

2022 NETWORK PROFILE
20TH ANNIVERSARY

YOU ❤️
THE HEROES

THE MEDICAL RESERVE CORPS TWO DECADES OF SERVICE



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The Medical Reserve Corps 2022 Network Profile

About this report

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Background

In the wake of the September 11, 2001 terrorist attacks, the George W. Bush Administration created a demonstration project with 42 community-based units to identify, train, and track volunteers who could serve if another human-made or natural disaster occurred. Twenty years later, the Medical Reserve Corps (MRC) has evolved into a national network of volunteers organized locally throughout the United States and its territories. Now, with over 300,000 volunteers and a network of approximately 800 community-based units, we celebrate the volunteers, medical professionals, and public health experts who improve the health and safety of their communities.¹

The Medical Reserve Corps Program Office is the national office of the MRC. The MRC Program Office supports the MRC network by providing technical assistance, coordination, communications, strategy and policy development, grants and contract oversight, training, and other associated services. The MRC Program Office provides information and best practices to help communities establish, implement, and maintain MRC units to achieve their local visions for public health and emergency preparedness. Originally housed in the U.S. Department of Health and Human Services' Office of the Surgeon General, it is now housed within the Office of Preparedness, Administration for Strategic Preparedness and Response (ASPR), U.S. Department of Health and Human Services (HHS).¹ At the local level, each MRC unit is led by an MRC unit coordinator, who matches community needs for emergency medical response and public health initiatives with volunteer capabilities. Local coordinators are also responsible for building partnerships, ensuring the sustainability of the local unit, and managing volunteer resources.

The MRC has continuously supported emergencies and disasters in the most uncertain of times. In response to the novel SARS-CoV-2 coronavirus, now commonly known as the COVID-19 global pandemic, MRC volunteers contributed over 3.8 million volunteer hours,² demonstrating the capability and resilience of the Medical Reserve Corps. This report shares the tireless work of MRC volunteers during this unprecedented time in areas such as call centers, testing sites, contact tracing, infection prevention, and vaccinations.

The ASPR MRC Program Office began to partner with the National Association of County and City Health Officials (NACCHO) in 2006 through a cooperative agreement to promote, support, and build capacity within the MRC network. Seventeen years later, the strong relationships continue among ASPR, MRC units, and local health department (LHD) leaders. This report highlights the work of the MRC in 2022, including data on unit demographics, training, capabilities, response activities, partnerships, and funding. These data, recommendations, infographics, and case studies can be used to assist MRC leaders and stakeholders in benchmarking their current activities and inform future actions. As a voice for our members, this report provides valuable information for policymakers, MRC unit leaders, and stakeholders on the strengths, challenges, and impact of the Medical Reserve Corps network.

Methodology

In 2023, NACCHO conducted its fifth comprehensive survey of the MRC network. This survey assessed public health emergency preparedness and response activities through the 2022 calendar year. Topics included demographics, volunteer management, training, capabilities, and funding. NACCHO included questions specific to COVID-19 in both the 2020 and 2022 questionnaires to examine the network's response during the pandemic. Input on the questionnaire was requested from unit leaders and staff prior to fielding the survey. On February 27, 2023, 744 active unit leaders received the survey via email. Data were collected between February and May 2023; 541 MRC units provided complete or partial responses, yielding a 73% response rate.

During data analysis, NACCHO compared statistics from 2022 with the 2020, 2017, 2015, and 2013 surveys, and notable differences over time are highlighted in this report.

All data in the survey are self-reported and are not independently verified. Units may have provided incomplete, imperfect, or inconsistent information for various reasons. In addition, non-response bias could impact the results presented in this report, and any comparisons presented are not tested for statistical significance. Results in this survey are not weighted by unit jurisdiction size, as estimates of population served were not readily available for non-responding units.

This report also presents data from the 2022 MRC Operational Readiness Awards final project evaluation, and findings from an intern project on RISE Award funding, which provide additional insights into the MRC Network but does not represent the entire network. As with previous surveys, the text responses provided in the "other" field will inform possible answer options for questions in subsequent surveys.

