



**TOP 3 PREPAREDNESS ACTIVITIES**



- Communications/texting drill
- Personal preparedness information campaigns
- Training and exercises



**TOP 3 PUBLIC HEALTH ACTIVITIES**



- Seasonal flu vaccination
- Community outreach events
- Health education



# Stronger together

A national network of volunteers



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

## INTRODUCTION

The 2013 Network Profile of the Medical Reserve Corps

# Stronger together

## A national network of volunteers

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### About this report

This report was prepared by NACCHO. The work that provided the basis for this publication was supported by funding under Cooperative Agreement 5 MRCSG101005-04-00 and 5 MRCSG101005-03-00 with the Office of the Surgeon General. 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.

### Acknowledgments

The 2013 Network Profile of the Medical Reserve Corps was a broad-based collaborative effort with contributions made by a diverse group of key stakeholders. The Division of the Civilian Volunteer Medical Reserve Corps (DCVMRC) and the Medical Reserve Corps Regional Coordinators contributed invaluable subject matter expertise during the planning and implementation of this project.

The NACCHO MRC Workgroup, led by Bobbi Alcock of CNY MRC, piloted the survey instrument and provided valuable feedback. Thanks also to the NACCHO Medical Reserve Corps staff for shaping this report: Jack Herrmann, Senior Advisor & Chief, Public Health Programs; Scott Fisher, Senior Director, Public Health Preparedness; A. Chevelle

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Finally, NACCHO thanks the 837 unit leaders that provided the information to make this research possible.

PRINTED APRIL 2014



## INTRODUCTION

# About the Medical Reserve Corps

The idea for a national volunteer corps emerged out of the tragic events of the 9/11 terrorist attacks. Thousands of medical and public health professionals, eager to volunteer in support of emergency relief activities, found that there was no organized approach to channel their efforts. Local responders were overwhelmed and did not have a way to identify or manage these spontaneous volunteers. Many highly skilled people were turned away. Americans' desire to lend a hand that day and in the months that followed revealed the need for a network to provide the infrastructure to organize and train individuals who wanted to volunteer their time and skills to benefit their community.

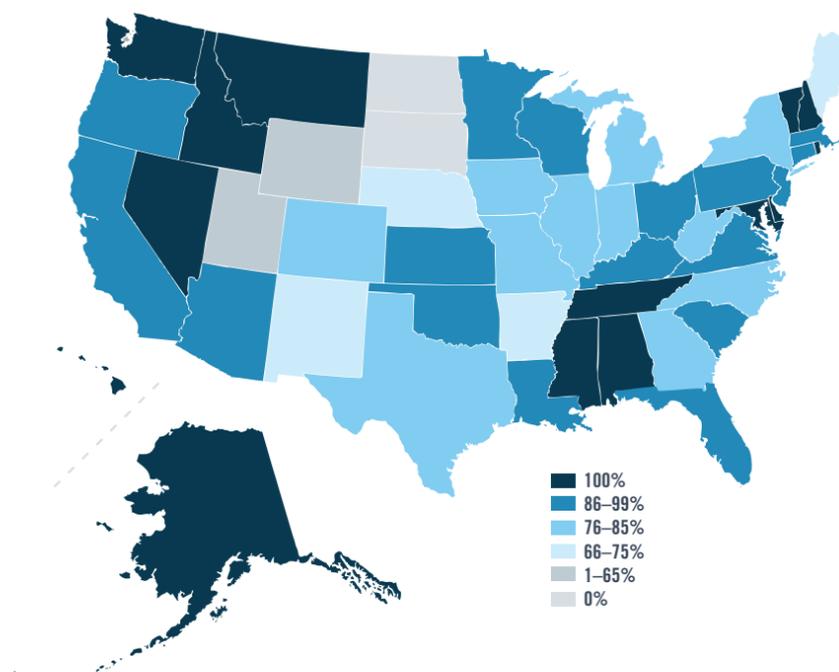
The Medical Reserve Corps (MRC) came directly out of this need. In the 2002 State of the Union Address, President Bush asked all Americans to volunteer for their community, and

by July 2002, Secretary of Health and Human Services Tommy G. Thompson officially had launched the MRC. The MRC offered a way to train and track medical professionals to serve in the event of another man-made or natural disaster and strengthen local public health. Congress allocated funds to establish the MRC Program Office (now DCVMRC) in the Office of the U.S. Surgeon General to initiate an MRC demonstration project and to provide national technical assistance to MRC units around the country. Since the MRC began, units have formed in every state, and tens of thousands of individuals have signed up to volunteer. Local leaders nationwide also have worked diligently and creatively to establish the foundation of community support and planning necessary for their units to function effectively.

After the MRC celebrated its 10th anniversary, the Network Profile project

was launched to fulfill the need for more in-depth information about the MRC network as a whole. In the past, data collected on the network provided some insights but were unreliable. Through this project the National Association of County and City Health Officials (NACCHO) was able to use the rich and reliable data gathered to test the previous understandings. As an organization, NACCHO was excited about the opportunity to bring these data to life through this report. Researchers were interested in obtaining information about the structure and operations of each local unit and gaining an understanding about unit leader and volunteer demographics, activities, training, unit administration, communication, partnerships, legal protections, and finances. The study was designed with the goal of revealing the national scope of the entire network through a survey of nearly 1,000 unit leaders. This report is a culmination of the results from the responses of 837 unit

## ☀️ Response rates by state



## ❖ Overall response rate

837 units out of 962 responded to the survey for a response rate of

# 87%

leaders. The results shed light on the needs, challenges, and successes of the network.

### Questionnaire design

NACCHO led the team to develop the questionnaire for the Network Profile. Existing unit profile questions, which MRC unit leaders updated quarterly, formed the basis of the survey. Additional questions were added to the survey about a wide range of topics pertaining to a unit's infrastructure, practice and processes, activities, and challenges.

### Data collection

The 2013 Network Profile questionnaire was piloted in January 2013 to NACCHO's MRC workgroup members, a group of unit leaders from across the United States who regularly provide input on NACCHO's MRC Program. The pilot study provided the initial "live" test of the survey software capabilities and allowed confirmation that the survey's wording would be

clear to respondents. Feedback was incorporated into the final iteration of the survey.

The final survey was delivered via e-mail to every active MRC unit leader or a designated alternate. The e-mail included a unit-specific link to a Web-based questionnaire, and paper copies of the questionnaire were available upon request. The survey was open for six weeks from April to mid-May. NACCHO and MRC Regional Coordinators encouraged completion of the survey through messaging and technical assistance via e-mail and a dedicated telephone number.

### Population and response rate

All 962 active unit leaders were invited to participate in the survey. Eight hundred and thirty seven unit leaders responded for a response rate of 87 percent (❖). Ohio had the most units respond. The response rate by state map above reveals that 14 states had a 100 percent response rate. (☀️)

### Survey weights

Unless otherwise specified, national statistics were weighted for nonresponse. Nonresponse bias assessment compared the distribution of respondents and nonrespondents from the same survey with respect to jurisdiction size. Jurisdiction size for nonresponders was obtained from each unit's profile indicating zip code catchment areas via the [medicalreservecorps.gov](http://medicalreservecorps.gov) website. The United States Census data were used for accurate zip code population estimates. Many survey questions presented within this report are stratified by jurisdiction size. This offered the greatest variability across categories. Other variables such as unit leader work status or MRC housing department did not provide variability across categories.

### Rounding

Due to rounding, numbers in pie charts may not always add up to exactly 100 percent. ◆

## MESSAGE FROM CAPT TOSATTO

## 'Tremendous and impactful...'

Dear Medical Reserve Corps network, colleagues, and partners,

Since its inception in 2002, the Medical Reserve Corps (MRC) has served to improve the health, safety, and resilience of the nation. The Office of the Surgeon General, and particularly the Division of the Civilian Volunteer Medical Reserve Corps (DCVMRC), has shared and highlighted information about the MRC network through a variety of reports, presentations, and briefings over the years. Now we are pleased to support the National Association of County and City Health Officials (NACCHO) and its work to produce this first Network Profile of the Medical Reserve Corps.

MRC volunteers are giving of their time, expertise, and hearts to benefit their neighbors and other community

members. This is a calling for many of them. MRC units, while federally recognized and supported, are truly a part of the fabric of their local communities—each one filling gaps where public health, emergency preparedness, and response agencies may lack resources.

This Network Profile brings deserved attention to the tremendous and impactful work of MRC units and volunteers across the country through narratives and graphical imagery to support their history, success, and strength. At the same time, it shows the diverse nature of the network, from characteristics of its administrative practices and budgets, to the demographics of its leaders and volunteers.

I thank the many MRC Leaders for being candid and sharing information

about their units, and NACCHO for surveying, compiling, analyzing, and presenting the data.

I know that this Network Profile will reinforce the beliefs of those who already know about the outstanding work of the MRC, and educate those new to the network. I hope that it inspires community leaders to increase their support for existing units and to initiate support in communities that are currently without units.

With warm regards,  
**Robert J. Tosatto, RPh, MPH, MBA**  
**CAPT, USPHS**

*Director, Division of the Civilian  
Volunteer Medical Reserve Corps*



## MESSAGE FROM RADM LUSHNIAK

## An 'incredible positive force...'

Dear MRC network,

As Acting Surgeon General, and previously as Deputy Surgeon General for four years, I have been honored to serve as the outward face of the Medical Reserve Corps (MRC). Through my travels, speeches, and reports, I always take great pride in sharing the incredible positive force and local impact of the MRC network. Additionally, it has been my pleasure to meet and speak with many MRC leaders personally, as this has afforded me the opportunity to not only encourage units to achieve important goals for the health and safety of our nation, but to thank them for being such important ambassadors of wellness, preparedness, and resilience on behalf of the Office of the Surgeon General.

The MRC network has made a tremendous difference in defense of the public's health through means such as disease detection and prevention, education on how to develop family preparedness plans, response to disasters, and support for physical fitness activities—all with a constant emphasis on the needs of their local communities. In a nation troubled by a system of sick care, the work done by MRCs to change the focus to health, prevention of disease and injuries, and elimination of health disparities is making a lasting impact. I applaud the MRC, as the network has proved that in America's backyards lies its resilience.

This profile of the national network of MRC units and volunteers brings the efforts of the network to greater

light, and demonstrates some of the characteristics of this amazing network. While challenges are noted, so are some innovative solutions and promising practices. I commend NACCHO for their work in creating this report, as I believe it will prove to be a valuable resource for local and state officials, federal policymakers, stakeholders, and others to better understand the MRC network.

