

Rising to the Challenge:

MRC Answers the Call in Unprecedented Times



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

THE 2020 NETWORK PROFILE
OF THE MEDICAL RESERVE CORPS

The Medical Reserve Corps

Rising to the Challenge: MRC Answers the Call in Unprecedented Times

- INTRODUCTION** 2
 - Background 3
 - Methodology 3
 - Messages from the ASPR and MRC Director 4
 - Infographic: A timeline of the MRC 6
- PART 1: MRC UNIT SNAPSHOT** 8
 - MRC: Champions for local communities 8
 - Case study #1: Nurturing a diverse volunteer base 11
 - Infographic: MRC unit snapshot 12
- PART 2: CAPABLE, READY, AND RESPONSIVE** 14
 - Lessons learned and reshaping to be ready 14
 - MRC response capabilities developed and deployed 15
 - Mission sets 16
 - Case study #2: Celebrating MRC volunteers—Laneigh Jones 17
 - Case study #3: Celebrating MRC volunteers—Teri Mills 19
 - Case study #4: Combating social isolation 20
 - Volunteer hours reported for 2020 21
 - Infographic: MRC capabilities snapshot 22
- PART 3: VOLUNTEER MANAGEMENT** 24
 - Stepping forward: Vetted and engaged 24
 - Volunteer training and core competencies 26
 - Case study #5: Addressing the needs of pets during an emergency 27
 - Communications 31
- PART 4: SUPPORTING THE MRC** 32
 - Cultivating resources for response readiness 32
 - Funding 33
 - Partnerships 34
 - Legal protections 35
- PART 5: EXAMINING BARRIERS TO DEPLOYMENT** 38
 - Medical Reserve Corps 2021 Deployment Workshop findings 39
 - Case study #6: Encouraging volunteer resiliency 41
- PART 6: MRC OPERATIONAL READINESS AWARDS** 42
 - Impact of the 2019–2020 ORAs 42
 - Case study #7: Meeting COVID-19 vaccination needs 42
- PART 7: FOCUSING ON THE FUTURE** 43
- References 43



ABOUT THIS REPORT

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Cover: Virginia, Fairfax County MRC

The photos in this report were taken between 2018–2020 and may not reflect current COVID-19 PPE guidelines.

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BACKGROUND

2020: A pivotal year in the history of the MRC

As the world attempted to grasp the medical and societal challenges that the COVID-19 pandemic would bring, MRC volunteers stood ready to meet the challenges.

The Medical Reserve Corps (MRC) is a network of over 200,000 volunteers supporting the health and safety of communities across the nation. Created under the George W. Bush Administration in the wake of the September 11, 2001 terrorist attacks, these volunteers, organized locally by MRC units, serve as local responders to public health emergencies.

As the MRC approaches its 20th year of service in 2022, the success of the MRC in adapting to individual community emergency response needs serves as a model for how to approach community centered emergency and public health preparedness. This report shares a snapshot of the MRC network in 2020, including the newest data on

unit demographics, funding, training, partnerships, response activities, and capabilities. It comes at a pivotal time in the MRC's history.

The challenges of 2020 tested the very foundation of the MRC structural and readiness integrity and impacted individual volunteers' willingness to serve in the most uncertain of times. The novel SARS-CoV-2 coronavirus, now commonly known as COVID-19, yielded a great deal of uncertainty as the world watched the initial outbreak quickly escalate to a global pandemic.

Throughout 2020 MRC volunteers worked tirelessly to support arising critical areas of need such as COVID-19 call centers, testing sites, contact tracing, infection prevention,

and PPE (Personal Protective Equipment) distribution and fit testing. Volunteers also adhered to COVID-19 precautions and the physical and societal adjustments needed to respond quickly and effectively to concurrent community needs including support for forest fires, storm shelters, and routine vaccination drives.

The skills, training, situational readiness, community engagement, and diversity of MRC volunteers afforded a clear advantage to communities by providing a ready surge workforce structure.

This report sheds light on the make up of that workforce locally, as well as the needs, challenges, and successes of the network.

METHODOLOGY

In 2021, the National Association of County and City Health Officials (NACCHO) deployed the 2020 MRC Network Profile survey to review the state of the MRC Network's public health emergency preparedness and response activities through the 2020 calendar year. Among other topics, the survey covered unit demographics, volunteer management, training, and deployment activities, especially related to the COVID-19 pandemic response. NACCHO updated the 2017 questionnaire based on prior results and input from unit leaders before sending it to 763 active unit leaders in January 2021.

Data were collected from January to March 2021. Overall, 461 MRC unit leaders completed the survey, yielding a 60% response rate. When possible, NACCHO compared data from the

2017, 2015, and 2013 surveys with data from 2020 and included only those comparisons that represented meaningful differences among data from the three previous surveys. Some variations in the data reported between 2013, 2015, 2017, and 2020 may be due to survey refinement.

The 2020 MRC 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.¹ U.S. Census data were used for accurate zip code population estimates.² Some survey questions presented within this report are stratified by jurisdiction size, which offered the greatest variability across categories. MRC units are classified as small if they serve fewer than 100,000 people; medium if they serve between 100,000 and 249,999 people; and large if they serve 250,000 people or more.

The report also presents two other data sources, the 2020 MRC Operational Readiness Awards final project evaluation and the qualitative inputs from the 2021 MRC Workshop "Examining MRC Barriers to Deployment." Both data sources provide additional insight into the MRC Network, but do not represent the entire network.

“Each of you is a credit to the character of this nation.”

To the Members of the Medical Reserve Corps:

Thank you so much for allowing me to introduce the 2020 Network Profile of the Medical Reserve Corps.

The MRC network has played and will continue to play a substantial role at every stage of the current response to the COVID-19 pandemic. Without a doubt, unit volunteers and leaders saved lives with their contributions to testing, contact tracing, call center support, vaccinations, and other response activities.

The MRC's success also validates units' efforts to train and prepare for public health emergencies. All the exercises you have done year after year, including

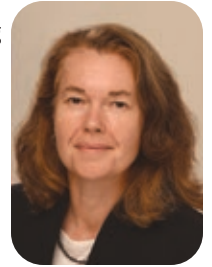
point of dispensing drills, were valuable preparation for the challenges the country has faced since the pandemic began.

As we continue to battle the pandemic and other threats to public health, I hope that the information in this profile will lead you to discover new strategies and approaches to promoting the health and health equity of your communities and effectively preparing for and responding to emergencies.

In my role as the ASPR, I also look forward to collaborating with MRC program leadership to ensure that the historic \$100 million investment in the program contained within the American Rescue Plan is spent in ways that sustain and strengthen the MRC network,

enabling it to answer both new and existing challenges to public health.

I am grateful for your sacrifices and service. Each of you is a credit to the character of this nation, and I look forward to supporting you as the network builds on its record of accomplishment.



Sincerely,

Dawn O'Connell

Assistant Secretary for Preparedness and Response, U.S. Department of Health and Human Services



“In this time of great need, the MRC answered the call.”



Connecticut
Capitol Region MRC

To MRC Network Colleagues, Partners, and Friends:

On behalf of the Medical Reserve Corps program, I write with gratitude, pride, and excitement to introduce you to this 2020 Network Profile of the Medical Reserve Corps.

Almost 20 years ago — in 2002 — the MRC program began in a time of national need to help each other during emergencies. The program was formed out of the spirit of service, volunteerism, and unity that inspired so many Americans in the wake of September 11, 2001.

These past 20 years — and, in particular, the past two years — have proven that this same spirit and willingness to step forward and help continues in our communities. The MRC mission and the MRC network

have not wavered; they have grown and strengthened.

Since early 2020 when the COVID-19 pandemic hit the United States, roughly 600 MRC units in 48 states, the District of Columbia, and U.S. territories have supported their communities in a wide array of response roles — dedicating more than two million volunteer hours.

Community members across the country raised their hands to help, joining their local MRC units and growing the network’s volunteer base to more than 300,000 volunteers nationwide. In this time of great need, the MRC network answered the call.

The network not only fought COVID-19, but also continued to respond to other emergencies facing local communities, including natural disasters and extreme weather events,

other disease outbreaks, and smaller local emergencies.

And to the extent possible, units have continued public health and preparedness initiatives that are critical to building resilient communities.

This Network Profile is a celebration of these achievements.

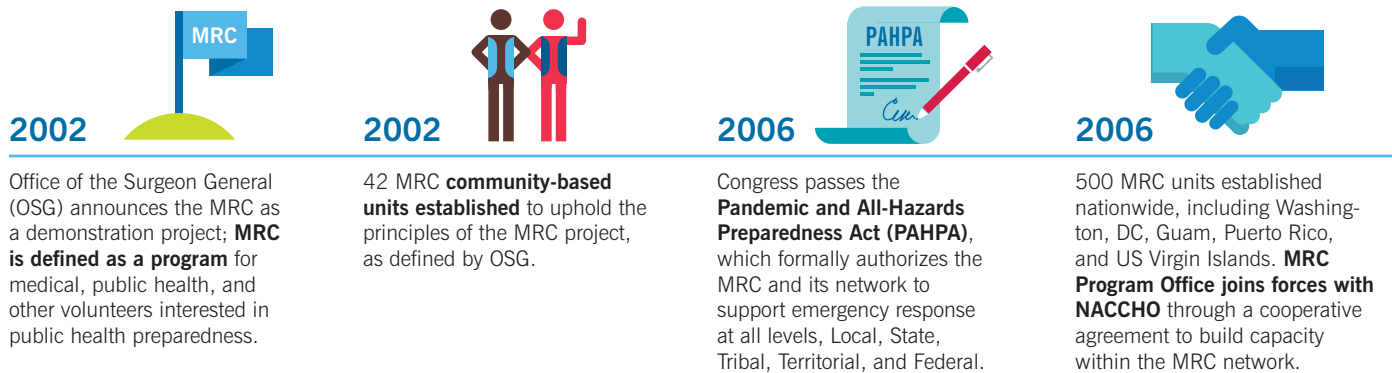
Leading the MRC program is an honor and a privilege. Thank you for the work you do day in and day out to improve the health of your communities and our country, especially during emergencies.



Sincerely,
Esmeralda Pereira
Director, Medical Reserve Corps

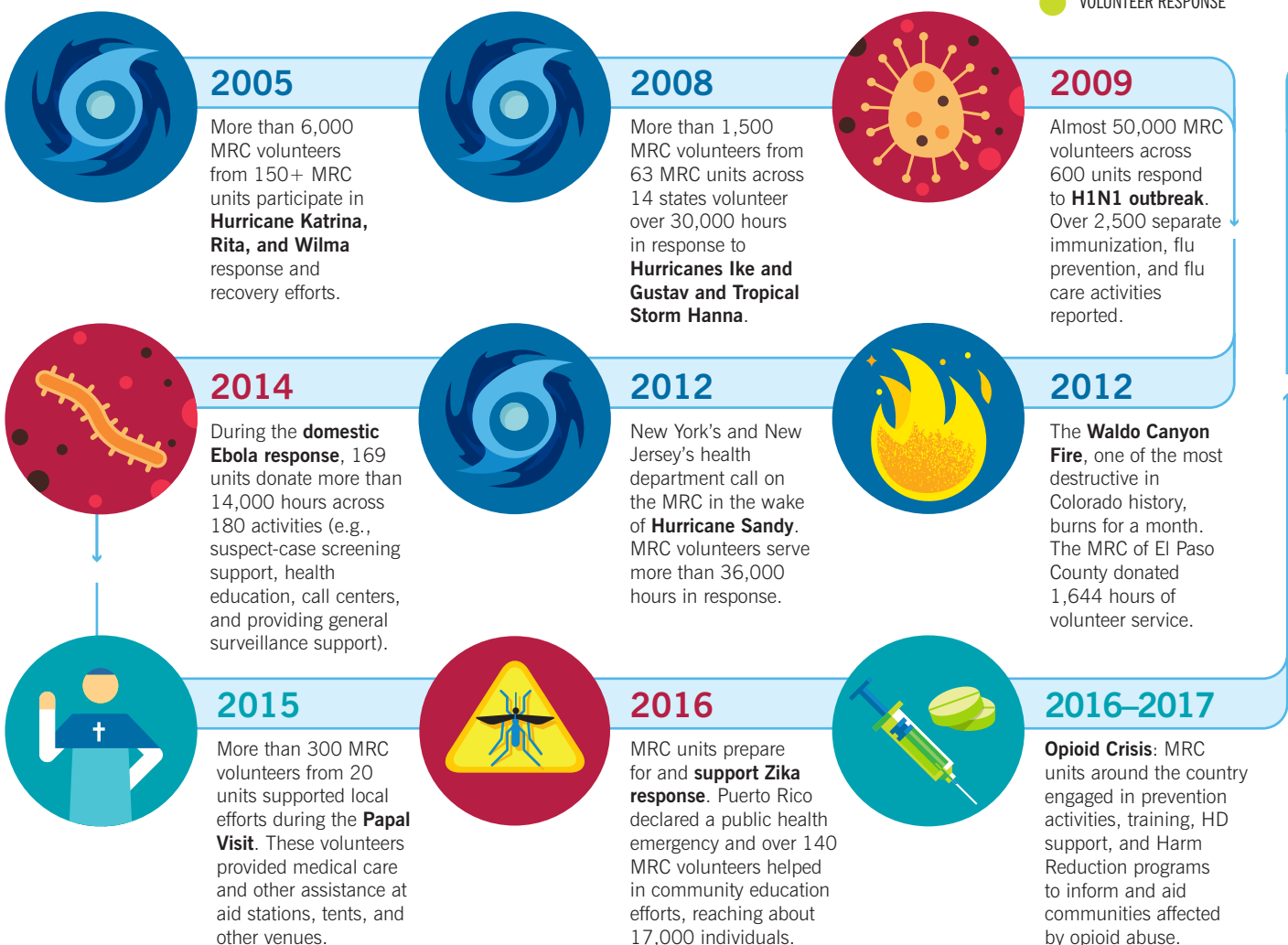
INFOGRAPHIC: A TIMELINE OF THE MRC

It's All About Service: A brief history







Rising to the occasion





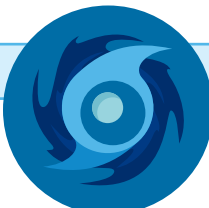

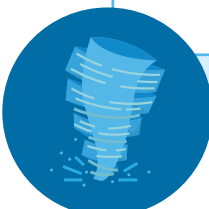

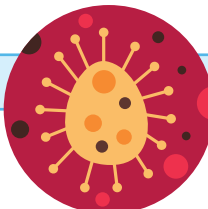
- NATURAL DISASTERS
- OUTBREAKS
- HUMAN INTEREST
- VOLUNTEER RESPONSE



of the Medical Reserve Corps

 <p>2010</p> <p>The MRC and the American National Red Cross issue a joint memorandum of understanding (MOU) to improve organizational coordination and cooperation to prepare communities for disasters.</p>	 <p>2013</p> <p>Congress passes the Pandemic and All-Hazards Preparedness Reauthorization Act (PAHPRA), which continues authorization for MRC, but moves authority and responsibility to the HHS Assistant Secretary for Preparedness and Response (ASPR).</p>	 <p>2017</p> <p>A Formal Letter of Agreement between the American National Red Cross and the MRC Program reauthorizes the collaboration between the two organizations to better prepare communities to withstand and recover from disasters.</p>	 <p>TODAY</p> <p>Nearly 200,000 volunteers among almost 800 units, including Washington, DC, American Samoa, Federal States of Micronesia, Guam, Northern Mariana Islands, Republic of Marshall Islands, Puerto Rico, and U.S. Virgin Islands.</p>
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Over the last five years, MRC units throughout the nation have been called upon to serve their communities during an increasing number of severe public health emergencies and disasters. MRC volunteers have risen to the occasion, assisting in a variety of natural disasters and communicable disease outbreaks, as well as ongoing public health emergencies such as the opioid epidemic.

 <p>2017</p> <p>Over 100 units responded to Hurricanes Harvey, Irma, and Maria, providing 100,000+ volunteer hours at an estimated economic value of almost \$4 million.</p>	 <p>2018</p> <p>Total of 889 MRC units nationwide with 188,200 volunteers participated in 17,396 total activities: 410,000 volunteer hours.</p>	 <p>2018</p> <p>MRC volunteers in the West contributed more than 15,000 service hours responding to wildfires by providing medical support, psychological first aid, and animal rescue and care efforts.</p>
 <p>2019</p> <p>848 total MRC units nationwide with 179,000 volunteers participated in 15,506 total activities contributed 47,250 volunteer hours.</p>	 <p>2018</p> <p>More than 200 MRC volunteers from states across the country responded to Hurricanes Lane and Florence in August and September.</p>	 <p>2018</p> <p>More than 100 MRC units engaged in training and prevention activities to inform and aid communities in response to the increase in opioid abuse across the country.</p>
 <p>2019</p> <p>Alabama and Mississippi MRC volunteers devoted more than 2,000 hours in response to tornadoes.</p>	 <p>2020</p> <p>MRC units nationwide participated in 16,584 total activities, totaling 820,000 volunteer hours. 650,000 of those hours were dedicated to COVID-19 response efforts.</p>	 <p>2021</p> <p>MRC units and volunteers nationwide continue to bolster local emergency response capabilities and serve as critical medical and public health response assets during the COVID-19 pandemic.</p>

MRC: Champions for local communities

January 2020 kicked off a new year and new decade full of promise. The year would also expose many gaps within the public health sector that required swift and innovative action. As the COVID-19 pandemic ravaged the country, public health was, and continues to be, at the forefront of the United States' emergency response.



KEY FINDINGS

A total of 85% of units have been with their housing organization for over five years, and 91% are integrated into the organization's emergency plan.

