The 2013 Network Profile of the Medical Reserve Corps

Top 3 Preparedness Activities
- Communications/texting drill
- Personal preparedness information campaigns
- Training and exercises

Top 3 Public Health Activities
- Seasonal flu vaccination
- Community outreach events
- Health education

Stronger together
A national network of volunteers

Medical Reserve Corps
National Association of County & City Health Officials
The National Connection for Local Public Health
The 2013 Network Profile of the Medical Reserve Corps

Stronger together
A national network of volunteers

Table of contents

Introduction 4
· Message from Captain Tosatto 6
· Message from Rear Admiral Lushniak 7
· A Medical Reserve Corps timeline 8

Part 1: Composition 10
· Infographic: Profile of unit leaders and volunteers 14

Part 2: Community Impact 18
· Infographic: Report overview 20

Part 3: Administration 28
Discussion 38

About this report
This report was prepared by NACCHO. The work that provided the basis for this publication was supported by funding under Cooperative Agreement 5 MRC5G101005-04-00 and 5 MRC5G101005-03-00 with the Office of the Surgeon General. NACCHO is solely responsible for the accuracy of the statements and interpretations contained in this publication and such interpretations do not necessarily reflect the views of the United States Government.

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

The NACCHO MRC Workgroup, led by Bobbi Alcock of CNY MRC, piloted the survey instrument and provided valuable feedback. Thanks also to the NACCHO Medical Reserve Corps staff for shaping this report: Jack Herrmann, Senior Advisor & Chief, Public Health Programs; Scott Fisher, Senior Director, Public Health Preparedness; A. Chevelle Glymph, Director, Community Preparedness and Resilience; Frances Bevington, Senior Marketing and Communications Specialist; Tahlia Gousse, Program Analyst; Alyson Jordan, Communications Specialist.

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

PRINTED APRIL 2014

Study staff
· Authors: Stacy Stanford, MSPH; Alyson Jordan, MPA; Frances Bevington
· Data Analysts: Stacy Stanford, MSPH; Jiali Ye, PhD; Rachel Schuman, MSPH, CPH
· MRC Project Director: A. Chevelle Glymph, MPH, CPM
· Graphic & Information Design: The Tremendousness Collective; www.tremendo.us

Glymph, Director, Community Preparedness and Resilience; Frances Bevington, Senior Marketing and Communications Specialist; Tahlia Gousse, Program Analyst; Alyson Jordan, Communications Specialist.
INTRODUCTION

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

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

After the MRC celebrated its 10th anniversary, the Network Profile project was launched to fulfill the need for more in-depth information about the MRC network as a whole. In the past, data collected on the network provided some insights but were unreliable. Through this project the National Association of County and City Health Officials (NACCHO) was able to use the rich and reliable data gathered to test the previous understandings. As an organization, NACCHO was excited about the opportunity to bring these data to life through this report. Researchers were interested in obtaining information about the structure and operations of each local unit and gaining an understanding about unit leader and volunteer demographics, activities, training, unit administration, communication, partnerships, legal protections, and finances. The study was designed with the goal of revealing the national scope of the entire network through a survey about a wide range of topics pertaining to a unit’s infrastructure, practice and processes, activities, and challenges.

Data collection

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

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

Population and response rate

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

Survey weights

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

Rounding

Due to rounding, numbers in pie charts may not always add up to exactly 100 percent.
Dear Medical Reserve Corps network, colleagues, and partners,

Since its inception in 2002, the Medical Reserve Corps (MRC) has served to improve the health, safety, and resilience of the nation. The Office of the Surgeon General, and particularly the Division of the Civilian Volunteer Medical Reserve Corps (DCVMRC), has shared and highlighted information about the MRC network through a variety of reports, presentations, and briefings over the years. Now we are pleased to support the National Association of County and City Health Officials (NACCHO) and its work to produce this first Network Profile of the Medical Reserve Corps. MRC volunteers are giving of their time, expertise, and hearts to benefit their neighbors and other community members. This is a calling for many of them. MRC units, while federally recognized and supported, are truly a part of the fabric of their local communities—each one filling gaps where public health, emergency preparedness, and response agencies may lack resources.

This Network Profile brings deserved attention to the tremendous and impactful work of the MRC, and educate those new to the network. I hope that it inspires community leaders to increase their support for existing units and to initiate support in communities that are currently without units.

