that the MRC was either effective or very effective in facilitating general public health activities.

PUBLIC HEALTH PREPAREDNESS ACTIVITIES

80% of respondents felt that the MRC was either effective or very effective in enhancing public health preparedness.

FUTURE DIRECTION

Implementation of the new MRC Core Competencies will improve collaboration and training between MRC units and response partners.



Challenge Award innovation projects serve as an incubator for ideas that can be implemented in communities nationwide.

Stanislaus County, California

MRC volunteers gear up for the Operation Strike Zone preparedness training.

MRC capacity and innovation

KEY FINDINGS:

89% of units participate or could participate in community outreach events.

19% of units participated in an emergency response last year.

The median budget for units decreased by 11% from 2013 to 2015.

MRC units have been essential to the field of public health for more than twelve years and have helped to shape the role of the volunteer in both day-to-day activities and times of disaster. All MRC units improve the health and safety of their communities; however, each MRC unit is unique in its mission. Whether a unit participates in public health promotion activities, public health preparedness campaigns, or emergency response depends on the unit's focus and the community's needs within a jurisdiction.

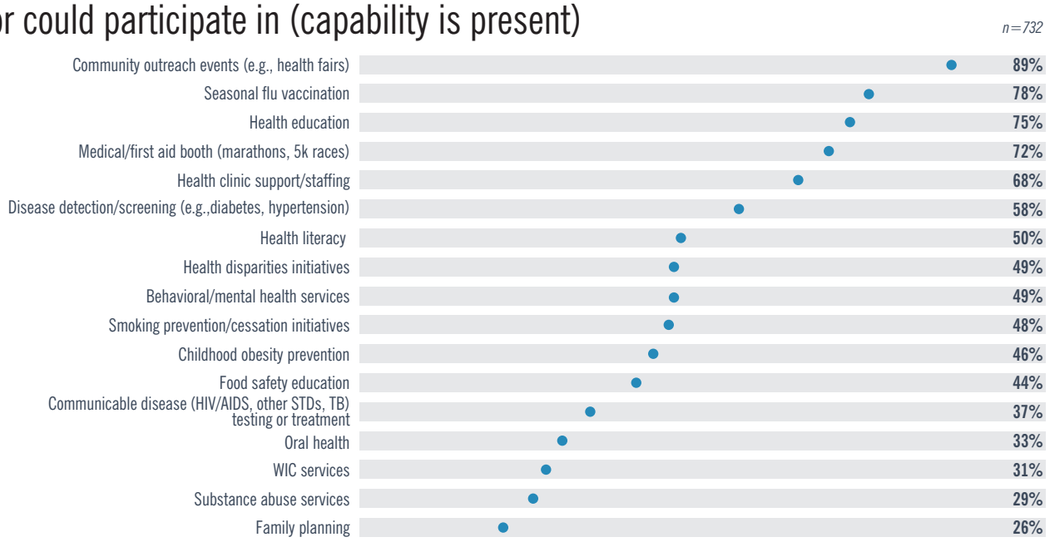
MRC CAPABILITIES

For each activity or service, respondents indicated whether or not units had performed the activity in the last year, could participate, could not participate (capability not present), or would not, because of their mission (see next page ✳). More than three-fourths of MRC units reported the capability present to participate in community outreach events (e.g., health fairs) (89%), seasonal flu vaccination (78%), and health education (75%). The results reveal that most MRC units are capable of participating in many public health activities, even those units that do not reside in the local health department. When presented with the same question for emergency preparedness activities, an overwhelmingly majority of units responded that they already performed these activities or had the capability to perform them in their community (see next page ❁). The top reported activities were information campaigns for personal preparedness and National Preparedness Month (90%), mass vaccinations/mass dispensing services (85%), Emergency Operations Center support (81%), and general shelter support (human or animal) (80%). Providing such services positions the MRC to be a valuable resource for planning and responding to emergencies.

"Each jurisdiction in our state has a different take on the use and construct of [its] MRC. The flexibility of the program allows the locals to use these volunteers as they see the best fit."

-Stakeholder survey respondent

Public health activities MRC units have participated or could participate in (capability is present)