Unit leaders were more likely to serve in a paid position (78%) rather than as a volunteer in 2020. Leaders increased hours devoted to MRC activities per week, a 10% increase from 2017.

Units generally experienced an influx of volunteers in the past year as the average number per unit increased from 196 in 2017 to 441 in 2020.

Throughout the COVID-19 response, volunteers have been crucial in supporting activities such as staffing testing sites and vaccination clinics. Local MRCs around the country have stepped up to work alongside local health departments (LHDs) and other partner organizations to ensure their communities are engaged and supported.

COLLABORATION

MRC units reported on their source of support through collaboration with housing organizations. Most units are

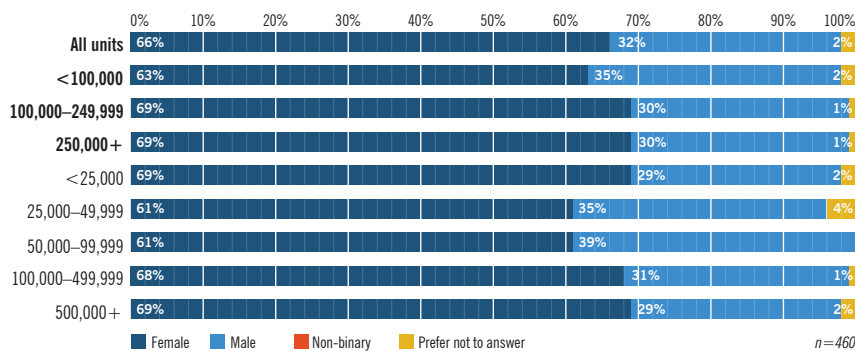
housed within LHDs (64% – a decrease compared to 68% in 2017) while the next leading partnerships were found to be with state health departments and emergency management agencies (both 8%). In correlation to when units were formed, a high percentage of units have been with their housing organizations for five or more years (85% – an increase compared to 74% in 2017). As these partnerships have expanded and strengthened over years of collaboration, preparedness and response capabilities have been developed, exercised, and improved upon. Although the COVID-19

pandemic tested these relationships, it is important to note that nearly all units are integrated into their housing organization's emergency plan (91% – an increase compared to 89% in 2017).

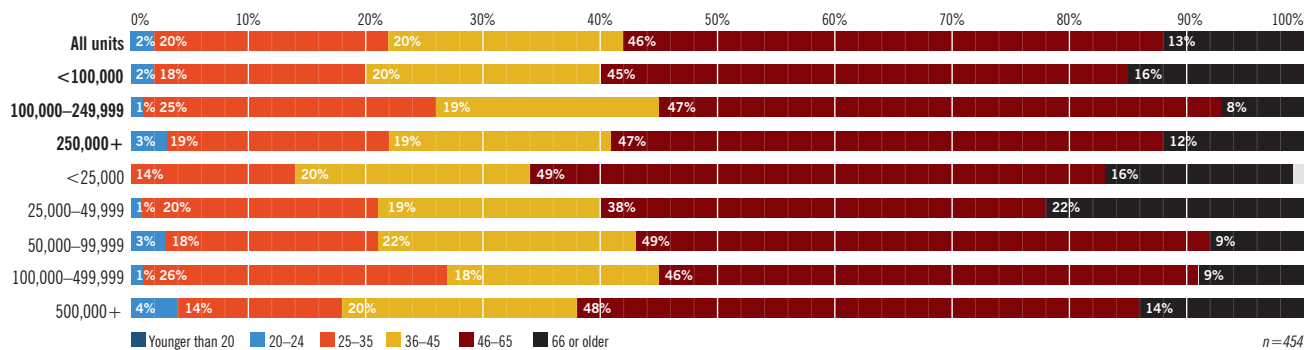
LEADERSHIP

MRC units thrive with the hard work and support of their volunteers; however, leadership plays an integral role in framing the structure, processes, and overall function of units. A total of 22% of unit leaders are volunteers themselves (a slight decrease compared to 23% in 2017), and nearly half of leaders are between the ages of 46 to 65 years old (46% – a slight decrease compared to 50% in 2017). Typically, volunteer leaders are older than paid leaders, which can be viewed as a testament to the time that those of retirement age are willing to dedicate to this work. **Figure 1** illustrates additional information regarding unit leader age and gender. **Figure 2** (see next page) highlights the degrees and corresponding fields of current unit leaders. A total of 43% of unit leaders have advanced degrees (master's or higher) (increase compared to 37% in 2017) and 36% of these advanced degrees are in Public Health/ Administration (a sharp decrease compared to 55% in 2017).

FIGURE 1
Unit leader gender identities



Unit leader ages

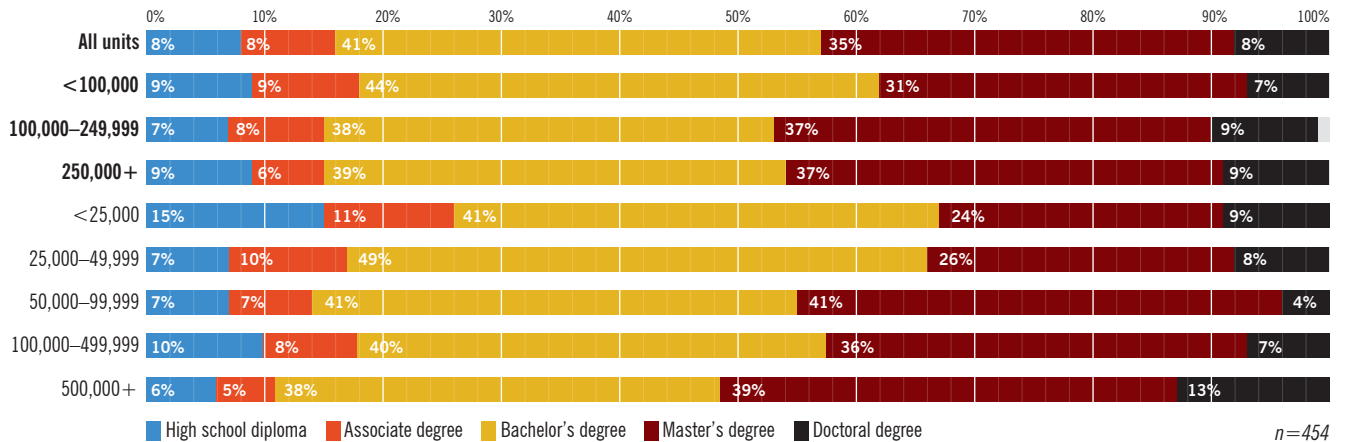


In 2020, 69% of unit leaders devoted, on average, five or more hours per week to their MRC unit—with 33% alone dedicating 15 or more hours per week (an increase compared to 25% in 2017). This sharp increase compared to 59% in 2017 may be attributed to the COVID-19 pandemic and associated rigorous work schedules. It should also be noted that units with less available funding are more likely to have leaders with fewer dedicated hours than those with more funding. As we examined time spent on MRC activities per week, we also reviewed how long unit leaders have served in their leadership roles. A total of 40% of respondents have served in their role for 1–5 years (decrease compared to 46% in 2017) and nearly a quarter have served for 10 or more years

FIGURE 2
Is the unit leader a volunteer?

	No	Yes	
All units	78%	22%	
<100,000	74%	26%	
100,000–249,999	80%	20%	
250,000+	82%	18%	
<25,000	59%	41%	
25,000–49,999	81%	19%	
50,000–99,999	77%	23%	
100,000–499,999	85%	15%	
500,000+	76%	24%	n = 459
2017	77%	23%	n = 760
2015	78%	22%	n = 794

Highest degree unit leaders hold



(24% – a sharp increase compared to 13% in 2017). The range of experience is compelling when viewed with a COVID-19 lens. A higher percentage of unit leaders are newer to their roles and have had to navigate the heavy lift of COVID-19 response activities potentially without the extensive experience and knowledge as those with 10 or more years' experience. Interactions among units within the MRC Network with varying levels of experienced leadership should be tapped into more frequently as a valuable resource.

VOLUNTEERS

MRC units are built on the challenging work and support of their volunteers. In 2020, units experienced a large influx of volunteers, most of whom identified as female (66% compared to 32% male and 2% unknown). Units serving small communities (populations ≤99,999) saw an increase from an average of 61 volunteers in 2017 to 87 in 2020; units serving medium communities (populations 100,000–249,999) saw an increase from an average of 143 volunteers in 2017 to 249 in 2020; and units serving large communities (populations ≥250,000) saw an increase from an average of 483 volunteers in 2017 to 934 in 2020. This flood of volunteers can potentially be attributed to the COVID-19 pandemic and the public's call to serve. Last year, the majority of volunteers were either nurses (28% – compared to 27% in 2017) or non-public health/non-medical personnel (36% – compared to 34% in 2017). **Figure 3** outlines the additional disciplines held by unit volunteers.

COMMUNITIES SERVED

Figure 4 outlines the size of communities served by MRC units across the country. Over three-quarters of units support small and large communities (43% and 38%, respectively). **Figure 5** highlights the distribution of MRC units across the country according to the type of communities they serve. Approximately one-third of units serve suburban communities (35%) while a combined 41% serve rural, frontier, and remote communities.

Throughout the past year, the United States has not only been confronted with challenges related to gaps in national preparedness for 21st century health security threats, but also a reminder that our nation's communities are not equal. Historically, vulnerable populations across the country have faced disproportionate access to healthcare, safe housing, stable employment, etc. and the COVID-19 pandemic amplified their burden. These communities most often include large Black/African American and Hispanic/Latinx populations with a history of mistrust in healthcare institutions and healthcare professionals. As the pandemic persists, mistrust has proven to be a major deterrent in the decision to be tested and vaccinated. A way to combat this mistrust and build rapport within affected communities is to show community representation during outreach events and educational campaigns.

Figure 6 compares race/ethnicity demographics among unit leaders, volunteers, and the communities to which they serve. Across the country in 2020, 75% of MRC volunteers identified as White and according to U.S. Census Bureau

statistics, units serve jurisdictions that are 76% White residents.³ Generally, Black/African American residents were well represented by volunteers of similar race/ethnicity (11% compared to 10%, respectively) while Hispanic/Latinx residents experienced a wider margin between residents and volunteers of similar race/ethnicity (11% compared to 6%, respectively). A total of 83% of unit

leaders identified as White, 6% Black/African American, and 4% Hispanic/Latinx. Community representation is critical during emergency response activities because a diverse volunteer base can incorporate varying levels of professional and personal experience. Diverse input can lead to more personalized response efforts that better engage the community served and improve trust and participation.

FIGURE 3
Disciplines held by unit volunteers

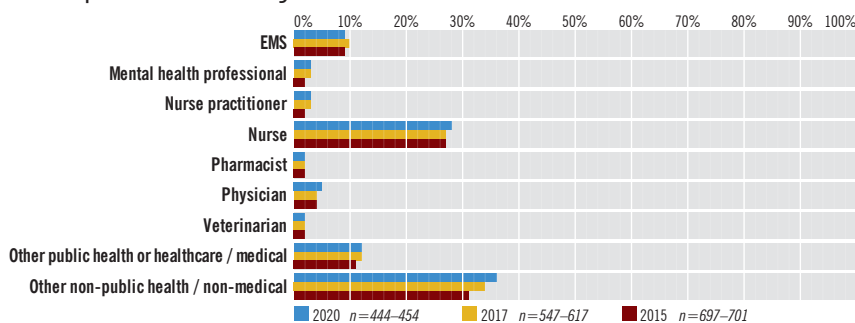


FIGURE 4
Populations served

	2020	2017
Less than 10,000	4%	6%
10,000–24,999	7%	9%
25,000–49,999	16%	17%
50,000–99,999	16%	17%
100,000–249,999	19%	20%
250,000–499,999	14%	12%
500,000–999,999	13%	9%
1,000,000 or more	11%	10%
	n = 456	n = 767

FIGURE 5
Community types

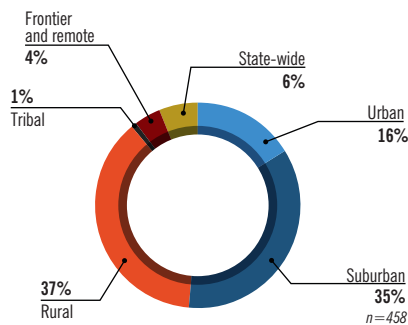


FIGURE 6
Ethnicities of unit leaders and volunteers

Unit leader (n=454)	Comparison (mean)	Jurisdiction	Volunteer
White	76%	76%	75%
Black or African American	11%	11%	10%
American Indian or Alaska Native	1%	1%	2%
Asian	3%	3%	2%
Native Hawaiian or other Pacific Islander	0%	0%	1%
Hispanic or Latinx	11%	11%	6%
Other	1%	1%	2%
Prefer not to answer	4%	1%	2%
	n = 384–392		87

CASE STUDY #1

NURTURING A DIVERSE VOLUNTEER BASE

Prior to COVID-19, the Oklahoma County MRC had about 2,100 volunteers. Unit Coordinator Dominique Baradaran used GIS (Geospatial Information System) to determine that, of those, only 13 lived in NE Oklahoma City, a predominately African American community. She also found few volunteers from South Oklahoma City, a predominately Latinx community. Dominique used an Operational Readiness Award to begin to broaden her volunteer base so that the community would see people that looked like them helping as MRC volunteers.

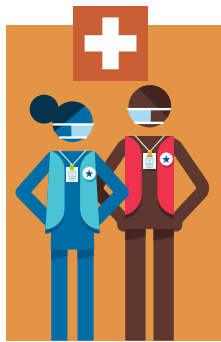
The unit’s outreach began with churches, reaching out to pastors and talking with them about emergency preparedness. With the advent of COVID, the unit pivoted its outreach efforts. The unit partnered with churches to do their own testing events. Thirty church members joined the MRC to help with such events. Most of those volunteers stayed on and helped recruit others from the community.



When it comes to diversifying your volunteer base, Dominique recommends involving your volunteers and including them in the planning process. She also suggests talking to and identifying leaders within the community. “Hear their needs and involve them in the beginning,” said Dominique.

INFOGRAPHIC: MRC UNIT SNAPSHOT

UNIT DEMOGRAPHICS:



64%

of units are housed in Local Health Departments (a decrease compared to 68% in 2017)



85%

of units have been with their housing organizations for five or more years (compared to 74% in 2017)

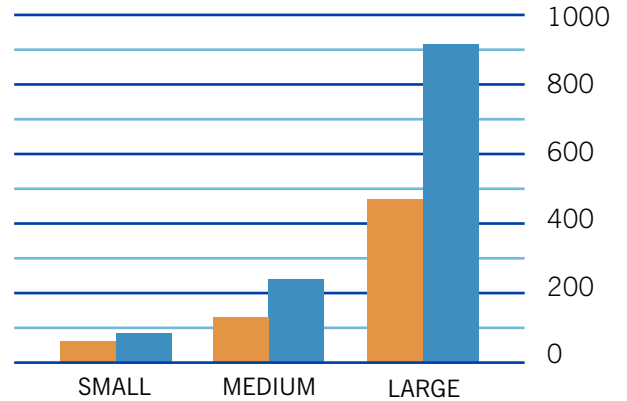


91%

of units are integrated into their housing organization's emergency plan (a slight increase compared to 89% in 2017)

AVERAGE NUMBER OF VOLUNTEERS:

2017 2020



COMMUNITIES SERVED BY MRC UNITS:

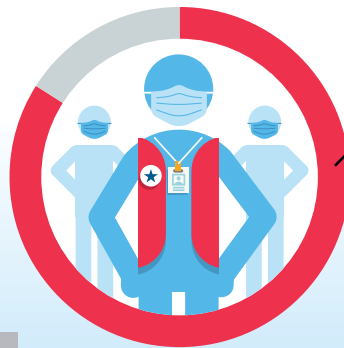


43% **SMALL** serving fewer than 100,000

19% **MEDIUM** serving 100,000–250,000

38% **LARGE** serving more than 250,000

RESPONDED TO COVID-19 DURING THE PAST YEAR:



84% of units overall:

SMALL 76%

MEDIUM 89%

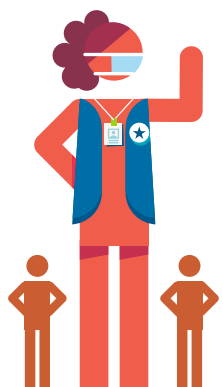
LARGE 91%



DISTRIBUTION OF UNITS: Urban **16%**

Suburban **35%**

UNIT LEADERS:



22% of unit leaders are volunteers (a slight decrease compared to 23% in 2017)

43% of unit leaders have advanced degrees (Master's or higher) (an increase compared to 37% in 2017)

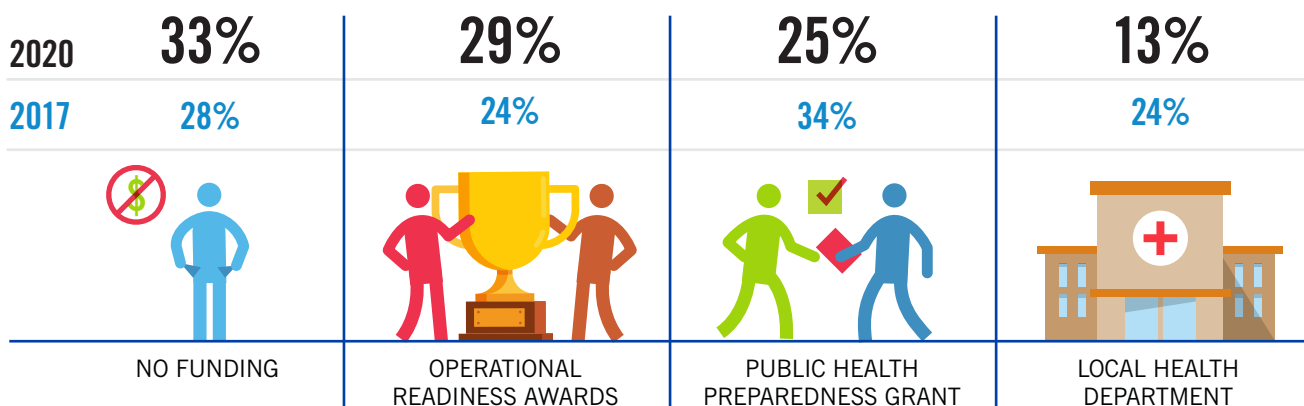
40% of current unit leaders have served in their role as MRC unit leader for six or more years (an increase compared to 34% in 2017)

