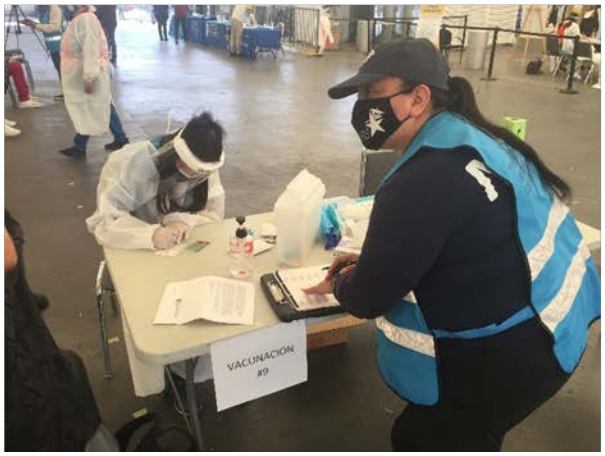
Medical Reserve Corps

2021 Deployment Workshop Findings

June 2021

PROMOTE, SUPPORT, AND BUILD CAPACITY IN THE MEDICAL RESERVE CORPS



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

medical reserve corps

Table of Contents

Findings from the Medical Reserve Corps Volunteer Deployments Barriers Workshop

Introduction and Background:

The National Association of County and City Health Officials (NACCHO) through a three-year cooperative agreement entitled "Medical Reserve Corps (MRC) Small Grant Program" aims to build the response capabilities of MRC units, identify and address barriers to the use of MRC units and volunteers during emergencies and disasters, and develop a sustainability plan to continue to maintain response capabilities. Through this cooperative agreement NACCHO conducted a virtual MRC Deployment Workshop on April 12, 2021.

Goals & Objectives:

One of the goals of NACCHO's cooperative agreement is to foster collaboration between MRC units and key stakeholder to facilitate the integration of the MRC in local, statewide, or interstate deployments. The workshop format and objectives were developed with this goal in mind and to gather input from MRC leadership and public health and emergency planners on the successes or challenges of deploying MRC volunteers.

The goal of the virtual 2021 MRC Deployment Workshop was to identify MRC volunteer deployment barriers, critical workforce roles, factors contributing to deployment barriers, successes that can be expanded across the network, and resources required to address barriers and future solutions.

Methodology:

ASPR MRC Regional Liaisons provided recommendations for local and state MRC leaders to participate in the workshop, with NACCHO sending out invitations to approximately 50 individuals. NACCHO invited select local and state public health planners that were members of NACCHO's Project Public Health Ready Program. A total of 38 participants were identified and randomly placed into four groups. Each group included two ASPR MRC Regional Liaisons, one State MRC Coordinator, two to three local or state Public Health Planners and or Emergency Planners, and finally four to five MRC Unit Leaders and or volunteers.

A platform called Mural was used for the virtual workshop to provide an interactive environment for participants. The platform allowed the design of a breakout room wall, where participants could add post-it notes during discussions (see Appendix A). To prepare for the workshop, participants received a pre-workshop assignment with the questions that would be discussed during the workshop. They were asked to pre-identify their top 3 deployment success and challenges and areas to be addressed before coming to the workshop. During the facilitated discussion, participants were asked to add their success and challenge inputs onto the breakout wall. The Roses, Buds, and Thorn's concept was used to categorize participant inputs and identify successes to be captured for the next generation of MRC deployments (Roses), challenges that we may not be able to fix or may be unique to a particular locality (Thorns) and finally areas that have potential to be a success with additional resources (Buds). After the inputs were identified as a Rose, Bud, or Thorn the groups were asked to identify the top priorities and capture key takeaways.

Evaluation of the workshop:

At the conclusion of the workshop a short evaluation was sent directly to participants to capture feedback on the format of the workshop and value of the overall workshop with 12 responses provided. Overall, 92.3 % of the participants were satisfied or very satisfied with the background information and purpose of the workshop and over 90 % satisfied or very satisfied with overall workshop discussion and opportunity to learn.

Workshop Findings:

Through the Mural platform and recordings of the workshop, NACCHO was able to capture the inputs (post-it notes) that each of the groups provided, as well as their identification of the top priorities and key takeaways. The inputs included areas of success and challenges, which NACCHO categorized by different identified themes. Finally, NACCHO examined these inputs and developed supporting recommendations to maintain the successes or actions needed to address the challenges.

