

THE 2017 NETWORK PROFILE OF THE MEDICAL RESERVE CORPS



The Medical Reserve Corps: *15 years of volunteers actively engaging to meet community needs*



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

TABLE OF CONTENTS

The 2017 Network Profile of the Medical Reserve Corps

The Medical Reserve Corps:

15 years of volunteers actively engaging to meet community needs

Introduction 4

· Message from Dr. Kadlec 8

· Message from Commander Payne 9

Infographic
Celebrating 15 years:
A timeline of the MRC

6

Part 1
The 2017 MRC
unit snapshot

10

Part 2
MRC connects
with the community

13

Infographic
MRC capabilities
snapshot

22



Part 3
Trained, exercised,
and ready

25

Part 4
MRC capabilities and
innovative solutions

31

Infographic
Impact of the 2015–2016
Challenge Awards

40

Part 5
Planning for the future

42

· 2017 Perspectives from Local Health Departments: A Stakeholder Study 38

References 43

ABOUT THIS REPORT

This publication was supported by the Department of Health and Human Services, grant #5 HITEP150032-02-00, "Demonstrate Capability and Build Capacity in the Medical Reserve Corps Network."

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

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ACKNOWLEDGMENTS

Thanks to NACCHO MRC staff Kathy Deffer, Senior Program Analyst; James Randall, Intern; Mahlet Moges, Intern; Crystal-Young Cole, Senior Program Assistant, who contributed to this report. NACCHO's Research and Evaluation and Publications teams also provided essential assistance.

All the graphic and information design in this report was created by Tremendousness (<http://www.tremendo.us>).

Thanks also to NACCHO MRC staff A. Chevelle Glymph, Senior Director of Safe, Healthy & Resilient Communities, and Calondra Tibbs, Senior Advisor of Public Health Programs, who

supported the Network Profile Study and their guidance is appreciated.

Finally, thank you to the 769 MRC unit leaders who provided the information that made this research possible.

—Kabaye Diriba, MPH, Program Analyst, 2017 Network Profile of the Medical Reserve Corps

INTRODUCTION



MRC unit leader workshop participants at the 2017 Preparedness Summit.

Some background...

The devastation caused by the September 11, 2001 terrorist attacks moved Americans to volunteer in masses and give their time, expertise, and heart in support of their country.

This willingness to respond in the face of adversity and the challenges of managing spontaneous volunteers shaped a civilian medical and public health volunteer corps. The Medical Reserve Corps (MRC), a national network of volunteers organized locally to improve the health and safety of their communities, was born in 2002 after President George W. Bush's State of the Union Address.

The Office of the Surgeon General, part of the Department of Health and Human Services' Office of the Assistant Secretary for Health, established the MRC as a demonstration project with 42 community-based units to create the mechanisms to identify, train, and track volunteers who could strengthen local public health and serve if another

human-made or natural disaster occurred. In 2006, the Pandemic and All-Hazards Preparedness Act authorized, in law, the MRC program. Later, the Pandemic and All-Hazards Preparedness Reauthorization Act of 2013 legislation assigned authority over and responsibility for the MRC to the Assistant Secretary for Preparedness and Response (ASPR). The MRC network now comprises nearly 200,000 local volunteers in almost 1,000 units.

In 2006, the MRC Program Office engaged the National Association of County and City Health Officials (NACCHO) in a cooperative agreement to promote, support, and build capacity within the MRC network. As the voice for

local health departments (LHDs), NACCHO established and expanded strong partnerships between MRC units and LHD leadership.

In 2013 and 2015, NACCHO conducted the first two comprehensive studies of the MRC network and subsequently released two reports based on its findings, the 2013 Network Profile of the Medical Reserve Corps and 2015 Network Profile of the Medical Reserve Corps. Data from the two reports were invaluable, informing decision-makers, supporting future unit goals, and sharing the impact the MRC has on the nation's health and safety. This document builds upon the previous iterations of the MRC Network Profile.



New Mexico

MRC volunteers conduct a morning briefing before kicking off the annual Baatan Memorial Death March.

METHODOLOGY

In 2017, NACCHO again examined how the MRC network has changed over time, how new programs have affected unit characteristics, and how the MRC program has contributed to the nation's state of preparedness on a national scale. NACCHO updated the questionnaire based on prior results and input from unit leaders and sent it to 943 active unit leaders in January 2017.

Data were collected from January to March 2017. Overall, 769 MRC unit leaders completed the survey, yielding a response rate of 82%. When possible, NACCHO compared data from the 2015 and 2013 surveys with data from 2017 and included only those comparisons that represented meaningful differences between data from the two previous rounds of the survey. Some variations in the data reported between 2013, 2015, and 2017 may be due to survey refinement.

The 2017 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. U.S. Census data were used for accurate zip code population estimates. 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.

To provide a richer picture, the report also presents two other data sources—NACCHO's 2017 *Local Health Departments Assessment*:

A Stakeholder Study and the *2015–2016 Challenge Award Evaluation*. Both data sources provide additional insight into the MRC network but do not represent the entire network. Due to rounding, numbers in pie charts may not always add up to 100%.

DATA LIMITATIONS

Data in this report were self-reported and not independently verified. The time estimated to complete this survey, based on the pilot, averaged 45 minutes. With unit leaders dedicating 10 hours per week on average to MRC activities, time constraints may have affected the richness of the data supplied, particularly among smaller sized units.

The data from some questions changed little from 2015 to 2017. NACCHO will consider adjusting the frequency of some demographic questions for future surveys. As with the 2015 survey, the text responses provided in the "other" field will inform possible answer options for questions in subsequent surveys. ●

CELEBRATING 15 YEARS: A timeline of the MRC

2002 Office of the Surgeon General (OSG) announces the MRC as a demonstration project; MRC is defined as a program for medical, public health, and other volunteers interested in public health preparedness.

2002 42 MRC community-based units established to uphold the principles of the MRC project, as defined by OSG.

2005 More than 6,000 MRC volunteers from 150+ MRC units participate in Hurricane Katrina, Rita, and Wilma response and recovery efforts.



2006 500 MRC units established nationwide, including Washington, DC, Guam, Puerto Rico, and US Virgin Islands. MRC Program Office also joins forces with NACCHO through a cooperative agreement to promote, support, and build capacity within the MRC network.

2006 Congress passes the Pandemic and All-Hazards Preparedness Act (PAHPA), which formally authorizes the MRC and its network to support emergency response at all levels, Local, State, Tribal, Territorial, and Federal.

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

2009 Almost 50,000 MRC volunteers across 600 units respond to H1N1 outbreak. Over 2,500 separate immunization, flu prevention, and flu care activities reported.

2010 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.

TODAY Nearly 200,000 MRC volunteers among almost 1,000 units nationwide, including Washington, DC, Guam, US Virgin Islands, American Samoa, Commonwealth of Northern Mariana Islands, Federal States of Micronesia, and Puerto Rico.

1,000 UNITS

200,000 VOLUNTEERS

15 YEAR ANNIVERSARY

2016 MRC units prepare for and support Zika response. In Puerto Rico, which declared a public health emergency, over 140 MRC volunteers participate in community education and outreach efforts, reaching about 17,000 individuals.

2015 More than 300 MRC volunteers from 20 MRC units supported local efforts during the Papal Visit. These volunteers provided medical care and other assistance at aid stations, tents, and other venues in Washington, DC, New York City, Philadelphia, and Camden, NJ.

2017 Formal Letter of Agreement established between the American National Red Cross and the MRC Program, thereby reauthorizing the collaboration between the two organizations to better prepare communities to withstand and recover from disasters.

2014 During the domestic Ebola response, 169 MRC units donate more than 14,000 hours across 180 Ebola-related activities (e.g. suspect-case screening support, Ebola-related health education, staffing call centers, providing general surveillance support).

PAHPRA

2012 The Waldo Canyon Fire, one of the most destructive in Colorado history, burns for a month in late June 2012. The MRC of El Paso County responds by donating 1,644 hours of volunteer service.

2012 New York's and New Jersey's health department call on the MRC in the wake of Hurricane Sandy. MRC volunteers serve more than 36,000 hours in response.

2013 Congress passes the Pandemic and All-Hazards Preparedness Reauthorization Act (PAHPRA), which continues authorization for MRC, but moves authority and responsibility to the Department of Health and Human Services' Assistant Secretary for Preparedness and Response (ASPR). MOU allows for continuation of operations within OSG and strategic oversight by ASPR.

“Trusted community partners and resources...”

To the Members of the Medical Reserve Corps:

As the Assistant Secretary for Preparedness and Response (ASPR) within the U.S. Department of Health and Human Services (HHS), I am honored and excited to be able to address the Medical Reserve Corps (MRC) Network and to write this introduction to the 2017 Network Profile of the Medical Reserve Corps.

The MRC is a program that I have closely watched evolve and grow over the last 10-plus years. In 2006, I had the privilege of serving as the staff director for the Senate subcommittee that drafted the original Pandemic and All-Hazards Preparedness Act that authorized the MRC program into law. Through that experience, I gained firsthand insight into public health preparedness and response issues and the value the MRC brings to local communities, HHS, and our nation.

In my first few weeks as the ASPR, I witnessed the positive impact of the MRC directly with responses to Hurricanes Harvey, Irma, and Maria. The efforts of local MRC units during these disasters and the willingness of leaders and volunteers to respond when needed most was inspiring, despite, in many cases, being personally affected by the storms. It is a testament to the strength and dedication of the members of this Network and the relationships local units have built as trusted community partners and resources.

Building prepared, healthy, and safe communities begins in our homes and our neighborhoods long before disasters strike. The MRC’s work on a daily basis to improve preparedness capabilities, strengthen public health, and promote community outreach helps ensure that communities across America reach and maintain health security in the face of disasters and on a daily basis.

This network profile illustrates the many ways MRC units connect and support the needs of the communities they serve. It also tells the program’s story, which highlights challenges, successes, evolving capabilities, and innovative solutions. I am proud and grateful for all that the MRC does to support ASPR’s mission and the health of our nation.



Sincerely,
Robert P. Kadlec, MD, MS
Assistant Secretary for Preparedness and Response

“This milestone year has been an exciting time...”

To Medical Reserve Corps Network, Colleagues, and Partners,

This year, the Medical Reserve Corps (MRC) celebrates 15 years of serving local community needs. What started as a demonstration project in 2002 with 42 community-based units has become an MRC network today of almost 1,000 units strong with nearly 200,000 volunteers nationwide.

This milestone year has been an exciting time to be able to reflect on the program’s growth and evolution. There is no doubt that the network is as strong and far-reaching as it is today because of the unwavering dedication and expertise of our unit leaders, volunteers, and committed partners. I am also inspired by the fact that the MRC’s core mission when it was established 15 years ago remains the same—to engage local communities to strengthen public health, reduce vulnerability, build resilience, and improve

preparedness, response, and recovery capabilities. The impact our network has had—and continues to have—in each of these areas is immeasurable.

Our MRC Program Office is proud to support the efforts of the National Association of County and City Health Officials (NACCHO) to produce this third edition of the Network Profile of the Medical Reserve Corps. This profile serves to continue to tell the MRC story and illustrate the many ways that the network is bringing our program mission to life and making our communities stronger and healthier. Through the profile, we are able to spotlight and share best practices, common challenges, and new innovations and capabilities spearheaded by MRC units across the country. It is an opportunity to celebrate the MRC’s current efforts, learn from each other, and look at our collective past and continued journey ahead.

I am proud of the story this Network Profile tells and thank the MRC unit leaders and volunteers who have shared their time, photos, stories, and unit information to make it all possible. Additionally, I thank the dedicated NACCHO staff who worked tirelessly to collect, analyze, and design this profile so that the diversity of the network and efforts of its volunteers are illustrated in such a meaningful way. I hope you all are as excited for the next 15 years as I am.



With warm regards,
Skip Payne, M.S.P.H., REHS/RS, CPH, CHEP
*Commander, U.S. Public Health Service
Deputy Director, Medical Reserve Corps Program*

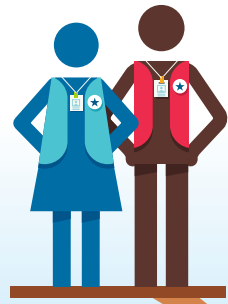
THE 2017 MRC UNIT SNAPSHOT

INFOGRAPHIC

NATIONALLY

68%

of units are housed in Local Health Departments.



74%

of units have been with their housing organizations for five or more years.



89%

of units are integrated into their housing organization's emergency plan.



79%

of unit leaders have a Bachelor's degree or higher education.

37%

of unit leaders have advanced degrees (Master's or higher).

55%

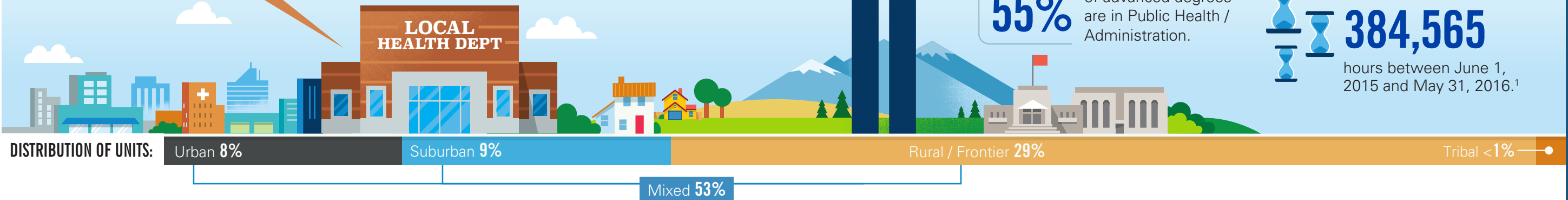
of advanced degrees are in Public Health / Administration.



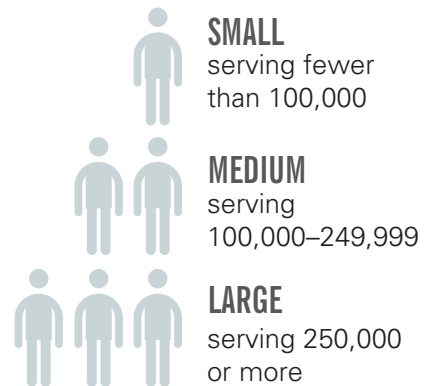
On average, MRC unit leaders devote **10.2** hours per week to MRC activities.