36% of advanced degrees are in Public Health/Administration (a sharp decrease compared to 55% in 2017)

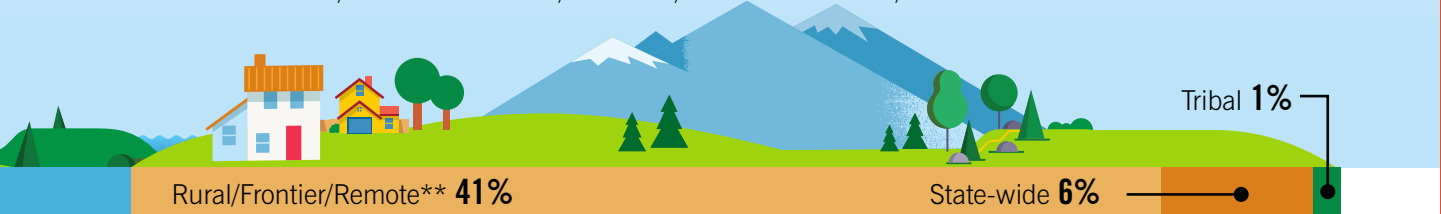
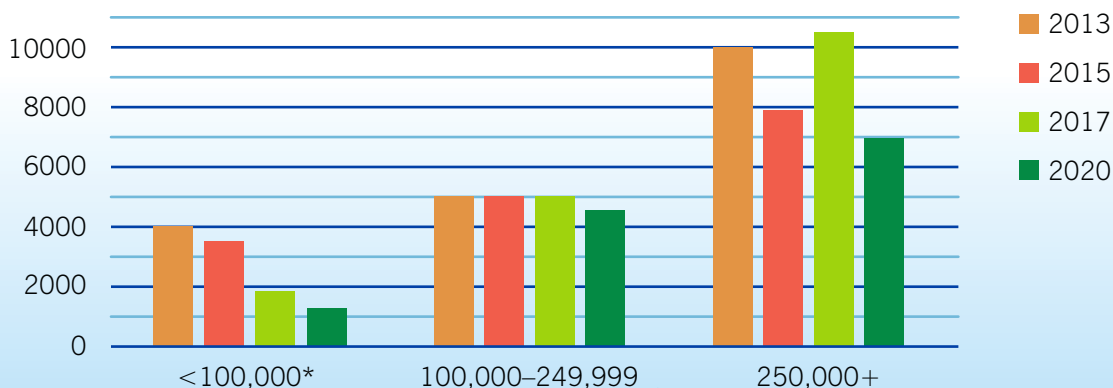
69% of unit leaders devote, on average, five or more hours per week to the MRC (a sharp increase compared to 59% in 2017)



TOP 4 FUNDING SOURCES:



MEDIAN OPERATING BUDGET:



*Small units operating on only 31% of original 2013 budget in 2020.

**Rural: In metropolitan statistical area (MSA) of 10,000 to 49,999 population that are not Frontier and Remote. Frontier and Remote: Populations up to 25,000 people that are: 45 minutes or more from an area of 25,000-49,999 people; and 60 minutes or more from an area of 50,000 or more people.

Lessons Learned: Reshaping to be ready

The hurricanes and wildfire disasters of 2017 were historic and reshaped how federal, state, and local agencies operated and planned for similar disasters in the future. MRC units played an integral role in supporting these historic disasters by deploying an unprecedented number of volunteers in a wide variety of response roles.



Hawaii

Oahu MRC Preparedness Outreach

KEY FINDINGS

82% of units provide community trainings and 81% engage in National Preparedness Month or preparedness campaigns.

89% of units are prepared to support medical Points of Dispensing (PODs) or mass vaccinations, with 51% reporting they have developed a mission set for this response capability.

53% of units reported they supported COVID-19 testing clinics or drive-through operations. Only 16% reported they did not support COVID-19 response or mitigation efforts in 2020.

In 2019, NACCHO launched a pilot project to capture lessons learned from the 2017 responses and others to gather best practices across the network. From this project, the *2019 MRC Deployment Readiness Guide* was developed with input from seven pilot sites and the NACCHO MRC Advisory Group.⁴ The deployment guide provides MRC units a common set of tools to develop emergency response capabilities to further support the integration of the MRC into the local public health and preparedness infrastructure.

Just a few months after the release of the *2019 MRC Deployment Readiness Guide*,⁴ the nation faced another historic emergency, the COVID-19 pandemic. MRC units once again responded in unprecedented numbers to the rapidly evolving

response needs of their communities. Many units were able to fall back on previously developed capabilities, while others demonstrated their ability to be adaptable, support resource gaps, and provide surge staffing requirements.

MRC RESPONSE CAPABILITIES DEVELOPED AND DEPLOYED

The findings from the MRC network survey provide a landscape of the variety of non-emergency and emergency response capabilities of the MRC. The array of capabilities presented demonstrate the ability of MRC units to tailor their trainings and activities to meet the needs of the communities they serve. The figures presented provide a representation of MRC capabilities, as well as the percentage of units that deployed these capabilities during 2020. This is the

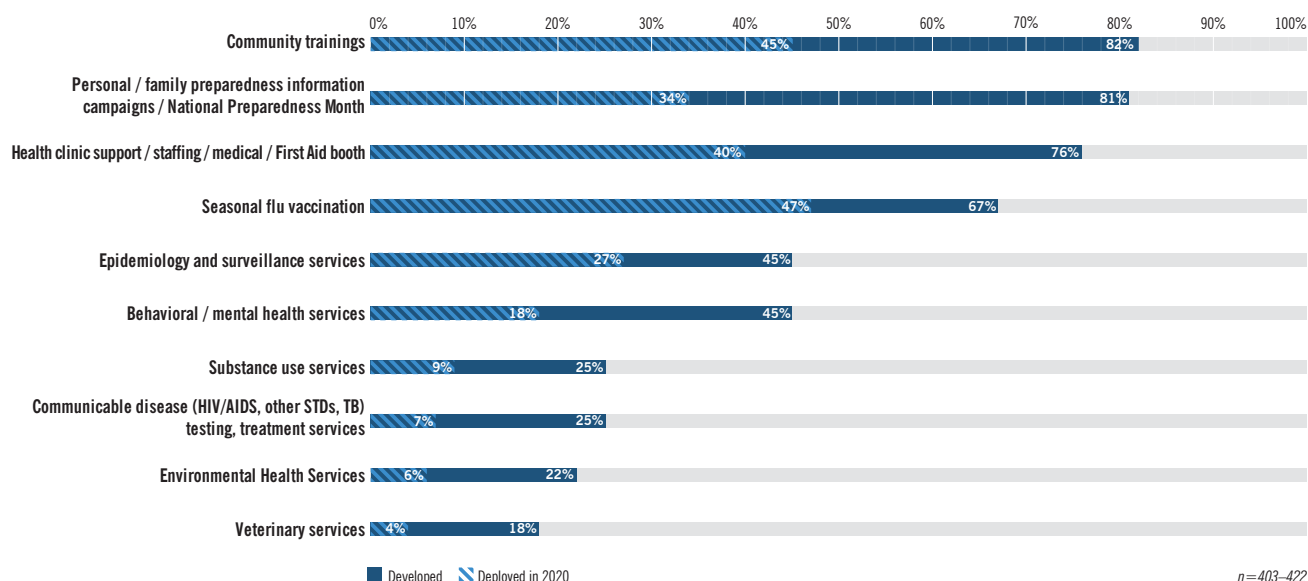
first network profile that asked MRC units to provide data on deployment activities during 2020 for capabilities that had been developed. Future Network Profiles may examine trends of types of deployment activities over multiple years versus a specific period, if the yearly data is readily available through other data sets.

NON-EMERGENCY CAPABILITIES

Figure 7 illustrates the type of non-emergency capabilities that units have developed. Capabilities can be developed through formal trainings, just in time trainings, or through in-person activities with supervision. The use of MRC volunteers in non-emergency activities builds community resiliency, establishes relationships with community partners, increases volunteers' knowledge of their roles

FIGURE 7

Non-emergency capabilities and activities



prior to an emergency, and provides opportunities to engage and retain volunteers.

The top findings for non-emergency capabilities indicate that 82% of MRC units provide community trainings and 81% participate in personal/family preparedness campaigns or promote National Preparedness Month. Community trainings may include “Until Help Arrives,” CPR (Cardiopulmonary Resuscitation) and Community First Aid, “STOP THE BLEED®,” Personal and Family Preparedness Planning, Countering Opioid Overdoses through Administration of Naloxone, and other public health priorities.

Findings also indicate that 76% of units provided medical support through health clinics or first aid booths and 67% supported annual flu vaccination campaigns. Developing and maintaining both capabilities provide opportunities to prepare and familiarize volunteers for potential emergency response roles.

The following non-COVID-19 response capabilities were reported as being developed before or during 2020, along with the percentage of units that deployed each capability to support non-COVID-19 activities during 2020.

NON-COVID-19 EMERGENCY RESPONSE CAPABILITIES

Figures 8–13 illustrate the types of emergency response capabilities that MRC units have developed and deployed during 2020. Respondents were asked to report their non-COVID-19 capabilities and deployments for 2020.

Almost all units (89%) reported they have developed medical point of dispensing or mass vaccination capabilities. This hallmark capability of the MRC continues to be the top capability of the MRC, with 87% reporting the capability in the 2017 Network Profile.

MISSION SETS

The concept of ‘Mission Sets’ was introduced in the *2019 MRC Deployment Readiness Guide* as a scalable response and recovery capability for MRC units and volunteers that is organized, developed, trained,

and exercised prior to an emergency or disaster for local, state, and/or regional deployment purposes.⁴

Mission sets are a planning tool that allow units to compile basic information using a standard template for response missions or activities that can be shared with volunteers, partner organizations,

or other MRC units to provide an understanding of the unit capabilities for that response or activity.

Figure 14 (see page 18) demonstrates the percentage of units that have developed a mission set for the following stated unit response capabilities that have been developed.

FIGURE 8

Emergency shelter response unit support

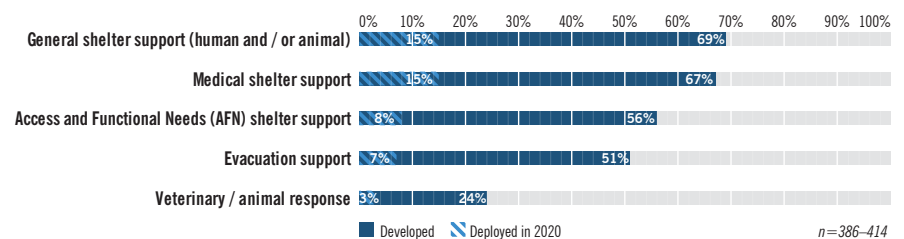


FIGURE 9

Emergency operation unit support

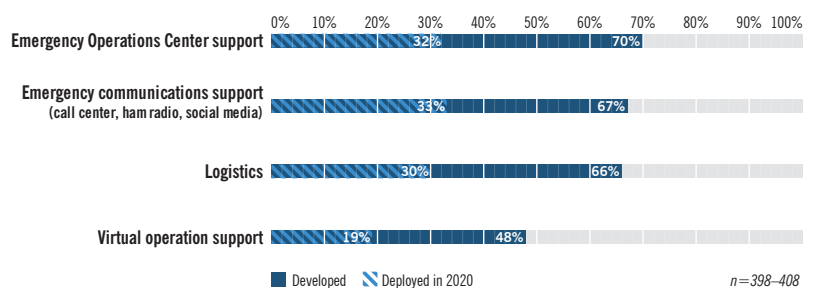


FIGURE 10

Emergency mass dispensing unit support

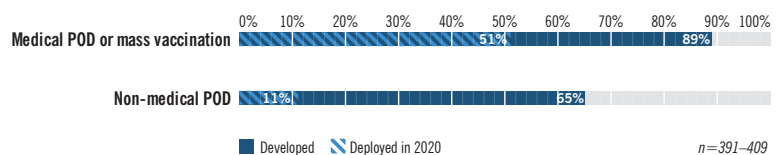
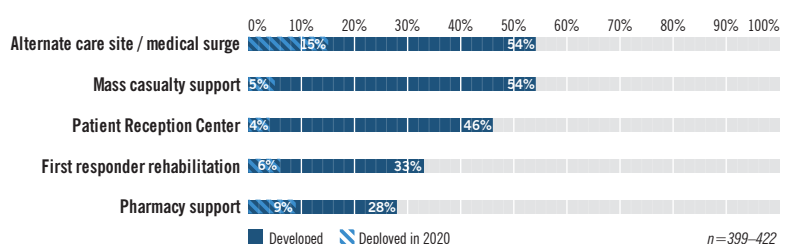


FIGURE 11

Emergency medical surge unit support



COVID-19 EMERGENCY RESPONSE DEPLOYMENTS DURING 2020

As the COVID-19 pandemic emerged early in 2020, many MRC units began deploying volunteers to support diverse and evolving response requirements. Although the data does not capture the rich stories behind the willingness of volunteers to serve and the responsiveness of MRC units, it does provide insight into how MRC units were able to pivot and support new and expanded response missions. **Figure 15** (see page 19) illustrates select COVID-19 emergency response deployments that MRC units supported. Over half of the respondents (53%) indicated they supported COVID-19 testing clinics or drive-through testing operations. Although COVID-19 vaccinations were not available for mass distribution until December of 2020, 44% of respondents indicated they supported mass vaccinations or PODs.

Exposure risk factors was identified as the top barrier to hinder the deployment of volunteers to support COVID-19 responses. This factor

most likely impacted the ability of MRC units to support medical surge missions involving direct or indirect patient care.

COMPARISON OF TOP COVID-19 RESPONSE CAPABILITIES BY JURISDICTION SIZES

Figure 16 (see page 19) illustrates the top COVID-19 responses when the size of the jurisdiction served is considered. Responses were categorized by Small (less than 100,000), Medium (100,000–249,999), and Large (250,000 or more). While 65% of large jurisdictions reported supporting COVID-19 testing and 60% of medium, only 39% of small jurisdictions reported deploying this capability. Findings indicate that overall small jurisdictions reported fewer response capabilities in comparison to medium and large jurisdictions. A correlation could be derived that reported staffing limitations had a greater impact on smaller jurisdictions response capabilities in comparison to medium or large jurisdictions. See **Figure 46** on page 40, which illustrates “Not enough

CASE STUDY #2

CELEBRATING MRC VOLUNTEERS



LANEIGH JONES, LARGO, MD

Looking to help in any way she could with combating COVID-19, LaNeigh Jones started volunteering with the Prince George’s County MRC in July 2020. A non-medical volunteer who is studying to become a physician’s assistant, LaNeigh started by supporting the COVID Cares program, which provides packaged foods to those who are awaiting their test results or have tested positive for COVID-19. She also worked with the rabies program, providing filing and phone support. More recently, LaNeigh has assisted with COVID vaccination clinics, serving as a runner, and helping with communications among staff and with patients.

LaNeigh volunteered three to four days a week initially and then transitioned to volunteering one to two days a week, depending on her work schedule. She appreciates meeting different types of people in her MRC volunteer role, as well as the exposure it gives her to different types of work.

FIGURE 12

Emergency community outreach unit support

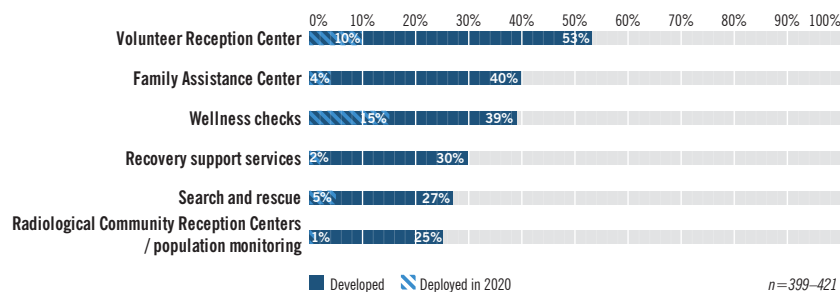
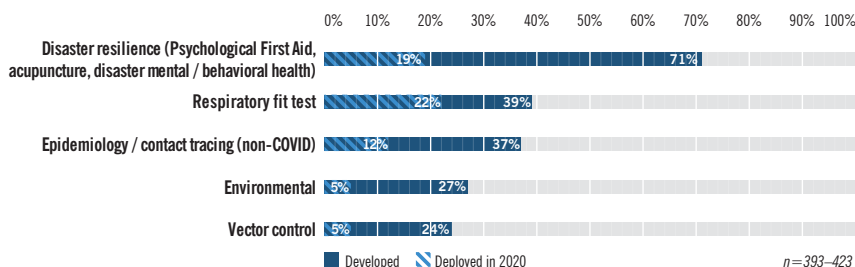


FIGURE 13

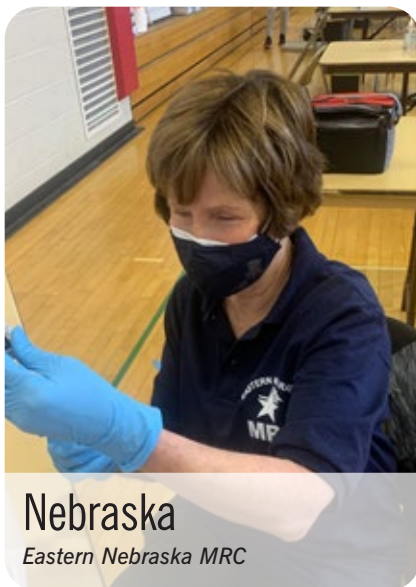
Other unit public health emergency support



staff” as a barrier to COVID-19 responses (46% of small, 37% medium, and 36% large jurisdictions).