Sincerely,  
**RADM Boris Lushniak, MD, MPH**  
*U.S. Acting Surgeon General*



# A timeline of the MRC

The MRC network brings individuals from all backgrounds, skills, and experiences to strengthen communities and build resilience in the people and places it reaches. Unit leaders screen, conduct credential and background checks, and train all volunteers prior to any community disaster so volunteers are able to answer the call when needed. Time and time again, units and volunteers assist communities in need of emergency help within and beyond their geographic borders.

Since its inception in 2002, the integration of the MRC into local public health, emergency management planning, and disaster response has contributed to a healthier and more resilient nation for all.



**2002** The Office of the Surgeon General (OSG) announces a demonstration project to establish the Medical Reserve Corps (MRC), a program for medical, public health, and other volunteers interested in local health and preparedness.

**2005** Following Hurricanes Katrina and Rita, over 6,000 MRC volunteers from more than 150 MRC units supported the response and recovery efforts. These volunteers spent countless hours helping people whose lives had been upended by these disastrous events.



**2002-2006**  
166 communities were chosen as part of the demonstration project.



**2006** The MRC Program Office joins forces with NACCHO through a cooperative agreement to promote, support, and build capacity within the MRC network.



**2006** The MRC reaches 500 units nationwide, including all 50 states, Washington, DC, Guam, Palau, Puerto Rico, and the U.S. Virgin Islands.



**2006** Congress passed the Pandemic and All-Hazards Preparedness Act (PAHPA), which formally authorized the MRC and recognized the potential of the MRC network to support emergency response at all levels.



**2012** The Waldo Canyon Fire, the most destructive in Colorado history, burned for a month in late June 2012. The Medical Reserve Corps of El Paso County, Colo. responded by donating 1,644 hours of volunteer services.



**2012** In response to the West Nile Virus outbreak, 22 MRC units participated in education campaigns and vector control efforts, serving more than 60,000 people in the Southwest United States.

**2010** The number of MRC volunteers reached 200,000.



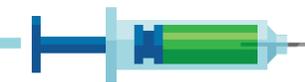
**2009** The MRC and American Red Cross issue a joint letter to improve coordination and cooperation between their organizations in order to better prepare and protect communities.



**2008** More than 1,500 MRC volunteers from 63 MRC units across 14 states volunteered over 30,000 hours in response to Hurricanes Ike and Gustav and Tropical Storm Hanna.



**2009** Pandemic flu preparedness plans were called into action for MRC units during the H1N1 influenza outbreak. Nearly 50,000 MRC volunteers in 600 units served in over 2,500 immunization, flu prevention, and flu care activities related to H1N1.



**2012**  
The MRC celebrates 10 years of supporting public health and emergency preparedness activities across the country.



**2013** Congress passed the Pandemic and All-Hazards Preparedness Reauthorization Act (PAHPRA), which continued the authorization for the MRC, but moved authority and responsibility of the program to the Assistant Secretary for Preparedness and Response (ASPR). A Memorandum of Understanding allows for continuation of operations within OSG and strategic oversight by ASPR.



## Provo, Utah

MRC volunteers assessing “victims” during a ‘Shake Out Take Out’ earthquake exercise.

## PART 1

# Medical Reserve Corps composition

The national Medical Reserve Corps program office is organized within the Department of Health and Human Services’ Office of the Surgeon General, but each MRC unit is locally based and functions independently of the national program office. Each unit is unique and shaped by many factors including its local infrastructure, housing organization, mission, and community needs. Since its inception in 2002, the MRC network has grown to include more than 200,000 volunteers enrolled in almost 1,000 units in all 50 states and territories.<sup>1</sup> MRC volunteers supplement dwindling local resources and fill gaps in public health services and emergency response activities. The result is a collaboration that can keep a community healthy and prepared for large-scale disasters and emergencies.

### Unit structure

The decentralized design of the network is underscored by the varied MRC housing agencies. Each MRC must have a public or private non-profit, community-based organization serve as its sponsor or housing agency. This organization can also be the MRC unit’s fiscal agent that financially supports the unit and accepts funds on its behalf. In some circumstances the housing agency and fiscal agent are two different organizations. The types of entities that support an MRC unit can vary significantly. Most units (67%) are housed within their local health department, but other housing organizations include emergency management agencies, volunteer centers, hospitals, colleges and universities, medical societies, civic organizations, faith-based organizations, non-governmental organizations, and regional councils of government (🌐). In addition, for 92 percent of the

### 🌐 Housing organization



- 7% Emergency management agency
- 7% Other
- 4% Nonprofit 501(c)(3) organization
- 3% Hospital/health system
- 3% State health department
- 2% Non-governmental organization
- 2% Fire/EMS
- 1% Medical society
- 1% Board of health
- 1% College/university
- 1% Citizen corps council
- 1% Faith-based
- <1% Police/sheriff department *n=836*

network, the housing organization is also their fiscal agent (🌟).

The 2013 Network Profile survey included a number of questions to assess unit structure. MRC units cover a range in jurisdiction sizes (population density), from less than 10,000 people to over one million (\*). Many units reported that their jurisdiction covers both rural and urban areas within the same catchment region. Forty-eight percent of units reported serving a mixed jurisdiction, while only nine percent

reported a strictly urban classification (❖). Most MRC units (87%) covered their prescribed jurisdiction exclusively and only 13 percent reported that there was more than one MRC unit serving their area (\*). Of these 13 percent (data not shown), more than two-thirds can be found in the most densely populated areas of the country.

Volunteers are the foundation of every MRC unit. Although the number of volunteers per unit varies throughout the network from 2 to over 7,000, the

### THE MEDICAL RESERVE CORPS AND LHD PARTNERSHIP

As the voice for local health departments nationwide, NACCHO works to help establish and expand strong partnerships between MRC units and local health department leadership. Because the mission of many MRC units is to conduct public health and emergency preparedness activities, a strong relationship between local health departments and EMAs is required to successfully fulfill this mission. A 2008 NACCHO report showed the results from a survey of people working in both MRC units and local health departments. Respondents supported partnerships and relationships between MRC units and local health departments, stated that MRC unit sustainability cannot happen without public health or emergency management partnerships, and believe that partnerships between MRC units and local health departments help to legitimize or bring credibility to the MRC unit in the field of emergency preparedness.<sup>2</sup>

average number of volunteers per unit is 224 (\*). There is also a variation between the numbers of volunteers in the different jurisdiction size categories (⊙). The difference between the overall median at 75 and the average at 224 indicates there is a skewed data distribution. The average volunteer count of 515 in those units serving populations of more than 250,000 is raising the overall average.

MRC units from smaller regions (populations of less than 100,000) average 50 volunteers per unit, while

those from larger regions (populations above 250,000) have an average of 515 volunteers. This may be the result of an increased need for additional volunteers combined with the availability of a larger pool of volunteers.

#### Unit leaders

An effective unit starts with a dedicated leader, and the MRC attracts individuals who care about the health and safety of their community. The MRC unit leader understands the needs of the community and what type of volunteers can fill those needs, often

orchestrating roles and responsibilities based on volunteer capabilities and skills. Nearly half of the unit leaders (47%) work on a full-time basis (●). However, 14 percent of unit leaders direct the unit as a volunteer.

#### Volunteers

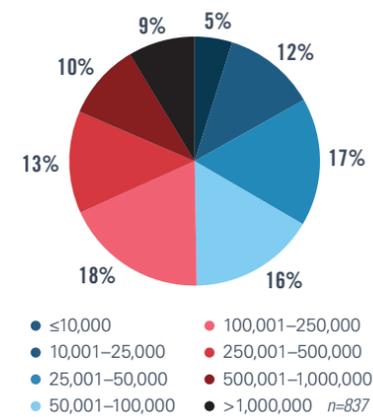
The MRC established a way to recruit, train, and activate medical and non-medical professionals to respond to community health needs, including disasters and other public

*Continued on page 16*

🌟 Is your housing organization also your fiscal agent?



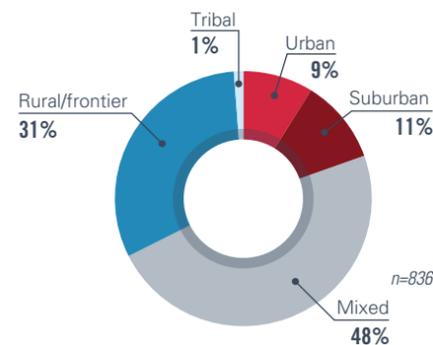
#### \* Jurisdiction size



\* Is there more than one MRC unit serving your area?



#### ❖ Jurisdiction type

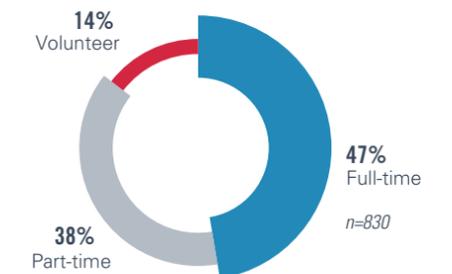


### Dallas, Texas

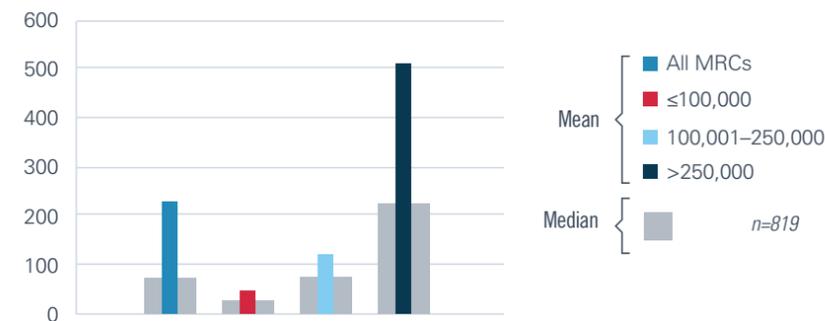


MRC Volunteers at the 2013 NACCHO Annual Conference.