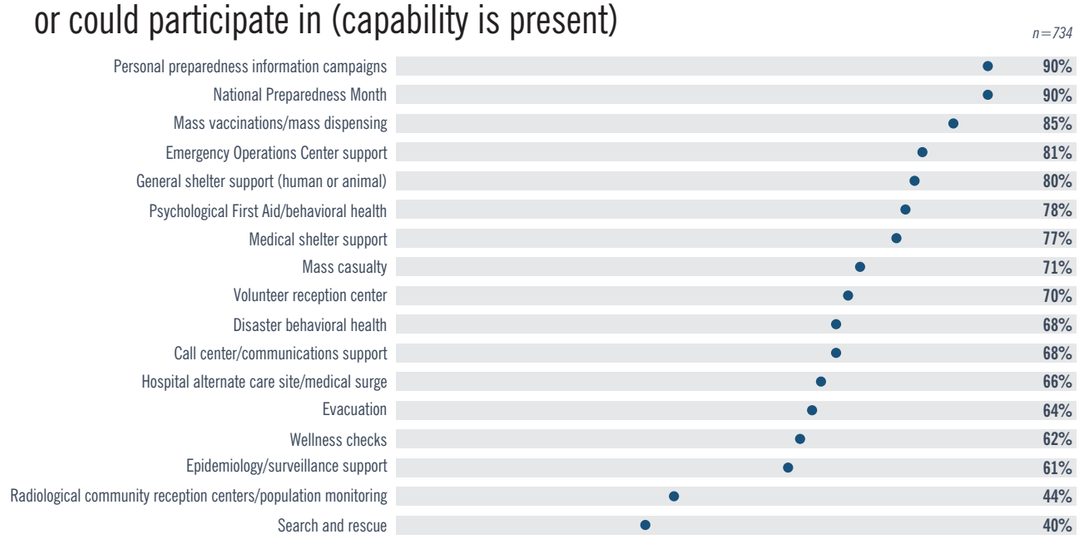


UNITS RESPOND TO EMERGENCIES

Initially created as a national corps of response volunteers for human-made and natural disasters, the MRC continues to assist communities with local and regional emergencies. Nearly a fifth of units (19%) responded that they had participated in an emergency response in the last year, down from 41% in 2013 (✣). The Federal Emergency Management Agency reports that in 2012 (the time period covered in the 2013 survey) there were 112 federally declared disasters, while in 2014 (the time period covered in the 2015 survey), that number decreased to 84.[3] In addition, Superstorm Sandy made landfall in October 2012; in response, 37 units deployed over 2,000 volunteers.[4] These differences between survey years (2012 and 2014) could help explain the decrease of MRC units that responded to emergencies. Future surveys may show if the percentage of units responding to emergencies is related to the federally declared disasters.

Of the 19% that did respond to some type of emergency, respondents cited the most common type of event as a natural disaster (64%), followed by an infectious disease outbreak (30%).

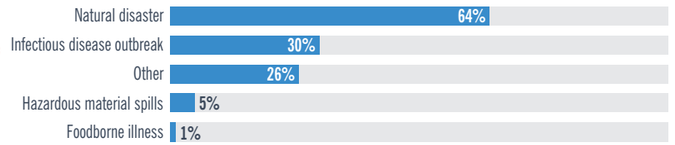
Emergency Preparedness activities MRC units have participated or could participate in (capability is present)



Response to emergency in previous year

2013	2015
41%	19%
n=812	n=781

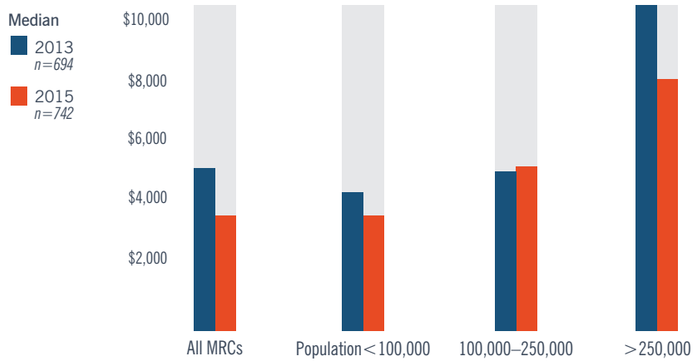
Type of emergency response activities



"The MRC is the most organized and effective emergency management-related volunteer organization in my state. MRC volunteers have responded and been utilized by public health and medical system organizations at some level in every large-scale disaster dating back to 2005."

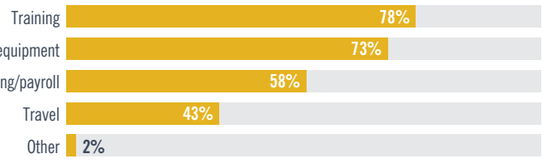
-Stakeholder survey respondent

✱Current operating budgets decreasing

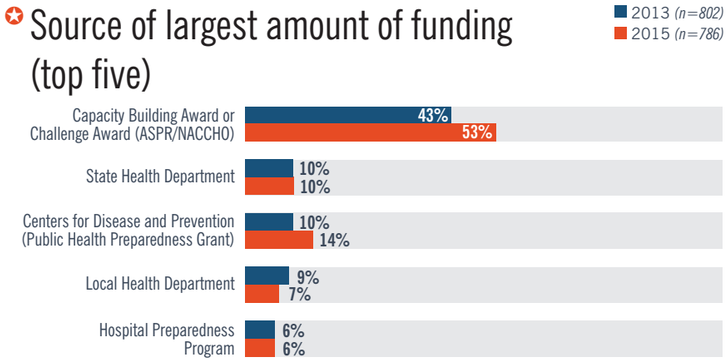


✹Budget items ranked among top three impacted by funding costs

n=689



✪Source of largest amount of funding (top five)