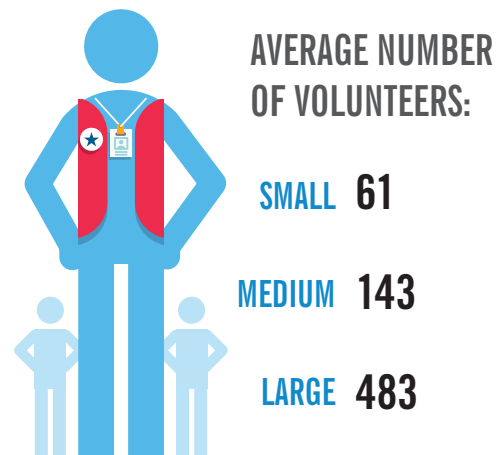
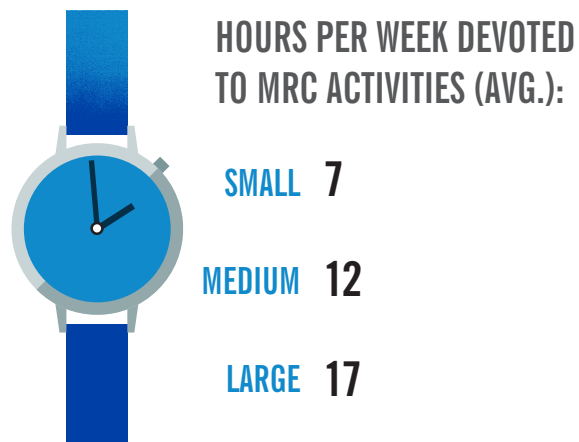
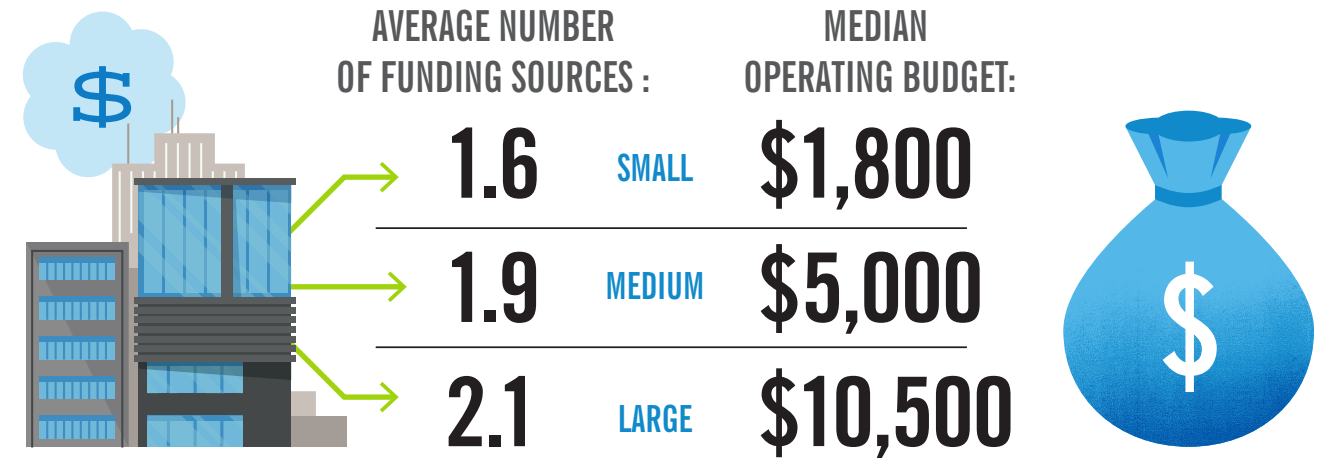
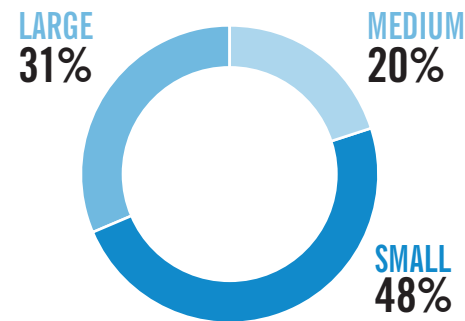
In total, MRC units reported contributing a cumulative **384,565** hours between June 1, 2015 and May 31, 2016.¹



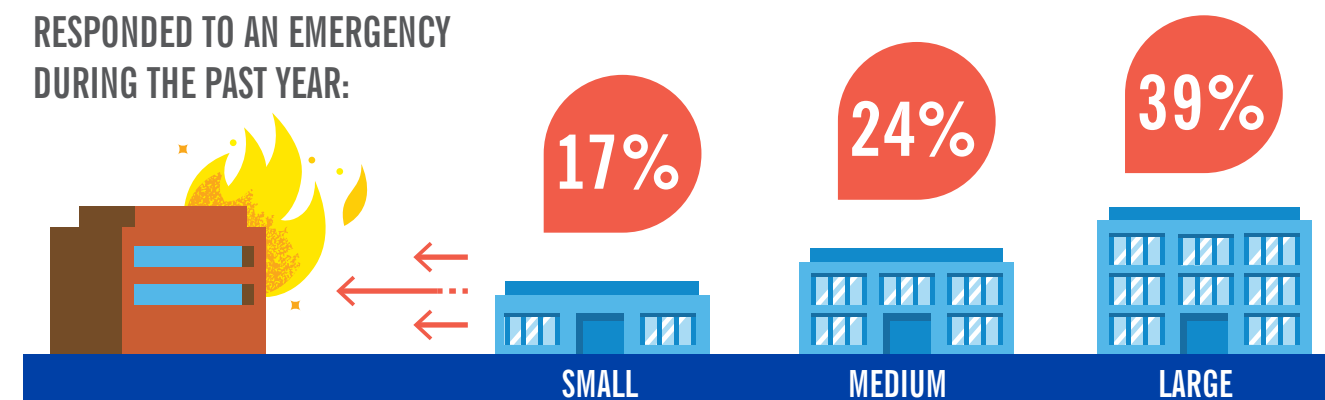
COMMUNITIES SERVED BY MRC UNITS:



PERCENTAGE OF MRC NETWORK:



RESPONDED TO AN EMERGENCY DURING THE PAST YEAR:





Massachusetts
An MRC volunteer provides services at a flu clinic.

MRC connects with the community

KEY FINDINGS:

Nearly three-quarters (74%) of units have been with their housing organization for more than five years and almost all (89%) are integrated into their housing organization's emergency plan.

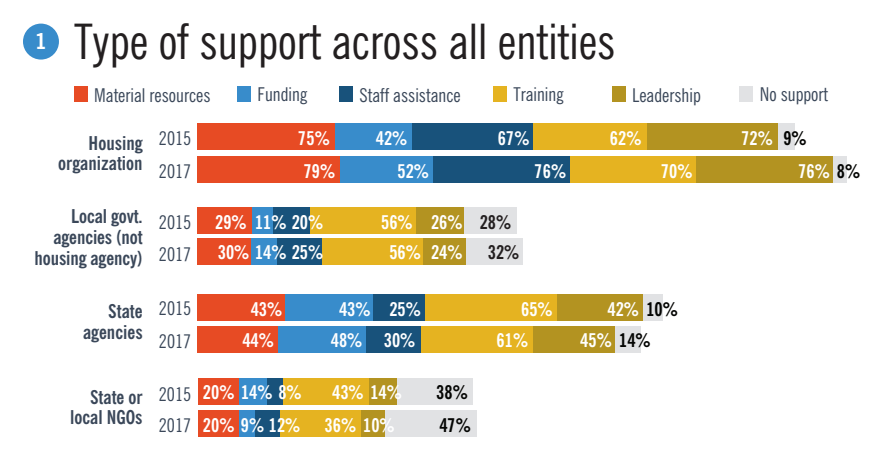
Almost all (92%) of MRC units reported training with another organization in the past year, a 7% increase from 2015.

MRC unit Facebook use increased from 37% in 2013 to 50% in 2017.

The hallmark of the MRC is its strength in engaging local communities. While the units' missions vary, the public health and preparedness activities MRC units reported engaging in reflect both their capabilities and the needs of their communities. As a result of these activities, units develop relationships with partnering champions who facilitate the integration of the MRC into the local public health and preparedness infrastructure.

COLLABORATION AND SUPPORT

MRC units reported on the type of support (i.e., material resources, funding, staff assistance, training, leadership, or none) that they received from various entities. A high percentage of MRC units reported receiving some level of support from their housing organizations (92%), state agencies (86%), local government agencies (not housing organization) (68%), and state or local non-governmental organizations (NGOs) (53%). **Figure 1** illustrates



HEALTHCARE COALITIONS

Robust community healthcare coalition preparedness, with critical partners, paves the way for a hospital's successful response in the event of a major disaster. Established in 2012 by ASPR, the Hospital Preparedness Program aims to strengthen community-wide planning for healthcare resiliency by strengthening Healthcare Coalition capabilities, not just the individual hospital.²

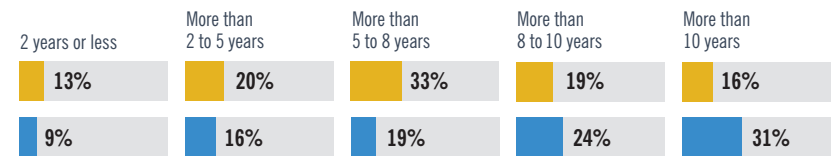
Through relationships cultivated in the Ventura Healthcare Coalition, the Ventura County MRC (CA) worked with hospitals, Emergency Medical Services Agency, and Public Health in their operational areas and demonstrated MRC volunteer skills and ability to seamlessly integrate into the hospitals' surge capacity during a large scale event. The Ventura County MRC conducted hospital assessments to identify a training curriculum, trained 95 MRC volunteers alongside 80 Public Health Nurses to prepare communities and hospitals for disaster-induced medical surges, and produced a "bedside credentialing toolkit."

Engagement with healthcare coalitions may take on different manifestations for other units across the country. As a member of its local Healthcare Coalition, the Southwest Florida MRC (FL) conducted hospital decontamination exercises and participated in medical surge simulations aimed at testing hospitals' emergency plans while the Alameda County MRC (CA) partnered with local community members including their local Healthcare Coalition members to support Alameda County in disseminating timely educational messages and inquiries related to Zika.

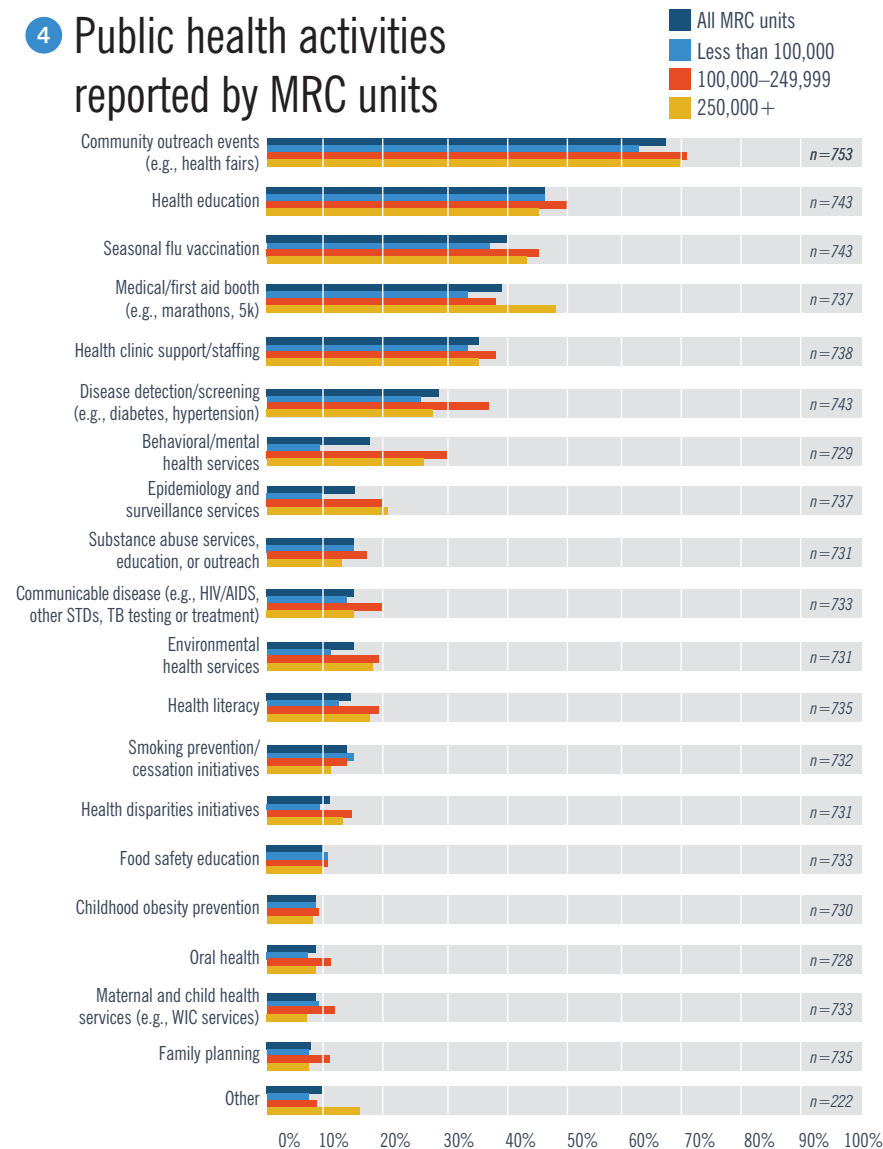
that across all entities, MRC units reported increased staff assistance compared to the 2015 study. Providing the highest level of support in each category, over three-quarters (79%) of housing organizations provided material resources, 76% provided leadership support, and 70% provided training. This is not particularly surprising given the

fact that MRC units continued to report staying with their housing organizations longer. Nearly three-quarters (74%) of units have been with their housing organization for more than five years, and more than half (55%) reported staying for more than eight years (Figure 2). Almost all (89%) are integrated into their housing organization's emergency plan.