COMPARISON OF TOP COVID-19 RESPONSE CAPABILITIES BY LEVEL OF FUNDING RECEIVED

Figure 17 (see page 20) illustrates the comparison between the percentage of MRC units reporting responses of a certain type and the amount of funding the unit received. MRC units with larger budgets were more likely to deploy some capabilities in response to COVID-19, compared to those with smaller budgets of less than \$5,000.



Nebraska
Eastern Nebraska MRC

COMPARISON OF TOP COVID-19 RESPONSE CAPABILITIES BY NUMBER OF VOLUNTEERS

Figure 18 (see page 20) illustrates the differences in response capabilities when examining the number of volunteers in an MRC unit. Not surprising, the larger the MRC unit, the greater capacity they had to support COVID-19 response efforts. It is notable that 30% of units with 25 or fewer volunteers supported COVID-19 testing efforts and/or COVID-19 outreach or education. Additionally, 26% supported mass vaccinations or PODs. MRC units with 500 or more volunteers reported higher numbers of deployments, with 79% supporting COVID-19 testing efforts and 73% supporting mass vaccinations or PODs.

FIGURE 14

Development of mission sets

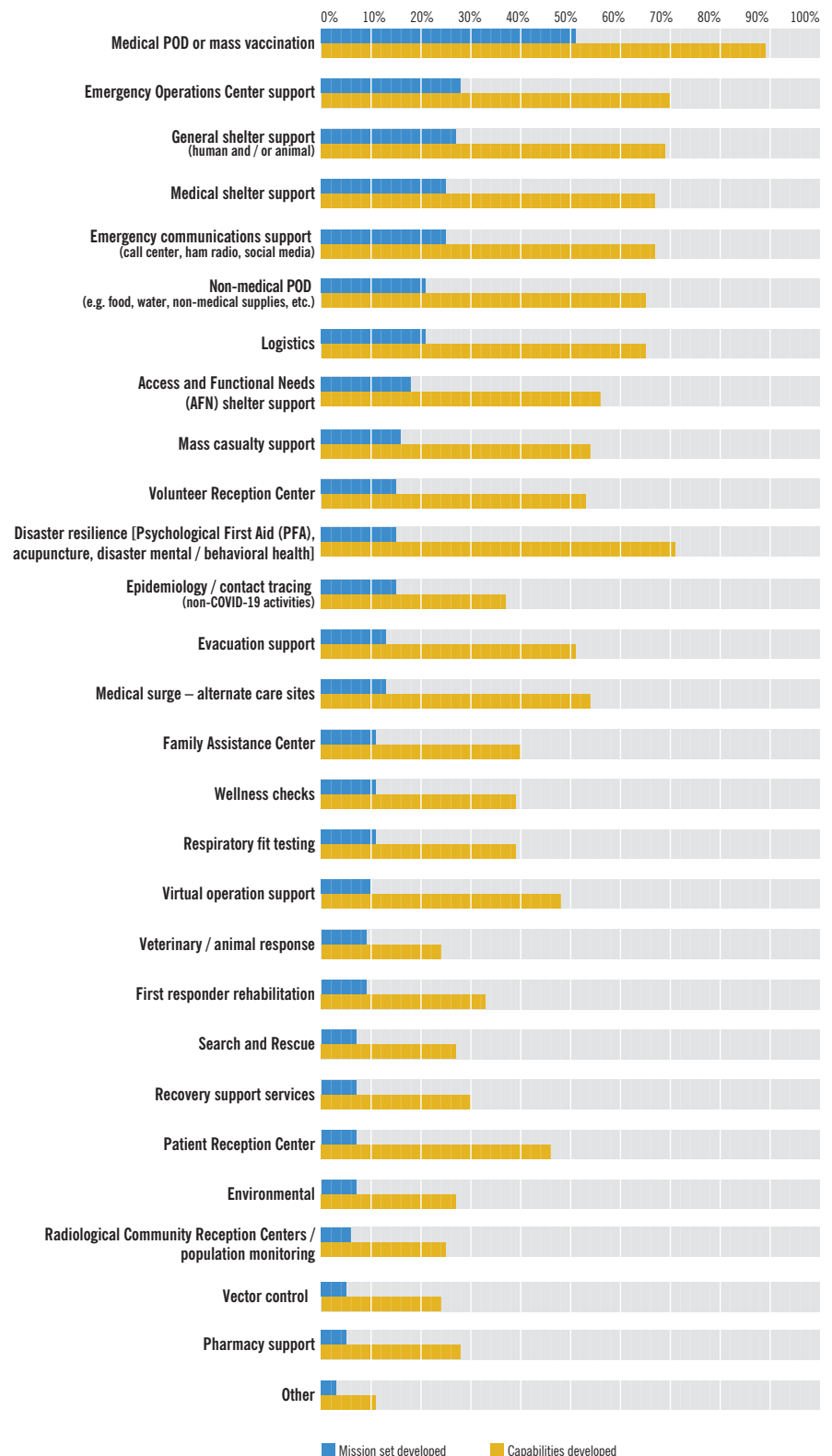


FIGURE 15
Units responding to COVID-19 during 2020

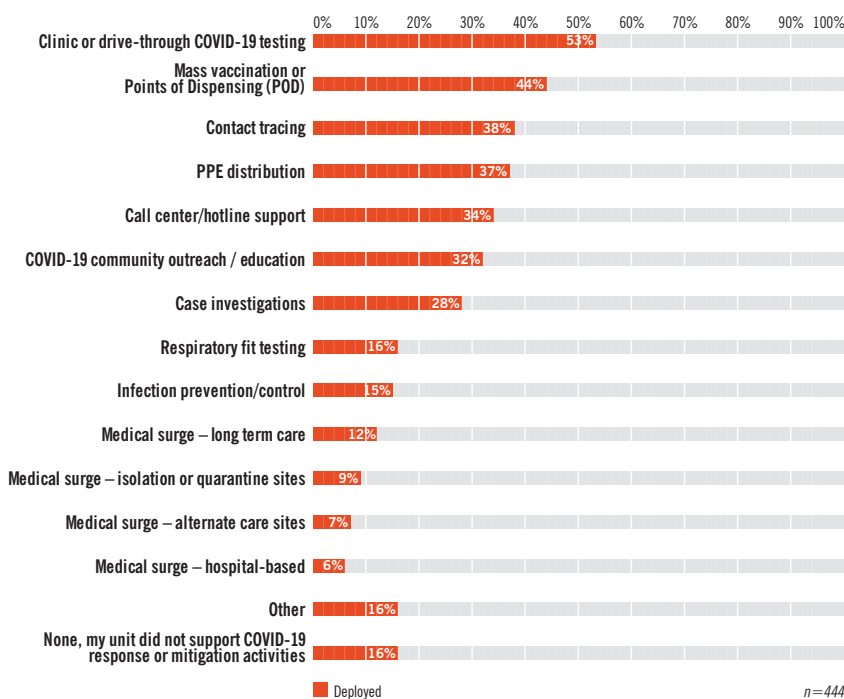
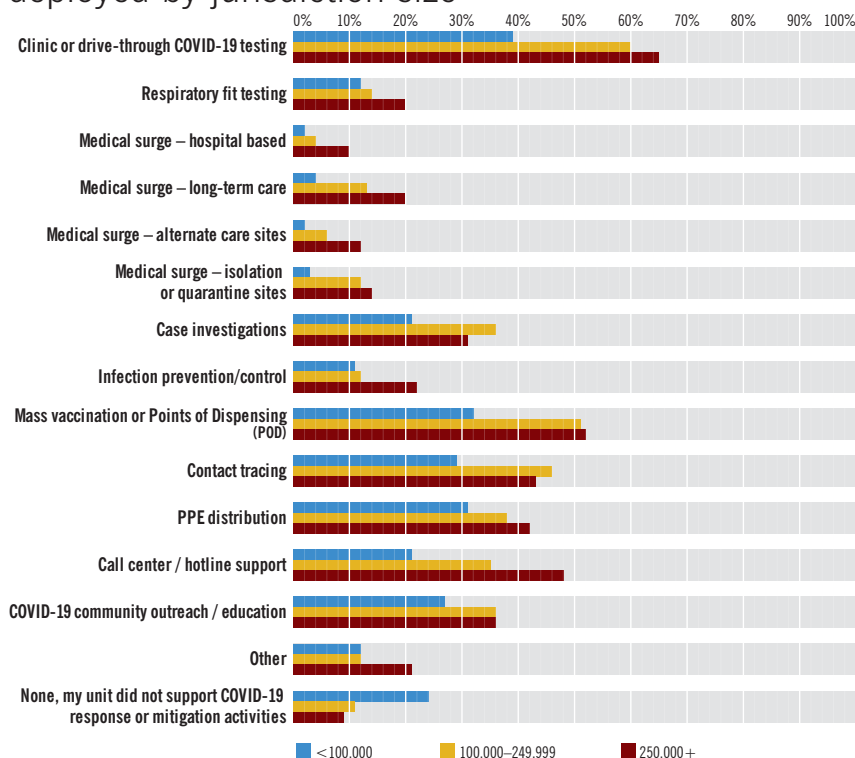


FIGURE 16
Top COVID-19 response capabilities deployed by jurisdiction size



CASE STUDY #3

CELEBRATING MRC VOLUNTEERS



TERI MILLS, HILLSBORO, OR

Teri Mills has been a Washington County MRC volunteer since April 2020. As a nurse, she serves as the medical lead for the unit, overseeing the medical component including vaccinators, vaccine control, and vaccine assistants. In this capacity, Teri identifies and troubleshoots issues, ensures communication is ongoing, and that expectations are clear. The unit has assisted with well over a dozen COVID-19 vaccination clinics so far, with many more scheduled in partnership with the Tualatin Valley Fire and Rescue and the Washington County Public Health Department. Teri assisted with flu clinics previously, which served as practice for these clinics.

“Serving as an MRC volunteer is a way to use all of our education and skills and put them to tremendous use,” said Teri. “It’s a way to give back to those not as fortunate in our community.”

CASE STUDY #4

**COMBATING
SOCIAL ISOLATION**

COVID-19 increased the degree to which community members experienced social isolation. This isolation was exacerbated by both winter holidays and weather keeping more people indoors and alone. MRC units helped to combat this isolation virtually through call programs.

On Vashon Island in Washington state, MRC volunteers staffed a Community Care Team Help Line 12 hours a day, seven days a week. The Help Line launched in mid-April 2020 and volunteers contributed more than 700 hours a month to providing mental health and spiritual support to members of the community.

The mental health extension of the call line was staffed by licensed mental health practitioners who provided crisis intervention rather than therapy. They served as a compassionate listener, assessed needs, gave practical advice, and linked callers with services. Volunteers did a warm handoff as needed to other community resources. Volunteers were provided with training, guidelines, and a list of community, state, and national resources. Volunteers for the spiritual extension of the helpline included retired priests and a Zen monk. Helpline services were free and community members were offered up to three sessions, although no one was turned away. For some, volunteers provided weekly 15-minute check in calls. The unit also started Zoom groups to foster connection with a Parenting and a Senior group.

Volunteers worked from home and used the Grasshopper app to manage calls. Trainings for the volunteers included sessions on Psychological First Aid, suicide prevention, domestic violence, and resiliency building.

FIGURE 17

COVID-19 response capabilities deployed by size of budget

n=410	No funding	<\$5K	\$5K–9,999	\$10K–19,999	\$20K+
Clinic or drive-through COVID-19 testing	43%	48%	49%	60%	70%
Mass vaccination or Points of Dispensing (POD)	33%	33%	47%	60%	62%
Contact tracing	28%	29%	47%	55%	42%
PPE distribution	28%	26%	46%	38%	49%
Call center / hotline support	23%	31%	40%	34%	44%
COVID-19 community outreach / education	21%	23%	44%	43%	42%
Case investigations	19%	23%	39%	36%	31%

FIGURE 18

COVID-19 response capabilities deployed by number of volunteers

n=410	<25	26–50	51–100	101–250	251–500	>500
Clinic or drive-through COVID-19 testing	30%	36%	47%	59%	55%	79%
Mass vaccination or Points of Dispensing (POD)	26%	25%	38%	45%	46%	73%
Contact tracing	6%	27%	40%	37%	38%	64%
PPE distribution	25%	31%	33%	35%	40%	55%
Call center / hotline support	17%	17%	31%	28%	35%	68%
COVID-19 community outreach / education	30%	19%	27%	27%	38%	50%
Case investigations	6%	20%	26%	30%	25%	50%

FIGURE 19

2020 volunteer hours for non-emergency activities

All units (mean rounded) **321** volunteer hours n=391

FIGURE 21

2020 volunteer hours for emergency activities including COVID-19

All units (mean rounded) **1535** volunteer hours n=327

FIGURE 20

2020 volunteer hours for non-emergency activities by jurisdiction size, funding

Size of jurisdiction	<25,000	25,000–49,999	50,000–99,999	100,000–499,999	500,000+
Average # volunteer hours	298	168	105	266	676
Amount of funding	No funding	<\$5000	\$5000–\$9,999	\$10,000–\$19,999	\$20,000+
Average # volunteer hours	180	222	525	480	430



Massachusetts
Northern Essex County MRC

FIGURE 22

2020 volunteer hours for emergency activities including COVID-19 by jurisdiction size and funding

Size of jurisdiction	<25,000	25,000–49,999	50,000–99,999	100,000–499,999	500,000+
Average # volunteer hours	345	298	278	2091	3279
Amount of funding	No funding	<\$5000	\$5000–\$9,999	\$10,000–\$19,999	\$20,000+
Average # volunteer hours	731	960	1893	1637	2601

FIGURE 23

Volunteer hours to support COVID-19

All units (mean rounded) **1352** volunteer hours
n=327

FIGURE 24

2020 volunteer hours to support COVID-19 by jurisdiction size and funding

Size of jurisdiction	<25,000	25,000–49,999	50,000–99,999	100,000–499,999	500,000+
Average # volunteer hours	318	261	262	1686	3093
Amount of funding	No funding	<\$5000	\$5000–\$9,999	\$10,000–\$19,999	\$20,000+
Average # volunteer hours	697	822	950	1594	2508

VOLUNTEER HOURS REPORTED FOR 2020

MRC units historically have reported their unit activities and volunteer hours to the MRC program office via the MRC website and unit portal. In addition, the MRC program office compiles periodic reports to highlight unit activities, volunteer hours, and monetary value of these activities. In the MRC Fiscal Year 2020 (10/1/2019 through 9/30/2020), 799 MRC units reported 820,000 volunteer hours, with 650,000 of those reported for COVID-19 response efforts.⁵

The 2020 MRC Network Profile is the first time that volunteer hours were requested in order to examine findings when comparing differences in sizes of jurisdictions served and amount of funding the unit received. Responses included volunteer hours for COVID-19-only activities, other emergency response activities, and non-emergency (steady-state) activities during 2020.

“Volunteers had such moving stories of helping in hectic environments, some saying it was the most meaningful service they ever provided.”

—Franklin MRC (MA)

NON-EMERGENCY VOLUNTEER HOURS

Figures 19–20 illustrate the mean (average) number of volunteer hours for non-emergency activities.

EMERGENCY VOLUNTEER HOURS

Figures 21–22 illustrate the mean (average) number of volunteer hours for emergency activities, including COVID-19.

COVID-19-ONLY EMERGENCY VOLUNTEER HOURS

Figures 23–24 illustrate the mean (average) number of volunteer hours for COVID-19-only activities.