FUNDS TO MRC DECREASED

MRC units reported on the operating budget for the most recent fiscal year. The median budget decreased by 11% from 2013 to 2015 (✱). The units serving the largest and smallest jurisdictions saw the biggest decreases, while units serving medium-sized jurisdictions (100,000–250,000) did not report a decrease over the same period. Unit leaders ranked the top three areas of their budget that were, or would be, affected by funding cuts (✹). Seventy-eight percent of units placed training in the top three of their concerns when ranked by priority. Cuts to volunteer training could have implications for a unit's capacity to provide services and support when called upon for an emergency.

When asked about types and sources of funding in 2015, 53% of units reported the Capacity Building Award (CBA) and Challenge Awards from NACCHO and ASPR as their largest funding source, an increase of 10% since 2013 (✪). The CBA can help increase a unit's capacity by funding projects, training, or other activities that address a community's local needs and interests in emergency response and public health activities. The Challenge Awards encourage innovation in areas that both align with national health initiatives and are significant at the local level (see pages 26 and 27 for information on the impact of the Challenge Awards). More units (14%) reported receiving Public Health Preparedness Grant funding from the Centers for Disease Control and Prevention, compared with 10% in 2013. The number of different sources of funding is still low, whereas most units (77%) report receiving funding from less than two different sources (✳).

"The minimal funding received to sustain an MRC unit may work for cities with lots of staff and resources, but it is not sufficient for smaller communities with limited resources. Often those are the communities that are the most vulnerable and the most in need of the services provided by the MRC."

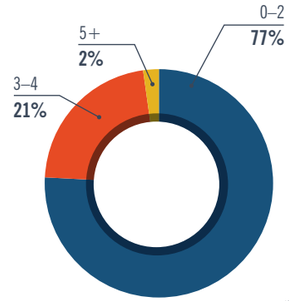
—Michael Klass, MD, San Mateo Coastside MRC

The Collin County MRC gathers for instructions prior to a training.

TECHNOLOGY USE DURING EBOLA OUTBREAK: COLLIN COUNTY, TEXAS

When Ebola first hit the United States in 2014 in Dallas, local healthcare workers were learning how to respond on the job. The Collin County Health Department, located less than 50 miles from Dallas, was called upon to assist in monitoring anyone who may have come in contact with the Dallas patient during the 30-day incubation period. When the health department was unable to find nurses willing to visit the homes of patients at higher risk of contamination, the Collin County MRC stepped in. The MRC decided to implement a unique approach for contact monitoring—using Apple FaceTime and Microsoft Skype. Through the use of technology, volunteers and healthcare practitioners were able to assess patients' health in real-time and watch patients take their own temperature (presence of fever could be a key indicator that someone might be infected with the virus). Real-time health monitoring may be a model for how MRC volunteers can assist in future infectious disease outbreaks.

✳Number of revenue sources in most recent fiscal year



n=797

2014–2015 MRC Stakeholder Study

MRC partnerships with state and local officials bring a workforce multiplier to public health and emergency response services. The need for partnerships to expand and strengthen is likely to increase as communities face ongoing budgetary declines in public funding, coupled with increasing demands on resources.

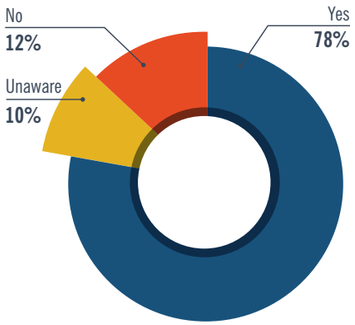
Jurisdictions that recognize the need for additional capacity during day-to-day activities or during surge events understand the importance of a volunteer corps to supplement public health workers and first responders. Understanding successful partnerships, or the reasons why partnerships do not exist, will help in identifying where and how to provide assistance moving forward. Additionally, the supporters of MRC units have the potential to influence policies and strategic decision-making from the local to federal level.

In fall 2014, NACCHO began work on a study of state and local health and emergency management officials on their perceptions of the MRC network and what partnerships exist, why they may not exist, and how best to strengthen those relationships. NACCHO conducted focus groups to understand the perspectives and opinions of the MRC from specific stakeholders.

Based upon the results of the focus groups, NACCHO developed the 2014–2015 MRC Stakeholder Survey. This survey provided data on existing partnerships with local MRC units, including strengths and challenges of these relationships. The survey, along with the focus groups, provided information on current relationships between stakeholders and MRC units and perceptions and expectations of the program. NACCHO gathered information from as many stakeholders as would participate in the study, with the understanding that the following findings may not represent the entire MRC network.