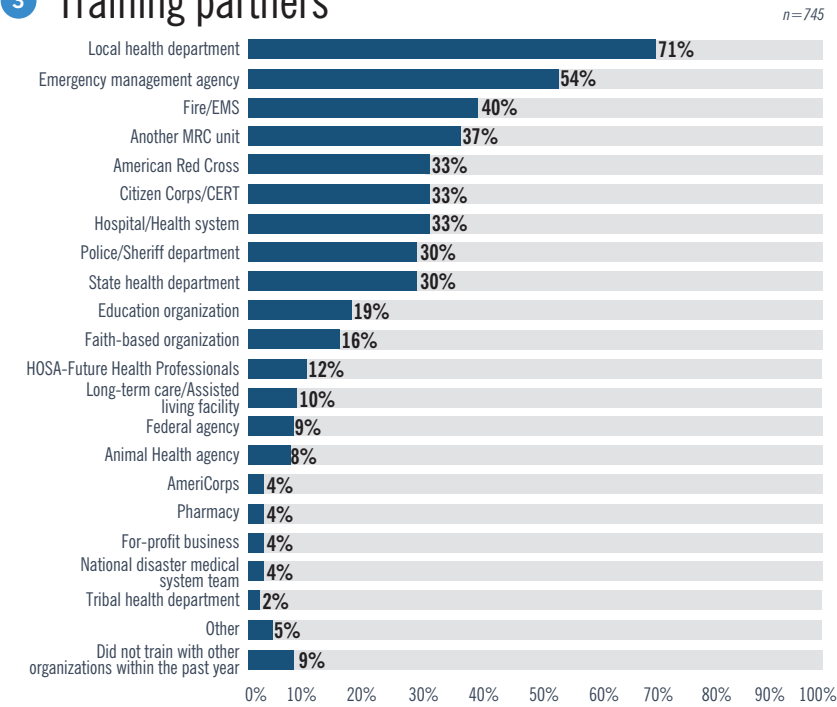
2 Unit under current housing organization



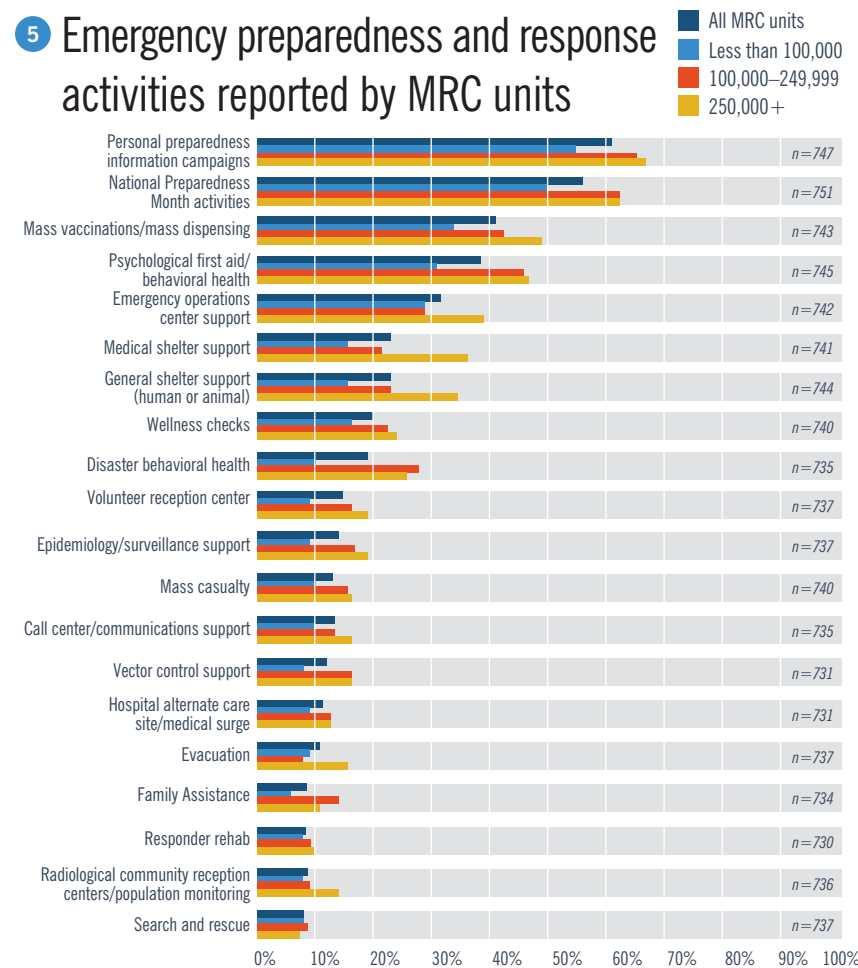
4 Public health activities reported by MRC units



3 Training partners



5 Emergency preparedness and response activities reported by MRC units



TRAINING PARTNERS

Addressing a community need often requires community collaboration. Recognizing that fact, almost all (92%) MRC units reported training with another organization in the past year, a 7% increase from 2015 (Figure 3). Large units were more likely than medium and small units to have at least one training partner. Nationally, unit collaborations were most often reported with local health departments (71%), emergency management agencies (54%), and fire/emergency medical services (EMS) (40%). Units also reported an increase in collaborations with less traditional partners, particularly with HOSA-Future Health Professionals, up from 9% in 2015 to 12% in 2017, and educational organizations, up from 16% in 2015 to 19% in 2017. NACCHO's National Profile of Local Health Departments study further illustrates an increase in MRC partnerships: Local health departments reported that they most often engage MRC volunteers in emergency preparedness activities, an increase from 49% in 2010 to 65% in 2016.³



Washington, DC

The George Washington Medical Faculty Association MRC conduct a large scale active shooter exercise, simulating an active shooter on the National Mall.

OPIOID CRISIS

America is suffering from an opioid crisis. According to the National Institutes of Health (NIH), opioid prescriptions such as hydrocodone and oxycodone have dramatically increased over the past 20 years from around 76 million prescriptions in 1991 to almost 207 million in 2013.⁴ Joining the fight to combat opioid addiction and overdoses, the following MRC units provide examples of how units around the nation are combatting the opioid crisis facing their communities by bringing together local faith leaders, law enforcement, healthcare providers, concerned family members, and other interest groups.

The Torrington MRC (CT) designed its program to focus on “providing training directly to care givers and high risk individuals,” however shifted their scope after receiving requests for training to be provided to agencies in their county that work with high risk individuals. To date, the unit has trained over 500 community members on harm reduction strategies, overdose recognition and reversal skills. Similarly, the LaSalle County MRC (IL) received requests to provide training from the LaSalle County Sheriff’s Office. The MRC unit trained 145 officers and 10 LaSalle County law enforcement agencies on opioid overdose and use of nasal naloxone. Their program ultimately saved 12 lives in 2016.

In the same effort to combat the crisis, volunteers from the Howard County MRC (MD) worked alongside the Howard County Health Department’s (HCHD) Bureau of Behavioral Health (BBH) to augment their existing Opioid Overdose Response (OOR) Program while the South Hadley MRC (MA) targeted healthcare providers, public health, and pharmacies to provide a comprehensive training to Sheltering Residents with Substance Dependency.



Howard County MRC Opioid Overdose Response Initiative poster presentation.

“Without the MRC, our community would be at a disadvantage as we would have a tremendous difficulty fully staffing emergency shelters and mass vaccination clinics. We also would not be able to accomplish nearly as much community outreach and education. Our MRC works heavily with MRC units in other counties in our region and we have all found this relationship to be important over the years.”

—Local health department (stakeholder) survey respondent

REPORTED ACTIVITIES

Since 2013, MRC units reported participating in activities aligning with their local mission. **Figures 4 and 5** illustrate the different types of public health and emergency preparedness activities of small, medium, and large units.

PUBLIC HEALTH ACTIVITIES

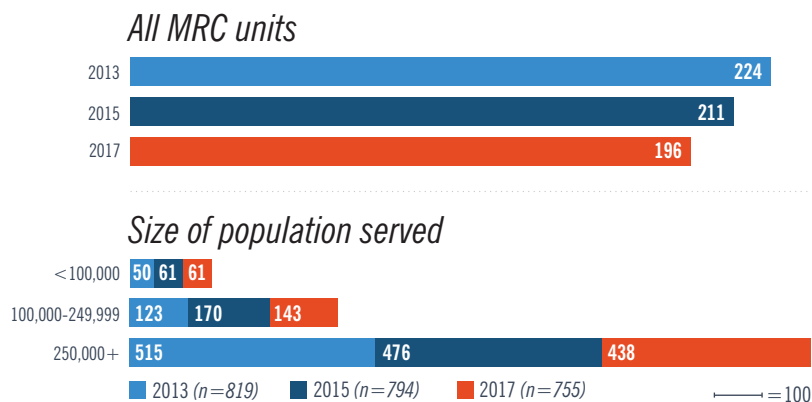
The 2017 Network Profile data indicate that community outreach events (67%), health education (46%), and seasonal flu vaccination (40%) are the top three public health activities units participated in during the past year. Given these data, it is not surprising that only 5% of units reported that community outreach events or mass vaccination/mass dispensing are not part of

their missions, with little variation among different-sized units. The least-common public health functions reported include family planning (7%), childhood obesity prevention (8%), and oral health (8%). Substance abuse services, education, and outreach has seen the greatest increase, from 6% in 2013 and 2015 to 15% in 2017.

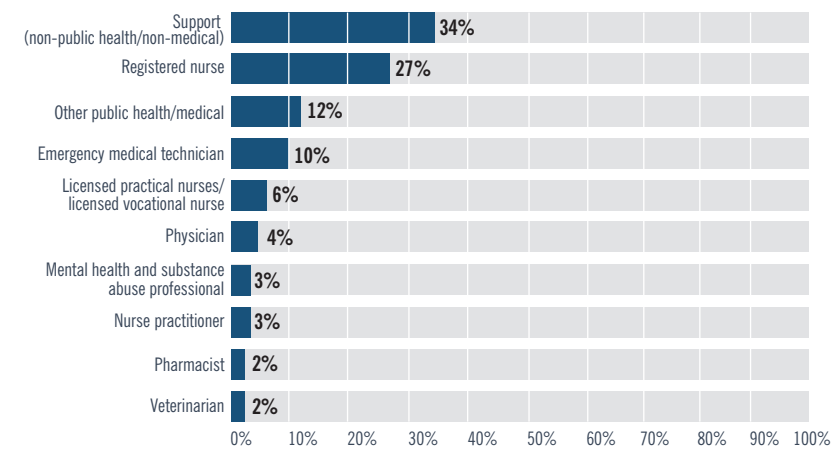
EMERGENCY PREPAREDNESS AND RESPONSE ACTIVITIES

During the same sample period, the top three emergency preparedness and response activities reported by units were personal preparedness activities (61%), National Preparedness Month activities (56%), and mass vaccination/mass dispensing (41%). A total of 49% of units also reported

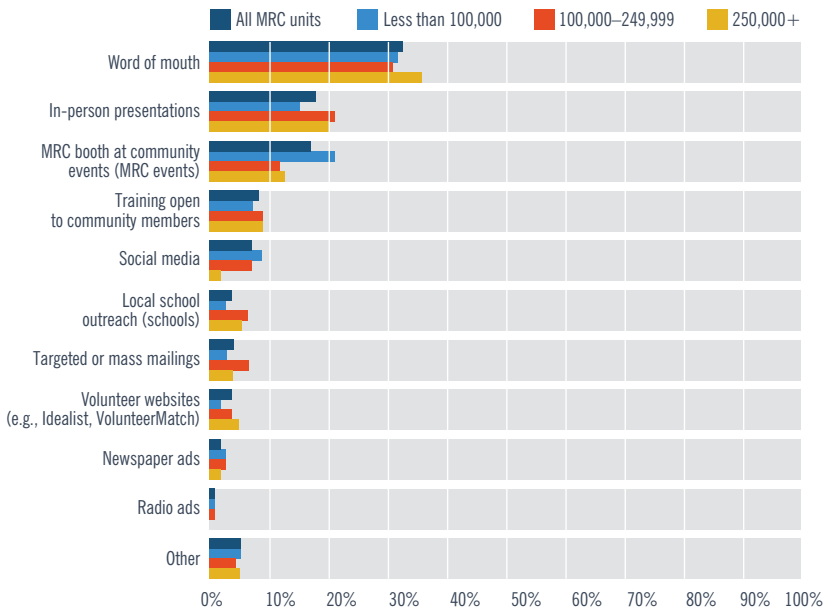
6 Average number of volunteers in unit



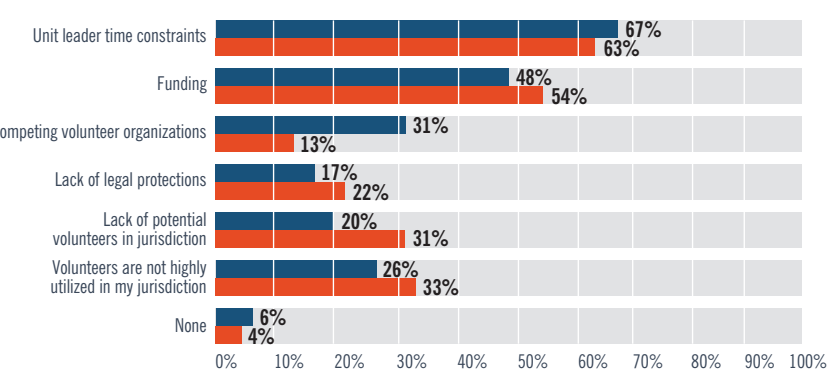
7 Top 10 MRC volunteer disciplines



8 Top recruitment methods



9 Obstacles to recruitment



participation in psychological first aid/behavioral health activities. Less than one-tenth of units reported that these functions are not part of their mission. Radiological community reception centers/population monitoring (7%) and search and rescue (7%) were the least common emergency preparedness and response activities reported. See page 32 for type of reported emergency response activities.

COMPOSITION OF THE MRC

MRC units reported an average of 193 volunteers per unit; however it is important to note that the number of volunteers varied greatly by the size of the jurisdiction that the MRC unit serves. While large MRC units (serving 250,000 or more) report an average of 438 volunteers, **Figure 6** illustrates that small-sized MRC units (serving <100,000) report an average of 61 volunteers per unit. The size of the population served by an MRC unit has clear implications for the number of volunteers reported.

From youth to retirees, MRC volunteers donate their skills to strengthen public health and emergency response in their communities. On average, a little over one-third of volunteers in MRC units are nurses: 27% were registered nurses, 3% were nurse practitioners, and 6% were licensed practicing nurses/licensed vocational nurses. Another one-third of volunteers in MRC units serve as other medical professionals (e.g., physician, veterinarian, pharmacist, emergency medical technician). The remaining one-third (34%) of MRC volunteers are support (non-medical/non-public health) volunteers (**Figure 7**).

RECRUITMENT METHODS

Several unique factors may motivate an MRC volunteer to serve and improve their community. MRC units were asked to rank the most effective recruitment method. **Figure 8** shows that word of mouth was

CHALLENGE AWARDS UNIT HIGHLIGHTS

STRENGTHENING PUBLIC HEALTH

The Dallas County MRC (AL) launched its program, Doc in a Bus, to increase access to primary care services. The unit partnered with local healthcare coalitions to serve discharged hospital patients without regular primary care physicians in an effort to reduce patient readmission rates—an indicator of healthcare access.

“The typical patient served by Doc in a Bus has no insurance, no regular primary care physician, and suffers from a chronic disease like diabetes or high blood pressure,” according to the MRC unit coordinator. These patients frequently use the emergency department as their source of primary care, leading to dramatic healthcare costs in the community. Dallas County MRC’s Doc in a Bus addresses this issue by providing mobile, free primary care to underserved populations. The bus has helped screen women who have never had Pap tests or mammograms and has helped people stay out of the emergency room by controlling their chronic diseases through medication and follow-up.

In 2016, Doc in a Bus served 422 patients in the community through 23 clinic visits and continues to provide primary care and education services to patients in need.



Minnesota
MN HOSA MRC volunteer engaging kids on emergency preparedness.

reported as the single most effective method by one-third of MRC unit leaders (33%). With an understanding that recruitment is an ongoing process, over one-third of unit leaders reported leveraging community engagement activities through in-person presentations (18%) or at MRC booths at community events (17%) as a top recruitment method.

While MRC unit leaders reported success with traditional methods of recruitment, only 4% of MRC unit leaders reported not facing any obstacles, with some variation by size of population served. The difference in obstacles to recruitment between small and large jurisdictions were the greatest for lack of legal protection. **Figure 9** illustrates that unit leader time constraints was reported as the top obstacle, although this category decreased slightly from the 2015

study. Similarly, competing volunteer organizations has decreased from 26% in 2015 to 13% in 2017, while lack of potential volunteers has seen an 11% increase from 2015 to 2017.

COMMUNICATION

The adoption and use of various communication channels facilitates collaboration and outreach to a wide range of community members. Since 2013, MRC units have reported an increase in the use of social media as a communication tool, although some platforms show greater increases than others. For example, the use of Facebook increased from 37% in 2013 to 50% in 2017, while the use of Twitter showed very little change during the same period. During emergencies, MRC units use different kinds of communications channels to mobilize volunteers, which varied by size of population served (**Figure 10**).

A large number of MRC units reported using telephone (81%) and e-mail/distribution list (70%) during an emergency. NACCHO added “ESAR-VHP System” (Emergency System for Advanced Registration of Volunteer Health Professionals) and “two-way radio” as options in this year’s survey based on text responses provided in the “other” field from the 2015 survey. Almost half (47%) of units reported using the ESAR-VHP system and 27% reported using two-way radio as a method for exchanging information during

an emergency. The difference in communication channels between MRC units serving small and large jurisdictions were the greatest for the ESAR-VHP system. Future studies may investigate the interoperability of some of these communication channels during emergency situations.