Areas of Success:

The successes identified were categorized by the following themes:

- **Surge Capacity**:
  - The COVID-19 response demonstrated that MRC units had the ability to expand and provide workforce surge support at levels never seen before and for an extended period.
  - Using COVID-19 funds some MRC units were able to build upon and expand the existing ESAR-VHP system to manage volunteers.
- **Responsive and Adaptable**
  - During COVID 19 response MRC units demonstrated their ability to adapt to the changing response requirements.
  - MRC units were able to expand MRC capabilities to provide support for new missions, large-scale events that included multiple agencies, and long-term support requirements, such as call centers, contact tracing, and mass vaccination clinics.
  - MRC units created specialized response teams to support different missions.
  - In terms of providing and delivering trainings MRC units were able to adopt quick to move most trainings to virtual.
- **Collaboration and Partnerships:**
  - MRC units collaborated and partnered with community, academic and medical institutions to recruit, train and even deploy volunteers to help with many missions like testing, assisting with patients care, and mass vaccination clinics.
  - Beside tapping into the existing partners, MRC were able to develop new community partnerships during COVID 19 response.
  - COVID-19 response demonstrated that MRC units with a solid foundational structure and established presence with community response partners were an integral component of local response efforts.
  - Consistent Community use of MRC that led to positive media coverage and explosion of new volunteers

Deployment Barriers:

The deployment barriers Identified were categorized by the following themes:

- **Funding:**
  - The lack of funding was identified as the main barrier to build, strength and sustain MRC units around the country.
- **Volunteers Recruitment Issues:**
  - The lack of Statewide awareness of MRC and potential, the lack of buy-in especially at Professional level were the reasons to the absence of diversity within volunteers which led to volunteers not being reflective of communities they served.
- **Volunteers Trainings:**
  - Standardization in training, training difficulties w/ frequent coordinator turnover and the trust in volunteers - consistency in training for all accountability at all levels are some of major barriers in terms of training.
- **Adequate Staff:**
  - Due to lack of sustainable funding, there is a high Unit Leaders turnover, Unit Coordinators assigned other duties in jobs plus most MRC Coordinators wear many different hats.
- **Volunteer Management Systems:**
  - Volunteer Management Software has limitations and outages plus the ESAR-VHP/MRC merge confuses volunteers.
- **Retention:**
  - No tools to Keep new volunteers engaged, lack of National MRC branding and not having tasks for new MRC Members.
- **Administrative:**
  - Liability workers compensation insurance coverage, organizational hesitancy for utilizing MRC without understanding of liability and reimbursement.
  - Inconsistent capacities & varying authorities to deploy.
    Lack of assistance with credential verification at state level and notification of results.
- **Volunteer Surge Capacity:**
  - Administration Management of the surge volunteers during disasters.
  - Issues Vetting of Non-registered volunteers.
- **Lack Management and Leadership involvement and support:**
  - MRC/Housing Agency staff confrontation.
  - Lack of trust in/ knowledge of volunteers.
  - Problems with local Emergency Management.
  - Managing Expectation.

NACCHO Recommendations:

Based on the identified themes for volunteer deployment successes and barriers, NACCHO proposes the following recommendations to improve the response capabilities of the MRC network.

- **Funding**
  - Increase funding is critical for the development and the sustainability of MRC units.
  - Funding provided to MRC local and state programs should be prioritized to support workforce/staffing needs, basic equipment and supplies to support training and response requirements, volunteer deployment gear, and administrative costs to support volunteer background screening, liability coverage, and workman's compensation as needed.
  - Increase funding to hire full time staff and to sustain existing unit leaders.
  - Provide centralized resources include funding to support administrative and legal requirements such as background checks for MRC volunteers.