Each unit serves its respective jurisdiction to meet local needs and improve the health and safety of communities. Survey respondents were asked if there is an MRC unit in their jurisdiction (✣). According to survey responses, the most important service that an MRC provides is public health preparedness and public health emergency response. Nearly all respondents (87% and 90% respectively) felt that preparedness and emergency response were important or very important for an MRC to provide in their respective jurisdictions (✵). Public health promotion activities followed closely with 66% of respondents feeling that these activities were either important or very important to provide.

✣ Is there an MRC unit in your jurisdiction?



✵ Importance of activities

Almost all (90%) respondents felt that public health emergency response activities are important or very important for an MRC to provide. *n=168*

Most (87%) respondents felt that public health preparedness activities are important or very important for an MRC to provide. *n=168*

Most (66%) respondents felt that public health promotion activities are important or very important for an MRC to provide. *n=168*

PUBLIC HEALTH PROMOTION

Many MRC units assisted with activities to improve public health in their community, such as increasing health literacy, supporting prevention efforts, and eliminating health disparities. MRC units used public health promotion opportunities to provide information about the program and to engage local community members in public health efforts.

ENHANCEMENT

More than half of respondents (58%) felt that the MRC had enhanced the public's health in their jurisdiction. Examples of activities provided in the survey included health education and disease prevention screenings.

RELIABILITY

Half of survey respondents either agreed or strongly agreed that they could rely on their jurisdictions' MRC units to provide public health promotion services when requested.

EFFECTIVENESS

With respect to health promotion activities, 73% of respondents felt that the MRC was either effective or very effective in facilitating general public health activities.

PUBLIC HEALTH PREPAREDNESS

MRC units may be involved in public health preparedness activities to support and better prepare both volunteers and their communities for disaster. Examples include community preparedness campaigns, exercises, and drills.

ENHANCEMENT

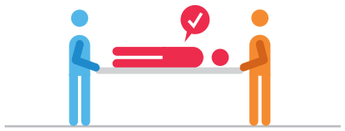
The majority of survey respondents (78%) either agreed or strongly agreed that the MRC had enhanced their jurisdictions' public health preparedness for an emergency or disaster.

RELIABILITY

Seventy-five percent of survey respondents either agreed or strongly agreed that they could rely on their jurisdictions' MRC units to provide public health preparedness services when requested.

EFFECTIVENESS

With respect to public health preparedness activities, 80% of respondents felt that the MRC was either effective or very effective in enhancing public health preparedness.



PUBLIC HEALTH EMERGENCY RESPONSE

MRC units may be called upon in times of need to provide support following a disaster or an emergency. If involved in emergency response, local units are part of an organized and trained team, ready and able to bolster local emergency planning and response capabilities. Public health emergency response activity examples include shelter support and mass vaccinations.

ENHANCEMENT

Over three quarters of the survey respondents (76%) either agreed or strongly agreed that the MRC had enhanced their jurisdictions' public health emergency response to a disaster or an emergency.

RELIABILITY

Seventy-seven percent of survey respondents either agreed or strongly agreed that they could rely on their jurisdictions' MRC units to provide public health emergency response services when requested.

EFFECTIVENESS

Not all MRC units participated in emergency response within the last two years, therefore the 2015 MRC Stakeholder Survey did not ask partners about the effectiveness of units for public health emergency response. ●

MRC Challenge Awards Take Root in Communities

In 2012, NACCHO and the Medical Reserve Corps Program developed the MRC Challenge Award to promote innovation within the network and demonstrate MRC unit capabilities.

As part of the application process, MRC units assess and determine community needs. Based on the results, MRC units may apply for an award in one of four focus areas drawn from federal strategies or guidelines: (1) Chronic Disease Prevention; (2) Community Resilience; (3) Mental and Emotional Health and Well-Being; or (4) Partners for Empowered Communities. In year one (2013–2014), NACCHO awarded 29 MRC units with $20,000. In year two (2014–2015), based on the program's success, NACCHO nearly doubled the number of awards at $15,000 each.

CULTIVATING AN IDEA

Each project required a project plan and investment from the award, but it took more than seed funding for the projects to be successful. Feedback from key informant interviews and final project evaluations indicate that a strong foundation of funding, leadership, and community support were critical for noticeable results and overall project success. Awardees credited successes to the following:

- Monetary funding and quality assistance from NACCHO allowed MRC units to address health issues that were often overlooked because of an overextended workforce or limited funding.
- A strong MRC unit leader or project coordinator to develop community partnerships was necessary to leverage untapped resources. Often communities have the resources needed to support public health initiatives but lack the coordination to see a project through. Additionally, the partnerships established through the Challenge Award can encourage future collaboration and funding opportunities.