#### ● Leader work status



#### ⊙ Number of volunteers in a unit



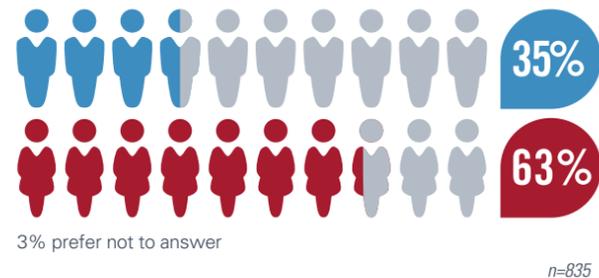
#### \* Average number



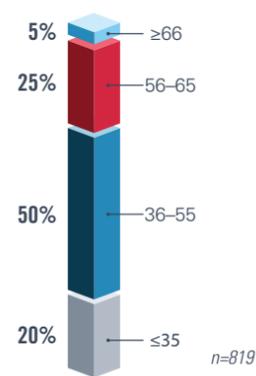
# Unit leader profile

# Unit volunteer profile

## GENDER



## AGE



## TENURE

Leaders who were part of MRC prior to becoming leader

28%

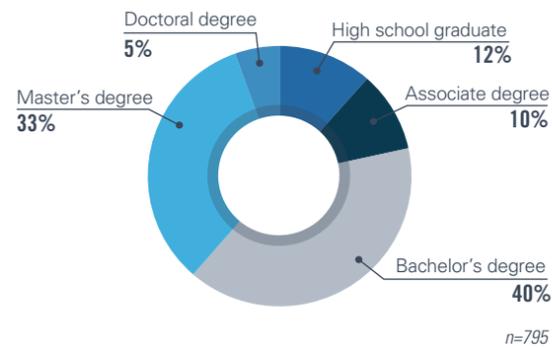
Average length of service in years

3.6

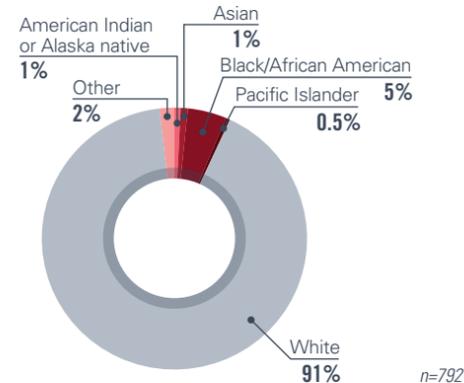
Units that have a succession plan in place for leader transitions or turnover

46%

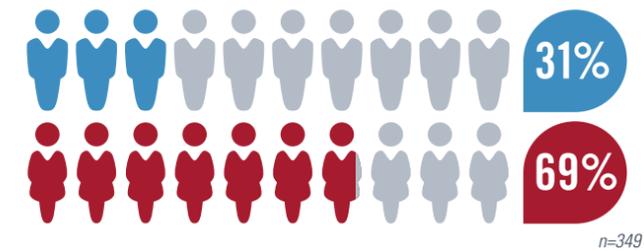
## EDUCATION



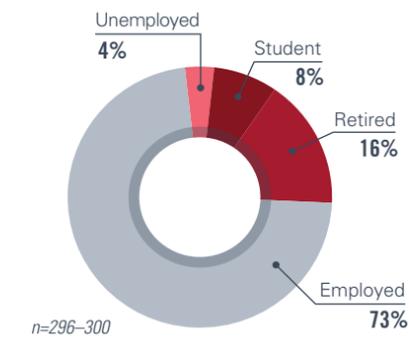
## RACE



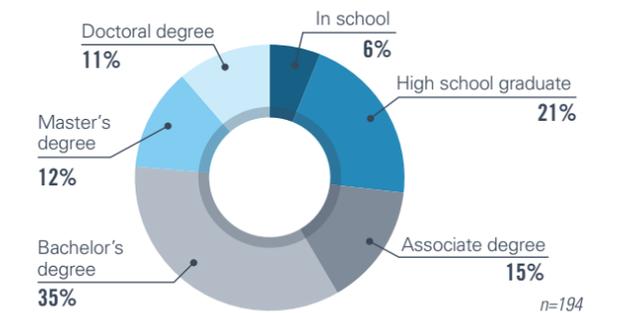
## GENDER



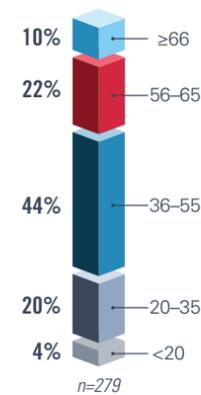
## WORK STATUS



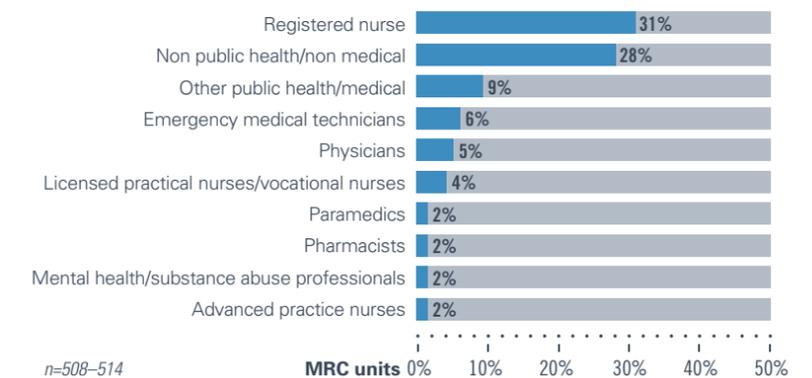
## EDUCATION



## AGE



## EXPERIENCE



## Kern County, California



MRC volunteers at a health fair.

*Continued from page 13*

health emergencies.<sup>3</sup> The individuals who volunteer for the MRC come from a wide range of backgrounds. From doctors and nurses, to language translators and information technology specialists, non-medical and medical professionals alike are drawn to the unique MRC volunteer opportunities. The MRC network operates as an episodic volunteer organization. Volunteers can choose the level of dedication; there are typically no required service commitment expectations.

### Communities large and small benefit from MRC volunteers

MRC units fulfill the unique needs of their communities by drawing on

## Arlington, Virginia



Captain Tosatto receiving a seasonal flu vaccination from the Arlington MRC during the 9/11 Day of Service and Remembrance. Photo by M.T. Harmon

their volunteer workforce. As data have shown, the composition of MRC units tends to reflect the image of their communities. In large, urban areas, MRC units tend to rely on a large volunteer pool. In smaller, rural areas, MRC units tend to be smaller in size but still boast dedicated volunteers who are often able to dramatically increase the public health and preparedness services offered in their communities. The differences between rural and urban units are reflected in the following stories from New York.

- The New York City MRC serves the largest U.S. city with over 7,300 volunteers in its ranks. With such a large volunteer force, the NYC MRC can quickly respond to the

many requests for assistance in this urban area. When Hurricane Irene made landfall in 2011, 222 volunteers donated 2,558 hours providing medical and mental health support. That number grew tremendously in 2012 with Hurricane Sandy, when more than 1,200 volunteers donated over 18,000 hours of service in the response. NYC MRC volunteers are also ready to respond to smaller scale events; in 2013, they jumped into action when three Hepatitis A outbreaks occurred over the course of the year. In conjunction with the NYC Department of Health and Mental Hygiene (DOHMH) staff provided emergency vaccinations to over 2,000 New Yorkers. Having so

## New York, New York



MRC staffing a Point of Dispensing site in response to a Hepatitis A outbreak.

many MRC volunteers ready and available helps reduce the response time, especially critical with weather-related emergencies and outbreaks like Hepatitis A. "NYC MRC has become an integral part of NYC DOHMH's response to local health emergencies. Volunteers' willingness to respond on very short notice is remarkable, and their efforts help to keep NYC healthy," said Betty Duggan, Director of the NYC MRC.

- Meanwhile, in nearby upstate New York, Orleans County Health Department paints a different picture of the MRC. With only 42,000 residents, Orleans County has been relying on their MRC

volunteers to continue their local preparedness education. Since 2004, the local health department has had only one emergency preparedness professional on staff due to programmatic and budget constraints. Thanks to the assistance of the Orleans County VALOR MRC, emergency preparedness and community resiliency education efforts through the health department continue. Orleans County VALOR MRC provides the only disaster risk reduction and community resiliency education in the county because there is no additional paid support. Because the state of New York bases preparedness funding on population size, Orleans County

## Albion, New York



Volunteers share preparedness information at a rabies clinic.

receives minimum funding that does not allow for outreach activities. However, as leaders in preparedness education throughout the community, MRC volunteers create events for the community based on local needs. In one instance, volunteers hosted a "Lakeshore Flooding" informational meeting for Lakeshore residents and stakeholders because Orleans County shares a northern border with Lake Ontario. Many attendees had not lived on the lake long enough to have experienced flooding. Because of this training, residents are now more informed about what they can do to protect their families and property during a flood. ♦



Arlington, Virginia

CPR training for MRC volunteers.  
Photo by J. Marchioli

PART 2

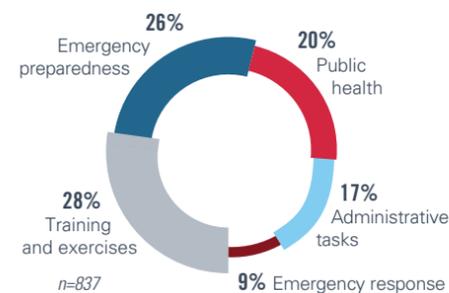
# Medical Reserve Corps' community impact

As a locally based volunteer group, each MRC unit determines the focus, direction, and activity plan for the unit based on community needs. Some communities look to the MRC unit for public health services like flu clinics and disease screenings,

while others focus on preparedness activities like points of dispensing exercises and shelter operations. The majority of MRC units have a dual approach addressing community needs for public health and emergency preparedness services. MRC units integrate both community needs and volunteer strengths. For instance, veterinarian MRC units focus on pet preparedness and animal health during an emergency response; Junior MRC units engage youth in volunteerism; and MRC units in close proximity to tribal nations focus on tribal health issues. Often the MRC unit will work with its housing organization to determine where gaps exist in delivering public health and emergency preparedness services and how volunteers can fill roles to meet community needs.

number of different MRC community activities reached almost 16,000. MRC units spend most of their time on the following activities: public health, emergency preparedness, training and exercises, administrative tasks, and emergency response. When asked about how they would divide up the time spent on each activity, on average more than half of a unit leader's time was spent on training and exercises (28%) and emergency preparedness (26%) (🌀). Training and exercises consume the most time on average for most units. While MRC units reported that they devoted the smallest percentage of time responding to an emergency, MRC units often respond to a broad range of incidents, including floods, tornadoes, and extreme weather events. In the last year, 41 percent of MRC units reported that they participated in an emergency response (data not shown). The