INFOGRAPHIC: MRC CAPABILITIES SNAPSHOT

DEMOGRAPHIC INFORMATION COLLECTED:



89%

collect demographic information about volunteers



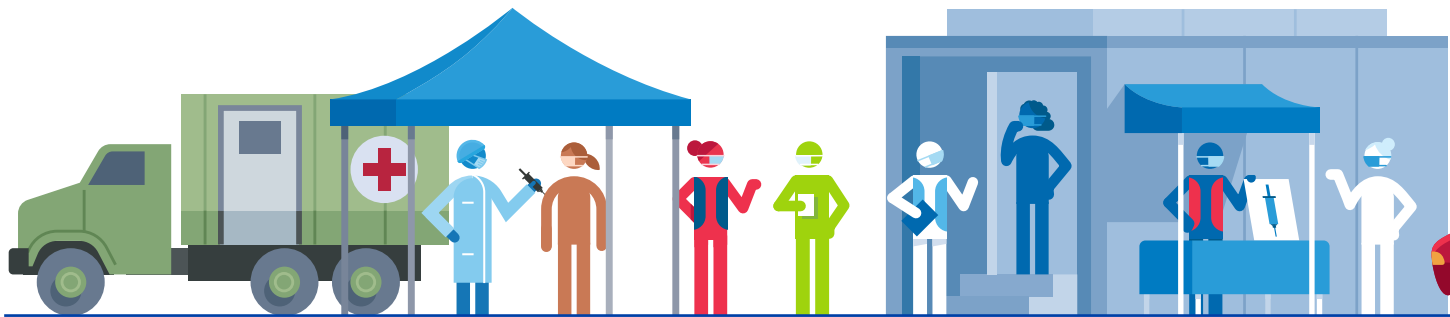
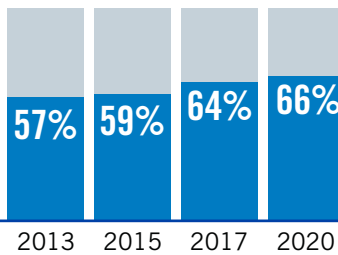
97%

of units verify medical credentials of volunteers

73%

are verified through their state registry or Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP)

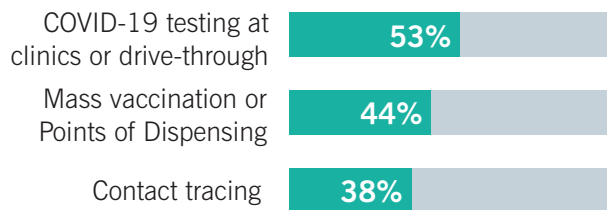
MRC units that conduct background check screening for all volunteers increased in 2020, despite increased influx of new volunteers during the pandemic



AVERAGE NUMBER OF VOLUNTEER HOURS PER MRC UNIT:

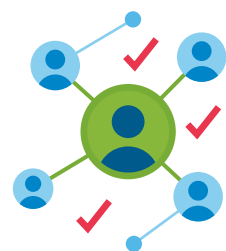


TOP COVID-19 CAPABILITIES DEVELOPED AND DEPLOYED:



TOP MISSION SETS DEVELOPED:

- ✓ Mass vaccination or mass dispensing
- ✓ Emergency Operations Center support
- ✓ General and medical shelter support



TRAINING:



97% conduct training for their volunteers



78% have a written volunteer training plan

TOP THREE TRAINING PARTNERS:

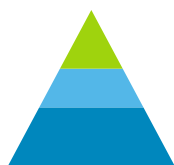


43%
Local health departments

43%
Emergency management agencies

38%
Fire/emergency medical services

TOP THREE TRAINING DEVELOPMENT METHODS:



44%
Informed by the MRC Core Competencies



32%
Informed by local needs/gaps assessments



29%
Supplied by our sponsoring organization (all or part)

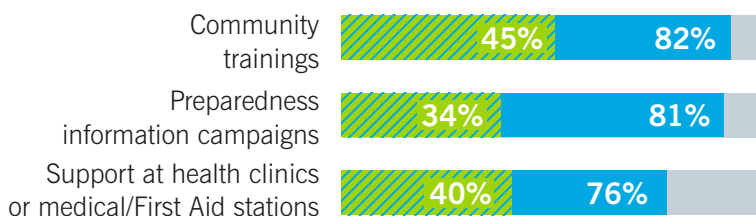


TOP UNIT CAPABILITIES:

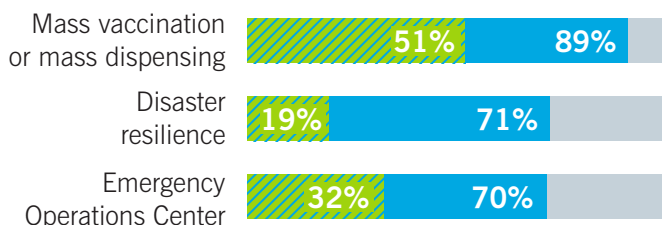
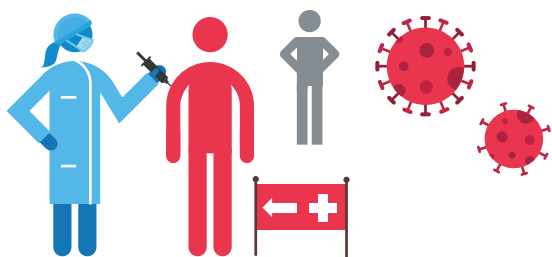
NON-EMERGENCY:



■ Capabilities deployed ■ Capabilities developed, or activities supported



EMERGENCY PREPAREDNESS:



Stepping Forward: Vetted and engaged

Recruiting and training MRC volunteers provides an essential workforce to the local communities that they serve. MRC's constant readiness of emergency preparedness capabilities allows units to respond to public health emergencies rapidly, as well as support ongoing public health missions that foster community wellbeing.



New York

Duchess County MRC

KEY FINDINGS

62% of MRC units recruit primarily by word of mouth.

66% of MRC units performed background investigations of all incoming volunteers despite the immense challenges of the pandemic.

Asked how NACCHO could assist MRC in the future, 63% stated that additional unit funding was their greatest need.

OVERVIEW

Appropriate recruitment, onboarding, and training are critical components for MRC units to be able to respond to public health emergencies. By understanding the skills, credentials, and background that volunteers bring to the MRC, units can provide them with the necessary training and experience to meet a variety of necessary roles and responsibilities. This expands on their knowledge to create a gratifying volunteer experience while maintaining a responsive and capable volunteer corps. Community partners and the public that the MRC serves value and expect a trained and ready force of volunteers as a workforce multiplier during times of crisis.

VOLUNTEER RECRUITMENT

The methods of MRC volunteer recruitment have continued to evolve.

MRC unit leaders were asked to identify their top three most effective recruitment measures from 2017 through 2020 (see *Figure 25*). Word of mouth has consistently been a most effective method of recruitment since 2015, with 62% of units' leaders citing this as the most impactful recruitment method. With the onset of the COVID-19 pandemic and encouraged social distancing, however, recruitment methods were found to shift when compared to previous 2017 and 2015 studies. Recruitment via social media was found to be another highly effective method, compared to the 2017 MRC Network Profile in which social media recruitment was the fifth most common means of attracting new volunteers.

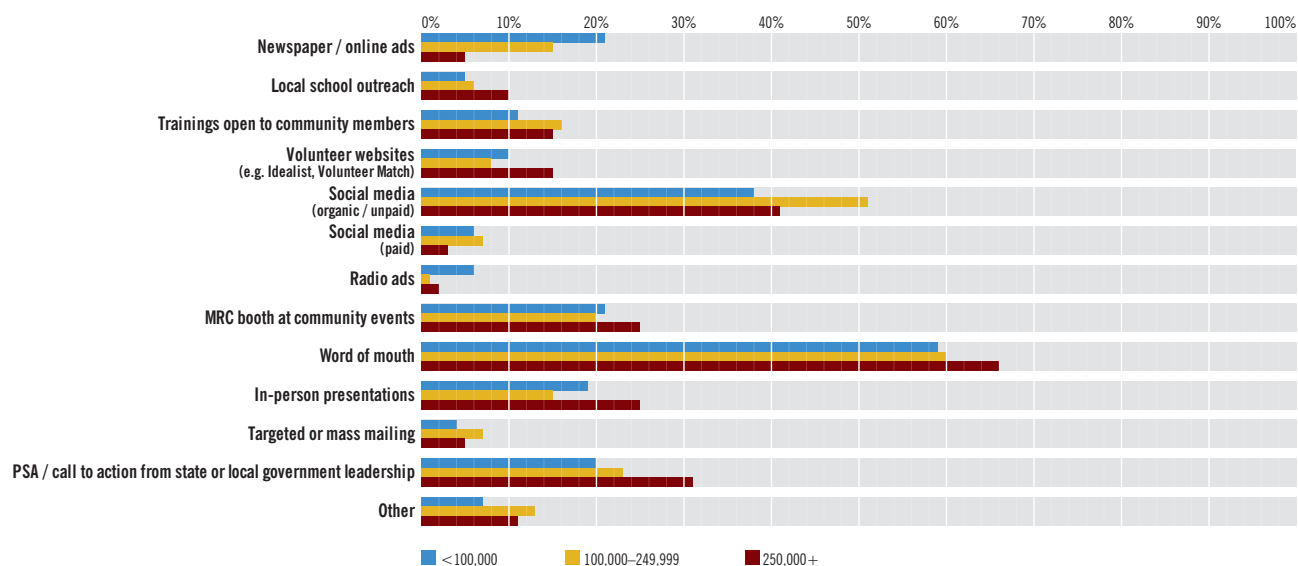
In-person engagement methods were still a major avenue of effective recruitment, with 43% of unit leaders citing outreach events such as MRC booths at community events (22%) and

in-person presentations (21%). Social media recruitment had significant gains as a method of outreach, with 42% of unit leaders citing this as an increasingly useful method of recruitment of MRC volunteers. Another notable method of recruitment that gained popularity—likely somewhat a factor of the emergency needs of the pandemic—was that of public service announcements or a call to action from state or local government leadership. A total of 25% of unit leaders noted this as one of their most effective approaches.

When MRC unit leaders were surveyed on their perceived barriers to volunteer recruitment, 13% noted that they did not experience any barriers, which is a 225% increase from 2017. For those who experienced barriers to volunteer recruitment, unit leader time constraints (56%) remained a key source of stress. Although unit leader time was identified as the top obstacle,

FIGURE 25

Most effective recruitment methods 2020 by jurisdiction size



the percentage of units reporting this constraint has dropped a considerable 23% since the question was first asked of unit leaders in 2013.

Funding was another primary barrier to recruitment that impacted MRC units, with 44% of units reporting it as an obstacle to volunteer enlistment. Funding was seen to also align as an obstacle between large and small jurisdictions, along with lack of local volunteer utilization, and a deficiency of potential volunteers available to be enlisted.

VOLUNTEER TRAINING AND CORE COMPETENCIES

A successful MRC program relies heavily on understanding the current skills of its membership, as well as how best to further develop volunteer skills and education through the proper application of training. The MRC Core Competencies were revised in 2019 to align with the response requirements of the National Center for Disaster Medicine and Public Health (NCDMPH) core competencies.⁷ These Core Competencies continue to be grouped into four distinct learning paths, which represent the overall motives and responsibilities of MRC volunteers. These four learning paths are:

- Volunteer Preparedness
- Volunteer Response
- Volunteer Leadership
- Volunteer Support for Community Resiliency

The bridging of both the NCDMPH and MRC Core Competencies allows for the MRC to have a firm, and universal knowledge and skill baseline that allows for collaboration between MRC units regardless of their geographical location. This, therefore, allows units the ability to better communicate both their unit capabilities and needs to partnering MRC units and stakeholders.

The 2020 Network Profile survey finds that 78% of units have developed a written volunteer training plan. MRC units serving smaller jurisdictions of fewer than 250,000 people are less likely than large jurisdictions of 250,000 or more people to have a written volunteer plan (74% vs. 84%), and overall, the number of units responding to the 2020 network profile survey

without written volunteer management plans dropped 19% compared to 2017 survey respondents (27%). When developing their training plan, MRC leaders reported plans were most often informed by the MRC Core Competencies

(44%); were created by a previous unit coordinator (35%); informed by local needs assessments (32%); or were supplied in all or in part by their sponsoring organization (29%). **Figure 27** shows that units representing smaller

FIGURE 26

Barriers to recruitment (over time)

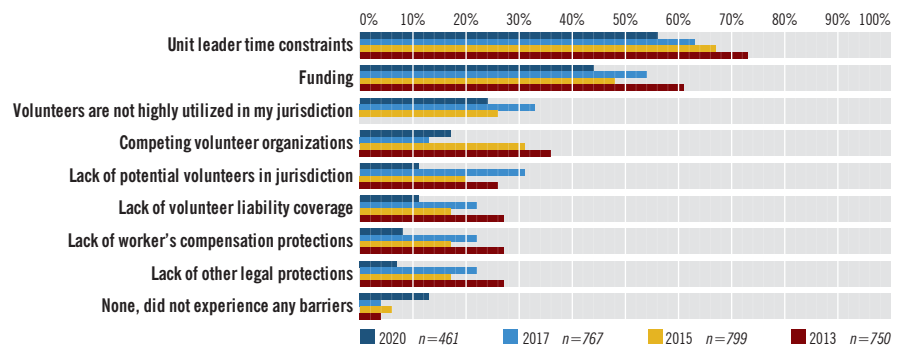


FIGURE 27

Development methods of MRC training plans among units with written training plans, by jurisdiction size

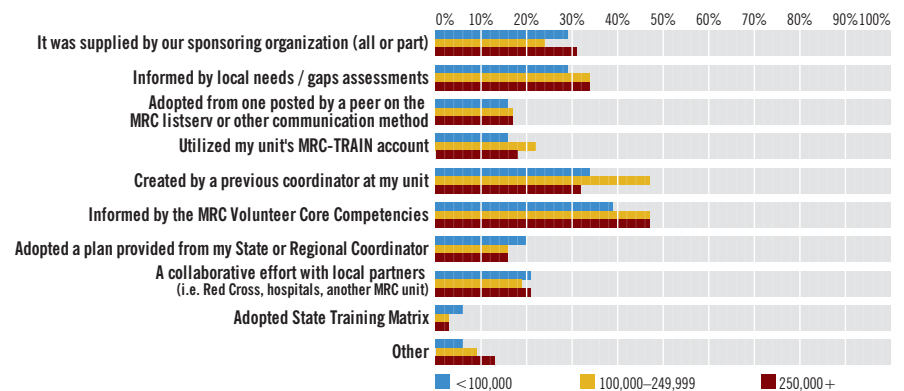
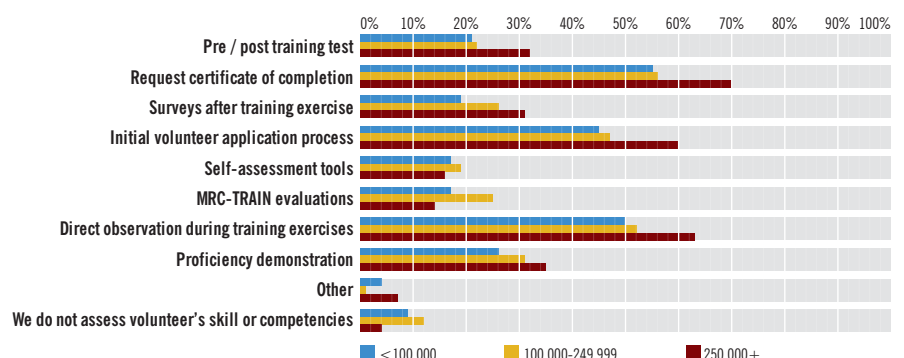


FIGURE 28

Volunteer skill assessment methods by jurisdiction size



jurisdictions were less likely to have MRC Core Competency-informed plans and were more likely to adopt their training plans from their state or regional coordinator (20%) or a previous unit leader (34%) compared to that of moderate and larger jurisdictions.

The three most common methods of assessing the skills of volunteers according to the 2020 survey were that of collecting certificates of completion of training (61%), direct observation during training exercises (55%), and by collecting information about volunteer skills during the initial volunteer application process (51%). **Figure 28** shows that this can vary depending on the jurisdiction size units serve. For example, MRCs in small and medium jurisdictions were less likely to evaluate skills through direct observation or during the initial volunteer application process versus their larger jurisdictional counterparts. Additionally, small and medium jurisdictions were more likely than larger jurisdictions to respond that they do not assess their volunteer skills or competencies.

In 2019, NACCHO developed the *2019 MRC Deployment Readiness Guide* with the assistance of the MRC Advisory Group, as a part of their MRC Deployment Ready Project, which sought to support the MRC priorities outlined by ASPR. Included in this guide were several tools to aid MRC units in the successful and orderly deployment of their volunteers to a variety of public health and emergency missions. Among these tools were the MRC volunteer tier level standardization chart, the MRC unit leader deployment readiness checklists, and the MRC Core Competencies volunteer training plan, as well as an MRC mission set guide.

In the 2020 Network Profile survey, units were asked about their awareness and use of the *2019 MRC Deployment Readiness Guide* tools for their volunteer programs. The MRC Core Competencies Volunteer Training plan was found to be the most used by units (36%) serving medium and large jurisdictions, which were more likely to have used the resource than those in small jurisdictions. Smaller

CASE STUDY #5

ADDRESSING THE NEEDS OF PETS DURING AN EMERGENCY

Since more than half of U.S. households own at least one pet, animals are a consideration for most local families during an emergency response. Specialized units within the MRC help to address those needs.

With almost 500 people as part of the Mississippi Animal Response Team (MART), the Mississippi Veterinary MRC aids people and animals across the state. The Mississippi Veterinary MRC comprises elite members within the MART—those who are trained and want to deploy. The unit consists of about 50 volunteers including veterinarians and non-medical volunteers with sheltering experience.

The unit has three primary teams. The Shelter Team deploys to assist with large-scale sheltering events like those that happen after hurricanes. The Veterinary Medical Response Team comprises veterinarians and vet techs to respond to disaster situations like the Mississippi River flood, tornados, and hurricanes. Missions have also included support to the dogs assisting with security at the National Governors Association meeting and to cadaver dogs assisting with a military chopper crash. In 2019, the Animal Assistance Crisis Response Team was formed. This six-member team includes people and therapy dogs. During COVID-19, the team was deployed for several months to conduct visits to the State Department of Health and the State Emergency Operations Center to help reduce stress among responders.

“It was amazing to see people’s response,” said Unit Leader Beth Adcock. “It provided a break from everyday stress.”



Oklahoma
OKMRC Animal Rescue

jurisdictional MRC units were less likely to be aware of each of the four resources than their medium and large jurisdictional counterparts. **Figure 29** details the characteristics of units that were unaware of the Deployment Readiness Guide tools. The majority of units that responded that they were not aware received no funding, were led by unit leaders with five years or less of experience within the role and dedicate nine hours or fewer per week to MRC unit leadership. Among those not aware who did receive financial support, usage of the tools varied, but were overall less likely to have been funded by NACCHO or the CDC.