With warm regards,
Robert J. Tosatto, RPh, MPH, MBA
CAPT, USPHS
Director, Division of the Civilian Volunteer Medical Reserve Corps

---

Dear MRC network,

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

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

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

Sincerely,
RADM Boris Lushniak, MD, MPH
U.S. Acting Surgeon General
The MRC network brings individuals from all backgrounds, skills, and experiences to strengthen communities and build resilience in the people and places it reaches. Unit leaders screen, conduct credential and background checks, and train all volunteers prior to any community disaster so volunteers are able to answer the call when needed. Time and time again, units and volunteers assist communities in need of emergency help within and beyond their geographic borders. Since its inception in 2002, the integration of the MRC into local public health, emergency management planning, and disaster response has contributed to a healthier and more resilient nation for all.

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

2005 Following Hurricanes Katrina and Rita, over 6,000 MRC volunteers from more than 160 MRC units supported the response and recovery efforts. These volunteers spent countless hours helping people whose lives had been upended by these disastrous events.

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

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

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

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

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

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

2010 The number of MRC volunteers reached 200,000.

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

2005 Following Hurricanes Katrina and Rita, over 6,000 MRC volunteers from more than 160 MRC units supported the response and recovery efforts. These volunteers spent countless hours helping people whose lives had been upended by these disastrous events.

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

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

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

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

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

2010 The number of MRC volunteers reached 200,000.
The national Medical Reserve Corps program office is organized within the Department of Health and Human Services’ Office of the Surgeon General, but each MRC unit is locally based and functions independently of the national program office. Each unit is unique and shaped by many factors including its local infrastructure, housing organization, mission, and community needs. Since its inception in 2002, the MRC network has grown to include more than 200,000 volunteers enrolled in almost 1,000 units in all 50 states and territories. MRC volunteers supplement dwindling local resources and fill gaps in public health services and emergency response activities. The result is a collaboration that can keep a community healthy and prepared for large-scale disasters and emergencies.

Unit structure
The decentralized design of the network is underscored by the varied MRC housing agencies. Each MRC must have a public or private non-profit, community-based organization serve as its sponsor or housing agency. This organization can also be the MRC unit’s fiscal agent that financially supports the unit and accepts funds on its behalf. In some circumstances the housing agency and fiscal agent are two different organizations. The types of entities that support an MRC unit can vary significantly. Most units (67%) are housed within their local health department, but other housing organizations include emergency management agencies, volunteer centers, hospitals, colleges and universities, medical societies, civic organizations, faith-based organizations, non-governmental organizations, and regional councils of government (<1%). In addition, for 92 percent of the MRC units, there is only one MRC unit serving the area. For 8 percent of the units, there is more than one MRC unit serving the area.

Housing organization

- **67% Local Health Department**: 7% Emergency management agency, 7% Other, 4% Nonprofit 501(c)(3) organization, 3% Hospital/health system, 3% State health department, 2% Non-governmental organization, 2% Fire/EMS, 1% Medical society, 1% Board of health, 1% College/university, 1% Citizen corps council, 1% Faith-based, <1% Police/sheriff department.

---

Provo, Utah

MRC volunteers assessing “victims” during a “Shake Out Take Out” earthquake exercise.
network, the housing organization is also their fiscal agent (†).

The 2013 Network Profile survey included a number of questions to assess unit structure. MRC units cover a range in jurisdiction sizes (population density), from less than 10,000 people to over one million (‡). Many units reported that their jurisdiction covers both rural and urban areas within the same catchment region. Forty-eight percent of units reported serving a mixed jurisdiction, while only nine percent reported a strictly urban classification (†). Most MRC units (87%) covered their prescribed jurisdiction exclusively and only 13 percent reported that there was more than one MRC unit serving their area (‡). Of these 13 percent (data not shown), more than two-thirds can be found in the most densely populated areas of the country.

Volunteers are the foundation of every MRC unit. Although the number of volunteers per unit varies throughout the network from 2 to over 7,000, the average number of volunteers per unit is 224 (§). There is also a variation between the numbers of volunteers in the different jurisdiction size categories (‖). The difference between the overall median at 75 and the average at 224 indicates there is a skewed data distribution. The average volunteer count of 515 in those units serving populations of more than 250,000 is raising the overall average.