On average, awardees utilized volunteers for

301 HOURS

per project—nearly $7,000 in workforce hours.

UNIT HIGHLIGHTS

The stories on the following page illustrate how the Challenge Awards can support local level projects and initiatives that can be replicated on a national scale.

FINAL EVALUATION THEMES

Each awardee completed an evaluation at the end of the project year. Seventy percent of the awardees provided insights into challenges and successes.

- **100%** of respondents reported new or enhanced partnerships that allowed units to leverage existing resources to maximize their impact on the community.
- **70%** reported that their projects could be replicated by another MRC unit. MRC units can share model practices from Challenge Award projects that have already been developed and proven effective.
- **50%** of respondents reported their projects were sustainable beyond NACCHO's award funding. Reasons include adoption of the project by the state or local health department, partner organization, or housing agency.
- **40%** reported addressing the needs of a vulnerable or at-risk population. Awardees created and maintained community resiliency by targeting underserved populations.

BROOKLINE MASSACHUSETTS MRC

The "Brookline Youth Wellness Project" is a collaboration between the Brookline Public Health Department and MRC to address the mental health of Brookline's youth. During an assessment, the MRC discovered a high percentage of students reported symptoms of anxiety, stress, and depression. Although Brookline had potential resources (e.g., MRC, student groups, social workers, the LHD), it lacked a collaborator. The Challenge Award provided a necessary resource. A mental health curriculum was developed and implemented in high school classrooms and parent meetings. A safe space approach gave teens a voice to speak to parents through anonymous letters. This program equips parents to recognize the symptoms of depression and anxiety and when and how to refer kids for treatment. As partners learned of the success, they adopted the curriculum into their own teaching programs. The project has paved the way for Brookline to obtain other funding from their school, LHD, and additional grants.

MARYLAND RESPONDS MRC

Through a unique partnership with the Maryland Institute College of Art (MICA) Center for Design Practice, the Maryland Responds MRC used art, design, and health communication strategies to build community resilience through a public information and volunteer recruitment campaign. MICA students attended MRC events to immerse themselves in the activities and culture of an MRC unit. Additionally, two students pursuing master's degrees in public health performed research to gain a holistic understanding of why people volunteer and who are the target groups for recruitment. Results guided the MICA students to develop a new brand and materials for the MRC. They also highlighted gaps in recruitment that limited the diversity in backgrounds for leadership roles within the MRC. Through collaboration between MICA and the Maryland Responds MRC, the rebranding of the MRC created a unified image to external audiences and an increased feeling of cohesion for volunteers.

CENTRAL GEORGIA MRC

Across the country, Veterans of Foreign Wars (VFW) posts participate in annual "Stand Down" events to provide health services to homeless veterans. In central Georgia, the VFW also conducts regular food drives. Through a needs assessment, the Central Georgia MRC found that, apart from Stand Down, no other programs reached out to veterans for ongoing health screenings. "Operation Get Healthy" set out to change that. Now, when veterans visit the VFW to pick up food, MRC volunteers administer blood glucose and blood pressure screenings to willing participants. Results are recorded and progress is monitored. Often, clients are referred to the community health center, where they receive care for little or no money. MRC volunteers also provide nutrition and basic laboratory testing education. The results show a positive change in screening outcomes. Participants are engaged and willing to adopt healthy nutrition practices and are thrilled when their test results show improvement.

PART 4

Trained and ready

KEY FINDINGS:

93% of units offer in-person CPR/first aid/automated external defibrillator (AED) training.

88% of units revise their training plan after volunteer feedback or following after-action reports.

60% of units familiar with the Factors for Success have completed the scoring matrix to gauge a unit's development and capacity.

OVERVIEW

Properly trained volunteers are essential in public health emergency response. Training can vary based on volunteer interests, skills, and backgrounds; however, ongoing, proper training for specific volunteer roles is vital. Emergency response partners value proper training and continually look to local MRC units as a source of workforce multipliers during a disaster.

VOLUNTEER TRAINING

MRC volunteers come from a variety of backgrounds and enter the program with varying credentials, capabilities, and professional experience. This diversity is a strength of the program but also makes standardization across the MRC network difficult. The use of common core competencies can allow for greater consistency in knowledge and skills of MRC volunteers and the identification of areas where work is needed for an MRC unit to fulfill its mission in the community.