When asked how NACCHO could further support MRC units, the top three categories that survey respondents said they needed assistance with were funding (63%), internet-based training such as webinars, e-learning courses, and podcasts (62%), and train-the-trainer model presentations (54%). **Figure 30** shows that additional funding is highlighted as a great need regardless of jurisdiction size, and that small and medium jurisdictions especially need additional internet-based training support.

The most common training events according to the 2020 Network Profile survey were the following:

- Incident Command System (ICS) Courses 100, 200, 700, 800
- Stop The Bleed
- MRC 101 or Unit Orientation
- CPR/First Aid and AED
- Personal and Family Preparedness

Of these, Introduction to ICS (46%), the National Incident Management System (40%), and MRC 101/Unit Orientation were the most common mandatory courses.

Since 2017, the delivery method—online, in person, or in the field—of the most common training courses offered by MRC units shifted to meet the circumstantial and logistical needs of both volunteers and MRC units. **Figure 31** shows that training events that could be easily held in a virtual format such as MRC unit orientations, Incident Command System courses (which are readily available on the FEMA website), bloodborne pathogens and others, moved

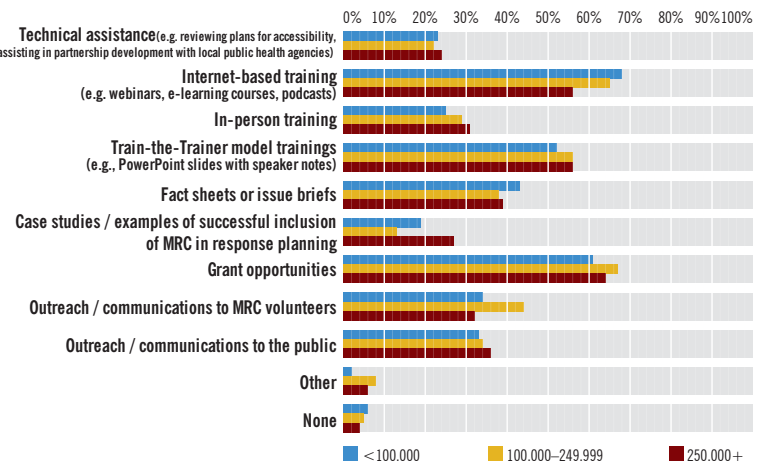
FIGURE 29

Characteristics of units unaware of 2019 MRC Deployment Readiness Guide resources

By budget size, among those not aware	No funding	<\$5,000	\$5,000–\$9,999	\$10,000–\$19,999	\$20,000+	
MRC volunteer tier levels	47%	23%	9%	8%	14%	
MRC unit leader deployment readiness checklists	50%	19%	13%	8%	10%	
MRC Core Competencies volunteer training plan	49%	24%	8%	7%	12%	
Mission sets	48%	24%	12%	5%	11%	
By funding source, among those not aware	NACCHO	CDC	Others			
MRC volunteer tier levels	16%	31%	53%			
MRC unit leader deployment readiness checklists	32%	27%	41%			
MRC Core Competencies volunteer training plan	26%	26%	47%			
Mission sets	22%	33%	45%			
By years as leader, among those not aware	<1 year	1–5 years	6–9 years	10+ years		
MRC volunteer tier levels	33%	33%	16%	19%		
MRC unit leader deployment readiness checklists	35%	31%	14%	19%		
MRC Core Competencies volunteer training plan	40%	34%	11%	15%		
Mission sets	33%	30%	14%	23%		
By hours devoted by leader, among those not aware	<5 hours	5–9 hours	10–14 hours	15–34 hours	35–40 hours	>40 hours
MRC volunteer tier levels	47%	20%	9%	19%	5%	2%
MRC unit leader deployment readiness checklists	49%	18%	9%	15%	4%	4%
MRC Core Competencies volunteer training plan	49%	20%	10%	15%	3%	3%
Mission sets	48%	22%	7%	14%	7%	2%

FIGURE 30

Future unit support needs from NACCHO by jurisdiction size



Across the nation, MRC volunteers are making a difference.



Louisiana



Maryland



California

FIGURE 31
MRC unit training opportunities (offered and/or available for volunteers)

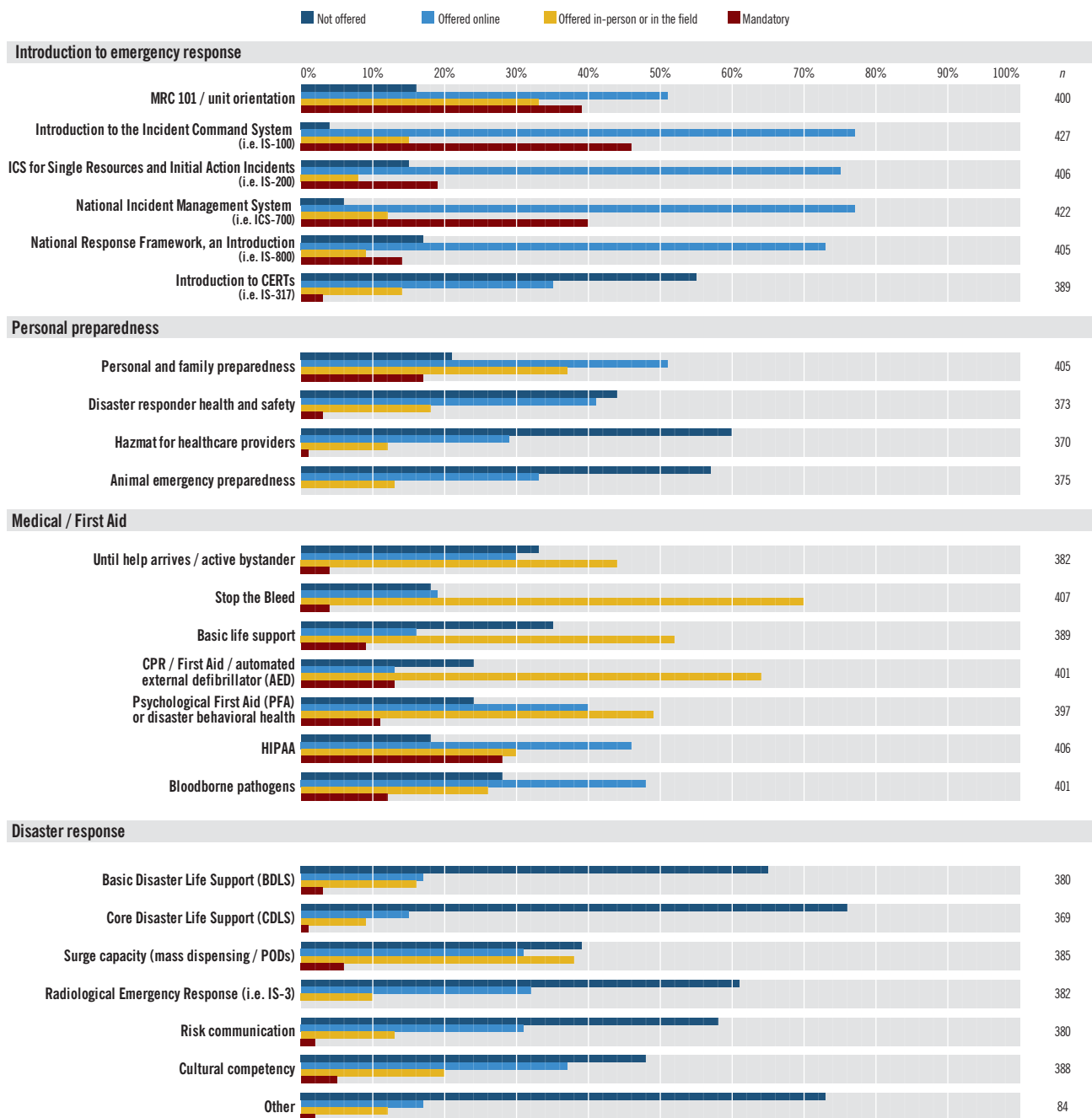


FIGURE 32
Method of volunteer training by course type

Over time	2020	2017	2020	2017	2020	2017		
MRC 101/unit orientation			Cultural competency			National Incident Management System		
Online	51%	23%	Online	37%	8%	Online	77%	68%
In person	33%	39%	In person	20%	9%	In person	12%	8%
Field setting		0%	Field setting		0.1%	Field setting		0%
Not offered	16%	38%	Not offered	48%	82%	Not offered	6%	24%
Mandatory	39%	51%	Mandatory	5%	4%	Mandatory	40%	56%
Basic life support			Core disaster life support			National Response Framework, an Introduction		
Online	16%	2%	Online	15%	2%	Online	73%	40%
In person	52%	33%	In person	9%	2%	In person	9%	3%
Field setting		1%	Field setting		0.1%	Field setting		0%
Not offered	35%	64%	Not offered	76%	95%	Not offered	17%	57%
Mandatory	9%	10%	Mandatory	1%	5%	Mandatory	14%	15%
Blood borne pathogens			Basic disaster life support			Active bystander		
Online	48%	13%	Online	17%	1%	Online	30%	3%
In person	26%	24%	In person	16%	15%	In person	44%	10%
Field setting		0%	Field setting		1%	Field setting		0.3%
Not offered	28%	63%	Not offered	65%	83%	Not offered	33%	87%
Mandatory	12%	15%	Mandatory	3%	1%	Mandatory	4%	1%
Mass dispensing / POD training			Introduction to the Incident Command System			Bleed control		
Online	31%	10%	Online	77%	73%	Online	19%	1%
In person	38%	44%	In person	15%	11%	In person	70%	12%
Field setting		9%	Field setting		0%	Field setting		1%
Not Offered	39%	37%	Not offered	4%	15%	Not offered	18%	86%
Mandatory	6%	21%	Mandatory	46%	67%	Mandatory	4%	3%
CPR / First Aid / automated external defibrillator			ICS for single resources and Initial Action Incidents			HIPPA		
Online	13%	1%	Online	75%	49%	Online	46%	18%
In person	64%	54%	In person	8%	4%	In person	30%	20%
Field setting		1%	Field setting		0%	Field setting		0.4%
Not offered	24%	44%	Not offered	15%	47%	Not offered	18%	61%
Mandatory	13%	24%	Mandatory	19%	27%	Mandatory	28%	23%
Psychological First Aid			Radiological emergency response			<i>n = 369-422</i> <i>n = 729-755</i>		
Online	40%	16%	Online	32%	6%			
In person	49%	48%	In person	10%	5%			
Field setting		1%	Field setting		1%			
Not offered	24%	35%	Not offered	61%	89%			
Mandatory	11%	20%	Mandatory	0%	1%			
Risk communication			Introduction to CERTs					
Online	31%	6%	Online	35%	9%			
In person	13%	9%	In person	14%	9%			
Field setting		0.1%	Field setting		1%			
Not offered	58%	85%	Not offered	55%	81%			
Mandatory	2%	2%	Mandatory	3%	4%			



“There are a lot of different opportunities to get involved. I work with a group of wonderful people at the health department—very kind and giving people, both staff and volunteers.”

— Ed Goe, Volunteer, Mid Ohio Valley MRC (WV)

FIGURE 33

Methods of information exchange with MRC volunteers

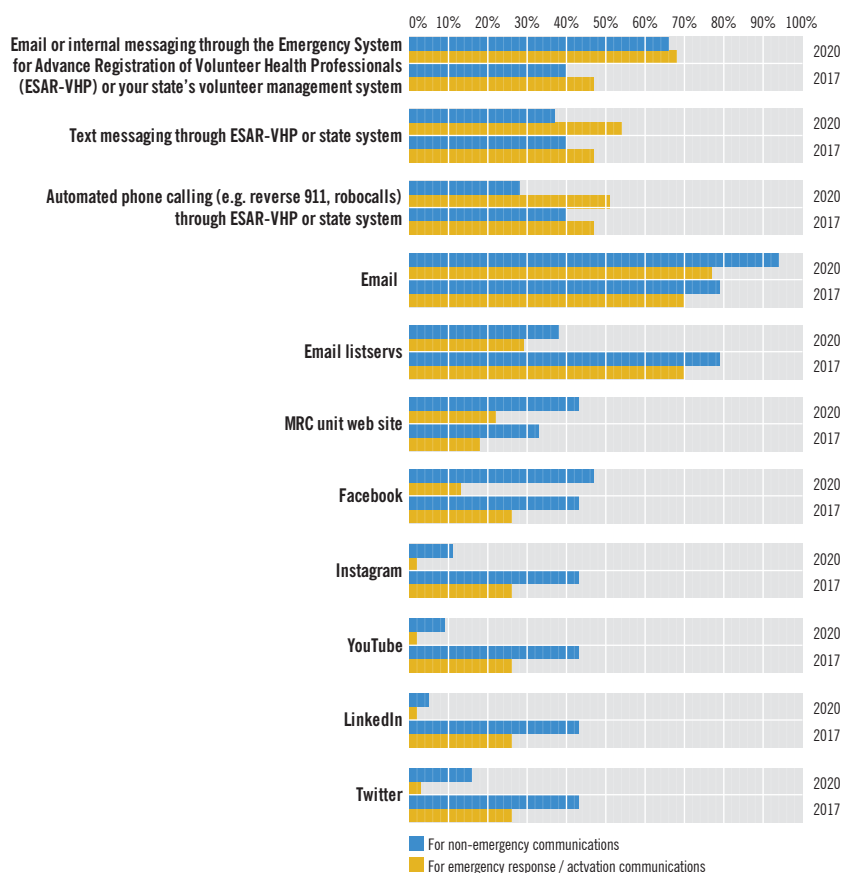


FIGURE 34

Barriers to utilizing social media to communicate

Population size, 3 categories	< 100,000	100,000–249,999	250,000+
Housing department limits use of those sites	20%	22%	34%
I do not have time to devote to social technology	46%	49%	50%
I do not see the value in participating in social technology	2%	5%	3%
I am not familiar with using the technologies listed	12%	10%	7%
Other	8%	6%	7%
I do not have any barriers to using social media technologies	33%	32%	29%

to online platforms, whereas trainings, which often require in-person skills assessment such as CPR/First Aid/AED training and bleed control courses, were offered in person or as just-in-time training in the field.

COMMUNICATIONS

The role of communication both internally to MRC members as well as externally to stakeholders and the public is crucial to MRC success. Communication with MRC members to provide situational awareness and emergency information is critical as well as ensuring a positive volunteer experience. Although most units (77%) reported using direct email to communicate with volunteers during emergencies, 2020 saw a considerable increase in the number of units communicating through an ESAR-VHP or other state system to notify volunteers. These systems were adopted to automatically generate emails (68%), text messages (54%), or automated phone calls (51%) to efficiently communicate to volunteers during emergencies. This is a considerable increase compared to 2017, in which 47% of units reported using an ESAR-VHP or state system to communicate directly with volunteers during an emergency. For non-emergent correspondence, most units used direct email and email listservs. An increased 43% of units optimized their MRC website as a shared communications resource.

The combined percentage for use of any social media option for non-emergency communications in 2020 was 51%, increasing from 23% in 2017. For emergency communications, it was 14%, a decrease from 26% in 2017. When units were asked what their barriers were to further social media integration into their communications, most units identified a lack of time to devote to social media technologies (see **Figure 34**). Additionally, respondents—especially those serving larger jurisdictions (34%)—state that their sponsoring department often limits their use of social media for human resource purposes, which inhibits their expansion into this area.

Cultivating resources for response readiness

The cultivation of resources is an important determinant of each unit's readiness capabilities and ongoing support mechanisms. By properly supporting MRC units, volunteers can better ensure safe and effective emergency and public health-focused deployments.



Texas
Harris County MRC

KEY FINDINGS

One third of MRCs reported having no funding for their operating budget.

Units serving small jurisdictions (<100,000 people) saw their median operation budgets decrease from 2013 by 69%.

Stand-alone non-profit MRC units are most motivated to purchase additional legal protections.

OPERATING BUDGET

An imperative need for any operating organization is adequate financial support and standing. NACCHO asked MRC units about their operating annual budgets for the most recent fiscal year. The median operating budget overall reported by MRC units in 2020 was \$2,500 with 33% of MRC units reporting that they have no current source of funding for their

operational activities. As **Figure 35** shows, since the first Network Profile of the MRC in 2013, units serving small jurisdictions (<100,000 people) have had the largest reduction in funding and have experienced a 69% reduction in funding.

AN IN-DEPTH FUNDING ANALYSIS

When asked about the source of their funding, the majority (90%) of MRC

units reported having two funding sources or less. An increased percentage of units relied more heavily on investments from Operational Readiness Awards (ORA) in 2020 (29%) compared to 2017 when 24% reported ORAs as a funding source. Public Health Preparedness grants (PHEP) (25%) and local health department funding (13%) have decreased over time (See **Figure 37**). Non-LHD sponsored units were especially reliant on ORAs, as 30% reported that they depended on ORAs as a primary source of funds.

An analysis of survey data found that on average, MRC units received 11% of their funding from other or non-traditional sources. Also, when adjusting for those units not receiving funding, NACCHO found that units receiving ORA funds were the most numerous when compared to all other funding categories (n=123). **Figure 38** further shows the impact of ORA funding on units, with 88% of units claiming an operational budget of \$19,999 or less, pointing to ORA as their primary source of funding.