MRC units from smaller regions (populations of less than 100,000) average 50 volunteers per unit, while those from larger regions (populations above 250,000) have an average of 515 volunteers. This may be the result of an increased need for additional volunteers combined with the availability of a larger pool of volunteers.

Unit leaders
An effective unit starts with a dedicated leader, and the MRC attracts individuals who care about the health and safety of their community. The MRC unit leader understands the needs of the community and what type of volunteers can fill those needs, often orchestrating roles and responsibilities based on volunteer capabilities and skills. Nearly half of the unit leaders (47%) work on a full-time basis (‖). However, 14 percent of unit leaders direct the unit as a volunteer.

Volunteers
The MRC established a way to recruit, train, and activate medical and non-medical professionals to respond to community health needs, including disasters and other public health emergencies.
Continued from page 13

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

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

• The New York City MRC serves the largest U.S. city with over 7,300 volunteers in its ranks. With such a large volunteer force, the NYC MRC can quickly respond to the many requests for assistance in this urban area. When Hurricane Irene made landfall in 2011, 222 volunteers donated 2,558 hours providing medical and mental health support. That number grew tremendously in 2012 with Hurricane Sandy, when more than 1,200 volunteers donated over 18,000 hours of service in the response. NYC MRC volunteers are also ready to respond to smaller scale events; in 2013, they jumped into action when three Hepatitis A outbreaks occurred over the course of the year. In conjunction with the NYC Department of Health and Mental Hygiene (DOHMH) staff provided emergency vaccinations to over 2,000 New Yorkers. Having so many MRC volunteers ready and available helps reduce the response time, especially critical with weather-related emergencies and outbreaks like Hepatitis A. “NYC MRC has become an integral part of NYC DOHMH’s response to local health emergencies. Volunteers’ willingness to respond on very short notice is remarkable, and their efforts help to keep NYC healthy,” said Betty Duggan, Director of the NYC MRC.

• Meanwhile, in nearby upstate New York, Orleans County Health Department paints a different picture of the MRC. With only 42,000 residents, Orleans County has been relying on their MRC volunteers to continue their local preparedness education. Since 2004, the local health department has had only one emergency preparedness professional on staff due to programmatic and budget constraints. Thanks to the assistance of the Orleans County VALOR MRC, emergency preparedness and community resiliency education efforts through the health department continue. Orleans County VALOR MRC provides the only disaster risk reduction and community resiliency education in the county because there is no additional paid support. Because the state of New York bases preparedness funding on population size, Orleans County receives minimum funding that does not allow for outreach activities. However, as leaders in preparedness education throughout the community, MRC volunteers create events for the community based on local needs. In one instance, volunteers hosted a “Lakeshore Flooding” informational meeting for Lakeshore residents and stakeholders because Orleans County shares a northern border with Lake Ontario. Many attendees had not lived on the lake long enough to have experienced flooding. Because of this training, residents are now more informed about what they can do to protect their families and property during a flood. 

Kern County, California
Arlington, Virginia
New York, New York
Albion, New York

MRC volunteers at a health fair.
Captain Tosatto receiving a seasonal flu vaccination from the Arlington MRC during the 9/11 Day of Service and Remembrance. Photo by M.T. Harmon
MRC staffing a Point of Dispensing site in response to a Hepatitis A outbreak.
Volunteers share preparedness information at a rabies clinic.
Medical Reserve Corps’ community impact

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

MRC activities
MRC units are encouraged to report every community activity they engage in to the DCVMRC. In 2013, the number of different MRC community activities reached almost 16,000. MRC units spend most of their time on the following activities: public health, emergency preparedness, training and exercises, administrative tasks, and emergency response. When asked about how they would divide up the time spent on each activity, on average more than half of a unit leader’s time was spent on training and exercises (28%) and emergency preparedness (26%). Training and exercises consume the most time on average for most units. While MRC units reported that they devoted the smallest percentage of time responding to an emergency, MRC units often respond to a broad range of incidents, including floods, tornadoes, and extreme weather events. In the last year, 41 percent of MRC units reported that they participated in an emergency response (data not shown).