## 🌀 Time devoted to activities



Percentage of time all MRC units devote to each type of activity

### MRC activities

MRC units are encouraged to report every community activity they engage in to the DCVMRC. In 2013, the

*Continued on page 22*

INFOGRAPHIC

THE 2013 NETWORK PROFILE OVERVIEW

49% of units use SOCIAL MEDIA



Rural/frontier 31%

Tribal 1%

Suburban 11%

Urban 9%

3.6 LENGTH OF SERVICE OF UNIT LEADER IN YEARS (MEAN)



SIZE OF VOLUNTEER CORPS 200,000+

Mixed 48%

HOW YOU CLASSIFY THE JURISDICTION YOU SERVE

224 AVERAGE NUMBER OF VOLUNTEERS PER UNIT



TOTAL NUMBER OF UNITS ALMOST 1,000

PERCENTAGE OF UNITS THAT ARE HOUSED WITHIN A LOCAL HEALTH DEPARTMENT 67%

41% REPORTED THAT THEY PARTICIPATED IN AN EMERGENCY RESPONSE IN THE LAST YEAR



VOLUNTEER SCREENING METHODS 89% use applications 60% do background checks 45% interview potential volunteers 24% check volunteer references 4% do not screen

**TOP 3 PREPAREDNESS ACTIVITIES**

- Communications/texting drill
- Personal preparedness information campaigns
- Training and exercises

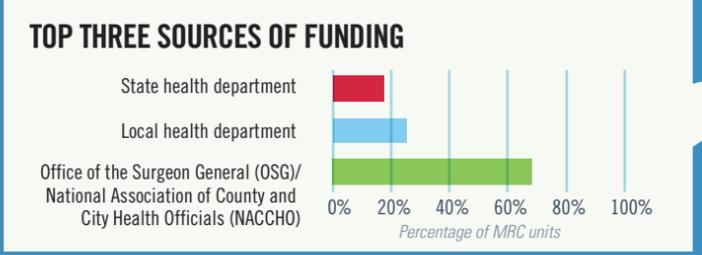
**TOP 3 PUBLIC HEALTH ACTIVITIES**

- Seasonal flu vaccination
- Community outreach events
- Health education

84% HAVE A TRAINING PLAN

**TRAINING PARTNERS**

- Local Health Department
- Emergency Management Agency
- American Red Cross
- Citizen Corps / CERT
- Fire / EMS



**VOLUNTEER ACTIVATION**

An e-mail distribution list is the most common method, followed by state-supported notification/activation, then a phone tree.

- TOP THREE RECRUITMENT METHODS**
- 90% word of mouth
  - 77% presentations
  - 71% MRC events



24% OF VOLUNTEERS PARTICIPATED IN AN MRC ACTIVITY QUARTERLY

Continued from page 19

findings from this survey indicate the average time spent on each type of activity does not vary widely nationwide.

Because the national MRC network was originally created to increase capacity for response to natural and man-made disasters, emergency preparedness activities are common among the network. The chart below shows a matrix of emergency preparedness activities MRC units often implement in their communities (☀). For each preparedness activity

or service, respondents were asked to indicate whether or not the unit participated in the activity in the last year, could participate but did not, could not participate, or would not participate. Eighty-eight percent of MRC units engaged in emergency preparedness training and exercises, the most common activity. This represents 846 units nationwide preparing their communities for local emergencies. Vector control activities were the least often reported preparedness activity. Almost half (49%) of MRC units could participate in services related to alternative care sites (capability present), but did not.

Many MRC units are also engaged in work that strengthens the public health infrastructure of their communities, a priority of the Office of the Surgeon General. The Surgeon General's priorities include considerations for the health of individuals and the nation as a whole and guide the MRC network. The Surgeon General has supported increasing awareness and activities related to disease prevention, eliminating health disparities, and improving public health preparedness.<sup>4</sup>

The chart below shows a matrix of public health activities MRC units often implement in their

communities (\*). Again, for each public health activity or service, respondents were asked to indicate their level of participation. Community outreach events (73%), health education (51%), seasonal flu vaccination (51%), and health clinic support/staffing (43%) were the four most common public health functions for the MRC network. Women, Infants, and Children (WIC) services (6%), substance abuse services (6%), and family planning services (5%), were the least common functions and most often reported as not part of the local mission.

**Training**

Emergency response requires planning and practice. MRC unit leaders must exercise their volunteers' special skills and expertise before a disaster strikes to test the integrity of written plans and to build confidence and morale in their volunteers. An overwhelming majority (84%) of MRC units reported having a training plan. MRC units that serve a population of more than 250,000 were more likely to have a training plan (data not shown). These units were also more likely to have responded to an emergency in the last year. This could suggest that those that have been through a local

**VOLUNTEER ENGAGEMENT**

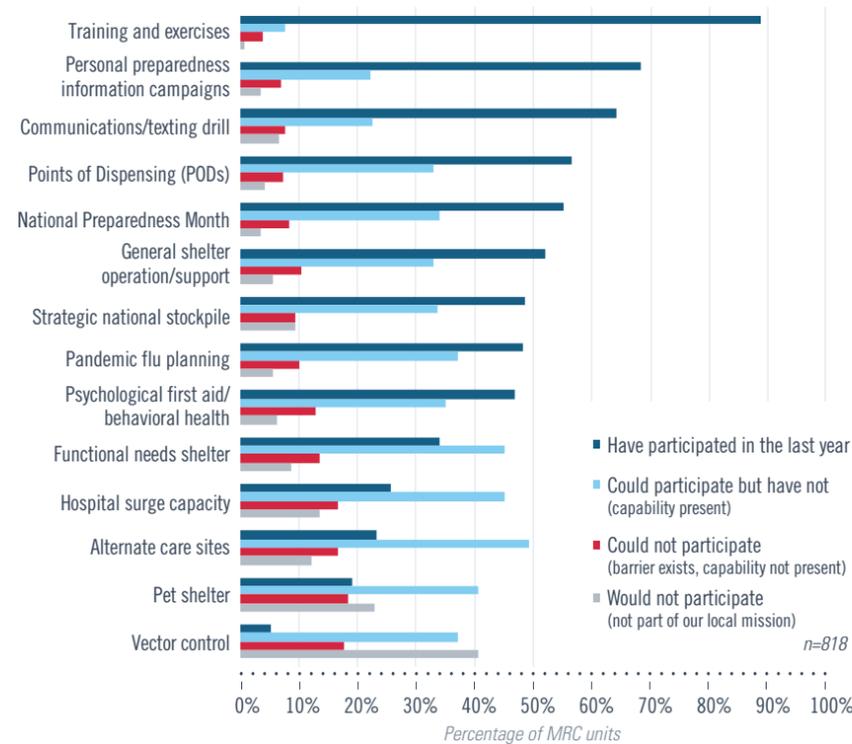
A 2010 research study in the *Journal of Disaster Medicine and Public Health Preparedness* emphasizes the importance of keeping volunteers engaged to ensure they are ready to respond when a disaster strikes. They report, "As expected, the level of motivation of the volunteers who participated in the flu clinics was higher than those who were called to participate but were unable to attend. In particular, motivation driven by a sense of community service was significantly higher between the Medical Reserve Corps unit members who attended the event than those who did not."<sup>5</sup>

**Honolulu, Hawaii**

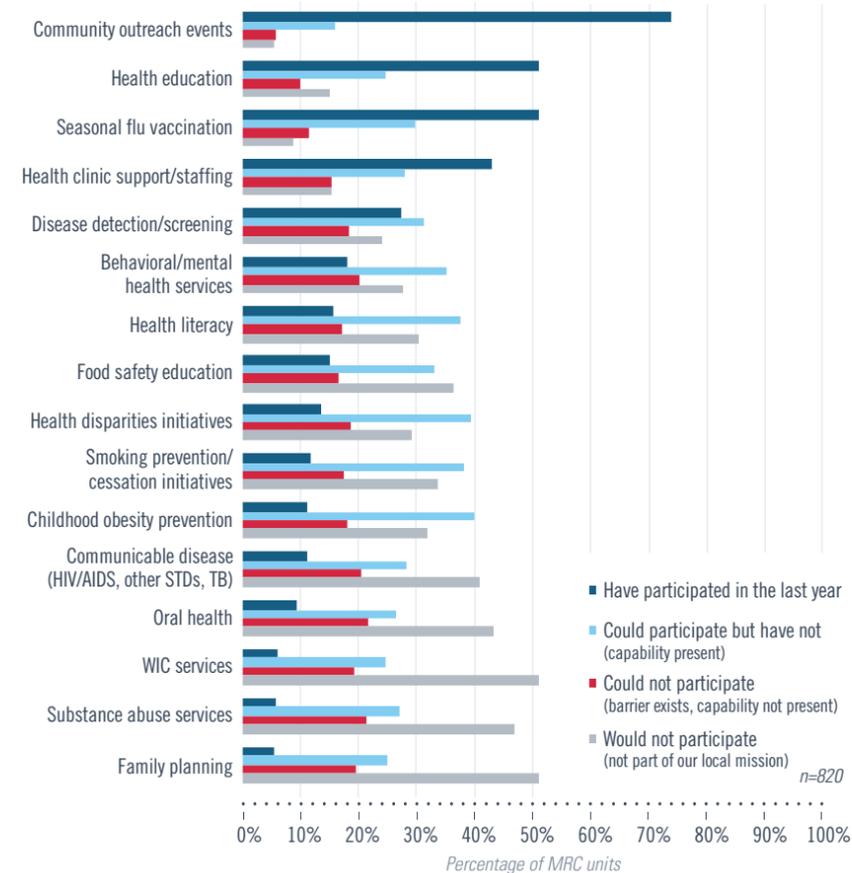


MRC units and volunteers participated in an exercise with Red Cross volunteers.

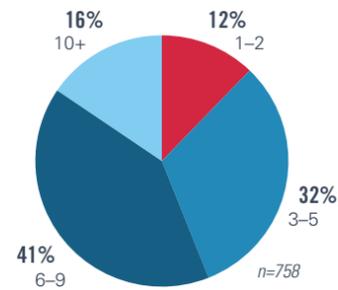
**☀ MRC preparedness activities**



**\* MRC public health activities**



### \* Number of volunteer training opportunities



Percentage of MRC units that offered multiple trainings in the last year.

emergency saw gaps in their process and completed training plans. Most MRC units (73%) offered three to nine different courses while only 12 percent of MRC units offered one or two trainings (\*). The most frequently offered trainings for volunteers were ICS-100 and ICS-700. These two courses were also the most likely to be mandatory for volunteers. Over half of MRC units also offered trainings in Psychological First Aid, CPR/First Aid/Automated External Defibrillators,

and ICS-200, but these courses were much less likely to be mandatory (⚙️).