MRC units continue to rely on social interactions to exchange information with their volunteers, other MRC units, and the public. Data from the 2017 MRC Network Profile study indicate that a majority

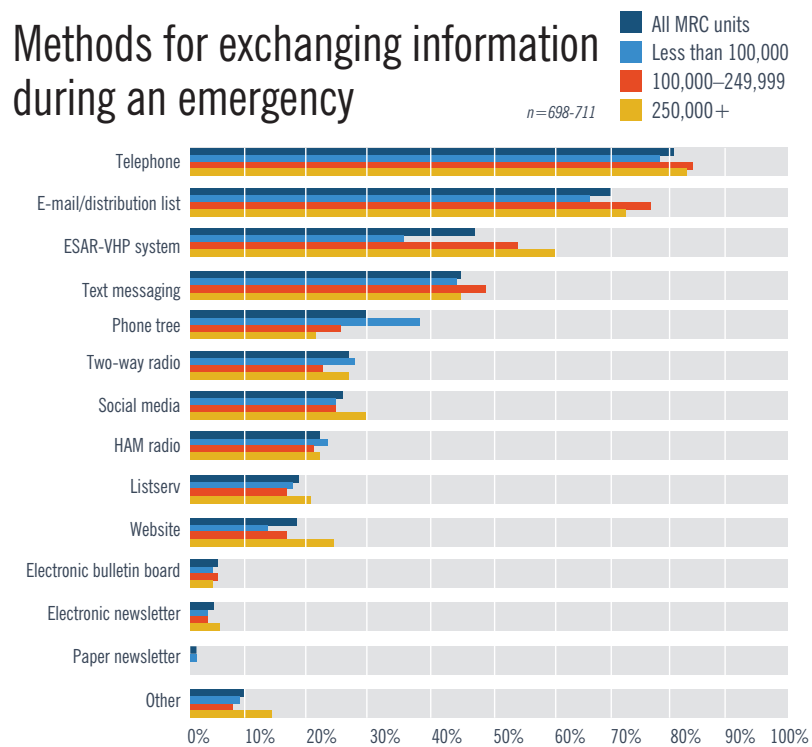
HOW THE MRC NETWORK AFFECTS THE HEALTH SECURITY INDEX

Measuring health security and preparedness at the national and state levels can guide policy and planning efforts for large-scale emergencies. An annual tool that examines the health security preparedness of the nation is the National Health Security Preparedness Index (NHSPI). By looking at collected data from states, the index examines 139 measures grouped into six broad domains of health security. Under the community planning and engagement domain, MRC units contribute to the measure of the index through the number of MRC members per 100,000 people, percentage of MRC members who are physicians, percentage of MRC volunteers who are nurses or advanced practice nurses, and percentage of MRC volunteers who are other health professionals.



An MRC volunteer participates in the Loudoun County MRC (VA) Tdap clinic for rising sixth graders.

10 Methods for exchanging information during an emergency



CHALLENGE AWARDS UNIT HIGHLIGHTS

PARTNERS FOR EMPOWERED COMMUNITIES

The Oklahoma MRC Nurses unit developed a Nursing Student Summer Externship to provide nursing students from several Oklahoma universities with knowledge and skills in disaster response. The program was a structured summer volunteer experience with nurse educators within the Oklahoma MRC, culminating in 1,283 hours of service and study.

The externship activities include staffing first aid stations, teaching preparedness to middle- and high-school students, and delivering inter-professional trainings for activities such as psychological first aid and volunteer training workshops. MRC Nurses offered creative solutions to expand and enhance public health education to nursing students in their communities. One had this to say of the program: "It taught me to look beyond the obvious physical results of a disaster and to see the social, psychological, and financial damage. I feel like I now have a more holistic view of how to help those affected by crisis and disaster." The Oklahoma MRC Nurses unit creatively partnered with local universities and engaged healthcare providers to provide valuable information and experience in public health, emergency preparedness and response to the next generation of nurses.



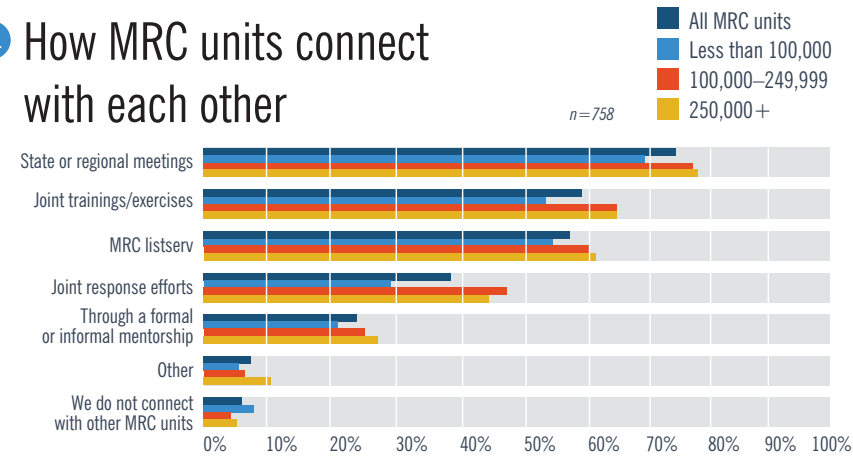
of MRC units connect with other units through both in-person and virtual settings. Nearly three-fourths (74%) reported connecting through state or regional meetings, 59%

through joint training/exercises, and 57% through the use of the MRC listserv. Only 6% of units reported not connecting with another unit (Figure 11).



Massachusetts
Boston MRC volunteers during the 2017 Boston Marathon.

11 How MRC units connect with each other



CASE STUDIES

ENGAGING ACCESS AND FUNCTIONAL NEEDS GROUPS IN EMERGENCY PREPAREDNESS

People with disabilities and activity limitations are frequently omitted from preparedness and planning activities. Further, "disaster preparedness and emergency response systems are typically designed for people without disabilities."⁵ It is therefore vital to consider people with special needs when developing disaster response protocols.

MRC units encourage vulnerable populations to participate in the dialogue and prepare for emergencies in varying capacities. For example, through presentations, TV programming, and other community outreach events, volunteers from Upper Merrimack Valley MRC (MA) and Greater River Valley MRC (MA) collaborated to provide emergency preparedness information and direct

training to vulnerable residents and their caregivers to reduce unnecessary 9-1-1 calls during large scale emergencies through greater self-sufficiency and disaster awareness. The Upper Merrimack Valley MRC also worked with local municipal departments to enroll 70 vulnerable Westford residents in the town's "Medical Special Needs Registry" while

making home visits with 72-hour kits, encouraging those with functional needs in a disaster to sign up in advance.

The Adams County MRC and Adams County Health Department (IL) also collaborated with 10 long-term care facilities in their jurisdiction to provide education on the importance of closed point of dispensing (POD) to build

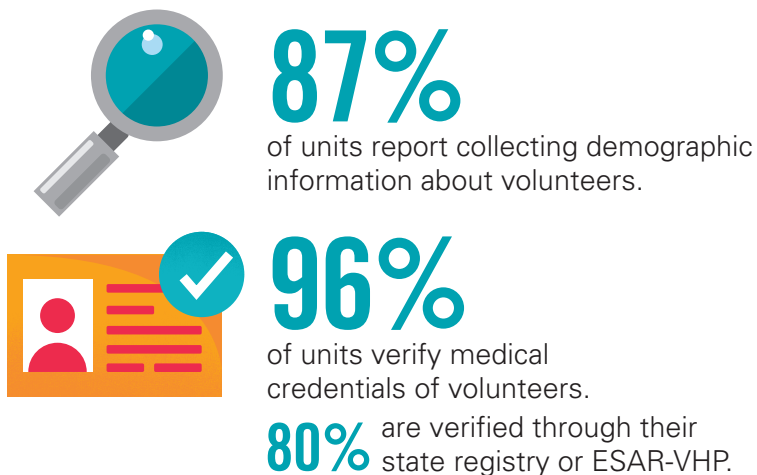
community resiliency. Memorandum of Understanding (MOUs) with the facilities were drafted in collaboration with local emergency management describing the technical assistance the Adams County Health Department and MRC unit would provide in establishing closed POD plans within the facilities. Training materials on closed PODs were also compiled for the long-term care facilities.

Designed to have a trickle-down effect, the University of Georgia MRC (GA) provided emergency preparedness train the trainer activities, developed specifically for local seniors to 10 agencies that work with seniors in their community. Preparedness kits and training materials were provided to each agency to train seniors with whom they work.

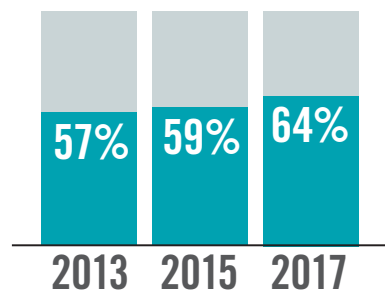
INFOGRAPHIC

MRC CAPABILITIES SNAPSHOT

BACKGROUND CHECKS

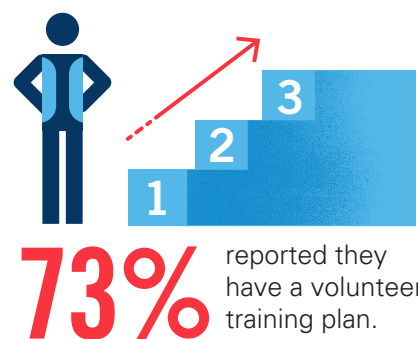


MRC units that conduct background check screening of volunteers increased from 2013 to 2017.

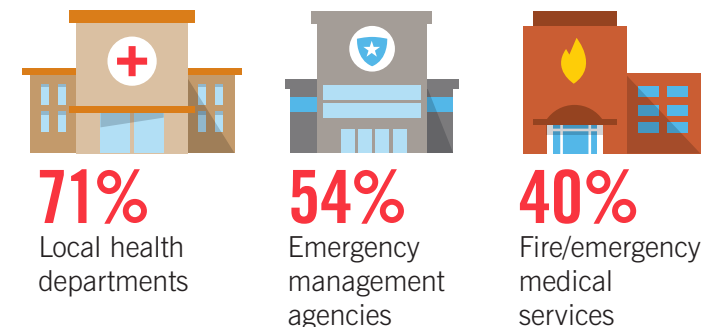


We simply could not do large-scale activities without MRC.
—Local Health Department (Stakeholder) Survey respondent

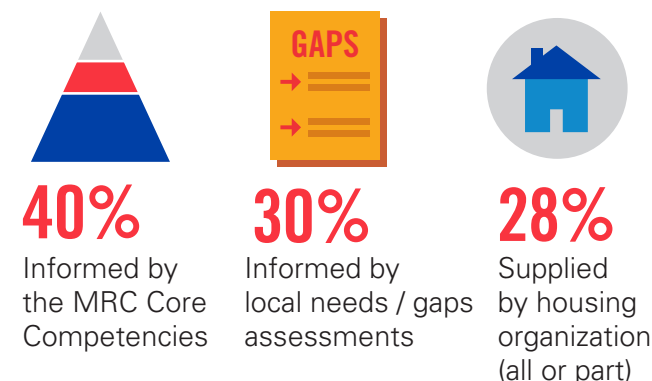
TRAINING



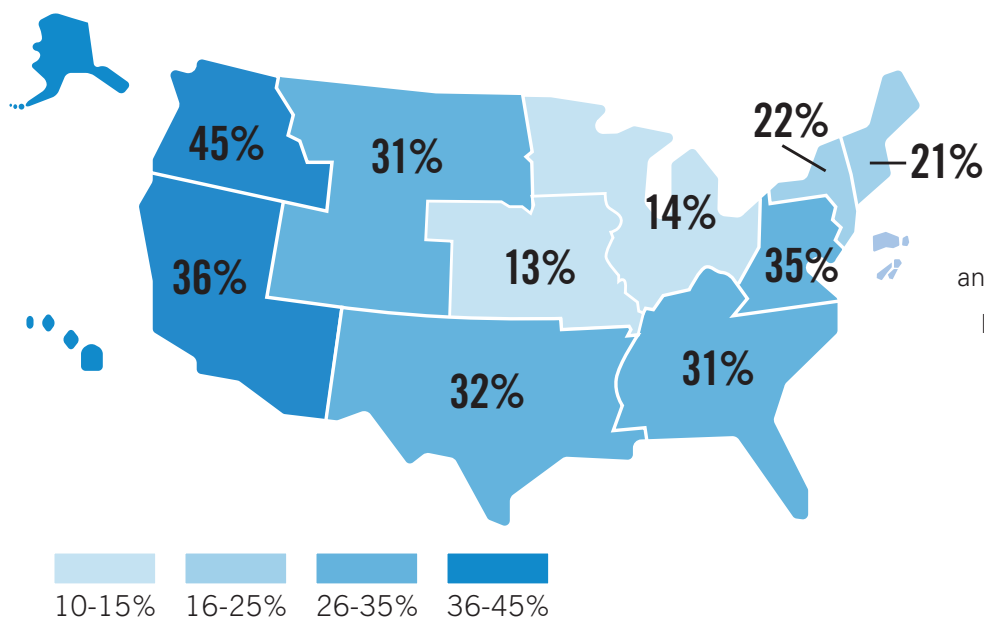
TOP THREE TRAINING PARTNERS:



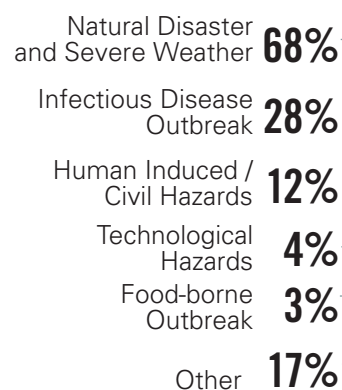
TOP THREE TRAINING DEVELOPMENT METHODS:



RESPONSE TO EMERGENCIES BY HHS REGION:



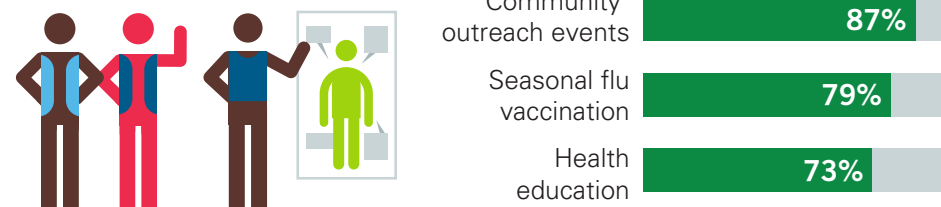
TYPES of EMERGENCIES:



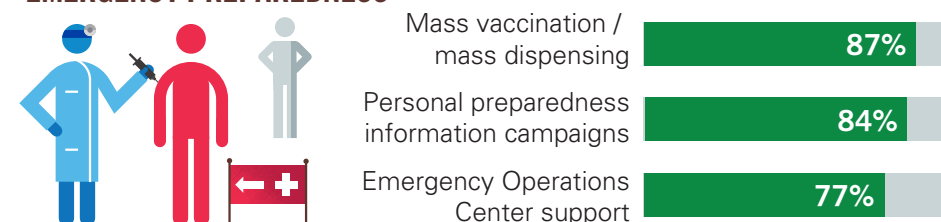
TOP UNIT CAPABILITIES

Activities in which MRC units have or could have participated:

PUBLIC HEALTH



EMERGENCY PREPAREDNESS

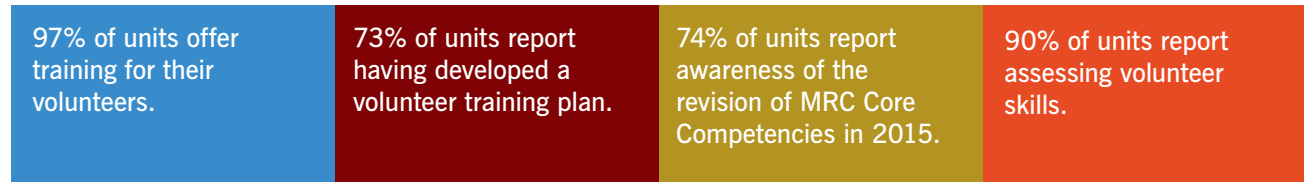




Rhode Island
MRC participants in an air show exercise.