Arlington, Virginia
CPR training for MRC volunteers. Photo by J. Marchioli

PART 2: MRC COMMUNITY IMPACT

Continued on page 22
INFOGRAPHIC

THE 2013 NETWORK PROFILE OVERVIEW

HOW YOU CLASSIFY THE JURISDICTION YOU SERVE

Mixed 48%

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

TOTAL NUMBER OF UNITS ALMOST 1,000

SIZE OF VOLUNTEER CORPS 200,000+

LENGTH OF SERVICE OF UNIT LEADER IN YEARS 3.6

PERCENTAGE OF UNITS THAT ARE HOUSED WITHIN A LOCAL HEALTH DEPARTMENT

Urban 9%
Suburban 11%
Rural/frontier 31%
Tribal 1%
Mixed 48%

TOP THREE RECRUITMENT METHODS

90% word of mouth
77% presentations
71% MRC events

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

224 AVERAGE NUMBER OF VOLUNTEERS PER UNIT

49% of units use SOCIAL MEDIA

VOLUNTEER ACTIVATION

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

24% OF VOLUNTEERS PARTICIPATED IN AN MRC ACTIVITY QUARTERLY

TOP THREE SOURCES OF FUNDING

State health department
Local health department
Office of the Surgeon General (OSG)/National Association of County and City Health Officials (NACCHO)

TOP THREE PREPAREDNESS ACTIVITIES

Communications/texting drill
Personal preparedness information campaigns
Training and exercises

TOP THREE PUBLIC HEALTH ACTIVITIES

Seasonal flu vaccination
Community outreach events
Health education

84% HAVE A TRAINING PLAN

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

VOLUNTEER SCREENING METHODS

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

THE 2013 NETWORK PROFILE OVERVIEW

INFOGRAPHIC

STRONGER TOGETHER: THE 2013 NETWORK PROFILE OF THE MEDICAL RESERVE CORPS

INFOGRAPHIC: OVERVIEW

TIMELINE: HISTORY OF THE MRC
Because the national MRC network was originally created to increase capacity for response to natural and man-made disasters, emergency preparedness activities are common among the network. The chart below shows a matrix of emergency preparedness activities MRC units often implement in their communities (.snapshot). For each preparedness activity or service, respondents were asked to indicate whether or not the unit participated in the activity in the last year, could participate but did not, could not participate, or would not participate. Eighty-eight percent of MRC units engaged in emergency preparedness training and exercises, the most common activity. This represents 846 units nationwide preparing their communities for local emergencies. Vector control activities were the least often reported preparedness activity. Almost half (49%) of MRC units could participate in services related to alternative care sites (capability present), but did not.

Many MRC units are also engaged in work that strengthens the public health infrastructure of their communities, a priority of the Office of the Surgeon General. The Surgeon General’s priorities include considerations for the health of individuals and the nation as a whole and guide the MRC network. The Surgeon General has supported increasing awareness and activities related to disease prevention, eliminating health disparities, and improving public health preparedness. The chart below shows a matrix of public health activities MRC units often implement in their communities (snapshot). Again, for each public health activity or service, respondents were asked to indicate their level of participation. Community outreach events (73%), health education (52%), seasonal flu vaccination (55%), and health clinic support/staffing (45%) were the four most common public health functions for the MRC network. Women, Infants, and Children (WIC) services (6%), substance abuse services (6%), and family planning services (5%), were the least common functions and most often reported as not part of the local mission.

Training
Emergency response requires planning and practice. MRC unit leaders must exercise their volunteers’ special skills and expertise before a disaster strikes to test the integrity of written plans and to build confidence and morale in their volunteers. An overwhelming majority (84%) of MRC units reported having a training plan. MRC units that serve a population of more than 250,000 were more likely to have a training plan (data not shown). These units were also more likely to have responded to an emergency in the last year. This could suggest that those that have been through a local emergency response training were also more likely to have responded to a local emergency. Should there be a disaster, they will be better prepared. The chart below shows a matrix of training activities MRC units often implement in their communities (snapshot).