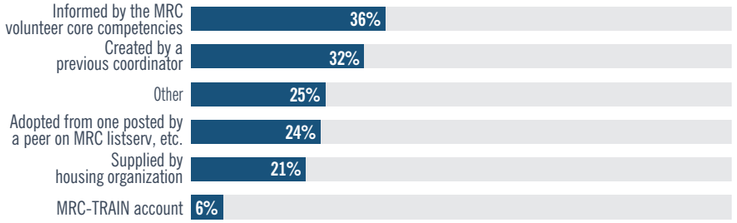
In 2012, the National Center for Disaster Medicine and Public Health (NCDMPH) released a set of core competencies for Disaster Medicine and Public Health (DMPH). These competencies closely align with the attitudes and overall national mission of the MRC to improve the health, safety, and resiliency of the nation. The MRC Program announced the adoption of the DMPH competencies for the MRC network in April 2015. Working with valued partners like NCDMPH on the creation of competency-based content and resources related to identified training gaps for the MRC will assist in raising the awareness of MRC capabilities through public health and disaster medicine communication channels. "The MRC is the first organization with a national reach to implement the core competencies. The NCDMPH is thrilled with the MRC adoption of the core competencies in DMPH and pledges to support the effort as much as possible," said Dr. Kenneth Schor, acting director of the NCDMPH.

IMPORTANCE OF MRC VOLUNTEERS CITED IN NATIONAL GUIDANCE

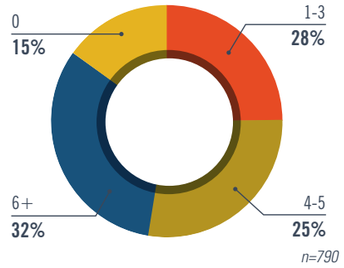
Volunteers have been essential during disasters when the need for first responders reaches capacity. Federal entities recognize the value the MRC brings to emergencies and promotes proper training of volunteers through national guidance and recommendations. The Centers for Disease Control and Prevention's Public Health Preparedness Capabilities, #15: Volunteer Management, states, "Prior to an incident and as necessary at the time of an incident, support provision of initial and ongoing emergency response training for registered volunteers. Training should be supported in partnership with jurisdictional MRC unit(s) and other partner groups."[5] In addition, within the context of ASPR's National Health Security Strategy, the workforces supporting emergency management systems will be "well-educated in their respective disciplines, established incident management practices, and safety protocols. Volunteers will be trained in key evidence-based competencies."[6]

Newaygo County, Michigan
The MRC partnered with EMT services to hold an evacuation drill.

How the training plan was developed



Number of training partners



"Aligning our trainings under the four learning pathways provided as part of the new MRC Core Competencies makes the purpose of the trainings very clear to the volunteer. I am particularly pleased to have a Volunteer Leadership pathway!"

-Loren Stein, Oklahoma Medical Reserve Corps Education Coordinator

Over 70% of MRC units have a written training plan, down from 84% in 2013. Units that serve medium and large jurisdictions are more likely to have a written training plan than units serving small jurisdictions (data not shown). When asked about how the training plan was developed, units most often cited the MRC volunteer core competencies (36%) (❄). Very few units (6%) used their MRC-TRAIN accounts to track their volunteer training plans. Some states are TRAIN affiliates and unit leaders may not realize their state TRAIN system and MRC-TRAIN are essentially the same platform thus affecting this selection. Integration of the new MRC volunteer core competencies in MRC-TRAIN will allow MRC units to track their volunteers' training and may help to catalog, evaluate, and raise the awareness of MRC capabilities among the network and partners at all levels.

The findings from the training section also revealed more about the training methods and how trainings are offered to volunteers—online or in-person (✳). The MRC Program Office recommends that all MRC units adopt the National Incident Management System and an Incident Command System for response.[7] Most Federal Emergency Management Agency courses that are offered to volunteers are online and mandatory. Nearly all MRC units (93%) offer in-person CPR/first aid/AED training. Most MRC units also offer in person basic life support (84%) and Psychological First Aid (80%) trainings to volunteers. The high percentage of units offering these three trainings provide a solid foundation of critical skills necessary for deployment in an emergency response.

Many MRC units collaborate with multiple partners to train volunteers. Almost a third (32%) of the network reported training with six or more entities in the past year, and 57% trained with four or more (✧). In this area, MRC units are well integrated into the community.