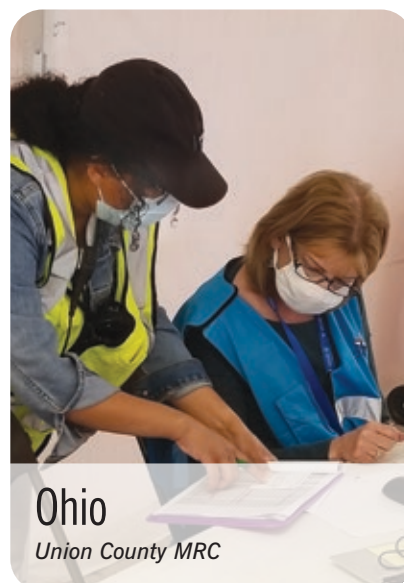
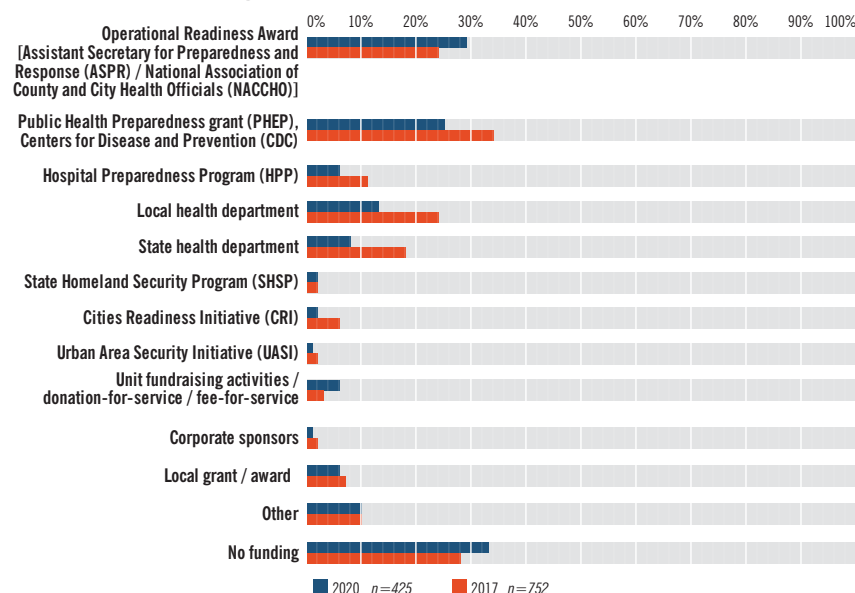
FIGURE 35

Median MRC unit operating budgets over time in dollars

Medians by size of population	2020	2017	2015	2013
<100,000	1250	1800	3500	4000
100,000–249,999	4500	5000	5000	4990
250,000+	6993	10500	8000	10000
	n=425	n=711	n=742	n=694

FIGURE 36

Primary funding sources for MRC units in FY 2020



Additionally, **Figure 37** shows that 45% of units reported that ORA funding accounts for as much as 75–100% of their full operating budgets.

When asked if funding changed (either increased or decreased), which areas would be impacted most significantly, MRC units ranked staffing and payroll (31%), supplies and equipment (26%) and training (19%) as the top areas. Additionally, MRC units stated that they could accept either cash (27%) or in-kind donations (38%) for their units. As **Figure 38** shows, MRCs sponsored by local health districts (42%) and those serving larger jurisdictions (47%) were less able to accept donations than their non-LHD and smaller jurisdictional counterparts. Overall since 2017, MRC units have become more open and reliant on cash (27%) or especially in-kind donations (38%) from third parties.

PARTNERSHIPS

Despite differences among individual local communities, it is imperative for all MRCs to engage and collaborate with local stakeholders to ensure positive emergency response outcomes. To promote public health, MRC units must develop partnerships to reduce vulnerability, build resilience, promote public health, and prepare a supplementary workforce focused on emergency response and recovery.

Partnerships with local organizations often also bring a variety of resources to MRC volunteer groups such as materials, funding, and other personnel-centered support. While MRCs housing organizations were a primary source of support regardless of their jurisdiction size, state and local governments, as well as non-governmental organizations, continue to contribute to MRC units in the areas of training and leadership (see **Figure 39**).

Community stakeholders often partner with MRC units in a variety of ways to share a common goal of public health and emergency response. Many MRC units closely partner with local health departments (89%) and their local or state emergency management agencies (89%), especially with respect to emergency response activities (76% and 71% respectively). It is also important

FIGURE 37

Average percentage of funding source to MRC units by budget size

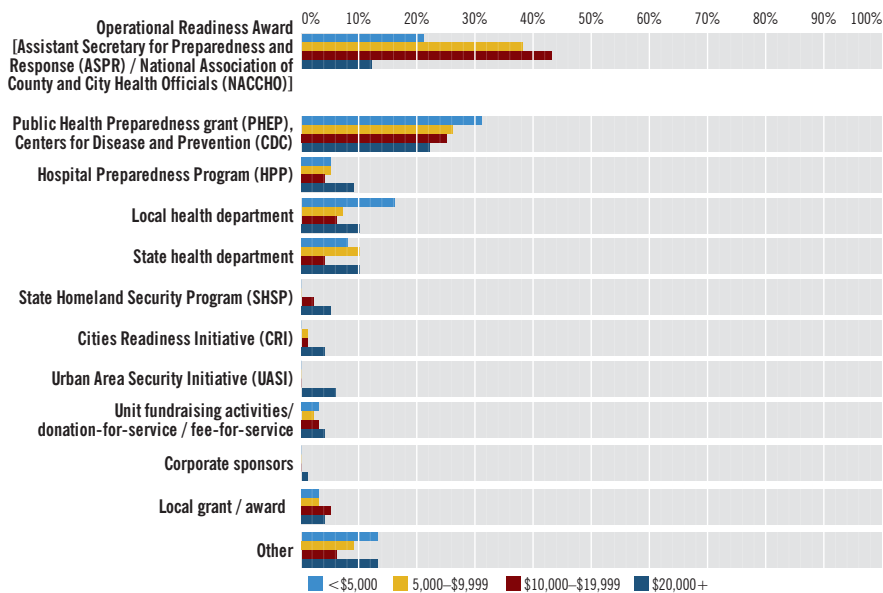


FIGURE 38

Percentage of funding to MRC units by source

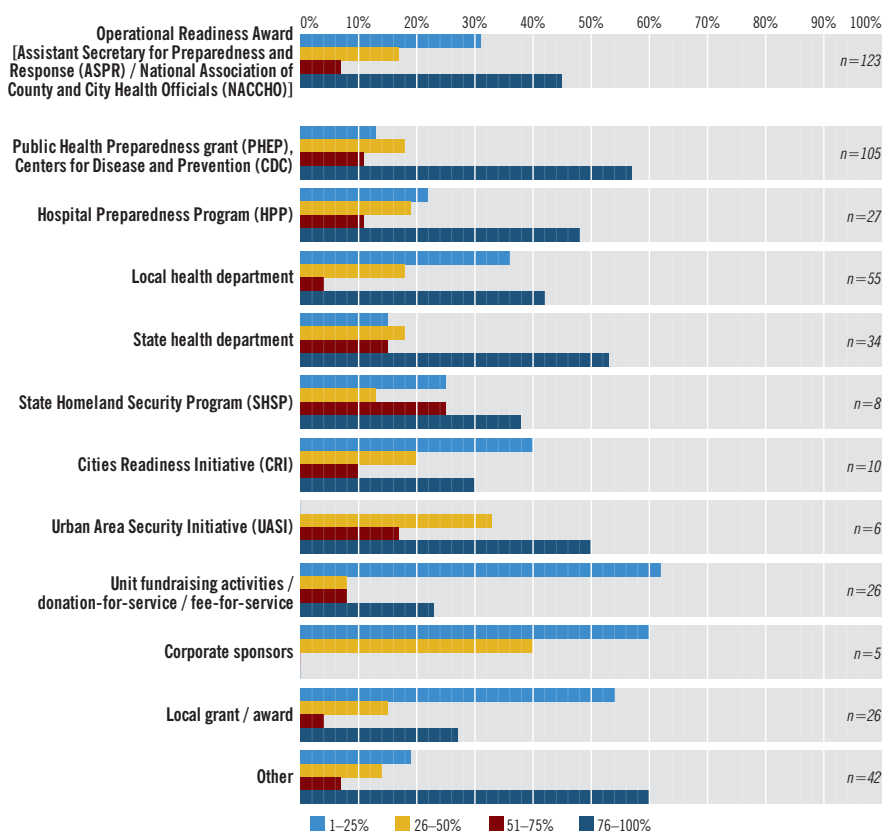


FIGURE 39

Characterization of MRC units based on their acceptance of donations

	Checked	n=461	
Yes, cash and / or check donations	27%		
Yes, in kind (e.g., goods, services, expertise, or cash equivalents)	38%		
No	37%		
Do not know	17%		
Population size	<100,000	100,000–249,999	250,000+
Yes, cash and / or check donations	28%	23%	27%
Yes, in kind (e.g., goods, services, expertise, or cash equivalents)	42%	28%	37%
No	24%	47%	47%
Do not know	27%	14%	8%
By sponsoring organization	LHD	NON-LHD	
Yes, cash and / or check donations	17%	44%	
Yes, in kind (e.g., goods, services, expertise, or cash equivalents)	32%	47%	
No	42%	28%	
Do not know	20%	12%	
Over time	2020	2017	
Yes, cash and / or check donations	27%	22%	
Yes, in kind (e.g., goods, services, expertise, or cash equivalents)	38%	15%	
No	37%	43%	
Do not know	17%	20%	
	n=461	n=761	

FIGURE 40

Types of organizational support to MRC

Housing organization	2020	2017	State agencies	2020	2017
Material resources	75%	79%	Material resources	45%	44%
Funding	61%	52%	Funding	41%	48%
Staff assistance	70%	76%	Staff assistance	24%	30%
Training	66%	70%	Training	59%	61%
Leadership	71%	76%	Leadership	45%	45%
No support	8%	8%	No support	14%	14%
Local government agencies (not your housing organization)			State or local non-governmental organizations (NGOs)		
Material resources	32%	30%	Material resources	15%	20%
Funding	20%	14%	Funding	14%	9%
Staff assistance	22%	25%	Staff assistance	8%	12%
Training	45%	56%	Training	32%	36%
Leadership	23%	24%	Leadership	11%	10%
No support	39%	32%	No support	53%	47%
			n=	235–363	429–677

to note that 57% of respondents said they have no relationship with their local pharmacies or National Disaster Medical System, respectively. Also, only 12% of MRC units surveyed have a partnership with tribal health departments, as compared to 2017. These are notable areas of future consideration, given the changing landscape of the COVID-19 response.

2020 saw a moderate reduction in capacity to work with other MRC units during the pandemic. Units were less likely to collaborate via the MRC



Listserv (33%) as well as via state and regional meetings (50%). In fact, 22% of 2020 respondents stated that they had no interaction with other MRC units, with 30% of siloed units serving smaller jurisdictions (<25,000 people). When compared to the percentage of small jurisdictions using formal or informal mentorships with other MRC units, only 7% are optimizing this form of partnership compared to large jurisdictions (500,000+ people), which reported adopting cross-MRC mentorships at a rate of 33% (see [Figure 44](#) on page 37).

LEGAL PROTECTIONS

A survey of MRC unit's legal protections showed that in addition to federal legal safeguards, units most often utilize state legislation (49%) and department or agency policies and regulations to supplement legal coverage for their organizations. Additional legal liability protections from state legislations

FIGURE 41
MRC 2020 working community partnerships

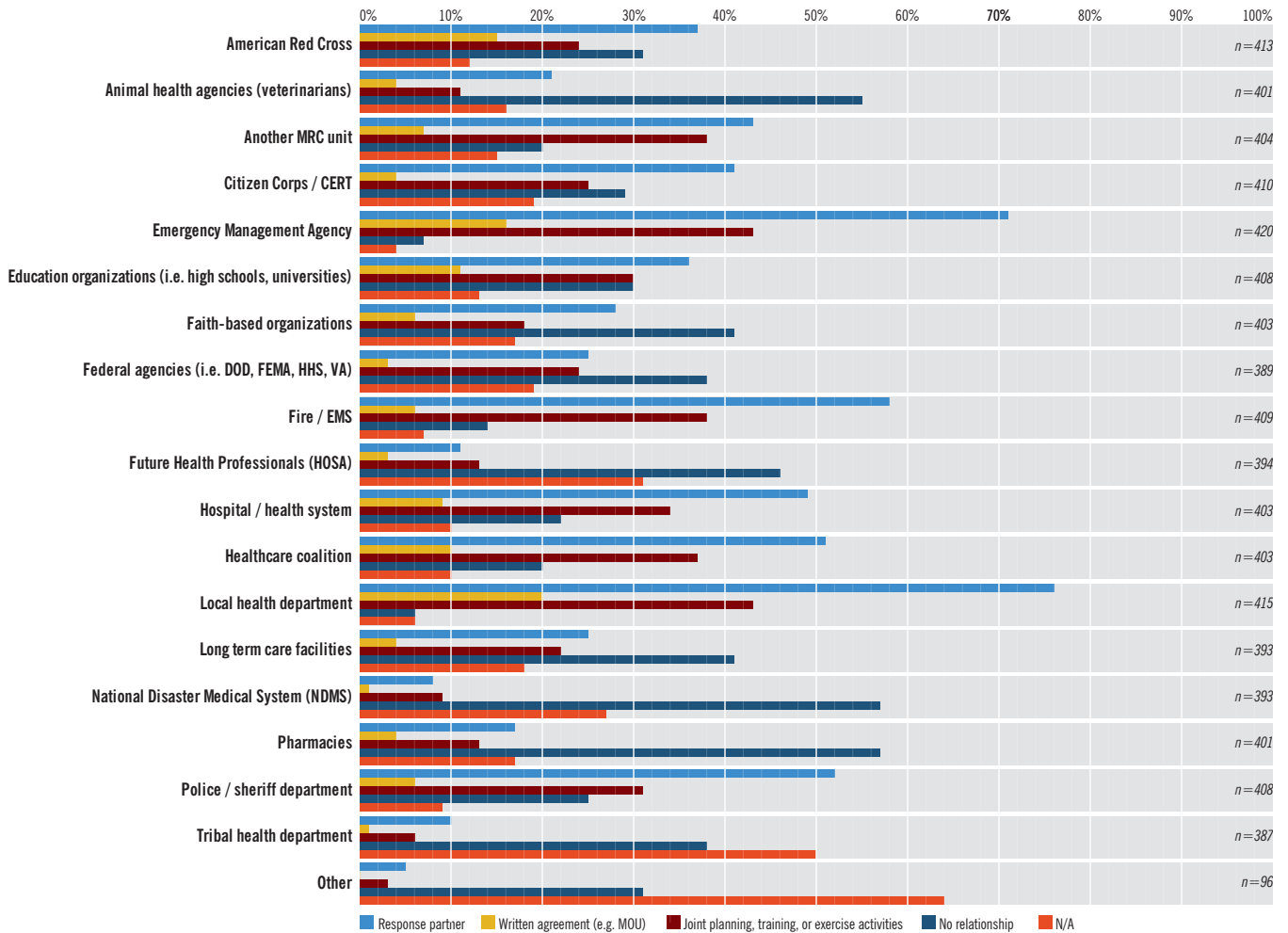


FIGURE 42
Entities units have trained with (over time)

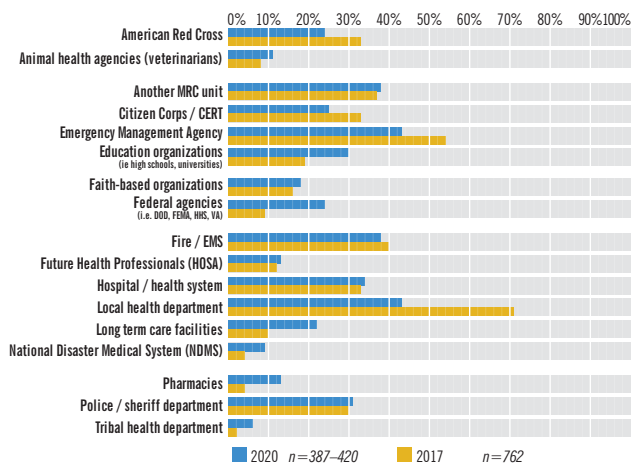


FIGURE 43
Have a partnership/relationship (over time)

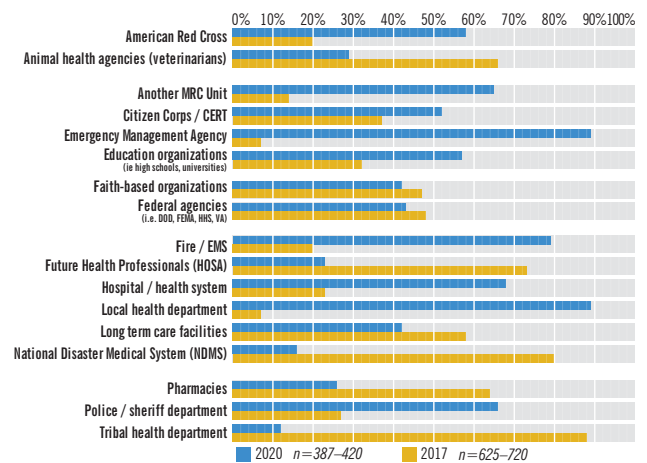


FIGURE 44
How MRC units partnered with each other

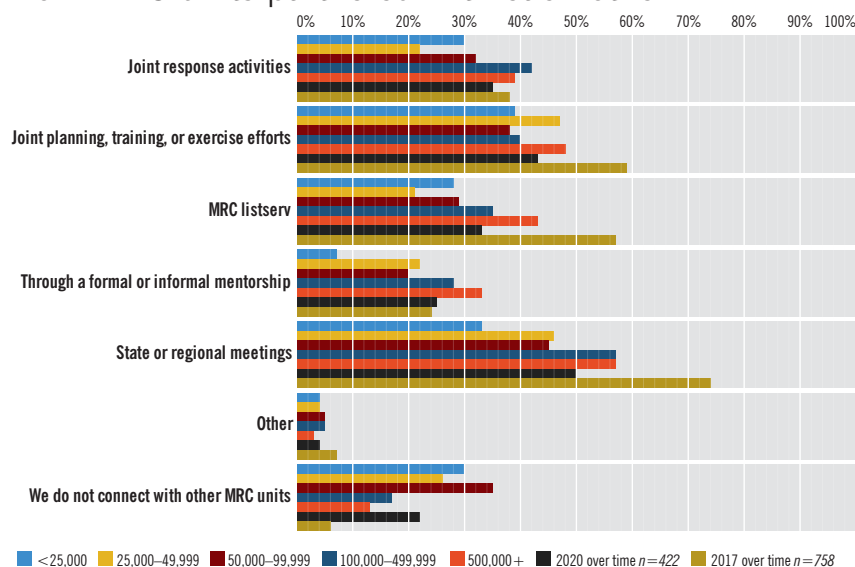


FIGURE 45
Circumstantial volunteer liability coverage by mission type

	Declared emergencies	Training activities	Public health activities	Activities outside your geographic jurisdiction
2020				
Professional liability coverage / malpractice	49%	33%	39%	20%
Other liability coverage	37%	31%	32%	18%
Workers compensation	29%	21%	23%	14%
Reemployment rights	1%	0%	0%	0%
Other	3%	3%	3%	3%
No legal protections	2%	10%	8%	15%
Do not know	21%	28%	26%	46%
	n=424	n=414	n=411	n=402
2017				
Professional liability coverage / malpractice	—	—	—	—
Other liability coverage	—	—	—	—
Workers compensation	58%	45%	46%	38%
Reemployment rights	10%	3%	3%	2%
Other	3%	2%	2%	3%
No legal protections	4%	11%	10%	27%
Do not know	18%	22%	23%	45%
	n=717	n=576	n=570	n=411

have also consistently remained a priority since 2017, regardless of the jurisdiction size their MRC served.