**AS A VOICE FOR OUR MEMBERS,
THIS REPORT PROVIDES
VALUABLE INFORMATION
FOR POLICYMAKERS, MRC UNIT
LEADERS, AND STAKEHOLDERS
ON THE STRENGTHS,
CHALLENGES, AND IMPACT OF
THE MEDICAL RESERVE CORPS
NETWORK.**

TIMELINE

A history of the MRC

MILESTONES AND HIGHLIGHTS FROM THE MRC'S 20 YEARS OF SERVICE

2002-2006



Office of the Surgeon General (OSG) announces the MRC as a demonstration project; 42 MRC community-based units established to uphold the principles of the MRC project, as defined by OSG.

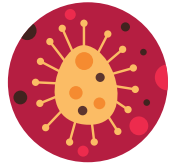


More than 6,000 MRC volunteers from 150+ MRC units participate in Hurricanes Katrina, Rita, and Wilma response and recovery efforts.



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.

2007-2011



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



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.

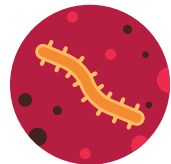


The MRC and the American National Red Cross issue a joint memorandum of understanding (MOU) to improve organizational coordination and cooperation to prepare communities for disasters.

2012-2016



The Waldo Canyon Fire, one of the most destructive in Colorado history, burns for a month. The MRC of El Paso County donates 1,644 hours of volunteer service.



During the domestic Ebola response, 169 units donate more than 14,000 hours across 180 activities including suspect-case screening support, health education, call centers, and providing general surveillance support.



MRC units prepare for and support Zika response. Puerto Rico declares a public health emergency and over 140 MRC volunteers help in community education efforts, reaching about 107,000 individuals.



Congress passes the Pandemic and All-Hazards Preparedness Reauthorization Act (PAHPRA), which continues authorization for MRC, but moves authority and responsibility to the ASPR.

2017-2022



MRC volunteers in the West contribute more than 15,000 service hours responding to wildfires by providing medical support, psychological first aid, and animal rescue and care efforts.



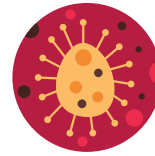
Over 100 units respond to Hurricanes Harvey, Irma, and Maria, providing 100,000+ volunteer hours at an estimated economic value of almost \$4 million.



MRC units around the country engage in response to opioid crisis, supporting prevention activities, training, HD support, and harm reduction programs to inform and aid communities affected by opioid abuse.



Alabama and Mississippi MRC volunteers devote more than 2,000 hours in response to tornadoes.



Over the COVID-19 pandemic's first two years, 80% of all MRC units provide volunteers to protect health in their communities. Volunteers devote over 3.8 million hours at an estimated economic value of \$132 million.



As of 2022, the MRC network includes nearly 800 units and 300,000+ volunteers.

A message from the ASPR

TO THE MEMBERS OF THE MEDICAL RESERVE CORPS

As 2022 marked the 20th anniversary of the Medical Reserve Corps, I am honored to recognize the MRC for its two decades of unwavering commitment to the health and well-being of communities nationwide. Since the MRC's inception, its members' dedication, selflessness, and expertise have helped shape the organization into an extraordinary force for good.



I've witnessed the positive impact that MRC volunteers have made during the COVID-19 response, and I thank you for your continued commitment to supporting public health and emergency response. From natural disasters to disease outbreaks, you have made a difference by helping your communities and providing support to those in need.

As we recognize this anniversary, I am thrilled to introduce the 2022 Medical Reserve Corps Network Profile. The 2022 Network Profile not only commemorates your journey but propels you into the future, inspiring you all to continue working for the greater good. The challenges may evolve, but the spirit of unity and service that defines the MRC remains unchanged.

In closing, I want to express my sincere gratitude to every member of the MRC. Your contributions are immeasurable. Let us move ahead with the same resilience and compassion, knowing that together, we can overcome any obstacle and ensure a healthier and safer world for all.

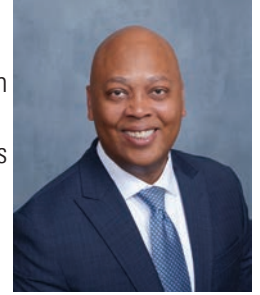
Here's to the MRC's 20 years of extraordinary impact and to many more productive years ahead.