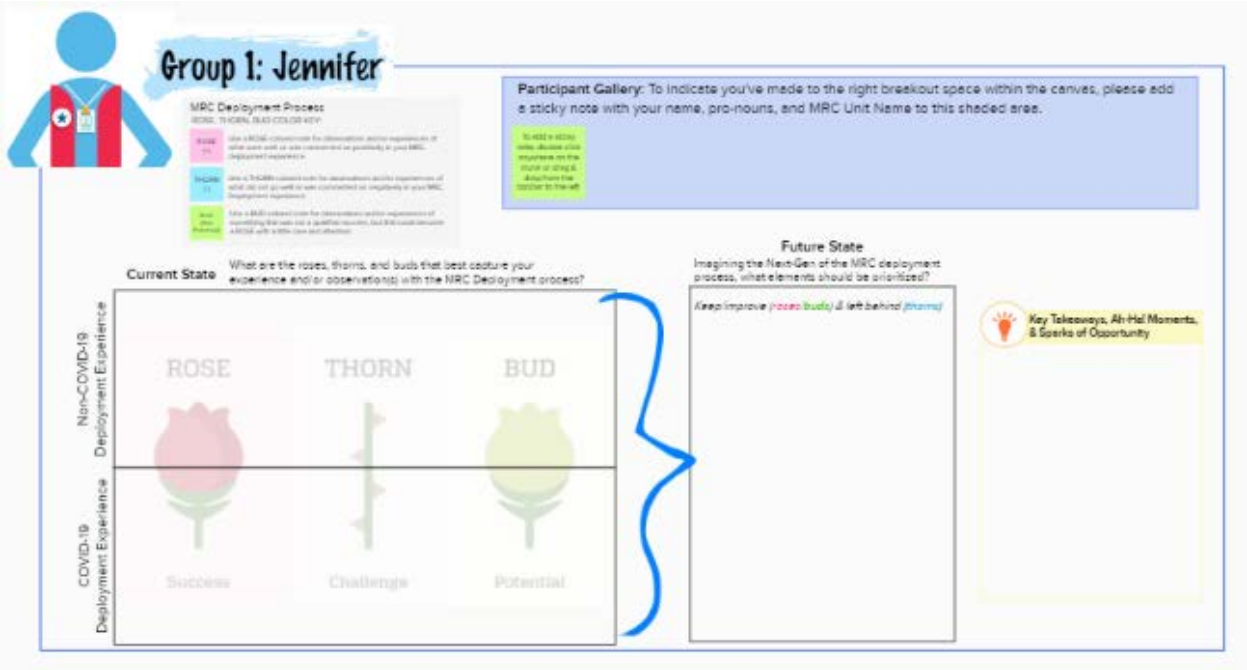
- **Volunteers Recruitment, Volunteers Trainings, Volunteers Retention**
  - Develop national level recruitment resource kits and media kits. (ASPR & NACCHO)
  - Create national medica campaign with strategies to promote and build awareness of the MRC program and response capabilities. (ASPR)
  - Work with NCDMPH and others to standardized trainings. (NACCHO)
  - NACCHO is working on developing Unit Leaders Trainings modules 2021-2022. (NACCHO)
  - Educate new units' leaders about the trainings and other available recourse to build their competencies and volunteers competencies.
  - Develop Covid- 19 mission sets.
  - Work with the PHIS Team to develop diversity and health equity training resources. (NACCHO)
  - Building out consistent trainings' programs help retain volunteers. (NACCHO)
  - Create tools on how to retain volunteers and keep them engaged. (ASPR & NACCHO)
- **Volunteer Management Systems:**
  - Create an approved national list of vendors that can support the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) system. (ASPR)
  - Upgrade the ESAR-VHP system to become a national system to manage volunteers. (ASPR)
  - Create tools to manage volunteers' surge. (NACCHO)

Follow on Steps:

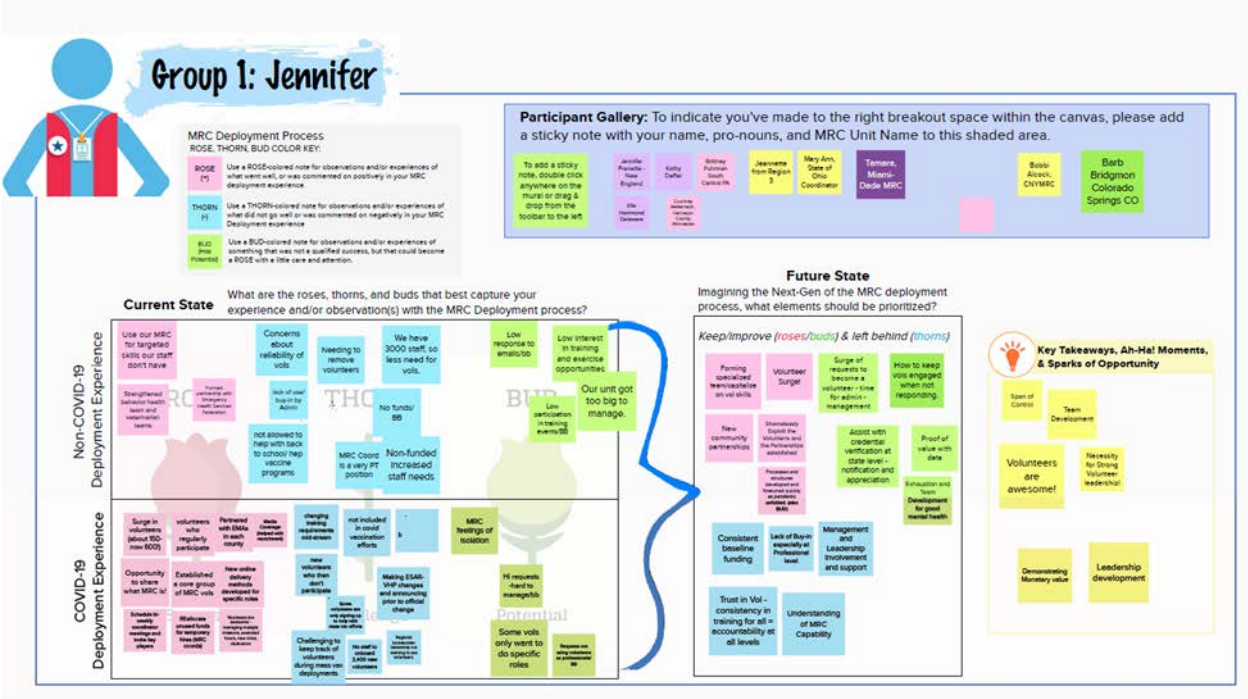
- NACCHO conducted a national webinar on 6/15/21 to share with 131 participants the findings of the workshop and potentially gather additional feedback. (Please see Appendix E1 & E2 for detailed list of additional input received from the webinar through Q & A and chat box)
- Publish a report of the findings and include an overview in the 2020 MRC Network Profile.