Trained, exercised, and ready

KEY FINDINGS:



MRC volunteers play an integral role in local community emergency preparedness and response plans and supporting public health activities that build community resiliency.

Understanding the skills that volunteers bring to the MRC and providing them with the necessary training and experience to perform a variety of roles and responsibilities is essential for a responsive and capable MRC volunteer base. Community partners, including emergency response agencies, value and expect trained and ready volunteers able to serve as a workforce multiplier.

VOLUNTEER TRAINING

MRC volunteers reflect the diversity of their local communities and enter the program with varying credentials, experience, and backgrounds. While this diversity complements the culture of each community, establishing a national baseline of knowledge and skills for MRC volunteers creates a stronger and more reliable MRC network.

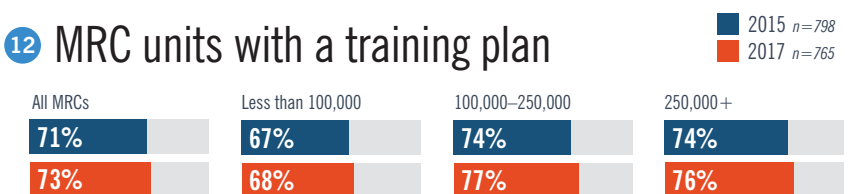
the National Center for Disaster Medicine and Public Health (NCDMPH) core competencies. These core competencies were grouped into four learning paths that capture the motivation, roles, and responsibilities of MRC volunteers. The four learning paths include the following:

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

The NCDMPH competencies represent a baseline level of knowledge and skills that all MRC volunteers should have, regardless

of their role within the MRC unit. Establishing NCDMPH competencies as the baseline for MRC volunteers makes collaboration between units more efficient. By providing a “common language,” MRC units can accurately communicate their volunteers’ capabilities to each other and to partner organizations. Findings from the 2017 Network Profile study indicate that nearly all (97%) of MRC units offer training for their volunteers and three-quarters reported having a written training plan for volunteers (Figure 12), with distinct variations based on jurisdiction size. Units that serve medium and large jurisdictions were more likely to

12 MRC units with a training plan



The MRC Core Competencies were revised in 2015 to align with

YOU ARE THE HELP UNTIL HELP ARRIVES

Launched in 2017, You are the Help Until Help Arrives (“Until Help Arrives”) is a national campaign and curriculum—spearheaded by FEMA, ASPR, MRC, and Uniformed Services University of the Health Sciences (USUHS)—designed to educate the public about the important role bystanders play in providing the injured care and comfort prior to the arrival of emergency services. The MRC is playing a critical role in promoting the “Until Help Arrives” program and educating the public in communities nationwide. The full campaign, available at ready.gov/untillhelparrives, features a variety of educational resources, including an interactive video, web-based training, and instructor-led curriculum.



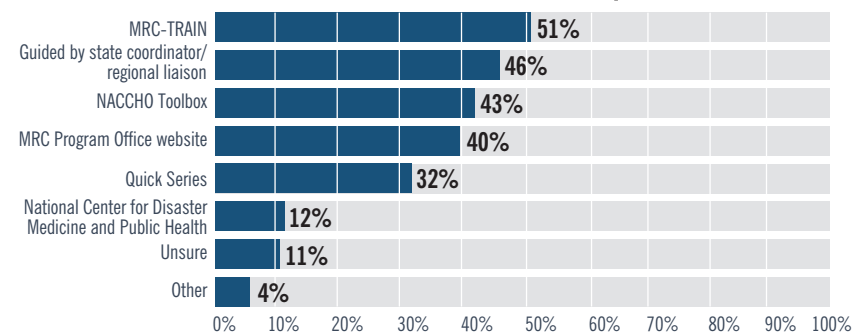
MRC unit leader conducting “Until Help Arrives” training.

have a written training plan. A total of 74% of units reported they were aware of the revision to the core competencies made in 2015. Unit leaders accessed resources related to the revised core competencies through MRC-TRAIN (51%), guidance from their state coordinator/regional liaison (46%), and the NACCHO Toolbox (43%) (Figure 13). Figure 14 illustrates that among units with a written training plan, unit leaders most often (40%) reported that the MRC Core Competencies informed the development of their training plan. A total of thirty-one percent of MRC units with a training plan indicated they made changes to their training plan based on the revised

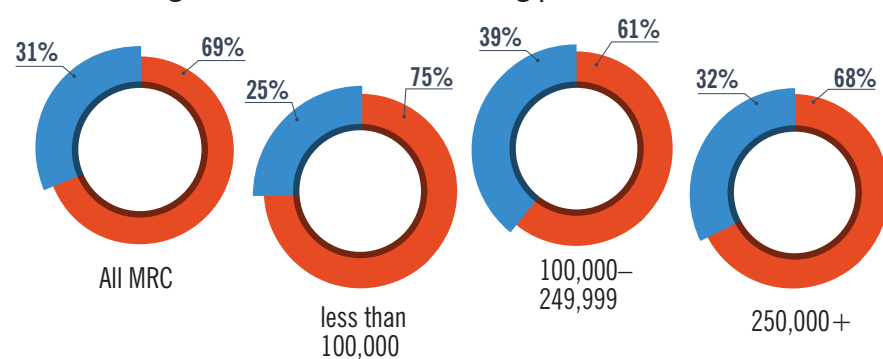
core competencies (Figure 15). Because the NCDMPH competencies establish only a minimum standard, units may choose to expand on the competencies in order to train volunteers at a more advanced level. Future surveys may investigate the percent of unit leaders that train their volunteers at a more advanced level.

MRC units develop their training plans to meet the needs of their communities, volunteers, and the resources available to support training. Units strive to offer flexibility in their volunteer training programs to meet the demands of volunteers’ time, match the appropriate learning format to the topic area, and accommodate

13 How MRC units accessed resources related to the 2015 revised MRC Core Competencies n=537



14 Have you made any changes to your training plan based on the 2015 revised MRC Core Competencies? (among MRC units with a training plan) n=544



Florida
The Manatee County MRC activating to support the Manatee County EMS and Manatee County Emergency Management.

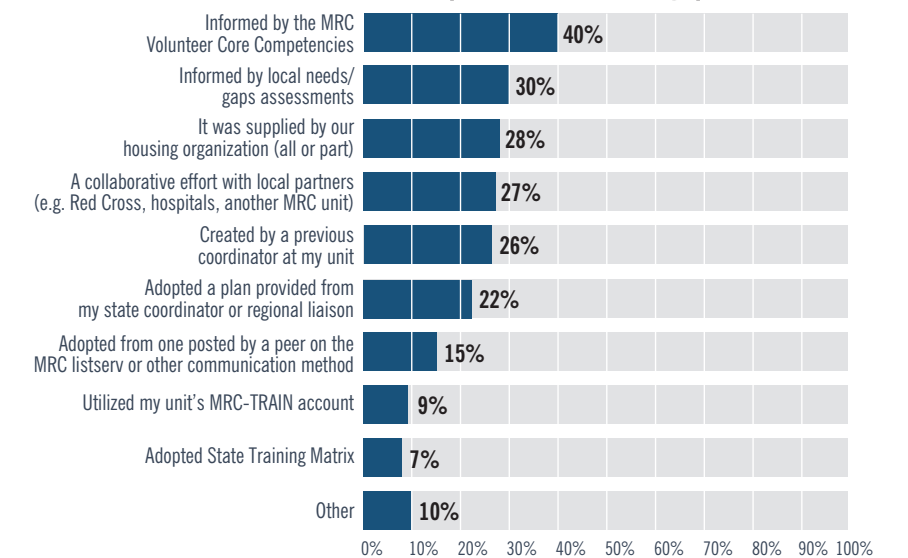
the learning preferences of the volunteers. MRC units most frequently reported offering trainings that blend online, in-person, and field settings. Nationally, the top reported trainings offered through MRC units are Psychological First Aid (65%), Introduction to the Incident Command System (ICS) (85%), and National Incident Management System (NIMS) (76%) (Figure 16, on the next page). All three of these trainings align with one of the MRC Core Competencies. Medium-sized jurisdictions were the most likely to offer these trainings, followed by large jurisdictions, and lastly, small jurisdictions. NACCHO added new trainings in the 2017 survey that address the prevalence of mass shootings, bombings, and other mass casualty events. Active bystander and bleed control measures now account for 14% of trainings being offered by MRC units. Mass Dispensing and CPR/AED/first-aid training remain staples of MRC units, with 64% and 58% of units offering such trainings respectively (Figure 16, on the next page).

The most common trainings offered by MRC units were delivered primarily in-person, with the exception of the courses available online through FEMA. The most common mandatory trainings offered by MRC units were MRC 101/Unit Orientation (81%), Introduction to ICS (79%), and NIMS (74%).

Given the number of in-person

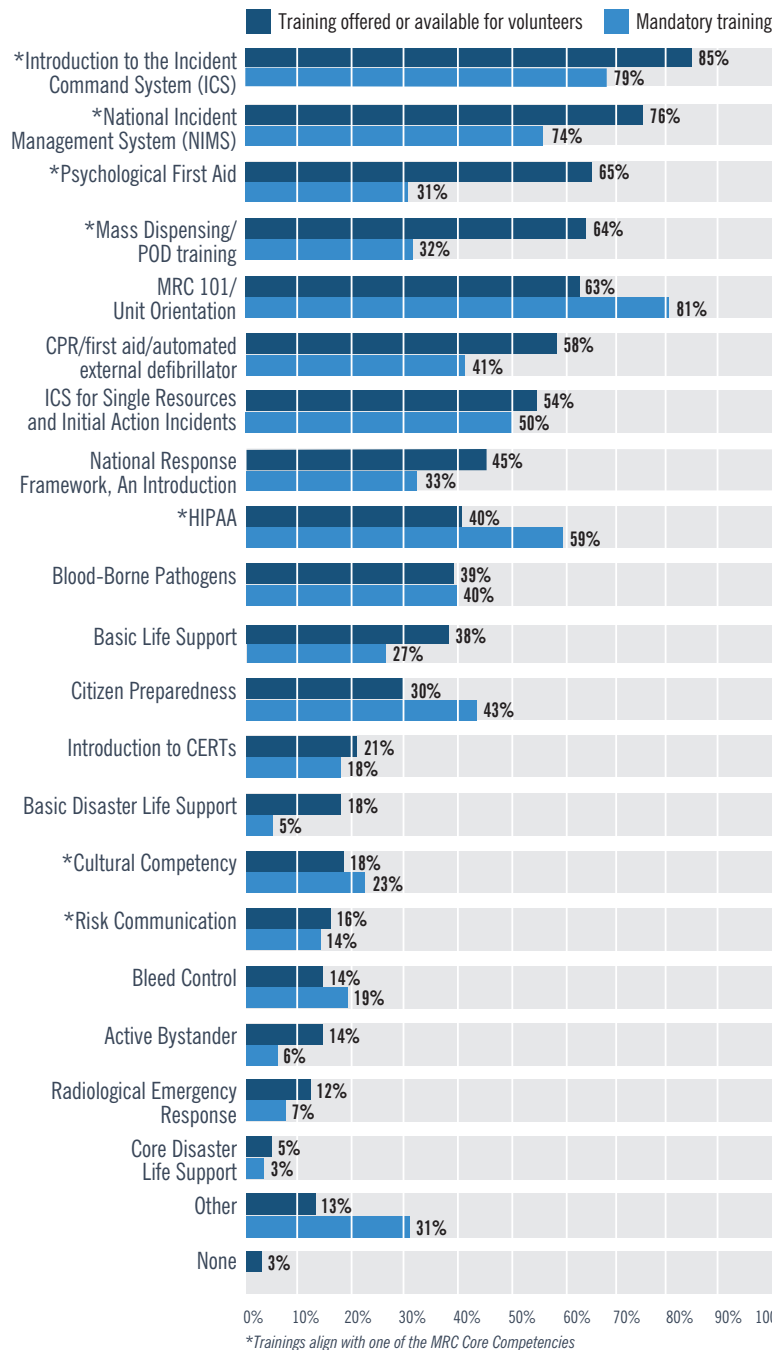
trainings that MRC units offer, it is natural that units have increased training with community partners to maximize resources available, obtain subject matter experts, and strengthen partnerships. Collaborating with community partners for trainings and exercises provides an opportunity for community stakeholders to develop their relationships prior to an emergency response.

15 How MRC units develop their training plans n=553

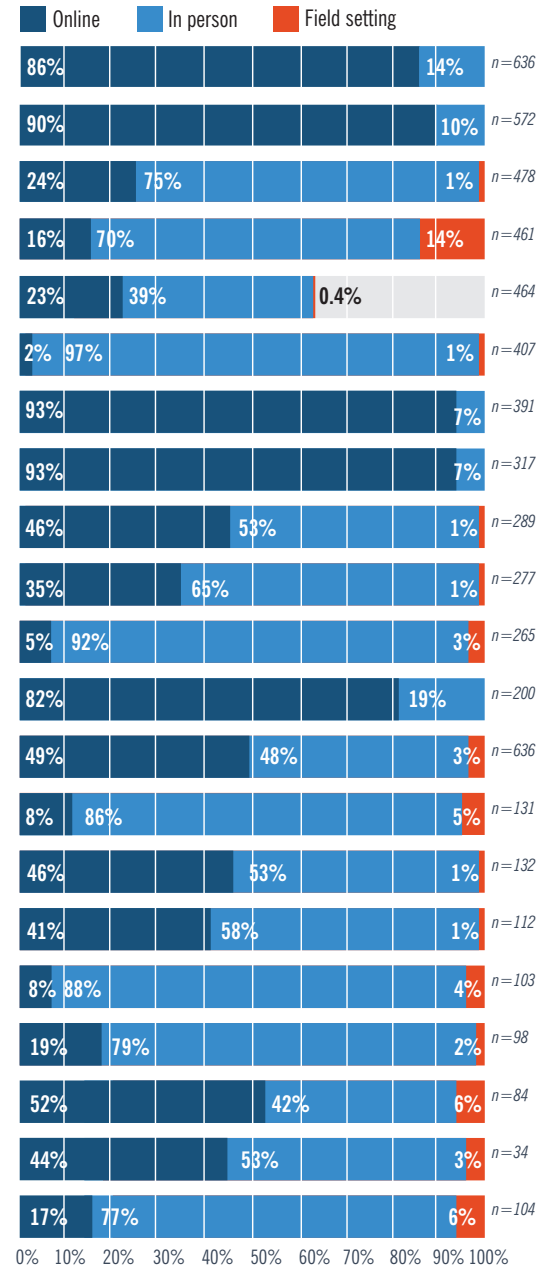


16 MRC unit training opportunities (offered and/or available for volunteers)

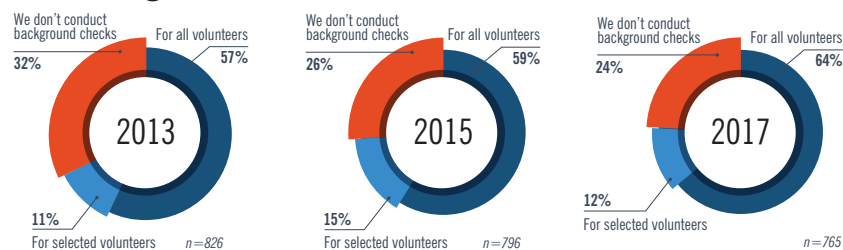
n=759



Method of MRC volunteer training



17 Background checks conducted



READY AND CAPABLE MRC NETWORK

Qualified and vetted volunteers are paramount to the success of MRC units. MRC unit leaders recognize this and continue to prioritize the recruitment and engagement of qualified volunteers. There has been a steady increase in the number of MRC units that conduct background screening of volunteers, up from 57% in 2013 to 64% in 2017 (Figure 17). The cost to conduct background screening remains the number one reason why MRC units opt not to conduct the screening. The number of units that verify medical

credentials remains steady at 96%, with 80% verified through their state registry or ESAR-VHP.