Sincerely,
Dawn O'Connell
*Assistant Secretary
 for Preparedness and Response*

A message from the MRC Director

TO MEDICAL RESERVE CORPS VOLUNTEERS, PARTNERS, AND SUPPORTERS

I am pleased to celebrate MRC's achievements and accomplishments over the last year. The MRC garnered recognition for exceptional service to the nation during the COVID-19 response—with communities turning to the MRC in times of need.



It is remarkable to see how the MRC evolved from its humble beginnings into a robust network of dedicated volunteers across the nation. You responded to various challenges—from natural disasters to disease outbreaks—demonstrating repeatedly that in the face of uncertainty, your collective spirit shined bright. Your readiness to step up, your countless hours of training, your willingness to offer a helping hand, and your ability to provide vital medical assistance in times of crisis saved lives, provided comfort, and redefined community support.

As we commemorate your accomplishments, I am delighted to share the 2022 Medical Reserve Corps Network Profile, a comprehensive overview of your achievements, progress, and goals. This profile encapsulates the positive impacts you had on your communities and underscores the immense potential that lies ahead. It is a testament to your dedication and resilience, and it is a source of inspiration for both present and future volunteers.

This profile serves as a reminder that the MRC is an organization united by a shared purpose. It is a community where individuals from all walks of life come together to make a difference, to stand as beacons of hope in times of crisis, and to remind us that we can overcome any challenge.

In closing, I extend my deepest gratitude to every one of you for your contributions to the success of the Medical Reserve Corps, your communities, and our nation.

Sincerely,
Dustun Ashton
*Director,
 Medical Reserve Corps*

AT RIGHT: MRC LOS ANGELES, CALIFORNIA



**“IT IS REMARKABLE TO SEE
HOW THE MRC EVOLVED
FROM ITS HUMBLE
BEGINNINGS...”**

DUSTUN ASHTON
Director, Medical Reserve Corps

A photograph of four Metro MRC volunteers standing in front of a blue banner that reads "FIRST AID". The banner has a white star pattern along its top and bottom edges. On the left, a man in a black shirt and cap stands with his hands on his hips. In the center, a woman in a blue polo shirt and cap stands with her hands on her hips. On the right, another woman in a blue polo shirt and cap stands with her hands on her hips. In the foreground, a woman with glasses and a black shirt is smiling. The background is a white wall.

FIRST AID

**"IT'S A JOY TO FEEL
LIKE YOU'RE DOING
SOMETHING WORTHWHILE
FOR THE COMMUNITY."**

BRIAN FINGERSON

Volunteer, Louisville Metro MRC (KY)

MRC Demographics and Composition



70% OF MRC UNITS ARE HOUSED WITH THEIR LOCAL HEALTH DEPARTMENT.



30% OF UNITS HAD NO LEGAL PROTECTIONS OR DID NOT KNOW WHAT LEGAL PROTECTIONS THEY HAD BEYOND FEDERAL PROTECTIONS FOR THEIR VOLUNTEERS.

Throughout the MRC's 20-year history, volunteers have been the backbone of community-level responses to public health needs. In 2022, 486 units reported more than 276,000 volunteers. Demographic information from unit volunteers and leaders provides a window into the composition of units. This information can assist unit leaders in filling the gaps in their units and guide volunteer recruitment efforts. The following data can also support unit leaders and sponsoring agencies in applying for grant funding, speaking with policymakers, and promoting to key stakeholders the MRC in their communities.

Unit demographics

An understanding of unit demographic data helps units, stakeholders, and leaders tailor training and response activities to the needs of their communities. The majority of units – 71% – are affiliated with their LHDs, an increase compared to 64% in 2020; and 8% partnered with their state health department. Of 524 MRC units that responded, 88% are integrated into their sponsoring agency's emergency preparedness and community response plans. The average time affiliated with the sponsoring agency was 13 years.

FIGURE 1 (page 10) describes the self-reported population size MRC units serve across the country. **FIGURE 2** (page 10) shows 31% of units self-identified as rural, frontier, or remote-only jurisdictions, 20% classified themselves as suburban only and 11% as urban only. Many units (15%) also self-reported as serving three or more jurisdiction types.