Appendix A: Examples of Mural Wall Breakout Room Template

Blank Template:



Breakout Room with Inputs:



Appendix B: Successes that have potential to impact the greater MRC Network (Roses)

- Volunteer Surge Capacity
- Strong partnerships established before COVID
- New community partnerships during COVID
- Deployment processes established that could be adapted.
- Specialized response teams
- Promote MRC response efforts
- Unit willingness & capacity to deploy/meet needs.
- Positive media coverage and explosion of new volunteers
- PREP Act to provide additional skills/liability
- Consistent community use of MRC
- Planning for future units
- One System that manages everything
- Virtual Training
- Expand MRC capabilities
- Google sheets for sharing volunteer deployment scheduling
- Collaboration with academic institutions and onboarding of volunteers

Appendix C: Areas for Improvement (Buds)

- Engaging volunteers during non-emergency and new volunteers
- Manage response fatigue and mental health during responses
- Process to verify credentials at the state level.
- Administrative workload to manage volunteer surge.
- Demonstrating monetary value of volunteer service
- Cross-train coordinators support different parts of activation.
- Health departments understand potential of MRC
- Ripe for building leadership
- Gaps in Volunteer Management tools
- Merged with CERT unit/work with Emergency Coordinators
- More MRC Diversity & Training resources
- Need an ESAR-VHP that speaks to national system
- Explore future missions and deployment scope
- Equipment purchased operationally ready
- Trainings had to be adapted for COVID

Appendix D: Challenges or Barriers that may hard to overcome or are unique to certain localities (Thorns)

- Consistent baseline funding for MRC units
- Reluctance to use volunteers, especially for professional roles.
- Understanding of MRC capabilities
- Lack of support and involvement by management and leadership
- Consistency in training for all responders
- Getting uniforms & badges to new volunteers-
- Inconsistent capacities & varying authorities to deploy
- Hesitancy to use volunteers - lack of understanding of liability
- Workman's compensation for volunteers
- Volunteers don't speak the same "Language" as staff
- Volunteers not reflective of communities served
- Tough getting PR and awareness of MRC activities
- Volunteer Management software limitations
- Lack of trust of volunteer's knowledge
- Retention of Units

Appendix E-1: List of Barriers noted from the Medical Reserve Corps Webinar "Findings from the 2021 Medical Reserve Corps Virtual Workshop"