Almost all (90%) of MRC units reported that they assess volunteer skills. The top three methods include requesting certificate of completion for trainings (59%), direct observation during training exercises (50%), and initial volunteer application process (50%) (Figure 18). This mix of assessment models provides MRC unit leaders with means to track the skills of the volunteers and identify volunteers capable of fulfilling leadership or specialized roles.



Kansas
MRC of Greater Kansas City conducting blood pressure screenings during a community event.

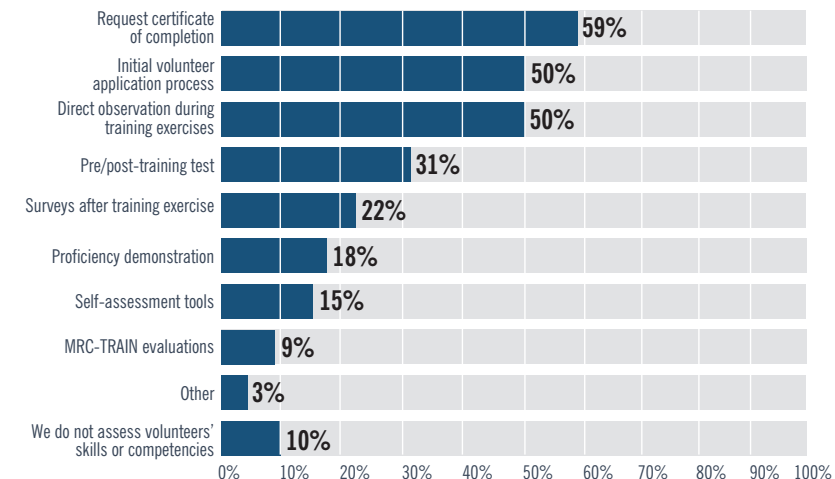
CHALLENGE AWARDS UNIT HIGHLIGHTS COMMUNITY RESILIENCE

The MRC LC Connect project was the Lake County MRC's (CA) initiative to increase local MRC membership, build volunteer competency, and strengthen community awareness of MRC unit capabilities. Through outreach campaigns at several health fairs, the Lake County MRC was able to recruit 57 active members who displayed great interest in the unit's mission while educating community members about disaster preparedness, response, and recovery. One of the many MRC volunteers who participated in the local health fair, Heroes of Health, recalled, "One teenager was so intrigued and asked, 'How do I get to educate the community on important emergency preparedness issues?' We all looked at each other and smiled. We discussed when she turns 18, we would love to have her join us. She took the initiative to reach out and ask for materials and started doing education on campus about germs and even self-preparedness!"

With a well-prepared and trained mass of volunteers, the Lake County MRC was able to successfully deploy and intervene during the Clayton fire, which destroyed nearly 200 homes. Deployment teams, including many volunteers recruited from different Lake County MRC partners across the county, were able to use their training and newfound numbers to benefit the community.

18 Method of volunteer skills assessment

n=760



PART 4

MRC capabilities and innovative solutions



Colorado

The Colorado Acupuncture MRC demonstrating the 5 needle ear protocol.



Tennessee

Shelby County MRC deployed to the 155th Battle of Shiloh to assist Jackson/Madison County staff a mobile field hospital.

KEY FINDINGS:

A quarter of units across the network report having developed Mission Ready Packages or response teams.

A quarter of units report responding to an emergency during the past year.

Units serving small jurisdictions (<100,000 people) saw their median operation budgets decreased by nearly half (49%).

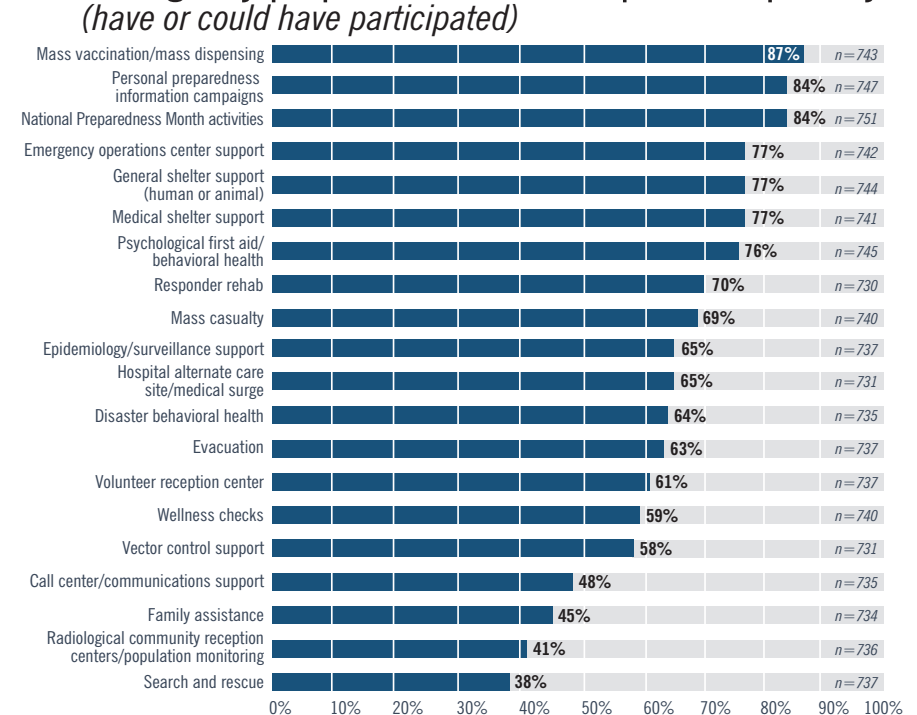
OVERVIEW

The MRC network continues to build capacity with a strong commitment to recruitment and assessment of qualified and vetted volunteers. A unit's capability to participate in any given public health and emergency preparedness activity is a reflection of dedicated training efforts, planning, and collaborative community partnerships.

CAPABILITY

Aside from activities MRC units have participated in during the past year, units also reported whether they could participate, could not participate (capability not present), or would not participate (not part of their mission) in a wide range of public health and emergency preparedness/response activities. **Figure 19** highlights the top three preparedness capabilities (activities MRC units have or could

19 Emergency preparedness and response capability (have or could have participated)



have participated in): mass vaccination/ mass dispensing (87%), personal preparedness information exchange campaigns (84%), and National Preparedness Month activities (84%). More than three-fourths of MRC units reported capability present in emergency operations center support (77%), general/medial support shelter (77%), and psychological first aid/ behavioral health (76%).

MRC units have demonstrated an increased ability to assist with their communities' ongoing public health needs. **Figure 20** illustrates the top three public health capabilities of MRC units: community outreach (87%), seasonal flu vaccination (79%), and health education (73%). Increased training and planning efforts increase unit capability to participate in these kinds of activities.

ADAPTING TO EMERGENCY RESPONSE NEEDS

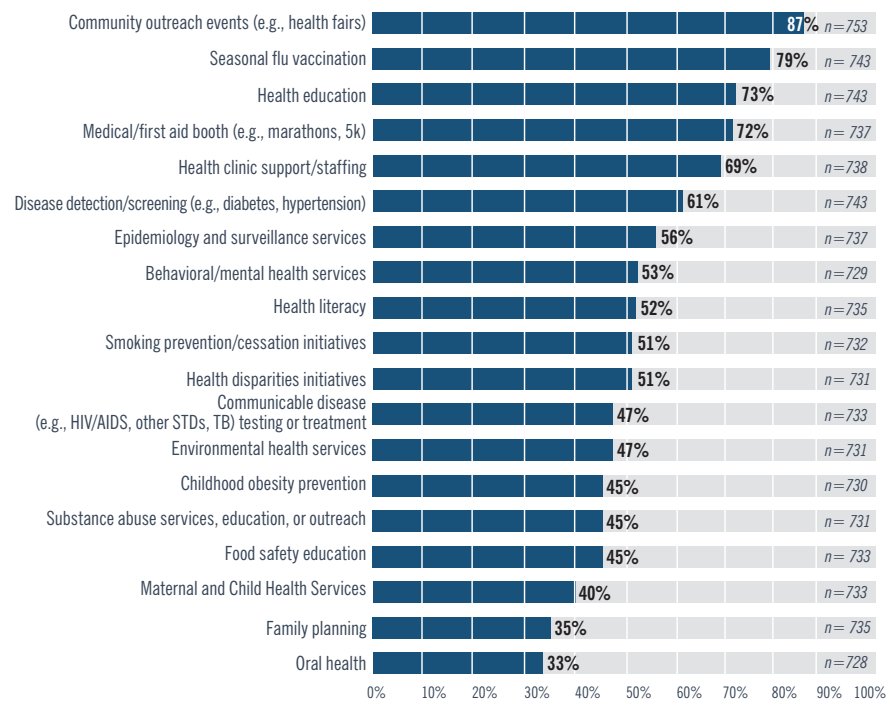
MRC units continue to demonstrate their active support of local and regional emergencies, with 25% of units reporting that they participated in an emergency response during the past year (**Figure 21**). This is an increase from 19% in the 2015 reporting period. Natural disasters were the most commonly reported response activity at 68% (up from 64% in 2015), followed by infectious disease outbreak response at 28% (down from 30% in 2015) (**Figure 22**). This increased percentage of units reporting emergency response activities, and in particular natural disasters, could be explained by the increased number of federally declared disasters as reported by FEMA from the 2015 and 2017 reporting periods (**Figure 23**).

The significant number of units reporting response activities related to natural disasters aligns with national trends. Data from the National Oceanic and Atmospheric Administration (NOAA), which has been tracking



Virginia
Virginia Beach MRC volunteer conducting door-to-door distribution of Zika information.

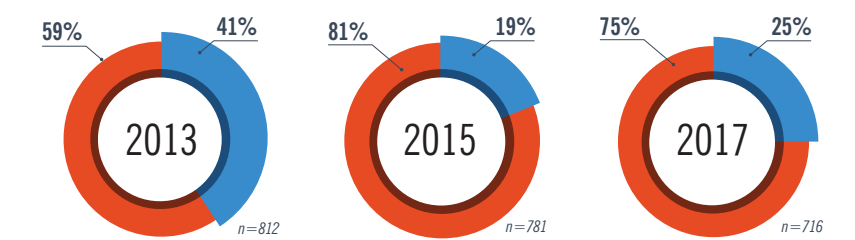
20 Public health capability (have or could have participated)



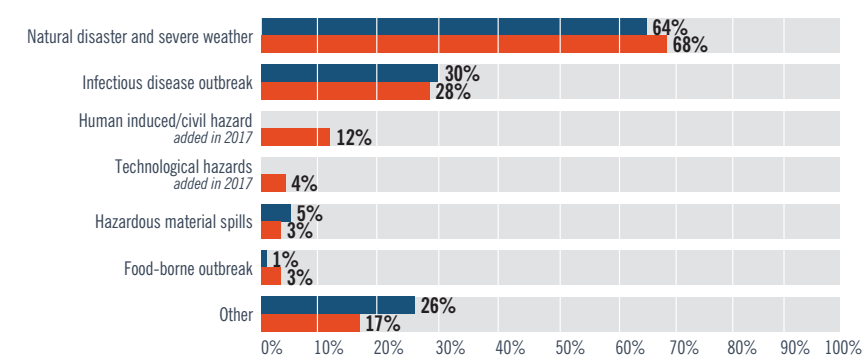
the distribution of damage from U.S. billion-dollar disaster events since 1980, suggest that these significant natural disasters are occurring more frequently. Although tropical cyclones have caused the most damage (\$579 billion, CPI-adjusted) and have the highest average event cost (\$16.5

billion per event, CPI-adjusted), severe storms have caused the highest number of billion-dollar disaster events (89) and the lowest average event cost (\$2.2 billion, CPI-adjusted) compared to all types of disasters tracked (flooding, freezing, fires, and drought).⁶

21 MRC units response to an emergency



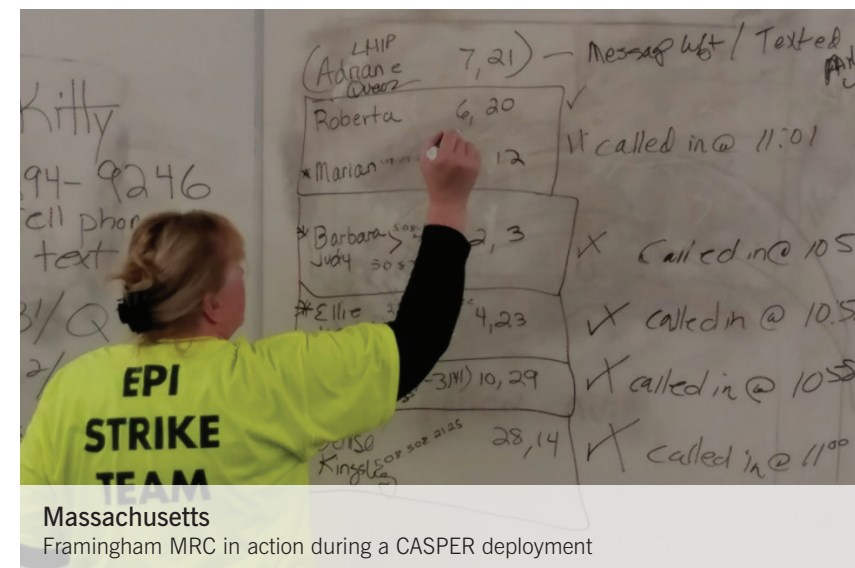
22 Type of emergency response activity



23 Disaster declarations by year



FEMA data from: https://www.fema.gov/disasters/year?field_dv2_declaration_type_value=All&=Apply



Massachusetts
Framingham MRC in action during a CASPER deployment

CASE STUDIES

DISASTER RISK REDUCTION

MRC units play a significant role in preparing their communities and planning for both general and region-specific disasters. For example, the Monroe County MRC (MI) implemented a face-to-face Potassium Iodide Community Awareness and Education Program using MRC volunteers to raise levels of community awareness, education, response, and resilience in the case of radiation exposure for those persons living, working, or going to school within a ten-mile radius of a nuclear power plant.