Regarding the circumstantial nature of when MRC members are covered by liability protections, leaders reported that the top coverage type despite jurisdiction size or unit LHD sponsorship during a declared emergency is that of professional liability coverage or malpractice, weighing in at 49%. Although this question was asked differently in previous reports, it is important to note that only 29% of units regardless of jurisdiction size cited workers' compensation as a coverage circumstantially available during declared emergencies, compared to 58% in 2017 (see **Figure 45**). This shift is likely due to the nature of the COVID-19 pandemic and the limitations of workers' compensation usefulness to the emergency at hand. Additionally, it is important to note that an increased number of LHD-sponsored MRC units reported unawareness of how or if liability protections for their volunteers would carry over beyond their designated jurisdiction compared to 37% of non-LHD sponsored units.

Responses showed that MRC units that purchased additional legal protections were primarily stand-alone 501(c)(3) organizations at a rate of 38%. Additionally, 63% of units primarily purchased additional professional liability or malpractice insurance, with the majority of units (68% of purchasing respondents) representing large jurisdictions.



Understanding deployment barriers

The increasing complexity of emergency responses and the substantial number of MRC deployments presents an opportunity to examine barriers for deploying volunteers and developing strategies to continue to build the network. NACCHO offers two sources of information that examine this topic: feedback from MRC unit leaders and planners⁵, as well as data findings from the 2020 MRC Network Profile survey.



Connecticut
Ledge Light Health District MRC

Funding for MRC units is a key barrier in strengthening and building response capabilities. Limited funding impacts adequate staff time and recruitment efforts. MRC units reported an average of \$2,500 per year.

MRC units responded to rapidly evolving missions and provided a record number of volunteer response hours to support workforce surge capacity. Over 800,000 volunteer hours were reported in 2020.

BACKGROUND

The first set of findings comes from a virtual workshop that NACCHO conducted in April 2021 that included 38 MRC unit leaders, state public health planners, and local public health planners. The goals of the 2021 MRC Deployment Workshop included identifying MRC volunteer deployment barriers, successes, and factors contributing to deployment barriers for COVID-19 and other emergency responses. Participants were asked to present three deployment barriers and three successes. These inputs were then prioritized collectively within four breakout groups. From the workshop findings, NACCHO identified several recurring themes for successes and barriers.

Areas of success

The top three areas of success identified were categorized by the following themes:

SURGE CAPACITY



The COVID-19 response demonstrated the network's ability to expand and provide workforce surge support at levels never seen before and for an extended period. The workshop findings are supported by data from the 2020 MRC Network Profile, which demonstrates the response capabilities developed to address the pandemic in 2020 (see **Figures 16–18** on pages 19–20).

RESPONSIVE & ADAPTABLE



During the COVID-19 response MRC units demonstrated their ability to adapt to the changing response requirements. MRC units created specialized response teams to support different missions. Through over 800,000 volunteer hours in 2020 alone, MRC units provided 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.

COLLABORATION & PARTNERSHIPS



MRC units collaborated and partnered with community, academic, and medical institutions to recruit, train, and even deploy volunteers to help with missions including testing, assisting with patient care, and mass vaccination clinics. The 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. The data from the 2020 MRC Network Profile shows that many MRC units continue to partner with traditional responders' partners (see **Figures 42–44**, pages 36–37).

Deployment barriers

The top five deployment barriers identified were categorized by the following themes:

FUNDING



Lack of funding was identified as the main barrier to building, strengthening, and sustaining MRC units around the country. This finding from the workshop is reinforced by the continual decline in funding for MRC units over the previous seven years (see **Figure 35**, page 33) along with decreased funding (44%) noted as the top obstacles impacting units' recruitment efforts (see **Figure 26**, page 26).

VOLUNTEER RECRUITMENT



Challenges with recruitment noted in the workshop included awareness of the MRC, understanding the value of developing a surge workforce, especially with medical professionals, and resources to develop a diversified volunteer base that reflects the community served. The data from the 2020 MRC Network Profile indicates that unit leader time constraints (56%) continued to be the top obstacle to volunteer recruitment. This time constraint can limit leaders' ability to effectively reach their recruitment goals (see **Figure 26**, page 26).

VOLUNTEER TRAININGS



Standardization in training, training difficulties with frequent coordinator turnover, and inconsistency in trainings at all levels are some of the major barriers in training. Data from the 2020 MRC Network Profile indicates 78% of MRC units have a written training plan and only 34% are informed by the MRC Core Competencies⁵ (see **Figure 27**, page 26).

VOLUNTEER TRAININGS, CONT'D

Although the MRC has a set of core competencies that are recommended for all volunteers, the MRC Core Competencies training plan only provides a list of recommended trainings to support each of the competencies. This contributes to inconsistent trainings across MRC units. The MRC program could benefit from a standardized curriculum for volunteers to achieve “credentialling” of core competencies training and provide consistency of training. Unit leaders cited resources needed for internet-based trainings (62%) and train-the-trainer resources (54%) as some of the top training gaps (see **Figure 30**, page 28).



ADEQUATE STAFF



Adequate staff has always been an issue due to lack of sustainable funding, unit leader assigned other duties, and unit leaders' turnover.

Units with less funding were more likely to have leaders with fewer dedicated hours than those with more funding. Smaller jurisdictions with less than 100,000 saw the greatest impact, with 46% of leaders devoting less than five hours per week and 72% indicating they received less than \$5,000 per year (see **Figure 46**).

In addition, NACCHO's *2019 National Profile of Local Health Departments*⁷ shows that health departments entered the pandemic down over 20% of their workforce capacity, compared to before the 2008 recession. This means that there are fewer staff to do the work of the health department, which could be partially supported by MRC volunteers; however, they also do not necessarily have the funds for a staff person to facilitate the health department's connection to an MRC unit. Funding and workforce challenges facing public health, and in particular the disparity in resources available to small jurisdictions, makes it difficult to build and operationalize an effective MRC unit.

ADMINISTRATIVE



The top administrative barrier noted in hindering the deployment of volunteers was workers' compensation and liability insurance as most organizations were hesitant to utilize the MRC without understanding of the liability and worker compensation insurances. Data from the 2020 MRC Network Profile indicated that only 29% of units regardless of jurisdiction size cited workers' compensation as a coverage circumstantially available during declared emergencies.

The full findings from the workshop are available on NACCHO's website.⁶



FIGURE 46

Top five barriers identified that hindered the effectiveness, scale, or quality of MRC unit's COVID-19 response

	Deployment barriers	Exposure risk factors for volunteers	Not enough staff	MRC replaced by other agencies or contracted staff	Lack of dedicated funding	Inconsistent guidance from state government
Size of jurisdiction						
100,000	37%	46%	16%	25%	24%	
100,000–499,999	45%	37%	34%	20%	29%	
500,000+	47%	36%	36%	26%	23%	
Amount of funding						
No funding	34%	48%	22%	28%	20%	
<\$5000	39%	37%	15%	21%	24%	
\$5000–\$9,999	39%	36%	27%	25%	25%	
\$10,000–\$19,999	57%	38%	43%	19%	26%	
\$20,000+	57%	37%	47%	29%	30%	
Checked	42%	41%	27%	24%	24%	
<i>n=436</i>						

“It was wonderful to see that even experienced leaders identified the same issues as barriers as newer members. To learn from more experienced folks who have been doing this forever was invaluable! Thank you for this professional workshop, kudos to the NACCHO folks for putting this on! Aloha.”

– Simone C. Polak, Maui County Health Volunteers MRC (HI)

NETWORK PROFILE BARRIERS TO DEPLOYMENT REPORTED FOR 2020 OR THE COVID-19 RESPONSE

In addition to the virtual workshop, the 2020 MRC Network Profile, for the first time, examined barriers that hindered the effectiveness, scale, or quality of MRC units' COVID-19 response. The barriers aligned with differences in sizes of jurisdictions served and amount of funding the unit received. The five most commonly reported barriers selected by the unit leaders regardless of size of jurisdictions served and amount of funding the unit received were not enough staff, exposure risk factors for volunteers, lack of dedicated funding, inconsistent guidance from state government, and finally, that the MRC were replaced by other agencies or contracted staff (see **Figure 46**).

Data from the 2020 MRC Network Profile indicated that 41% responded that not having enough staff was the top barrier that hindered the effectiveness, scale, and quality of their MRC unit's COVID-19 response, despite the differences in sizes of jurisdictions served and amount of funding the unit received.

Exposure risk factors for volunteers, especially at the beginning of COVID-19 response when PPE supplies were limited and guidelines were changing every week, created a major barrier as 42% agreed that the exposure risks deterred volunteers from responding to requests for deployments. Regardless of the differences in sizes of jurisdictions served, about 24% indicated that the lack of dedicated funding impacted the effectiveness, scale, and quality of their MRC unit's COVID-19 response. About 24% stated that the inconsistent guidance, especially from state governments, played a significant role at the beginning of the COVID-19 response.

MRC replaced by other agencies or contracted staff was identified as an issue (16%), especially within the mid-to larger jurisdictions size and those with more funding. The lack of awareness and lack of trust in the knowledge of volunteers may be two of the factors that led leadership at local health departments to replace volunteers with staff from other agencies or contracted staff. Refer to **Figure 46** for more information.

CASE STUDY #6

ENCOURAGING VOLUNTEER RESILIENCY

In a tornado response several years ago, Southwest Virginia MRC Unit Leader Kristina Morris saw the need for breaks and relaxation among volunteers. Recalling that experience, when stay-at-home orders were issued in response to the COVID-19 pandemic in spring 2020, she was immediately concerned about the overall mental wellness of volunteers. Morris reached out to volunteers who were mental health professionals to create what became known as the Resiliency Team.

Weekly from March to October 2020, the Resiliency Team sent unit volunteers a mental wellness tip sheet with a focus on a particular issue. Topics ranged from

Grieving as a Community and Home School Challenges to Exercise and Sharing Good News. Each tip sheet shared a variety of resources from podcasts to YouTube videos to professional articles. Some keys to success:

- Each tip sheet had just one focus.
- It was never more than one-page long.
- The tip sheet shared resources that already exist in a small, simple format.



To create each tip sheet, the team, which included a psychologist, a psychiatrist, and licensed professional counselors with varying backgrounds, had a weekly 30 to 45-minute call to discuss possible topics and resources. Another volunteer (previously a Communication Specialist and now two work-study students) handled writing and editing.



New Jersey

Hunterdon County MRC, with the Governor

PART 6: MRC OPERATIONAL READINESS AWARDS

Impact of the 2020 ORAs

The 2019–2020 award year saw the launch of the MRC Operational Readiness Awards (ORAs), designed to build the operational readiness capabilities of MRC volunteers and meet the emergency preparedness and response needs of local, regional, and statewide stakeholders.

NACCHO awarded a total of 202 ORAs, totaling over \$1.1 million, through two funding tiers: Tier I awards provided 83 MRC units with \$2,500 to fund projects designed to strengthen MRC volunteer capabilities and Tier II awards provided 119 MRC units with \$7,500 to fund projects designed to strengthen MRC unit response capabilities.

A total of 91.5% of all awardees completed the final evaluation survey, providing outcomes and impacts of their award activities. Their responses highlighted the broad successes of the ORAs. For example, 85% of awardees felt that their ORA activities improved the capability or capacity of their MRC unit thanks to the service of 14,000 MRC volunteers across 40 states. The monetary value of ORA activities totaled over \$7 million, or nearly \$38,000 per awardee. For every dollar that NACCHO provided in ORAs, MRC units saw \$6.85 returned through award activities.

Awardees were expected to support at least one of the four ASPR priorities for the MRC through their award activities:

1. Medical screening and care in emergencies.
2. Points of Dispensing, mass vaccinations, and other mass dispensing efforts.
3. Deployment of volunteers outside of local jurisdiction.
4. Community response outreach and training.

Their ORA activity highlights include:

MEDICAL TESTING & SCREENING

24% of awardees used their award to participate in COVID-19 testing and screening activities.

“MRC volunteers have come out to work [at COVID-19] test sites in extreme weather — from near

100-degree [temperatures] in the summer to freezing cold [in the] winter. When paid staff was unable to be there at the last minute, the MRC was called in to make sure the operation could continue.”

– *Snohomish County MRC, Tier II Awardee*

MASS VACCINATIONS

38% used their award to participate in mass vaccination activities.

“Recognizing an opportunity to practice vaccination clinics in advance of the [COVID-19] vaccine release, MRC eagerly deployed to support three successful North Country community influenza clinics. The well-prepared MRC volunteers were integral in supporting vaccine delivery.”

– *Northern NH Unit MRC, Tier II Awardee*

INTERJURISDICTIONAL DEPLOYMENT

“The ORA allowed procurement of cached and assigned equipment and supplies that enhance efficient medical/radiological screening, decontamination, and referral for additional follow up. [The award] helped assure that appropriate and familiar equipment and supplies are available during deployment of volunteers outside of local jurisdiction without having to rely on non-unit sources.”

– *Colorado Radiation Response Volunteer MRC, Tier II Awardee*

COMMUNITY OUTREACH

33% of awardees used their award to conduct community outreach.

“This [award] permitted the MRC to provide outreach and education for local communities pertaining to STOP THE BLEED®. During the September 2020 wildfires in Oregon, people found themselves evacuating from the fire... If people became injured, the STOP THE BLEED® training [would have been] foundational in assisting out in the field.”

– *Linn County MRC, Tier I Awardee*

CASE STUDY #7

MEETING COVID-19 VACCINATION NEEDS

For several months, MRC units across the country supported COVID-19 vaccination clinics of all sizes. From mobile clinics to large-scale drive-through sites, volunteers filled a variety of roles.

The Denton County MRC (TX) serves approximately 700,000 people. The unit activated the second week of March 2020 with call center operations; work that continued for six to seven months. They then began supporting COVID-19 testing clinics. In December 2020 and January 2021, the unit began supporting vaccinations. The unit staffed a 16-lane drive-through POD at the Texas Motor Speedway. Roughly 300 volunteers in two, six-hour shifts supported the clinic, which administered as many as 14,947 shots in one day. The unit supported as many as four of these large-scale PODs in one week. Once racing season was underway at the site, they transitioned to supporting one clinic weekly, with an average of 10,000–11,000 shots per day.

MRC volunteers fulfilled every role at clinics, except as vaccinators. They drew the vaccine, provided medical screening and observation, manned traffic control, volunteer check-in, and registration. In addition to on-site support, two shifts of 15 volunteers came in twice a week to support prep work for the clinics, a great option for those who could not physically be at the POD, but wanted to help in a big way.

PART 7: FOCUSING ON THE FUTURE

Investing in the future

Due to the careful cultivation of an equipped, capable, and prepared volunteer workforce, the MRC stood ready to take on the United States' most complex and challenging vaccination effort in history.

When community health needs arise from disasters and other public health emergencies, the MRC responds. In fiscal year 2020 alone, over 800,000 volunteer hours supported new missions, large-scale events that included multiple agencies, and long-term support requirements, such as call centers, contact tracing, and vaccination clinics.

The COVID-19 response demonstrated the MRC's readiness and adaptability as an essential provider of local workforce surge support. It

also showed that units with a solid foundational structure and established presence with community response partners were an integral component of local response efforts.

The 2020 MRC Network Profile illustrates the unique attributes and the commonalities among units across the nation. It also highlights opportunities to invest in the MRC.

As the MRC looks forward to its 20th anniversary in 2022, its stakeholders must serve as champions for network resiliency.

This includes advocating for sustainable funding for units, increased awareness of the MRC and its capabilities, resources to continue to develop a well-trained and diverse volunteer base, and support for unit leadership at the local level.

The vision once held of a dynamic, scalable public health emergency workforce trained and ready to respond has proven to be an essential resource and will continue to appreciate in value as the MRC garners future funding and policy support.



Texas

Northeast Texas MRC



Virginia

Loudoun County MRC

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THE 2020 NETWORK PROFILE OF THE MEDICAL RESERVE CORPS

Rising to the Challenge: MRC Answers the Call in Unprecedented Times

NACCHO

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