Many MRC units join with other organizations to provide training opportunities. Only 16 percent of MRC units did not conduct training with other organizations, which may mean that they either did not offer any training at all, or they provided training themselves. Eighty-four percent of MRC units collaborated with at least one organization to

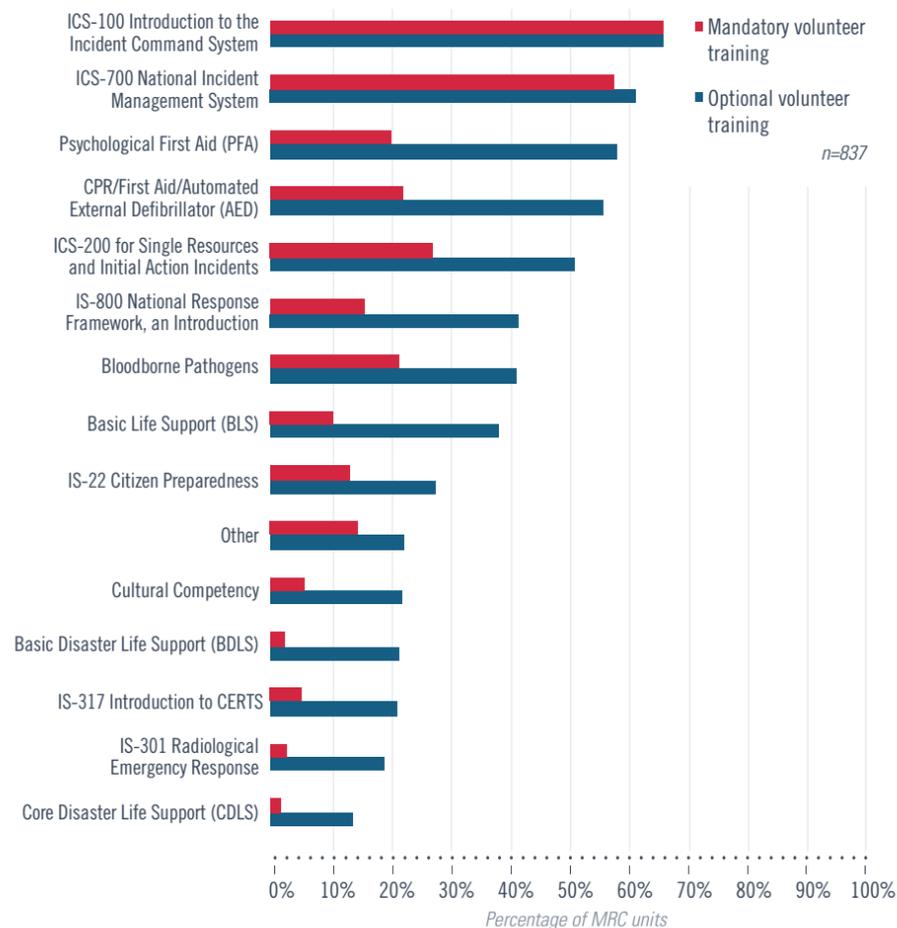
conduct training. One out of four MRC units conducted training with six or more partners (⚡️). MRC units most frequently reported collaborating with local health departments, emergency management agencies, and the American Red Cross. HOSA, for-profit businesses, and AmeriCorps were reported least frequently (⚡️).

management, first responders, faith-based and community organizations, and other volunteer programs, the MRC network is building awareness and providing services for public health and emergency preparedness initiatives. MRC units have found strong partners to advance their work in disease prevention, health equity, and emotional well-being, and have better prepared their communities for responding to and recovering from emergencies. Creating

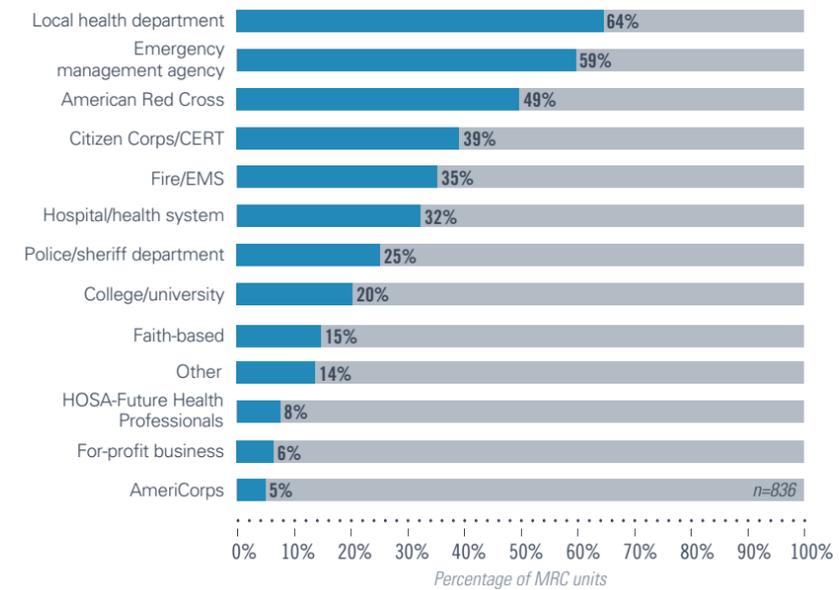
coalitions, establishing memoranda of understanding, sharing resources, and building partnerships can result in innovative ways to reach and empower wide-ranging populations for community change.

Sixty-seven percent of MRC units partnered with or deployed alongside another organization (\*). Units most commonly reported partnerships with local health departments (48%) and emergency management

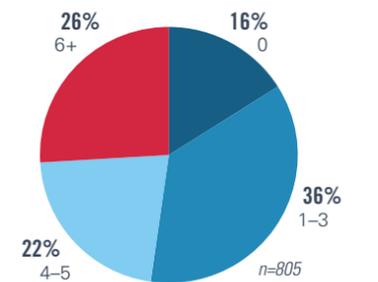
### ⚙️ Optional and mandatory training



### \* Training partners



### ⚡️ How many other organizations do you conduct training with?



### \* Partnerships

How many MRCs have partnered with or deployed alongside another organization?

**67%**

agencies (42%) (❖). Almost half (49%) of all MRC units reported partnering with another organization to conduct an exercise activity over the last year (❖). Many units look to their community for partnership opportunities. Nearly a third (32%) of MRC units have partnered with four or more organizations to further their units' mission in the last year (🌐). MRC units in larger jurisdictions have more partners; 22 percent of the units serving populations with more than 250,000 people reported partnering with at least six organizations. Only nine percent of units serving jurisdictions with smaller populations

had equal partner connections (data not shown).

**Spotlight on unique partnerships that strengthen MRC activities**

Although the two most common partnerships MRC units formed were with the local health department and local emergency management agency, many MRC units have formed more unique partnerships with other organizations and community members to further their missions. From partnering with the local baseball team to raise awareness about immunizations to working with school districts to plan for school-based

incidents, MRC look for partnerships to meet the needs of the community.

**HOSA-Future Health Professionals**

Founded in 1976, HOSA-Future Health Professionals is a national career and technical student organization consisting of 120,000 secondary and postsecondary/collegiate students. HOSA's mission is to promote career opportunities in the healthcare industry and to enhance the delivery of quality healthcare for all people. For several years, the DCVMRC has fostered a strong and positive partnership with the national HOSA organization that has been beneficial for many local MRC units and HOSA chapters. The MRC-HOSA partnership reinforces the value and mission of the MRC, promotes volunteerism, and provides HOSA members the opportunity to learn from MRC volunteers how to prepare for and respond to emergencies, promote healthy living, and supplement existing emergency and public health resources.

Several MRC units were comprised primarily of HOSA students and met the two-fold mission of creating learning opportunities for students and serving the needs of the community. The Minnesota HOSA MRC is one example of a successful HOSA MRC unit. Following the devastating floods in Northeast Minnesota in June 2012, the Minnesota HOSA MRC student members hosted the "Triple 'R' Disaster Camp: Relief, Restore, Rebuild." This day-long camp helped children affected by the flooding talk through their feelings and learn how to prepare for future disasters. HOSA student members taught campers psychological first aid and CPR and led a mini-drill involving a tornado. Children left the camp with new preparedness skills and peace of mind, while the HOSA students were able to practice their training.

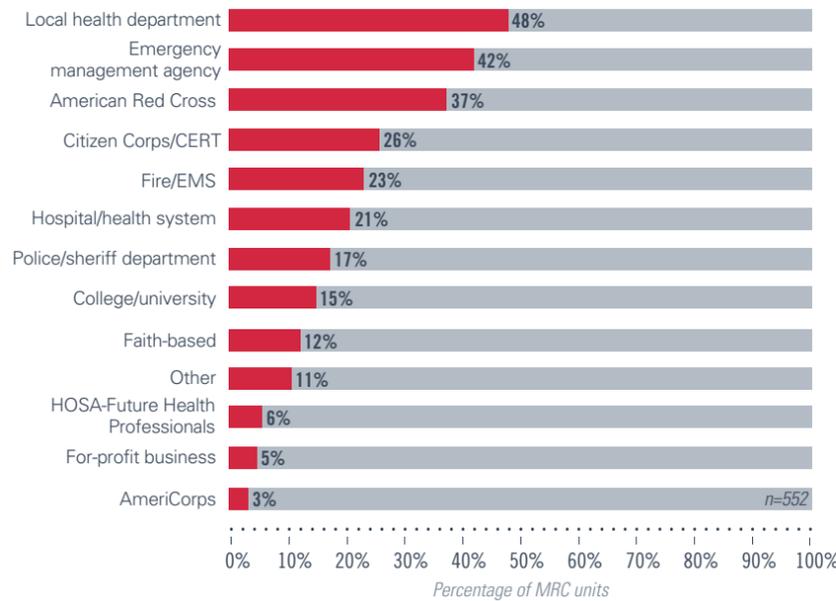
**Unique community partners**

Ventura County MRC (CA) has leveraged its relationships in the community to enhance its annual

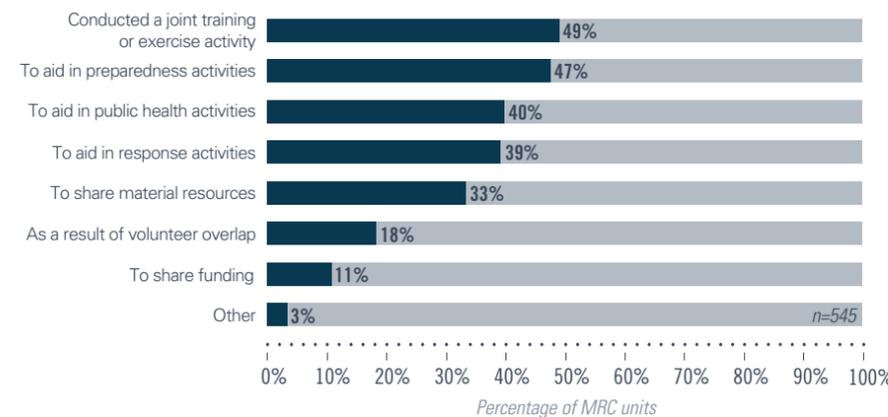
“HOSA is benefiting our nation by improving the personal preparedness of its members, increasing awareness about a way to better the health and safety of communities, and promoting the MRC for volunteering and the U.S. Public Health Service as a potential career choice.”