Other units, such as the Clay County MRC (IL), have trained and mobilized their volunteers to conduct a Community Assessment for Public Health Emergency Response (CASPER) in order to identify health perceptions in their rural community and assess resilience and emergency preparedness to improve health outcomes. Similarly, the Milford MRC (CT) designed a project to address the drastic impacts natural disasters had on their community in the last few years. By assessing basic levels of risk perception and preparedness of Milford MRC members, as well as intended behaviors and available resources during a storm, the unit aimed to identify best practices to prepare their volunteers to support response efforts in the event of an emergency and ultimately ensure that storm preparedness is not an afterthought for the community.

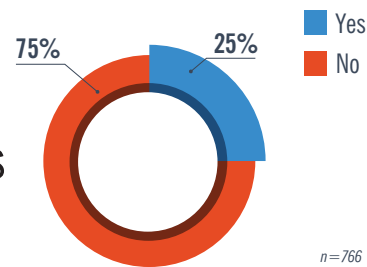
The Sacramento MRC (CA) also understood that life-sustaining water is at risk of being compromised by flood, fire, chemicals and other impurities, and increased access to clean water available to Sacramento area residents and other areas of CA in times of an emergency. The Sacramento MRC trained and exercised their volunteers on the use of a water purification unit to assist communities and mitigate a disaster during droughts or floods.

MISSION READY PACKAGES

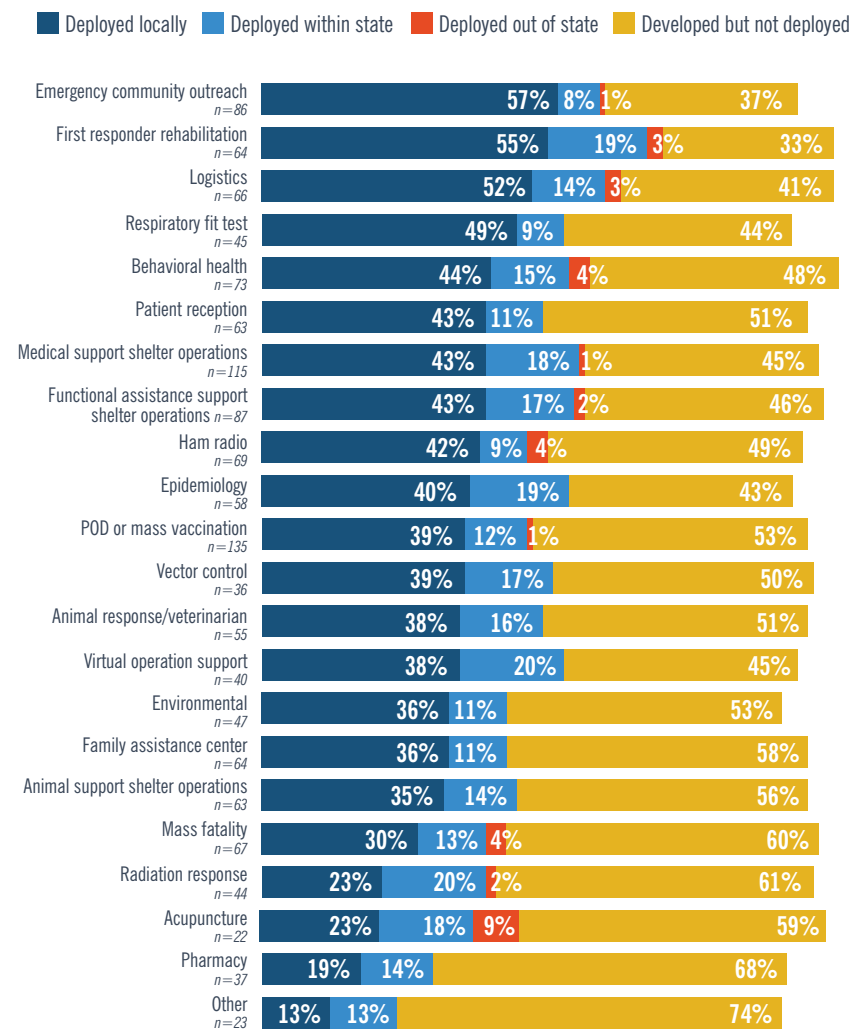
The economic and human toll of severe weather and natural disaster events on local communities can be significant. MRC units' readiness to assist their local communities in response to natural disasters is a strength of the network and demonstrates its capability to be a responsive asset. As the number of major emergencies impacting local communities increases, MRC units continue to demonstrate their ability to adapt and meet the needs of their communities.

National efforts to improve emergency managers' ability to quickly identify response resources has resulted in the development of Mission Ready Packages (MRPs). MRPs are pre-identified response resources that clearly outline the capabilities of the resources, costs associated with the response, limiting factors, and other information that helps an emergency planner quickly assess the available resources. Although MRPs were designed to support the Emergency Mutual Assistance Compact, there is value in using the model to catalog and pre-identify MRC resources and capabilities at the local, regional, or state level. MRC units have inherently identified their response capabilities to support local community response plans, although not in a uniform manner. The MRPs provide nationally standardized tools that MRC units can use to demonstrate their unit response capabilities and formalize the development of trained and ready response volunteers. A quarter of units reported having developed MRPs or response teams (Figure 24). The types of MRPs or response teams developed reflect the diversity of the network and its ability to respond to the needs of its communities. The largest number of reported MRPs or response teams developed were for POD or

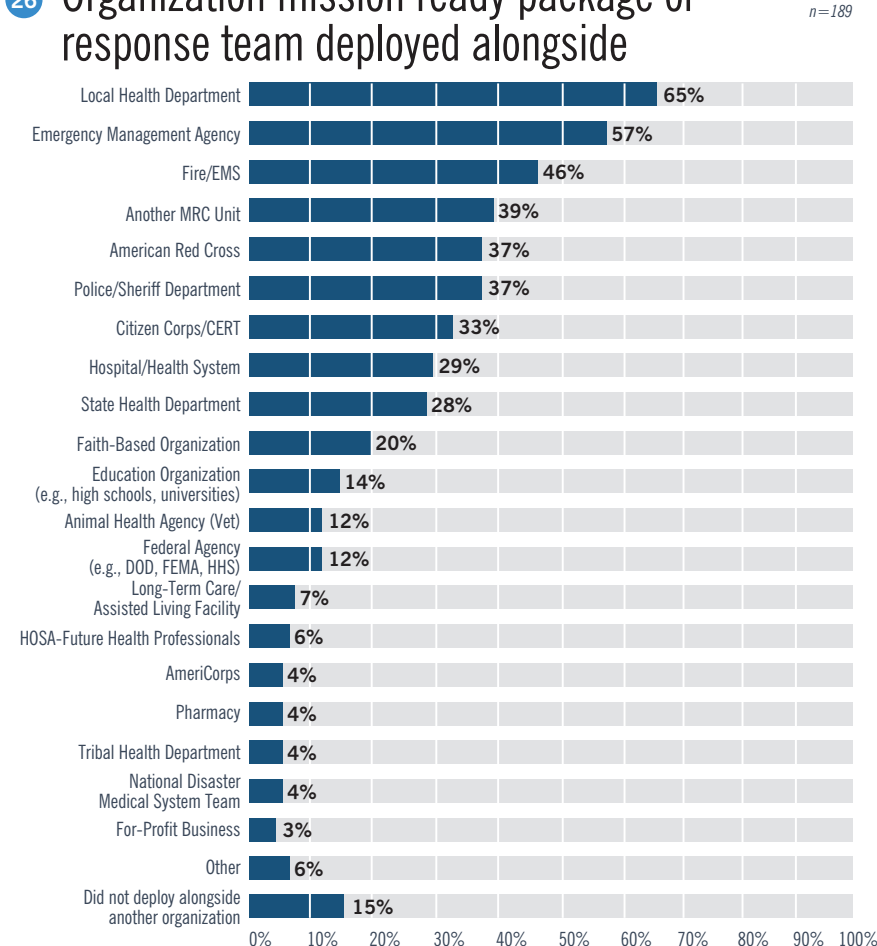
24 MRC units report development of mission ready packages or response teams



25 Type of mission and deployment activity closely represent reported mission ready package or response team



26 Organization mission ready package or response team deployed alongside



mass vaccination, medical support shelter operations, and emergency community outreach (Figure 25). The MRPs or response teams reported as the top locally deployed missions were Emergency Community Outreach, First Responder Rehabilitation, and Logistics. These missions align with response activities for natural disasters and their popularity could be related to the increase in the number of units reporting responses to natural disasters.

MRC units reported deploying alongside many of their community stakeholders and partners such as local health departments, emergency management agencies, fire/EMS, other MRC units, the American Red Cross, police/sheriff departments, Citizen Corps/CERT, hospital/health systems, and faith-based organizations (Figure 26). The breadth of the types of partner organizations reinforces the image of the MRC as an adaptable and flexible network of volunteers that is fully integrated in community response efforts.

CHALLENGE AWARDS UNIT HIGHLIGHTS

STRENGTHENING PUBLIC HEALTH

The Public Health Reserve Corps of Seattle King County (WA) unit enhanced community resiliency and collaboration by increasing their total number of volunteers with a targeted focus on increasing multilingual volunteers. In addition to diversifying its unit through their Enhancing Community Collaboration and Coalition project, they improved community preparedness and access to care; providing 7,464 volunteer hours in over four days as part of a multi-organization event aimed at providing healthcare, dental services and vision services to over 4,000 people with limited or no

insurance at the Seattle King County Clinic. The unit also led an initiative to conduct outreach and increase services to veterans experiencing homelessness and increase participation of veterans volunteering in the Public Health Reserve Corps.

Through their relationships with nontraditional partners, the MRC unit successfully recruited new volunteers across a broader cultural and linguistic spectrum. The Public Health Reserve Corps worked to ensure a more resilient community and a stronger public health infrastructure with a focus on a vulnerable and at-risk population.



Washington

The Public Health Reserve Corps of Seattle King County Volunteers set up Seattle King County Clinic.

OPERATING BUDGET

NACCHO asked MRC units about their operating budgets for the most recent fiscal year. A total of 44% of units reported receiving a Public Health Emergency Preparedness (PHEP) grant from the Centers for Disease Control and Prevention (CDC) as a funding source during the sample period (Figure 27). A little over one-third (34%) of units reported receiving funding from local health departments and 30% of units reported receiving funding through the MRC Challenge Awards. Six percent of units reported no funding. The Challenge Awards encourage innovation in areas that align with select National Health Security Strategy objectives and local needs (see pg.40 for an evaluation of the 2015–2016 Challenge Awards). When asked about top funding sources, almost one-third of MRC units (29%) cited CDC’s PHEP grant as their top source of funding (Figure 29). A total of 17% of units reported the MRC Challenge Awards as their largest source of funding.

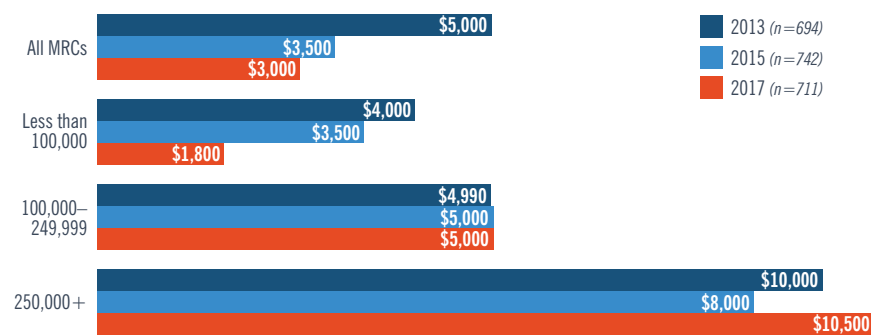


Florida
Okaloosa-Walton MRC volunteer conducting an assessment.

27 Sources of funding for recent fiscal year n=715

	All MRC	<100,000	100,000–249,999	250,000+
Public Health Preparedness grant (PHEP)	44%	42%	49%	45%
Local health department	34%	40%	32%	26%
Challenge Award	30%	23%	32%	39%
State health department	22%	19%	23%	25%
Hospital Preparedness Program	12%	7%	15%	18%
Cities Readiness Initiative	9%	5%	9%	13%
Local grant/award	7%	6%	5%	10%
Unit fundraising activities	3%	2%	3%	5%
Homeland Security Funds Citizen Corps	3%	4%	1%	3%
Urban Area Security Initiative (UASI)	2%	0.3%	2.1%	4.8%
State Homeland Security Program (SHSP)	2%	2%	2%	2%
Corporate sponsors	2%	1%	0%	4%
Metropolitan Medical Response System	0%	0%	0%	1%
Other	12%	9%	13%	17%
No funding	6%	9%	6%	3%

28 Current operating budget



Arizona
A Navajo County MRC volunteer provides assistance to a “victim” during a training exercise.

“The MRC is invaluable to this LHD... Staffing cuts have decimated the LHDs’ ability to effectively staff response activities and the MRC is a critical component to filling this gap. The MRC, however, still needs support—both fiscally and throughout all facets of PHEP/EM planning. The awareness of the MRC and their potential role MUST be championed at all levels—it will assist with official response efforts, but in the meantime through preparedness activities, bolster community health and resiliency.”

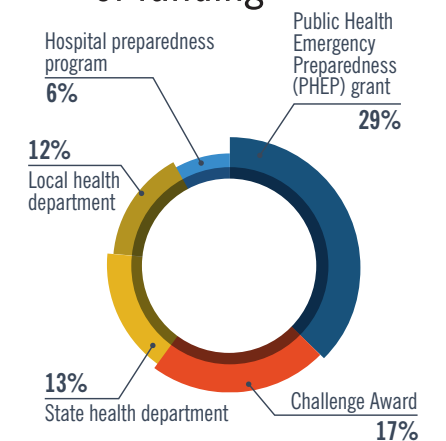
—Local health department (stakeholder) survey respondent

AN IN-DEPTH ANALYSIS

A majority of MRC units (73%) reported receiving funding from only one or two sources. Small units were more likely to receive only one source of funding when compared with medium or large units. MRC units reported a 14% decrease in their median operating budget from 2015 to 2017; however, budget decreases varied greatly by size of population served (Figure 28). Small-sized units (serving <100,000) saw their median operating budgets decrease by nearly half (49%), while large MRC units (serving 250,000+) reported a 31%

increase in their median operating budget over the same period. Medium-sized MRC units did not report any change from 2015 to 2017. These significant budget decreases among small-sized units is especially alarming as small units represent almost half (48%) of the MRC network. A total of forty percent of units reported accepting donated funds or resources; large MRC units were less likely to accept donated funds or resources. In the face of federal and local budget cuts, it is evident that MRC units need to diversify funding and continue to seek non-traditional funding sources.