There were disparities between the race and ethnicity of the population served and the race and/or ethnicity of the unit leader, **FIGURE 3** and **FIGURE 4** (page 10). For example, Hispanic communities comprise 12% of the population served by MRC units, 19% of the U.S. population according to the Census Bureau,³ but only 5% of unit leaders are Hispanic or Latinx. Black or African Americans comprise 11% of the people served by MRC units, 14% of the U.S. population,³ but only 7% of unit leaders are Black or African American. White unit leaders are over-represented in unit leadership, comprising 83% of unit leaders, while only 76% of the U.S. population is White,³ and 78% of those served by MRC units are White.

Unit leader demographics

Unit leader demographic information provides housing agencies with a greater understanding of the diversity and capacity of individuals to lead their units. MRC unit leaders work in collaboration with their housing agency to guide units. A total of 17% of MRC units across the country are led by volunteers compared to 22% in 2020. A majority, 83%, of unit

leaders hold paid positions. Approximately half of the unit leaders are between the ages of 46–65 years old (48% – a slight increase from 46% in 2020, and 71% of unit leaders identify as female). The least represented age groups are 20–24 years old and people 66 years and older, as shown in **FIGURE 5**. Just over half of unit leaders hold a bachelor's degree (51%) and 41% hold an advanced degree (master's or higher); numbers are not displayed in the figures. Public health and medical professions are among the more common degree fields of unit leaders.

FIGURE 6 demonstrates the hours per week unit leaders devote to the MRC. A majority (67%) of unit leaders devote five or more hours to MRC work per week with 34% devoting 15 or more hours per week. Only one in six unit leaders or 17% devote more than 34 hours per week to the MRC, which is approximately the equivalent amount of time of a full-time staff person. Unit leaders in smaller jurisdictions (< 100,000) spent less time on MRC than unit leaders serving medium or large jurisdictions (>100,000), **FIGURE 6**. Unit leaders have many roles in their agencies; however when looking at the time devoted to MRC

by jurisdiction size, smaller jurisdictions seem to be the most unevenly split in time, giving them less time to support their MRC unit. Large units are more likely to have a full-time staff person or volunteer to support their MRC unit.

Overall, 23% of respondents reported serving less than one year as unit leaders, and 41% have served between one and five years. About one-third (36%) of unit leaders have served six years or more, **FIGURE 7**.

Volunteer demographics

Volunteers are the foundation of the MRC and data about their demographics help to ensure that volunteers reflect the communities they serve and that units have the needed skillsets to meet their capabilities. The total number of unit volunteers in 2022 was 276,600 across 486 units that reported volunteer counts. Units had an average of 126 volunteers per unit.

In 2022, most units (50% or more) collected volunteer demographic information of age (61%), employment status – employed or retired

FIGURE 1: Population size served

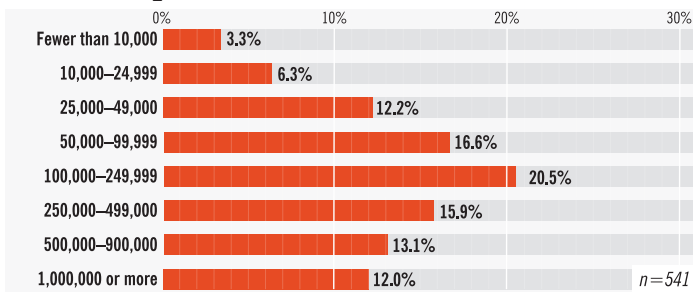


FIGURE 2: MRC unit community types

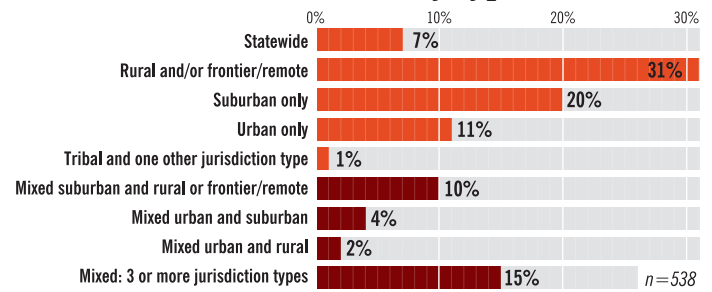


FIGURE 3: Racial/ethnic demographic

Race/Ethnicity	All Units Average	US Average
White	78.3%	75.5%
Black or African American	11.3%	13.6%
American Indian or Alaska Native	1.3%	1.3%
Asian	4.4%	6.3%
Hispanic or Latinx	12.1%	19.1%
Native Hawaiian or other Pacific Islander	0.4%	0.3%
Two or More Races	3.7%	3%
Other	5.9%	--