— CAPT Rob Tosatto, Director, Division of the Civilian Volunteer Medical Reserve Corps

**❖ Partner organization**



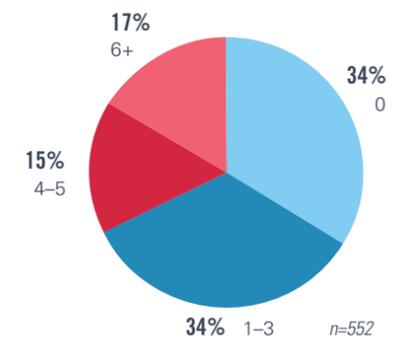
**\* Reasons to partner**



full-scale exercise. Dan Wall, Ventura County Emergency Preparedness Office Manager, has formed relationships with diverse individuals in the community, and these partners enjoy contributing in whatever ways they can to the Ventura County MRC's annual Austere Medical Deployment. The location of this exercise is free of charge thanks to Wall's relationship with the owners of Bodee's Rancho Grande, a remote ranch near Ojai, CA. The family enjoys giving back to the community by sharing their 200 acre-ranch with the MRC volunteers one weekend every year so that volunteers can become fully immersed in wilderness medicine and learn how to respond to a disaster without cell phone or Internet service. Because the ranch owners have a relationship with local caterers, they receive discounted meals for the volunteers. Wall also invites his partners in the field of austere medicine to offer free trainings during Day One of the deployment, providing MRC volunteers with unique trainings such as "Field Care of a Trauma Patient," "Gun Shot Wounds," and helicopter safety demonstrations. These unlikely partnerships allow participants to receive a broader depth of training and experience at a much more affordable rate.

**🌐 Number of entities with which MRC units partner**

Percentage of MRC units and the number of partner collaborations in the past year.



**Chanhassen, Minnesota**



HOSA/MRC volunteers train children in CPR.

## PART 3

# Medical Reserve Corps administration

Operating and sustaining an MRC unit is time intensive. All unit leaders face the complex administrative challenges of recruiting, screening, organizing, and deploying volunteers, managing finances, and ensuring legal protections for the unit and volunteers. Many unit leaders split their time across several roles; however, despite the time constraints unit leaders face, well-organized operations are the foundation for a successful MRC unit.

## Volunteer recruitment and screening

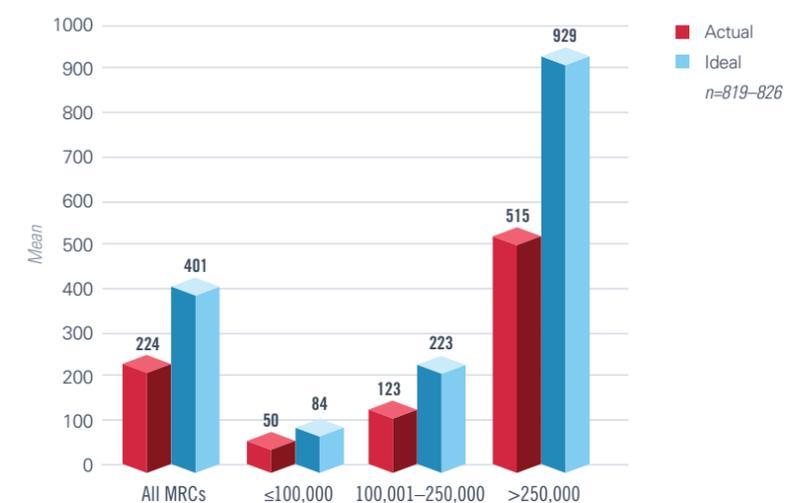
The national MRC network is based on an all volunteer model. As such, recruiting volunteers is a continuous task for unit leaders. Units must identify their role in the community as part of their vision and mission planning. Having a clear, compelling vision for the unit is the first step in recruiting prospective volunteers who strongly identify with the unit's shared vision. All volunteers need to feel that their contribution is valuable and believe that they will gain a sense of achievement from

their involvement with the MRC unit. Because the focus of each MRC unit is determined by community needs, the number and skills of volunteers vary. However, all MRC units report that they would like to have more volunteers in their unit. Unit leaders reported their ideal average number of volunteers, which ranges from 84 to 929 depending

on jurisdiction size (🌐). MRC units in all jurisdictions reported an ideal number of volunteers 70–80 percent higher than their actual volunteer numbers. As the jurisdiction size increases, so does the ideal number of volunteers.

Ninety percent of MRC units rely on word of mouth as a recruitment

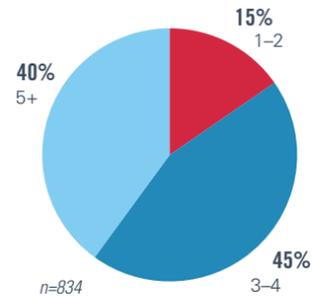
## 🌐 Actual vs. ideal number of volunteers



## Denton, Texas

Denton County MRC creates preparedness kits for the Prepare Denton County program. Photo by M. Wiggins

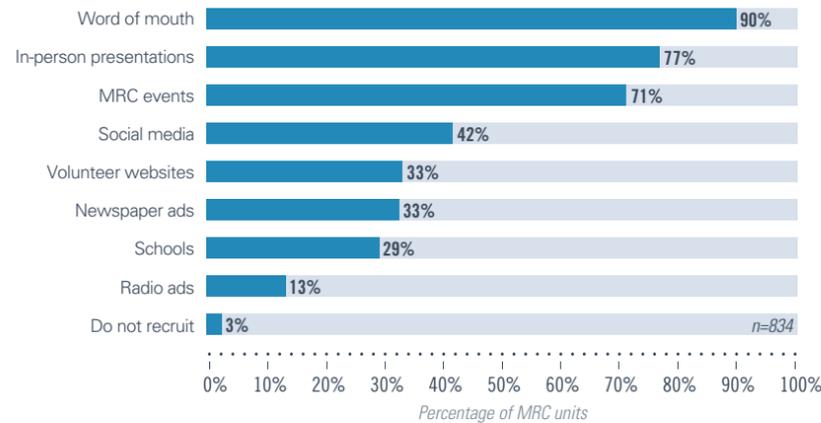
### \* Number of recruitment methods



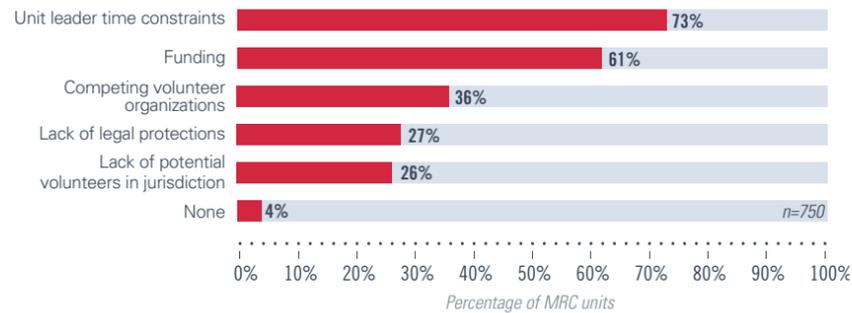
strategy; however, presentations (77%) and MRC events (71%) are overwhelmingly common recruitment methods (\*). Most MRC units recruit volunteers through multiple methods. Eighty-five percent of the network reported employing three or more different recruitment strategies (\*). Active recruitment takes time and money; this is supported by unit leaders citing time constraints (73%) and funding (61%) as the most common obstacles to recruitment (❖). Only four percent of MRC units reported no obstacles to recruiting volunteers.

MRC units reported information about screening methods, background checks, and medical credentialing of prospective volunteers. Developing an MRC unit involves recruiting for specialized roles. It is important to screen volunteers and match them to assignments based on interest, skills, and experience. The majority of units (89%) use an application process to

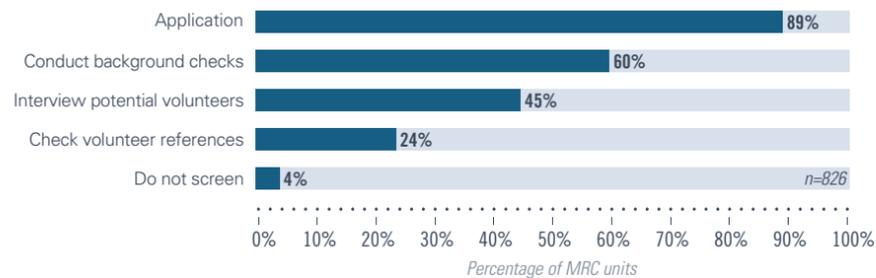
### \* Recruitment methods



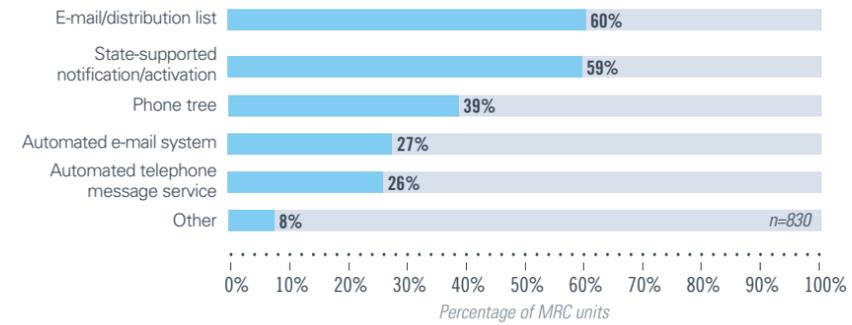
### ❖ Obstacles to recruitment



### \* Screening methods



### \* Volunteer activation method



screen volunteers, and nearly half (45%) of unit leaders interview potential volunteers as part of an initial screening process (\*). In order to answer the call if a disaster strikes, medical volunteers must be screened and credentialed prior to the event. An overwhelming majority (94%) of MRC units verify the medical

credentials of their volunteers (data not shown).