**MRC preparedness activities**

<table>
<thead>
<tr>
<th>Activity</th>
<th>≤100,000</th>
<th>101,001–250,000</th>
<th>&gt;250,001</th>
</tr>
</thead>
<tbody>
<tr>
<td>Points of Dispensing (PODs)</td>
<td>49%</td>
<td>47%</td>
<td>45%</td>
</tr>
<tr>
<td>Community outreach events</td>
<td>41%</td>
<td>40%</td>
<td>39%</td>
</tr>
<tr>
<td>Health education</td>
<td>31%</td>
<td>29%</td>
<td>27%</td>
</tr>
<tr>
<td>Seasonal flu vaccination</td>
<td>26%</td>
<td>25%</td>
<td>22%</td>
</tr>
<tr>
<td>Health clinic support/staffing</td>
<td>24%</td>
<td>23%</td>
<td>21%</td>
</tr>
<tr>
<td>Disease detection/screening</td>
<td>20%</td>
<td>19%</td>
<td>18%</td>
</tr>
<tr>
<td>Behavioral/mental health services</td>
<td>19%</td>
<td>17%</td>
<td>16%</td>
</tr>
<tr>
<td>Health literacy</td>
<td>17%</td>
<td>16%</td>
<td>15%</td>
</tr>
<tr>
<td>Food safety education</td>
<td>15%</td>
<td>14%</td>
<td>13%</td>
</tr>
<tr>
<td>Health disparities initiatives</td>
<td>13%</td>
<td>12%</td>
<td>11%</td>
</tr>
<tr>
<td>Smoking prevention/cessation initiatives</td>
<td>12%</td>
<td>11%</td>
<td>10%</td>
</tr>
<tr>
<td>Commensurate disease (HIV/AIDS, other STDs, TB)</td>
<td>12%</td>
<td>11%</td>
<td>10%</td>
</tr>
<tr>
<td>Oral health</td>
<td>11%</td>
<td>10%</td>
<td>9%</td>
</tr>
<tr>
<td>WIC services</td>
<td>10%</td>
<td>9%</td>
<td>8%</td>
</tr>
<tr>
<td>Substance abuse services</td>
<td>9%</td>
<td>8%</td>
<td>7%</td>
</tr>
<tr>
<td>Family planning</td>
<td>8%</td>
<td>7%</td>
<td>6%</td>
</tr>
</tbody>
</table>

**MRC public health activities**

<table>
<thead>
<tr>
<th>Activity</th>
<th>≤100,000</th>
<th>101,001–250,000</th>
<th>&gt;250,001</th>
</tr>
</thead>
<tbody>
<tr>
<td>Points of Dispensing (PODs)</td>
<td>49%</td>
<td>47%</td>
<td>45%</td>
</tr>
<tr>
<td>Community outreach events</td>
<td>41%</td>
<td>40%</td>
<td>39%</td>
</tr>
<tr>
<td>Health education</td>
<td>31%</td>
<td>29%</td>
<td>27%</td>
</tr>
<tr>
<td>Seasonal flu vaccination</td>
<td>26%</td>
<td>25%</td>
<td>22%</td>
</tr>
<tr>
<td>Health clinic support/staffing</td>
<td>24%</td>
<td>23%</td>
<td>21%</td>
</tr>
<tr>
<td>Disease detection/screening</td>
<td>20%</td>
<td>19%</td>
<td>18%</td>
</tr>
<tr>
<td>Behavioral/mental health services</td>
<td>19%</td>
<td>17%</td>
<td>16%</td>
</tr>
<tr>
<td>Health literacy</td>
<td>17%</td>
<td>16%</td>
<td>15%</td>
</tr>
<tr>
<td>Food safety education</td>
<td>15%</td>
<td>14%</td>
<td>13%</td>
</tr>
<tr>
<td>Health disparities initiatives</td>
<td>13%</td>
<td>12%</td>
<td>11%</td>
</tr>
<tr>
<td>Smoking prevention/cessation initiatives</td>
<td>12%</td>
<td>11%</td>
<td>10%</td>
</tr>
<tr>
<td>Commensurate disease (HIV/AIDS, other STDs, TB)</td>
<td>12%</td>
<td>11%</td>
<td>10%</td>
</tr>
<tr>
<td>Oral health</td>
<td>11%</td>
<td>10%</td>
<td>9%</td>
</tr>
<tr>
<td>WIC services</td>
<td>10%</td>
<td>9%</td>
<td>8%</td>
</tr>
<tr>
<td>Substance abuse services</td>
<td>9%</td>
<td>8%</td>
<td>7%</td>
</tr>
<tr>
<td>Family planning</td>
<td>8%</td>
<td>7%</td>
<td>6%</td>
</tr>
</tbody>
</table>
emergency saw gaps in their process and completed training plans. Most MRC units (73%) offered three to nine different courses while only 12 percent of MRC units offered one or two trainings (6). The most frequently offered trainings for volunteers were ICS-100 and ICS-700. These two courses were also the most likely to be mandatory for volunteers. Over half of MRC units also offered trainings in Psychological First Aid, CPR/First Aid/Automated External Defibrillators, and ICS-200, but these courses were much less likely to be mandatory (9).