29 Top five sources of funding



2017 Perspectives from Local Health Departments: A Stakeholder Study

For the past 15 years, MRC partnerships with state and local officials have provided key support to public health and emergency response services. The reasons for such partnerships vary from one jurisdiction to another, depending on the mission of the local MRC unit and the needs within the community. Despite local differences, every MRC unit engages its community to meet a common mission: strengthening public health, reducing vulnerability, building resilience, and improving preparedness, response and recovery capabilities.

To better understand the dynamics of these relationships and assess external perspectives and expectations of the MRC, NACCHO conducted an assessment of one subset of MRC stakeholders: local health departments. In January 2017, NACCHO subsampled preparedness coordinators from NACCHO's 2016 Preparedness Profile study, a statistically representative sample of 871 preparedness coordinators. NACCHO selected local health department preparedness coordinators who indicated that they had participated in preparedness drills and exercises with the MRC in the past two years to partake in the assessment. The survey gathered information on current relationships between local health departments and MRC units within their jurisdiction and does not represent stakeholders from the entire MRC network.

Local health departments reported partnerships with MRC units in a variety of different capacities; the most frequently cited reason for partnering with or supporting an MRC unit was to work together on preparedness

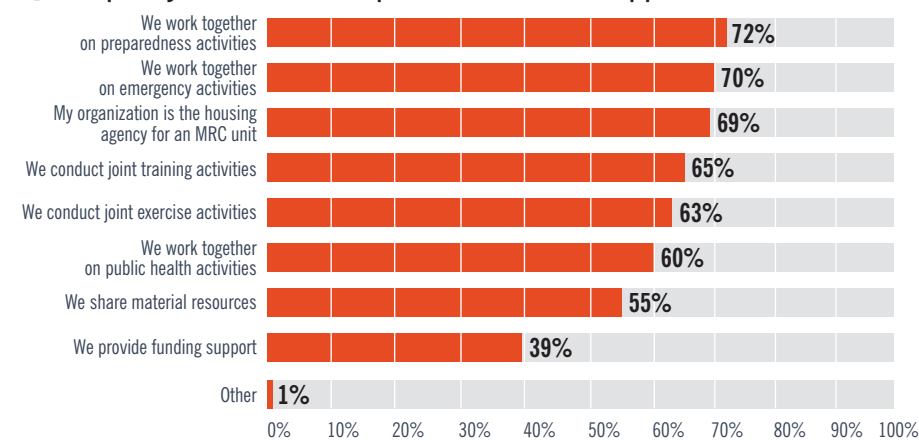
activities (Figure 30). A vast majority of respondents reported that public health preparedness (81%) and emergency response (76%) were important or very important activities that MRC units provided in their respective jurisdictions (Figure 31). According to survey respondents, the most valuable emergency preparedness and response activity MRC units provide is mass vaccination/mass dispensing (85%), medical shelter support (75%), and general shelter support (73%), Figure 33. Under the umbrella of public health activities, respondents cited seasonal flu vaccination (55%), community

outreach events (53%), and medical/first aid booth (45%) as the top three most valuable activities in which MRC units participate (Figure 32). Figure 34 further illustrates that most local health departments reported MRC units were very reliable or reliable in providing those kinds of services.

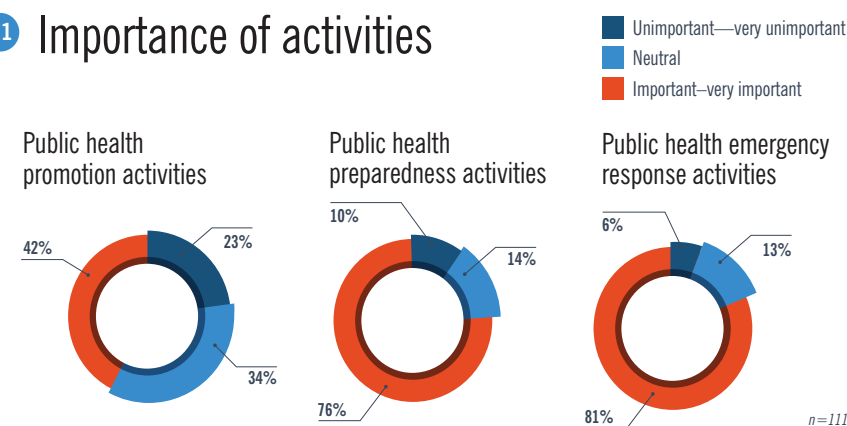
Through a common national vision, the 2015–2018 National Health Security Strategy (NHSS) aims to minimize the health consequences of emergency incidents and disasters. It complements the mission of the MRC and incorporates the day-to-day operations of every

local health department across the country. The local health department assessment asked participants to select the NHSS strategic objectives that the MRC supports. A majority of respondents indicated that MRC units within their jurisdictions build and sustain community resilience (72%), enhance the national capability to produce and effectively use both medical countermeasure and non-pharmaceutical interventions (63%), and enhance the integration and effectiveness of the public health, healthcare, and emergency management systems operation (52%) (Figure 35). Over half (56%) of local health departments reported that emergency response activities would be reduced without the assistance of the MRC in their jurisdiction (Figure 36).

30 Capacity in which LHDs partnered with or supported the MRC n=111

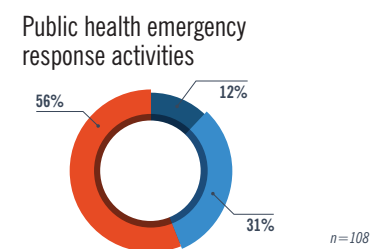
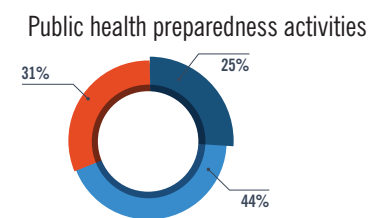
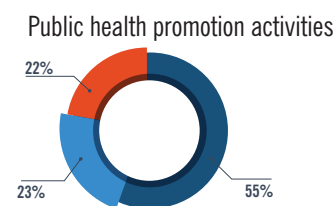


31 Importance of activities

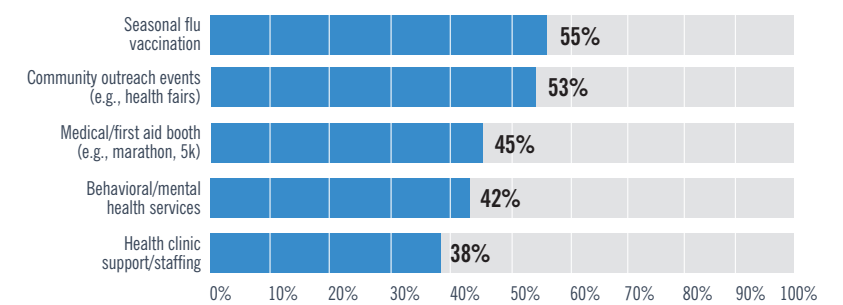


36 Levels of services provided by LHDs without MRC assistance

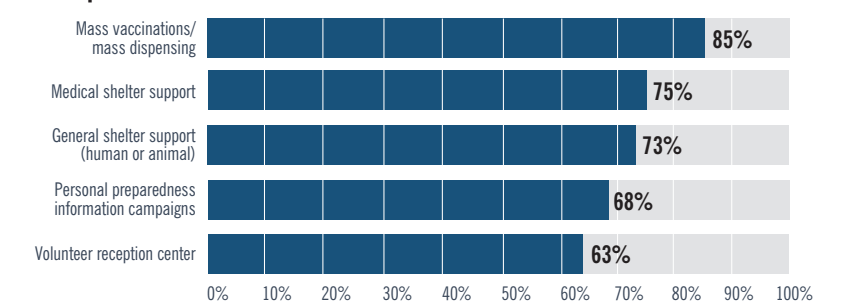
Will remain the same (dark blue), Same but with some difficulties (medium blue), Will be reduced (orange)



32 Top 5 most valuable public health activities (moderately—extremely valuable) n=109-111

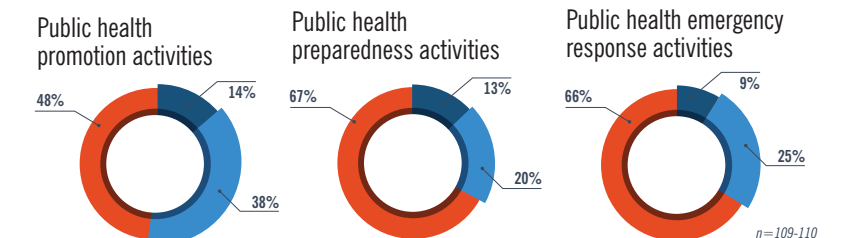


33 Top 5 most valuable emergency preparedness and response activities (moderately—extremely valuable) n=107-109

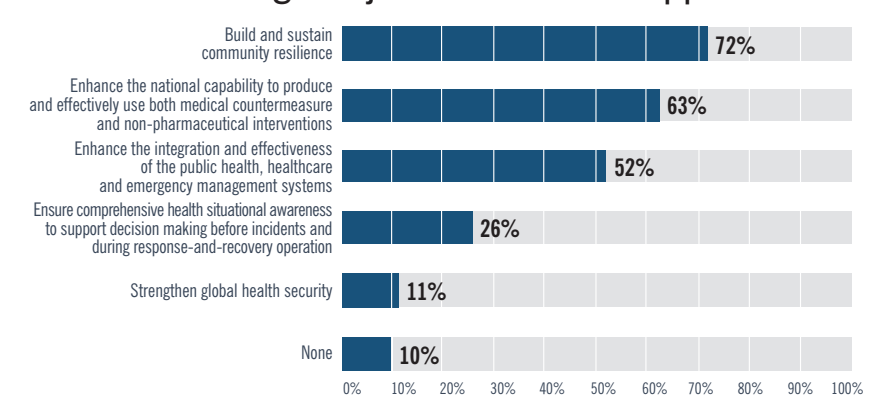


34 Reliability of activities

Unreliable—very unreliable (dark blue), Neutral (medium blue), Reliable—very reliable (orange)



35 NHSS strategic objective the MRC supports n=110





PARTNERS FOR EMPOWERED COMMUNITIES



COMMUNITY RESILIENCE



STRENGTHENING PUBLIC HEALTH

Impact of the 2015–2016 Challenge Awards

First launched in 2013, the MRC Challenge Awards support innovation in four focus areas aligned with national health initiatives that are also significant at the community level.

Such areas include community resilience, chronic disease prevention, partners for empowered communities, and mental/emotional well-being. The Challenge Awards have expanded from building unit capacity to encouraging innovation to better exemplify the diversity and capability of the MRC to other units, partners, and stakeholders.

Recipients of the 2015–2016 Challenge Awards completed an evaluation of their yearlong project. A total of 80%, or 133 of the 166 MRC units that received the award, provided input on the impact of their awarded project on their local community and MRC unit. The responses indicated that 4,714 MRC volunteers from across the country donated a total

of 45,042 hours of service toward Challenge Award projects, with the support of 485 MRC staff members, who contributed 36,356 hours. Recipients reported that Challenge Award projects have directly affected a total of 350,661 community members and have indirectly affected 13,086,586 people in communities across the nation.

PARTNERSHIP
76% of Challenge Award recipients reported forming or promoting new partnerships through implementing their project. Evaluation themes identified partnerships with local organizations, healthcare facilities, colleges / universities, and healthcare coalitions.

COMMUNITY EDUCATION
70% reported that they educated the community in some capacity around public health or emergency preparedness.

TRAINING AND EXERCISE
60% indicated that they offered community or MRC training opportunities. Major evaluation themes related to training and exercise were safety and preparedness, Psychological First Aid, and Chronic Disease Prevention.

DIRECT SERVICE
40% reported offering some form of direct service to the community. Activities involved services open to all community members and targeted members of the community including vulnerable population and seniors.

RESEARCH AND EVALUATION
16% reported that their projects involved elements of research and evaluation. A majority of recipients indicated their research and evaluation project consisted of conducting a needs assessment.



California
The Porterville Jr. MRC volunteers after a mass vaccination event.

Planning for the future

Since its inception, the MRC has evolved from just 42 community-based units to a network of almost 1,000 units and nearly 200,000 volunteers with a mission to increase capacity for response to large-scale emergency situations and demonstrated capability to support public health. One example of such support is the increase in substance abuse services, education, and outreach activities reported by units since 2015 in response to the national opioid crisis. The unit case studies highlighted within this report demonstrate how MRC units are engaging their local communities through innovative and replicable approaches to meet the current needs of their jurisdictions.

As units continue to expand their public health and emergency response capabilities, train volunteers at an advanced level using the MRC Core Competencies, and develop trainings for specialized missions, demonstrating the value of the MRC network must remain a priority. The translation of specialized teams to MRPs, nationally standardized tools, provides an opportunity to further illustrate the development of a trained and ready response volunteer network. These expanded services pave the road for units to build on community partnerships and increase participation in healthcare coalitions.

Understanding stakeholders' perspectives and expectations is

crucial to illustrating the value of the MRC, especially in under-resourced communities. The assessment of local health departments revealed the network's contributions to the NHSS and public health preparedness; however, the reported MRC median operating budget has decreased, particularly among small jurisdictions (<100,000). The unique capabilities each unit demonstrates is a result of a variety of engagement activities guided by the local community need, volunteer skills and interest, and partner support, all of which are equally important. To maintain the strength and capability of the MRC, unit leaders and partnering champions must continue to advocate for the program. ●



REFERENCES

- ¹ Medical Reserve Corps. Summary Activities Report webpage. Retrieved July 11, 2017, from <https://mrc.hhs.gov/Reports/SummaryUnitActivitiesReport>
- ² Department of Health and Human Services. Office of the Assistant Secretary for Preparedness and Response. Hospital Preparedness Program Overview. Retrieved August 25, 2017, from <https://www.phe.gov/Preparedness/planning/hpp/Pages/overview.aspx>
- ³ National Association of County and City Health Officials. (2017). 2016 National Profile of Local Health Departments webpage. Retrieved July 10, 2017, from <http://nacchoprofilestudy.org/reports-publications/>
- ⁴ Volkow, N. D. (May 14, 2014). America's Addiction to Opioids: Heroin and Prescription Drug Abuse [testimony to Congress]. Bethesda, MD: National Institute on Drug Abuse, National Institutes of Health. Retrieved July 14, 2017, from https://www.drugabuse.gov/about-nida/legislative-activities/testimony-to-congress/2016/americas-addiction-to-opioids-heroin-prescription-drug-abuse#_ftn9
- ⁵ National Council on Disability. (2005). Saving Lives: Including People with Disabilities in Emergency Planning. Washington, DC: National Council on Disability. Retrieved July 26, 2017, from https://ncd.gov/rawmedia_repository/fd66f11a_8e9a_42e6_907f_a289e54e5f94.pdf
- ⁶ National Centers for Environmental Information. (2017). U.S. Billion-Dollar Weather and Climate Disasters webpage. Washington, DC: NOAA. Retrieved July 17, 2017, from <https://www.ncdc.noaa.gov/billions/>

The 2017 Network Profile of the Medical Reserve Corps

The Medical Reserve Corps:

*15 years of volunteers actively engaging
to meet community needs*

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U.S. Department of Health and Human Services (HHS)
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Washington, DC 20024
<https://mrc.hhs.gov>

To volunteer with the Medical Reserve Corps, find the nearest MRC unit to you by visiting the Find an MRC tool at <https://mrc.hhs.gov/FindMRC>



NACCHO

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The National Connection for Local Public Health