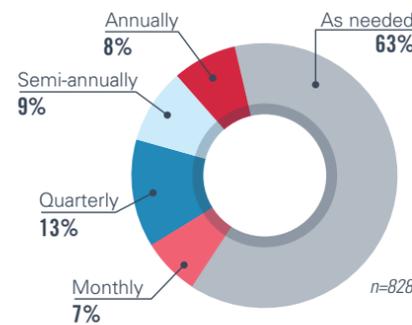
A necessary next step in recruitment is orientating the volunteers to the MRC unit and its mission. There is no recommended frequency for conducting orientation. As such, most MRC units do not follow an

orientation schedule but conduct new volunteer orientations as needed (63%). Thirty-seven percent do follow a schedule and provide orientation annually, semi-annually, quarterly, or monthly (\*).

### Communications

Communication between unit leaders and volunteers occurs in a variety of ways. The type of activity (e.g., call down drill, training, exercise or activity opportunity, response to a disaster) dictates the type of communication channel a unit leader will use. For example, call down drills, often solicited via e-mail or text, measure volunteer readiness, timeliness, accuracy of contact information, and level of commitment. The two most commonly reported methods for volunteer activation are notification through e-mail/electronic distribution lists (60%) and a state-supported notification/activation system (59%) (\*).

### \* Orientation frequency



### Albuquerque, N.M.



MRC volunteers provided first aid during the Bataan Death March event.

When asked about social media technology, 51 percent of MRC units reported they did not use any social media technology, while 49 percent reported using Facebook, Twitter, YouTube, LinkedIn, or blogs (\*). MRC units serving larger jurisdictions are more likely to use these tools than those units serving smaller jurisdictions (data not shown). Unit leaders employ different methods for information exchange with volunteers

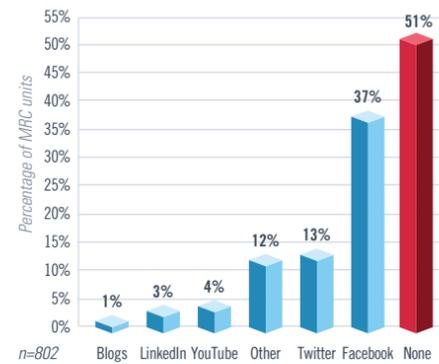
during non-emergency and emergency situations. In a non-emergency situation, 68 percent of MRC units use an e-mail or electronic distribution list to exchange information with volunteers. During an emergency, MRC units rely heavily on traditional communication channels, 59 percent use the telephone, and 42 percent use an e-mail/distribution list to exchange information with volunteers (⊗).

### Virginia Beach, Virginia

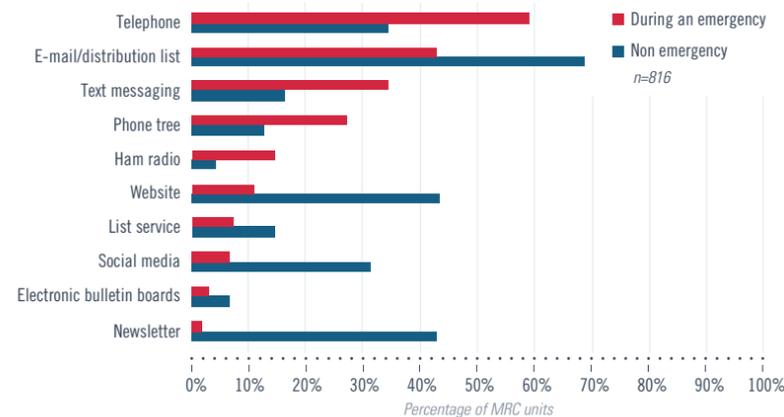


MRC volunteer Naomi Mitchell, right, shows a student how to conduct a blood pressure screening.

### \* Social media use



### ⊗ Information exchange method



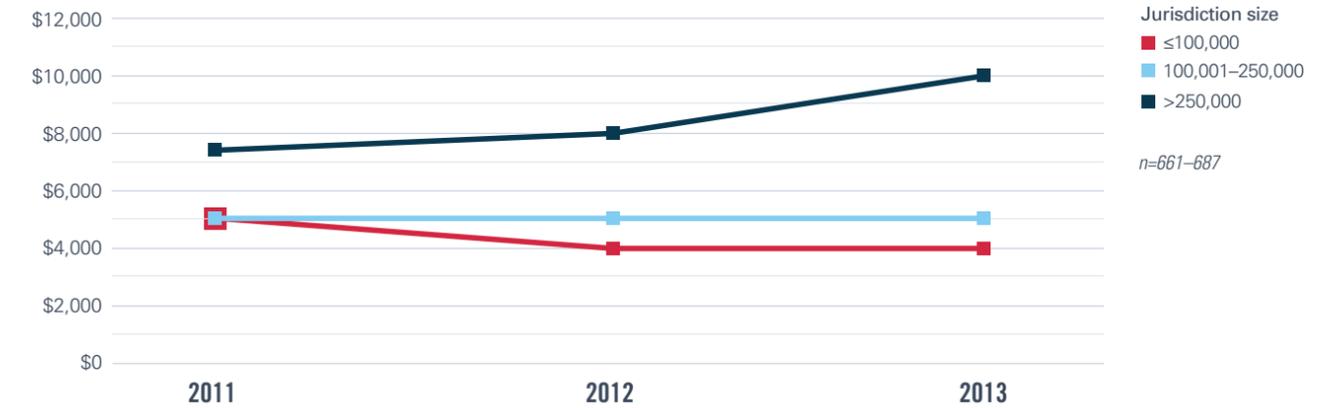
### Funding

MRC units reported expenditures and revenues for fiscal years 2011 and 2012. They also reported the current operating budget for 2013. Mean expenditures increased by 12 percent for MRC units from FY2011 to FY2012. Revenues in the same time period did not increase but decreased slightly. Average revenues in 2012 were higher for urban and mixed jurisdiction types and lowest

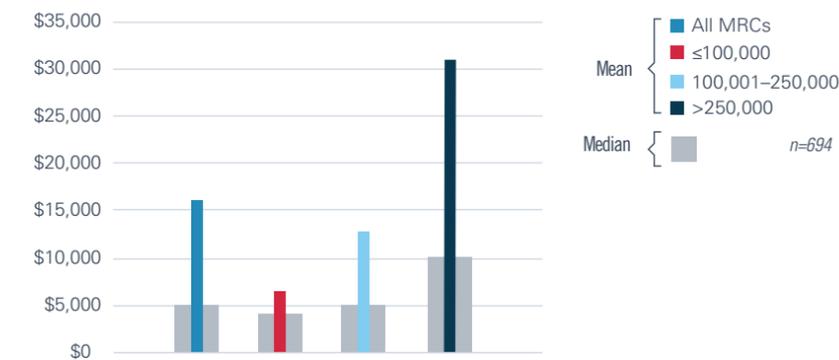
for those MRC units that reported serving rural or frontier jurisdictions (data not shown). The median expenditures for all MRC units stayed level over the three year range 2011–2013 but when stratifying by jurisdiction size served, the data reveal that expenditures declined for those serving smaller jurisdictions and increased for those serving larger jurisdictions (\*). The mean operating budget for all MRC units

is \$15,945 (\*), while the median is only \$5,000. The difference between the mean and median for those units serving jurisdictions with populations up to 100,000 is 60 percent, while the same difference for those units serving jurisdictions with populations over 250,000 is 200 percent. This indicates that the average operating budget is skewed higher by units serving larger populations.

### \* Median expenditures 2011-2013

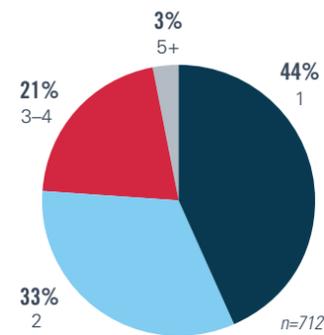


### \* Current operating budget



Most MRC units (77%) reported only one or two sources of revenue for their units, while only three percent received five or more different sources of revenue (\*). The difference in staff resources between larger and smaller units may account for fewer funding opportunities. The most common source of revenue for units was the Capacity Building

\* Number of revenue sources in most recent fiscal year



Award from the Office of the Surgeon General/NACCHO (🌐). Sixty-seven percent of units reported receiving this award.

Legal protections

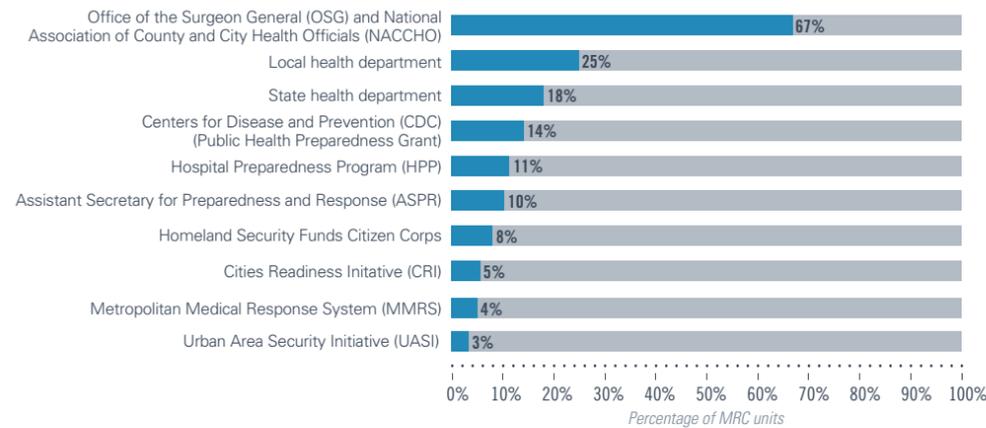
Every U.S. state has at least one law that pertains specifically to the legal liability of volunteers. These laws and protections differ greatly

Clark County, Ohio



A Medical Reserve Corps volunteer nurse discusses patient forms with Ohio Army National Guard member at a health screening event.