- Lack of consistent funding, and the ORA awards take way too much time to write and apply during pandemic disasters.
- No specific funding for MRC coordinators at local level, buck stops at the top and stays there.
- Trouble recruiting leaders, incentives like short-term stipend contracts might draw in more leaders.
- New volunteers who potentially signed up just to get vaccinated and were not heard from again.
- Skilled MRC seemed like an afterthought for deployment.
- Health care systems that provided many volunteers but did not want them background checked.
- TRAIN system is not user friendly.
- Lack of time for MRC training with Covid clinics for and new MRC volunteers.
- Many volunteers did not have the technical ability required since the volunteers are mostly older/retired.
- During COVID many unit leaders are also the health department emergency response coordinator or another roll.
- No back up that can step in for as MRC Unit Coordinator.
- Volunteer coordinators becoming the central point of contact for questions from the community that was well outside the scope of volunteer coordinator leadership.
- MRC leaders also have other obligations; difficult to wear many hats with limited time and resources available.
- Earlier in the pandemic had lots of new volunteers, with project ideas, but volunteer leaders interested in driving projects. Health department staff were engaging in the more direct response missions.
- Lack of integrated database for volunteer management and deployment.
- Systems unable to work in conjunction with others.
- No background check Standards.
- Requestors do not want to "manage" volunteers.
- Keeping good records when volunteers are deployed by the different departments at the Health Department and the office of emergency management at the same time in many locations.
- Difficulties managing last minute deployments requests.
- Barriers were volunteer hours vs. Health Dept hours. There was very little overtime/comp time allowed so not every volunteer was able to be utilized effectively as work hours are 8- 4:30.
- Background checks of medical and non-medical applicants, and scheduling/communicating with 800 volunteers (membership quadrupled) during surge.
- Overwhelming of out of area volunteers that signed up for multiple areas.
- Lack of understanding that MRC exists and its capabilities.
- lack of trust from local leaders and public health officials in MRC volunteers' capabilities.
- Lack of good reporting software on National site.
- Need of MRC regional coordinators to be reaching out to Units a little more often. .

Appendix E-2: List of recommendations noted from the Medical Reserve Corps Webinar "Findings from the 2021 Medical Reserve Corps Virtual Workshop"

Recommendations:

- Develop user friendly training and efficient platforms accessible by units and volunteers.
- Build on the relationship with NDMS (DMAT) for joint operations in all states/territories.
- Utilize Volunteers memberships in professional organizations to reduce barriers
- Explore development of web-based resources to easily schedule volunteers for deployments.
- Vehicle decal/placard to allow volunteers ease of entry into controlled areas where events are taking place.
- Training for volunteers to build capacity.
- More collaboration among MRC coordinators to share successes and challenges.
- Recruitment of bilingual/multilingual volunteers in their own community.
- Develop a universal MRC volunteer database, or a central application process, with same membership criteria across the board.
- Standardized media release to news outlets about MRC Hours and Monetary Values.
- A need for a volunteer tracking system to deploy/activate volunteers.
- Standardized MRC Handbook with Inserts as events occur; example COVID 19 training and practices; Wildfire Response Training and Practices; MRC working within a Red Cross shelter, etc.
- Fund a dedicated MRC Coordinator in each district with assistants as necessary.
- Have VVHS update ESAR-VHP when Groups/Roles are entered.
- Regarding surge planning, NACCHO can add that to their leadership training.
- Train unit leaders to recognize potential leaders within their unit and a process to train those people to leadership positions.
- Find ways to retain those leaders in non-deployment times.
- A better process for orientation and background checks during surge.
- A national badging system with check-in/tracking for automatic record keeping is entirely feasible with a hundred million to spend.
- All MRCs need base funding to cover at least a part time coordinator and other basic needs, like uniforms, etc.
- Clear, easy to use tools from the national level, deployment program, more templates, etc.
- Allocate funding just for recruitment promotions and recognition awards.
- Recommendations on supervision of volunteers in clinic setting and letting partners know all volunteers are not as skilled as they say they are.
- Research methods and design details to be available. For example, sampling plan, geo/demo/experience of chosen participants, process details (how obtained consensus). essential to understand and then interpret results.
- A nationwide ESAR-VHP system that covers all the needs at both a state and national level.
- Guidance on communicating to organizations that they cannot control the volunteers for their missions; and communicating outside MRC.
- A development of a national award pin or some such for all of those who have responded to major national events.

- Standard General Liability Statement to provide to those covering, i.e.: Government, Health Dept, etc., would be helpful to them.
- An app that sends out and records time for volunteers.
- More support for MRC not housed in health department/health district.
- NACCHO issued thank you stipends grants for volunteer leaders that commit leading and facilitating future projects and deployments.
- A clear structure of recognition for volunteers' hours or shifts taken.
- A system to submit application and timesheet so it populates into A shared system w hours and license expiration, structured training staff on use of volunteers.
- A deployment process for multiple daily events in a large rural region.
- Need to have a common equipment roster for items such as portable/mobile shelters i.e. DEPLOYED LOGIX brand for the ability to build larger or scale down field operations for MRC or joint MRC-DMAT events.
- Find a better process to integrate volunteers who come from health care systems into MRC volunteers without the administrative barriers.
- Would there be any chance/opportunity for NACCHO or ASPR to help develop a liability insurance option for MRC's in volunteer situations?