Many MRC units join with other organizations to provide training opportunities. Only 16 percent of MRC units did not conduct training with other organizations, which may mean that they either did not offer any training at all, or they provided training themselves. Eighty-four percent of MRC units collaborated with at least one organization to conduct training. One out of four MRC units conducted training with six or more partners (7). MRC units most frequently reported collaborating with local health departments, emergency management agencies, and the American Red Cross. HOSA, for-profit businesses, and AmeriCorps were reported least frequently (8).

**Partnerships**

Through collaboration with health departments, emergency management, first responders, faith-based and community organizations, and other volunteer programs, the MRC network is building awareness and providing services for public health and emergency preparedness initiatives. MRC units have found strong partners to advance their work in disease prevention, health equity, and emotional well-being, and have better prepared their communities for responding to and recovering from emergencies. Creating coalitions, establishing memoranda of understanding, sharing resources, and building partnerships can result in innovative ways to reach and empower wide-ranging populations for community change.

Sixty-seven percent of MRC units partnered with or deployed alongside another organization (9). Units most commonly reported partnerships with local health departments (48%) and emergency management (49%). MRC units were much less likely to partner with for-profit businesses (19%) or for-profit businesses (15%).
PART 2: MRC COMMUNITY IMPACT

STRONGER TOGETHER: THE 2013 NETWORK PROFILE OF THE MEDICAL RESERVE CORPS

agencies (42%) (9). Almost half (49%) of all MRC units reported partnering with another organization to conduct an exercise activity over the last year (10). Many units look to their community for partnership opportunities. Nearly a third (32%) of MRC units have partnered with four or more organizations to further their units’ mission in the last year (6). MRC units in larger jurisdictions have more partners; 22 percent of the units serving populations with more than 250,000 people reported partnering with at least six organizations. Only nine percent of units serving jurisdictions with smaller populations had equal partner connections (data not shown).

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

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

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

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

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

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

Chanhassen, Minnesota

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

Volunteer recruitment and screening
The national MRC network is based on an all volunteer model. As such, recruiting volunteers is a continuous task for unit leaders. Units must identify their role in the community as part of their vision and mission planning. Having a clear, compelling vision for the unit is the first step in recruiting prospective volunteers who strongly identify with the unit’s shared vision. All volunteers need to feel that their contribution is valuable and believe that they will gain a sense of achievement from their involvement with the MRC unit. Because the focus of each MRC unit is determined by community needs, the number and skills of volunteers vary. However, all MRC units report that they would like to have more volunteers in their unit. Unit leaders reported their ideal average number of volunteers, which ranges from 84 to 929 depending on jurisdiction size (\(d\)). MRC units in all jurisdictions reported an ideal number of volunteers 70–80 percent higher than their actual volunteer numbers. As the jurisdiction size increases, so does the ideal number of volunteers.

Ninety percent of MRC units rely on word of mouth as a recruitment method. The next most common recruitment method is in-person presentations, followed by MRC events, social media, and volunteer websites. The least common recruitment methods are newspaper ads and schools. Radio ads are the least used method, with only 3% of MRC units using them. The prevalence of each recruitment method varies by jurisdiction size, with larger jurisdictions more likely to use more methods than smaller jurisdictions.