🌐 MRC unit funding from local, state, and federal sources

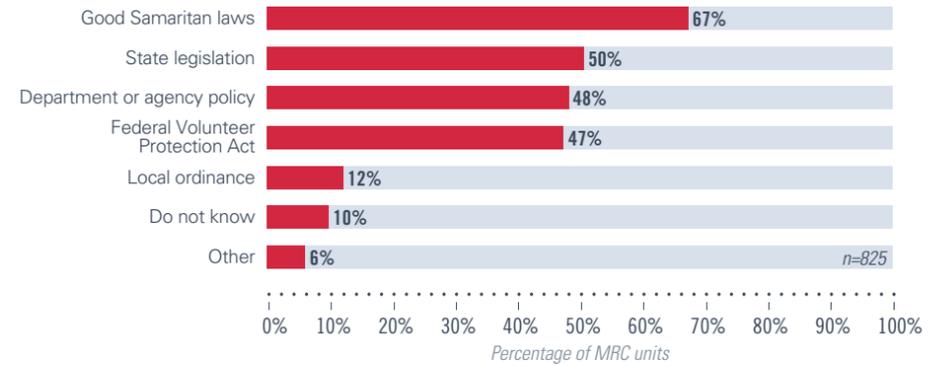


from state to state and jurisdiction to jurisdiction. MRC units reported information about various legal protections for the unit and for the volunteers during different activities. The most commonly reported legal protections for units were Good Samaritan laws (67%) and state legislation (50%) (🌟). When asked about volunteer legal protections, 19

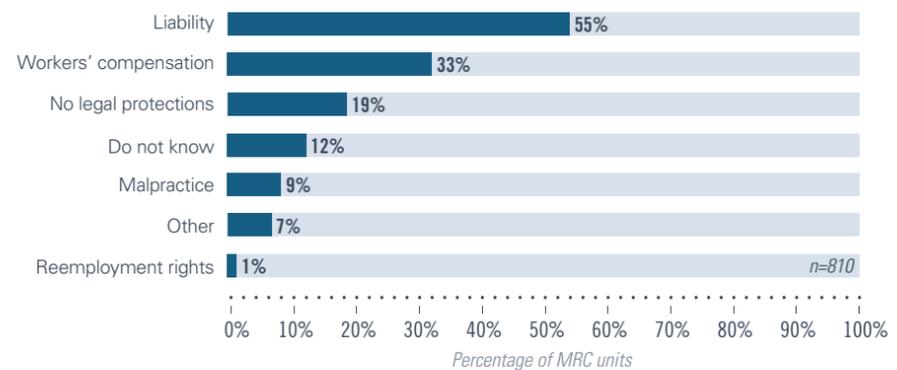
percent reported no legal protections for volunteers (❖). Fifty-five percent of units offer liability coverage for their volunteers and 33 percent of units reported that the volunteers are covered under the sponsoring agency's workers' compensation.

Several different types of legal protections could protect volunteers

🌟 Sources of legal protections for unit



❖ Types of legal protection provided for volunteers



## Oklahoma



MRC volunteers in the aftermath of the May 2013 Oklahoma tornado outbreak.

during different circumstances (\*). During declared emergencies, only seven percent of units reported that volunteers have no legal protections. Seventy-four percent of units report liability coverage and 44 percent reported workers' compensation protection during declared emergencies. Only a small portion of MRC units report that volunteers are legally protected when responding to an event outside their jurisdiction. These data do not reveal if these volunteers are covered by the jurisdiction or housing organization of the MRC unit that they are assisting. Only three percent of units reported an incident where legal protections were invoked for the volunteer, unit, or sponsoring agency (data not shown). This reflects a larger number of units than previous accounts, and should be confirmed with additional research.

### MRC units tackle administrative challenges in creative ways

Like other volunteer organizations, MRC units face challenges when implementing their mission. However, many MRC units have found creative solutions to address common administrative challenges. MRC unit leaders have formed creative partnerships to bring in alternate sources of funding; implemented integrated communications campaigns to recruit volunteers; and challenged weak legal protections for their volunteers. The following MRC units turned what seemed like a bad situation into an opportunity to grow and strengthen their unit.

- Volunteer recruitment can be tough during non-emergency situations and even more difficult once many volunteers are needed for emergency response. When one EF4 and two EF5 tornadoes tore through parts of

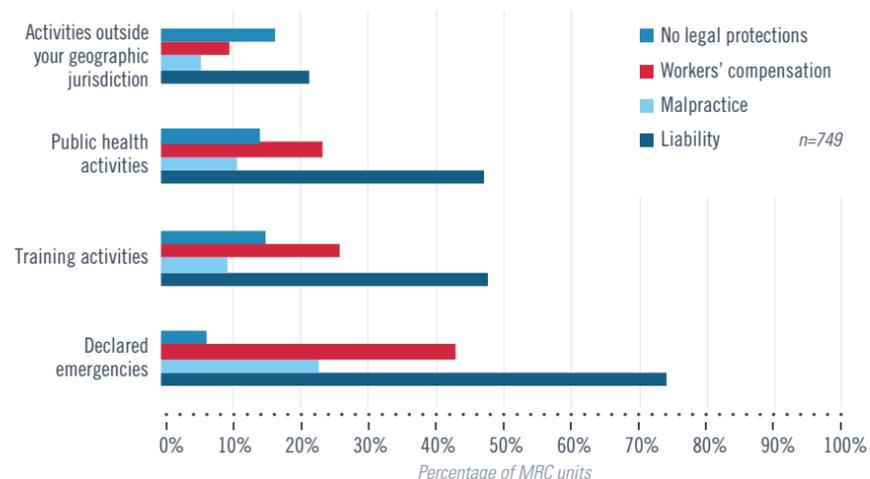
Oklahoma in May 2013, thousands of individuals were eager to help, but they were unregistered and turned away. Fortunately, Oklahoma Medical Reserve Corps (OKMRC) State Coordinator Debi Wagner saw an opportunity to message out the importance of registering with the MRC before a disaster strikes and referred these potential volunteers to the state's MRC website to begin the volunteer registration process. Over 600 individuals were added to the OKMRC database during this time. To ensure that new and seasoned volunteers remain engaged with the MRC network and are ready to respond to the next disaster, MRC unit leaders across Oklahoma have been discovering new training opportunities through lessons learned during the response to the tornadoes. For example, MRC units are now developing animal response teams and offering

trainings in psychological first aid and stress response. While it was difficult to turn individuals away in the aftermath of the May tornado outbreak, new volunteers and training opportunities are strengthening the OKMRC capacity to respond to the next event.

- While legal uncertainties have created challenges for volunteer recruitment and protection, some MRC units are demonstrating leadership in this area and have sought stronger protections for their volunteers. In 2010, a Rhode Island MRC volunteer was injured after breaking down a field hospital tent after a training mission at the state's Air National Guard Air Show. The volunteer was treated and transported to the hospital, where she was observed overnight for a concussion. While the volunteer sought workers' compensation,

the claim was ultimately denied. Rhode Island Disaster Medical Assistance Team (DMAT), Inc., the MRC unit's housing organization, paid the volunteer's hospital bills but began working on updating legal protections for DMAT/MRC volunteers. After two years, the process was updated so that the DMAT/MRC now requests a mission number from the Rhode Island Emergency Management Agency prior to each planned training event, which provides them coverage under the emergency management title in the state law in the instance of liability or injury. The updated process appeared to work in 2013 when a volunteer was injured and his right to protection was recognized, although he did not seek compensation. Rhode Island MRC volunteers can now feel safer when they carry out their important work throughout the state. ♦

### \* Legal protections



## Ojai, California



MRC volunteers assessing a "victim" during Ventura County MRC's annual Austere Medical Deployment exercise.

## West Greenwich, R.I.



Rhode Island DMAT/MRC volunteers assist with Hurricane Sandy response.

# Discussion

## Next steps

The intent of this report is to provide the MRC network's internal and external stakeholders with current statistics about MRC unit leader and volunteer demographics, activities, training, unit administration, communication, partnerships, legal protections, and finances. This data set serves as a comprehensive picture of the various functions of the MRC network at this point in time. The results from this report allow stakeholders to learn about the challenges facing MRC units, such as the desire for more volunteers or a lack of awareness about legal protections, and implement intervention strategies to address these challenges. This survey provides a baseline measure. Future surveys provide the opportunity to compare new data against this data set to observe how the network changes over time.

Additionally, this report may provide a springboard for further research into the MRC network. One avenue for further research could include an investigation of the attributes (e.g., size of budget, number of volunteers, number of training partners) that correlate with highly productive units. There may be common characteristics that allow these units to have a high impact in their community. Another research query could investigate the various funding sources for MRC units and explore whether or not stable sources of funding, such as the OSG/NACCHO Capacity Building Awards, contribute to the long-term success of units.

If you have suggestions on what future Network Profiles should

include, send a message to the team at [mrc@naccho.org](mailto:mrc@naccho.org).

## Data limitations

A comprehensive survey instrument is the best method to gather standard information from a large group. However, this method has some recognized limitations. The descriptive statistics provided by a survey of this nature do not allow for determining correlation or causation. Interviewing or conducting small focus groups to collect qualitative data could augment research of this nature to provide additional insight.

The Network Profile of the Medical Reserve Corps survey data were self-reported by unit leaders and not independently verified. Self-reported data collection is the most convenient method for reporting, but it does leave some room to question the reliability and validity. Some unit leaders were new to their position and may have provided incomplete information about their unit.

This survey was fairly time-intensive and the pilot study indicated it may take a unit leader an average of 45 minutes to complete. Consequently, some unit leaders skipped some of the more difficult sections. The volunteer demographic information was hampered by a low rate. Data on specific demographic characteristics in the volunteer section were inconsistently reported and thus not weighted; therefore the results may not be nationally representative.

When analyzing the data for this report, researchers identified a number of areas that can be improved

upon in subsequent surveys. The text responses that unit leaders provided in the "other" field for a handful of questions offer additional options that will be considered for inclusion. For instance, one question supplied a list of potential organizations with which units partner. The additional partners that unit leaders included can be considered for a more comprehensive list in future iterations. Researchers also found that under the revenue questions, the option to select private donations was missing. Those MRC units that are non-profit 501(c)(3) organizations are able to collect donations for their program, but this is not reflected in the results. Finally, because the volunteer section was hampered by a low response rate, it will be important to investigate how this section can be adjusted to achieve a higher response in the future.

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The 2013 Network Profile of the Medical Reserve Corps

# Stronger together

## A national network of volunteers

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# NACCHO

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