FIGURE 4: Unit leader race/ethnicity

Race/Ethnicity	Percentage
White	82.6%
Black or African American	6.9%
American Indian or Alaska Native	0.7%
Asian	2.4%
Hispanic or Latinx	4.9%
Native Hawaiian, or other Pacific Islander	1.1%
Other	1.3%
Prefer not to answer	3.5%

FIGURE 5: Unit leader ages

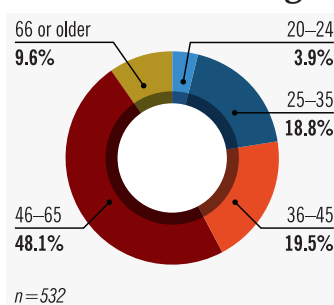
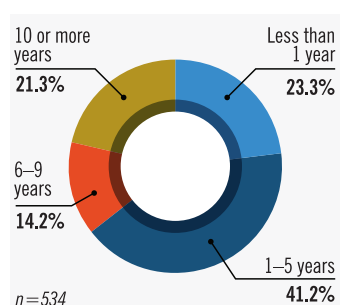


FIGURE 6: Unit leader hours

Hours/Week	All Units	<25,000	25K–49,999	50K–99,999	100K–499,999	500,000+
Less than 5 hours/week	33%	58%	49%	38%	29%	19%
5–9 hours/week	19%	15%	20%	26%	20%	13%
10–14 hours/week	14%	13%	16%	15%	14%	13%
15–34 hours/week	16%	12%	9%	16%	19%	19%
35–40 hours/week	14%	2%	6%	6%	16%	26%
Over 40 hours/week	3%	0%	0%	0%	1%	10%

FIGURE 7: Years as leader



(59%), gender (57%), and employment information (54%), **FIGURE 8**. The least commonly collected volunteer demographic information were education level (41%), race/ethnicity (25%), and other (21%); 15% of units reported not collecting any demographic information.

Volunteer gender

Overall, 68% of all MRC volunteers in 2022 identified as female, 31% as male, and 1% as non-binary.

Volunteer race/ethnicity

Among survey respondents, 129 units reported collecting race/ethnicity demographic information, however, only 49 units provided the race/ethnicity percentages of volunteers. Of the units who reported race/

ethnicity of their volunteers in 2022, 82% were white, 16% were Black or African American, and 6% were another race, **FIGURE 9**.

Volunteer ages

The most common age group among MRC volunteers in 2022 was 46 to 65 (38%), followed by 66 years or older (24%), 36 to 45 (19%), 25-35 (12%), 20-24 (5%) and less than 20 years old (2%). Of note, capturing the number of volunteers younger than 20 years old is a new survey response category to reflect demographics among the growing number of junior MRC units, which comprise youth volunteers. In comparison to 2020, 62% of volunteers in 2022 were older than 46, while 59% of volunteers were older than 46 in 2020. **FIGURE 10** (page 12) shows the comparison of volunteer ages over the last few years.

FIGURE 8: Volunteer demographics collected

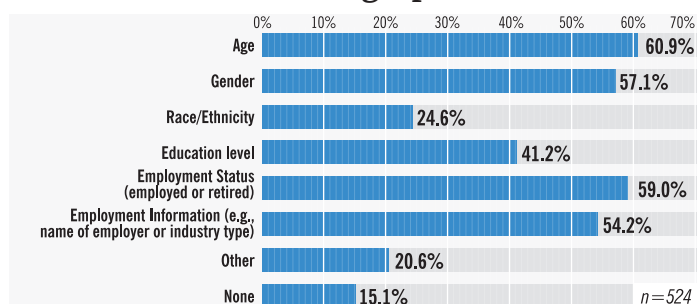


FIGURE 9: Volunteer race/ethnicity

<i>n=49*</i>	Overall mean	US Average ³
White	82.2%	75.5%
Black or African American	16.2%	13.6%
American Indian or Alaska Native	1.6%	1.3%
Asian	8.9%	6.3%
Hispanic or Latinx	6.1%	19.1%
Native Hawaiian or other Pacific Islander	0.4%	0.3%
Two or More Races	3.1%	3%
Other	5.9%	-