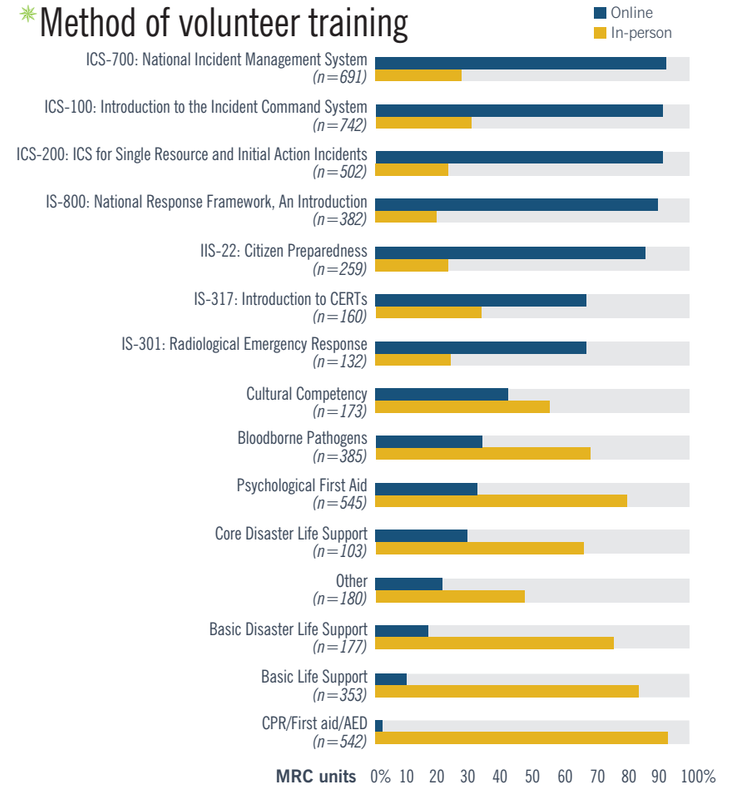
71%
of MRC units have a written training plan

READY TO SERVE

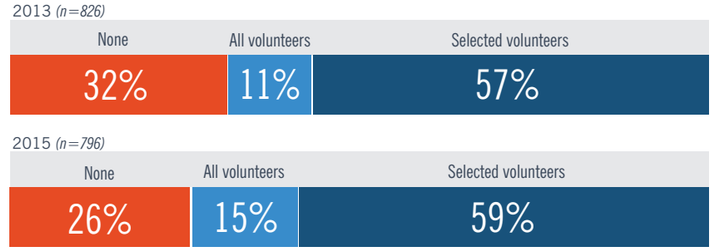
Understanding the skills volunteers bring to the MRC unit is an important task for unit leaders. Many use an initial application (43%) to assess the skills a volunteer is bringing to the unit. After volunteers are trained, unit leaders use different methods to assess volunteer skills. Thirty percent conduct pre- and post-training tests, and 73% of units request a certificate upon completion of a training course. Feedback received through these methods also helps shape future trainings; in fact, 88% of unit leaders change their training plan after volunteer feedback or after-action reports (data not shown).

Vetting volunteers through background checks and confirming credentials for medical professionals interested in joining an MRC unit is part of any unit's procedures. In 2013, 32% of MRC units reported that they did not conduct background checks on their volunteers (❄). That number has decreased to 26% in 2015. Although not a large difference, the results indicate more units are finding ways to vet their volunteers properly. Of the 26% that still do not conduct background checks, the top reason cited by unit leaders (61%) is the cost of performing the checks (data not shown). When asked about credentialing medical

Method of volunteer training



Background checks



NATIONAL HEALTH SECURITY STRATEGY: MACOMB COUNTY MRC, MICHIGAN

In 2015, ASPR released the updated National Health Security Strategy, a document designed to minimize the health consequences of large-scale emergencies. At more than 100 pages, it can be overwhelming, but that did not stop Kara Marsh, the MRC coordinator of the Macomb County unit in Michigan, from using the guide in her unit's development. The strategy appealed to her because the national vision applied to all levels of government and focused on the role of volunteers in health security. When she first read the document, she removed all sections that did not directly apply to her unit. Soon after creating a 15-page version of the strategy that applied to the Macomb County MRC, Kara noticed that the unit's activities already fit into many of the strategy's objectives. "The strategy provides national support for what MRC units are already trying to accomplish," said Marsh. She presented her adaptation of the strategy at the 2015 Preparedness Summit. Since then, she has helped units across the country to implement the National Health Security Strategy in their planning. The Macomb County MRC is also reorganizing its volunteer training program to highlight the National Health Security Strategy and updated MRC Core Competencies so new volunteers will understand the MRC's role in the country's public health preparedness.

An MRC volunteer participates in a drive-in point-of-dispensing training.

Tulsa, Oklahoma

Volunteers provide free dental services during the February Missions of Mercy event.

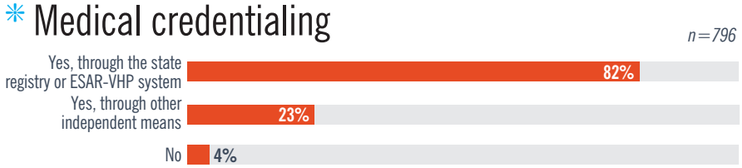
volunteers, 96% of units verify medical credentials of their medical volunteers through state registry, the ESAR-VHP system, or independent means (✳). The number of units that do not verify medical credentials decreased from 6% in 2013 to 4% in 2015.

FACTORS FOR SUCCESS

The Factors for Success, a set of programmatic elements or "stepping stones" that form a path unit leaders can follow to navigate unit development, operation, and sustainment were introduced in 2013. The Factors for Success incorporate generally accepted practices of organizational development, especially those associated with volunteer or non-profit organizations. Forming, developing, operating, and sustaining an MRC unit can be challenging; this tool provides leaders with an easy-to-navigate checklist to facilitate the steps required.