The chart below shows the distribution of volunteer numbers and recruitment methods across different jurisdiction sizes. The x-axis represents the number of volunteers, ranging from 0 to 1000. The y-axis represents the percentage of MRC units, ranging from 0% to 100%. The bars indicate the actual and ideal number of volunteers for MRC units in different jurisdiction sizes. The chart highlights the gap between actual and ideal volunteer numbers, with the largest gap occurring in the 100,001–250,000 jurisdiction size category.
PART 3: MRC ADMINISTRATION

STRONGER TOGETHER: THE 2013 NETWORK PROFILE OF THE MEDICAL RESERVE CORPS

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

MRC units reported information about screening methods, background checks, and medical credentialing of prospective volunteers. Developing an MRC unit involves recruiting for specialized roles. It is important to screen volunteers and match them to assignments based on interest, skills, and experience. The majority of units (89%) use an application process to screen volunteers, and nearly half (45%) of unit leaders interview potential volunteers as part of an initial screening process (>). In order to answer the call if a disaster strikes, medical volunteers must be screened and credentialed prior to the event. An overwhelming majority (94%) of MRC units verify the medical credentials of their volunteers (data not shown).

A necessary next step in recruitment is orientating the volunteers to the MRC unit and its mission. There is no recommended frequency for conducting orientation. As such, most MRC units do not follow an orientation schedule but conduct new volunteer orientations as needed (63%). Thirty-seven percent do follow a schedule and provide orientation annually, semi-annually, quarterly, or monthly (>).

Communications
Communication between unit leaders and volunteers occurs in a variety of ways. The type of activity (e.g., call down drill, training, exercise or activity opportunity, response to a disaster) dictates the type of communication channel a unit leader will use. For example, call down drills, often solicited via e-mail or text, measure volunteer readiness, timeliness, accuracy of contact information, and level of commitment. The two most commonly reported methods for volunteer activation are notification through e-mail/electronic distribution lists (60%) and a state-supported notification/activation system (59%) (>).
When asked about social media technology, 51 percent of MRC units reported they do not use any social media technology, while 49 percent reported using Facebook, Twitter, YouTube, LinkedIn, or blogs (i). MRC units serving larger jurisdictions are more likely to use these tools than those serving smaller jurisdictions (data not shown). Unit leaders employ different methods for information exchange with volunteers during non-emergency and emergency situations. In a non-emergency situation, 68 percent of MRC units use an e-mail or electronic distribution list to exchange information with volunteers. During an emergency, MRC units rely heavily on traditional communication channels, 59 percent use the telephone, and 42 percent use an e-mail/distribution list to exchange information with volunteers (ii).

**Social media use**

![Social media use chart](chart1.png)

**Information exchange method**

![Information exchange method chart](chart2.png)

**Funding**

MRC units reported expenditures and revenues for fiscal years 2011 and 2012. They also reported the current operating budget for 2013. Mean expenditures increased by 12 percent for MRC units from FY2011 to FY2012. Revenues in the same time period did not increase but decreased slightly. Average revenues in 2012 were higher for urban and mixed jurisdiction types and lowest for those MRC units that reported serving rural or frontier jurisdictions (data not shown). The median expenditures for all MRC units stayed level over the three year range 2011–2013 but when stratifying by jurisdiction size served, the data reveal that expenditures declined for those serving smaller jurisdictions and increased for those serving larger jurisdictions (iii). The mean operating budget for all MRC units is $15,945 (iv), while the median is only $5,000. The difference between the mean and median for those units serving jurisdictions with populations up to 100,000 is 60 percent, while the same difference for those units serving jurisdictions with populations over 250,000 is 200 percent. This indicates that the average operating budget is skewed higher by units serving larger populations.

**Median expenditures 2011-2013**

![Median expenditures chart](chart3.png)

**Current operating budget**

![Current operating budget chart](chart4.png)
Most MRC units (77%) reported only one or two sources of revenue for their units, while only three percent received five or more different sources of revenue (n=749). The difference in staff resources between larger and smaller units may account for fewer funding opportunities. The most common source of revenue for units was the Capacity Building Award from the Office of the Surgeon General/NACCHO (33%). Sixty-seven percent of units reported receiving this award.

Legal protections
Every U.S. state has at least one law that pertains specifically to the legal liability of volunteers. These laws and protections differ greatly from state to state and jurisdiction to jurisdiction. MRC units reported information about various legal protections for the unit and for the volunteers during different activities. The most commonly reported legal protections for units were Good Samaritan laws (67%) and state legislation (50%) (n=825). When asked about volunteer legal protections, 19 percent reported no legal protections for volunteers (n=810). Fifty-five percent of units offer liability coverage for their volunteers and 33 percent of units reported that the volunteers are covered under the sponsoring agency’s workers’ compensation. Several different types of legal protections could protect volunteers.

Number of revenue sources in most recent fiscal year

MRC unit funding from local, state, and federal sources

Types of legal protection provided for volunteers

Percentage of MRC units
Oklahoma

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

MRC units tackle administrative challenges in creative ways

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

- Volunteer recruitment can be tough during non-emergency situations and even more difficult once many volunteers are needed for emergency response. When one EF4 and two EF5 tornadoes tore through parts of Oklahoma in May 2013, thousands of individuals were eager to help, but they were unregistered and turned away. Fortunately, Oklahoma Medical Reserve Corps (OKMRC) State Coordinator Debi Wagner saw an opportunity to message out the importance of registering with the MRC before a disaster strikes and referred these potential volunteers to the state's MRC website to begin the volunteer registration process. Over 600 individuals were added to the OKMRC database during this time. To ensure that new and seasoned volunteers remain engaged with the MRC network and are ready to respond to the next disaster, MRC unit leaders across Oklahoma have been discovering new training opportunities through lessons learned during the response to the tornadoes. For example, MRC units are now developing animal response teams and offering trainings in psychological first aid and stress response. While it was difficult to turn individuals away in the aftermath of the May tornado outbreak, new volunteers and training opportunities are strengthening the OKMRC capacity to respond to the next event.

- While legal uncertainties have created challenges for volunteer recruitment and protection, some MRC units are demonstrating leadership in this area and have sought stronger protections for their volunteers. In 2010, a Rhode Island MRC volunteer was injured after breaking down a field hospital tent after a training mission at the state's Air National Guard Air Show. The volunteer was treated and transported to the hospital, where she was observed overnight for a concussion. While the volunteer sought workers' compensation, the claim was ultimately denied. Rhode Island Disaster Medical Assistance Team (DMAT), Inc., the MRC unit's housing organization, paid the volunteer's hospital bills but began working on updating legal protections for DMAT/MRC volunteers. After two years, the process was updated so that the DMAT/MRC now requests a mission number from the Rhode Island Emergency Management Agency prior to each planned training event, which provides them coverage under the emergency management title in the state law in the instance of liability or injury. The updated process appeared to work in 2013 when a volunteer was injured and his right to protection was recognized, although he did not seek compensation. Rhode Island MRC volunteers can now feel safer when they carry out their important work throughout the state.

<table>
<thead>
<tr>
<th>Legal protections</th>
<th>Percentage of MRC units</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activities outside your geographic jurisdiction</td>
<td>![bar chart]</td>
</tr>
<tr>
<td>Public health activities</td>
<td>![bar chart]</td>
</tr>
<tr>
<td>Training activities</td>
<td>![bar chart]</td>
</tr>
<tr>
<td>Declared emergencies</td>
<td>![bar chart]</td>
</tr>
</tbody>
</table>

Activities outside your geographic jurisdiction: No legal protections: 25%, Workers' compensation: 50%, Malpractice: 67%, Liability: 67%

Public health activities: No legal protections: 25%, Workers' compensation: 50%, Malpractice: 67%, Liability: 67%

Training activities: No legal protections: 25%, Workers' compensation: 50%, Malpractice: 67%, Liability: 67%

Declared emergencies: No legal protections: 25%, Workers' compensation: 50%, Malpractice: 67%, Liability: 67%

Ojai, California

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

West Greenwich, R.I.

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

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

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

If you have suggestions on what future Network Profiles should include, send a message to the team at mrc@naccho.org.

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

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

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

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

References
4 Division of the Civilian Volunteer Medical Reserve Corps. About the Medical Reserve Corps. Retrieved Nov. 14, 2013, from https://www.medicalreservecorps.gov/pageviewpdf/about
The 2013 Network Profile of the Medical Reserve Corps

Stronger together
A national network of volunteers

National Association of County and City Health Officials
1100 17th St NW, 7th Floor
Washington, DC 20036
(202) 783-5500
www.naccho.org

Division of the Civilian Volunteer Medical Reserve Corps
The Tower Building
1101 Wootton Parkway, Room 181
Rockville, MD 20852
(240) 453-2839
www.medicalreservecorps.gov