When asked about knowledge of the Factors for Success, 87% of MRC units reported they were familiar with them (✤). The 13% of units unfamiliar with the Factors for Success reveals the need for continued messaging to show units the value of the resource in unit development. Of those that reported familiarity with the Factors, 83% said they used them in the technical assistance assessment (TAA) with regional coordinators, and 60% had completed the scoring matrix to gauge a unit's development and capacity. Seventeen percent had done all three activities—used the Factors for Success with regional coordinators as part of the TAA, completed the scoring matrix, and updated administrative policies and procedures based on the assessment (data not shown).

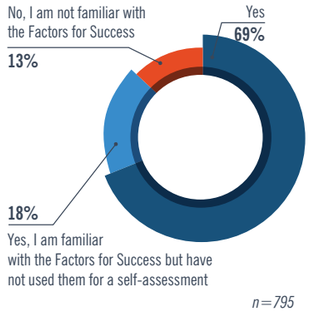
✳ Medical credentialing



New York City, New York

The NYC MRC participates in community outreach to underserved populations in the area.

✤ Familiarity with the Factors for Success tool



PART 5

Future of the MRC

For the MRC to become a trusted resource to all communities, it must be seen as a reliable and recognized partner on the local, state, and national scale. The MRC Stakeholder Study revealed that a small number of jurisdictions are still unaware of the MRC network and how it can assist in public health and emergency preparedness. Partners and those that are familiar with the MRC have identified opportunities to incorporate MRC into public health and preparedness activities and emergency response plans. They continually use MRC volunteers and have a high degree of trust in and comfort with the program. Consequently, those that lack a local unit or are unaware of the program do not share the same perceptions. Thus, the MRC network must continue to remind potential partners of its value and importance by sharing stories and promoting the program, thereby ensuring continued support to local MRC units. In addition to program promotion and sustainability, the MRC should investigate persistent challenges related to legal protections and standardization. The MRC must work to provide potential volunteers with the security of legal protections in the event of an incident and inform jurisdictions of capabilities of the MRC and what jurisdictions can expect in terms of baseline training and abilities of its members.

The DMPH competencies for the MRC is one step toward baseline standardization. They provide an organizing principle for professionals and MRC volunteers that systematizes the knowledge and competence needed for public health, disaster preparedness, response, and recovery. By providing a common language, MRC units can communicate their volunteers' capabilities to each other and to partner organizations. Through the national MRC Training Plan and input from the MRC network, consistent use of the DMPH competencies will improve the overall training practices and methods of the MRC network and better enable collaboration and promotion of MRC capabilities at the local, state, and federal levels. Future research obtained through MRC Network Profile studies may reveal the impacts the DMPH competencies have on training and the standardization of the MRC nationwide.

Legal protections continue to be a challenge for MRC units and their volunteers. The number of units that do not have any protections for their volunteers has decreased since 2013 from 19% to 17% in 2015. However, legal protection is still an area of concern for many states because liability coverage can be a limiting expense. Volunteers assisting during a declared emergency may be explicitly immune through liability protections found in public health emergency statutes, such as those in states that have adopted the Model State Health Emergency Powers Act.[8] However, unit leaders are also concerned with legal protections of their volunteers during day-to-day activities between emergency deployments.[9] Further, as LHDs experience funding cuts, MRC volunteers often step in to fill gaps. Local and state advocacy is necessary to encourage the protection of volunteers during routine trainings and exercises in addition to response and recovery activities.

Federal funding for the MRC program by the Department of Health and Human Services' Public Health and Social Services Emergency Fund peaked in 2010 with a high of $12.5 million. At the time of this report, current funding for the MRC both nationally and locally is threatened. The Senate Appropriations Committee recently voted to cut the budget to just $4 million in the 2016 fiscal year. A decrease in funding reaching MRC units could have implications for future training, supplies, or equipment to carry out missions. Many LHDs rely on this funding to support activities such as dispensing vital medications during a pandemic or other infectious disease outbreak, providing accurate and up-to-date risk information to their communities, and staffing shelters for those displaced by a disaster.[10] Over time, the reduction of federal funds without the replacement of other resources could decrease the local capacity for communities to plan for and respond to emergencies and impact the overall health and safety of the nation.

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New programs and initiatives for the MRC, such as the Factors for Success, MRC Connect, and the Core Competencies, address some challenges facing the program. Partnerships with national organizations and support from ASPR and the MRC program office continue to build capacity for the MRC nationally. Further research will reveal the impact these interventions have on the program at the local, state, and national levels.

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The 2015 Network Profile of the Medical Reserve Corps

Connecting with communities

The MRC: A network of dedicated volunteers

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