**Only 49 units provided information, Not representative of total population*

WILCO MRC, TEXAS



“IT’S AN OPPORTUNITY TO **IMPACT POPULATION HEALTH RATHER THAN A PERSON**, AND TO SEE WHAT PUBLIC HEALTH IS ABOUT; TO SEE WHAT TRUE PREVENTION IS.”

Volunteer disciplines

Volunteers across many disciplines donate their skills to public health and emergencies in their community. In 2017 and 2020, most volunteers were classified as general support (non-public health/non-medical) or nurses. Following this trend, in 2022 general support (33%) and nurses (17%) continued to comprise most volunteers. **FIGURE 11** outlines additional disciplines represented by volunteers.

On average, there were 282 general support volunteers per unit, 111 registered nurses, and 38 physicians per unit. Of note, youth and students accounted for an average of 65 volunteers, and overall, there were 5,046 youth and student volunteers from responding units across the U.S. The least common disciplines were psychiatrists and acupuncturists, not shown in the figure.

On average, MRC units had more general support volunteers, physicians, EMT, advanced EMT, paramedics, nurse practitioners, pharmacists, and veterinarian volunteers than there were in 2020, represented as the mean in **FIGURE 11**.

Volunteer hours

MRC units report their unit activities and volunteer hours to the ASPR MRC Program office. Additionally, the 2020 MRC Network Profile collected volunteer hour information to examine it in relation to jurisdiction size and unit funding levels. Responses included volunteer hours for COVID-19 activities only, other emergency response activities, and non-emergency (steady-state) activities. The same questions were asked in 2022 and detailed in **FIGURE 12**.

MRC Units reported a total of 443,283 hours to support non-emergency (steady state) activities between January 1, 2022, and December 31, 2022. The average number of hours supporting non-emergency activities per unit was 933 hours.

Volunteers dedicated a total of 671,335 hours to support emergency response activities (including COVID-19 response), an average of 1,419 hours per unit.

Lastly, volunteers dedicated a total of 603,587 hours to only COVID-19 response activities between January 1, 2022, and December 31, 2022, an average of 1,268 hours per unit.

FIGURE 10: Volunteer ages

	2022 All units	2020 All units	2017 All units
<20*	2%	-	-
20–24	5%	2%	2%
25–35	12%	20%	5%
36–45	19%	20%	12%
46–65	38%	46%	23%
66+	24%	13%	22%
	n=304	n=300	n=607

CASE STUDY

Nurturing the next generation of MRC volunteers



MACON COUNTY MRC, MISSOURI

The Macon County MRC serves a rural area in Missouri that is experiencing medical personnel shortages. With funding from a NACCHO grant three years ago, the unit identified, through its strategic planning process, a recruitment and retention strategy involving youth.

To help fill the gap, the unit first identified 4-H as a potential partner in youth recruitment. Then they happened upon the HOSA (Future Health Professionals) health occupations class at their local high schools, which are run by a nurse. The MRC works with school instructors to supplement and support trainings, and the students then serve as MRC volunteers in a variety of capacities.

Students have assisted with mass vaccination clinics, including flu clinics each October that serve six-to-seven different towns. School seniors serve as vaccinators under nursing supervision. Students also help out at health fairs at six public and two private schools, with volunteers from two classes taking morning and afternoon shifts. Student volunteers have also worked in-house, shadowing staff at the health department.

“This provides students with a little bit of a different view on health,” said Macon County Health Department Administrator Mike Chambers. “It’s an opportunity to impact population health rather than a person and to see what public health is about; to see what true prevention is.”

FIGURE 11: Most common volunteer disciplines

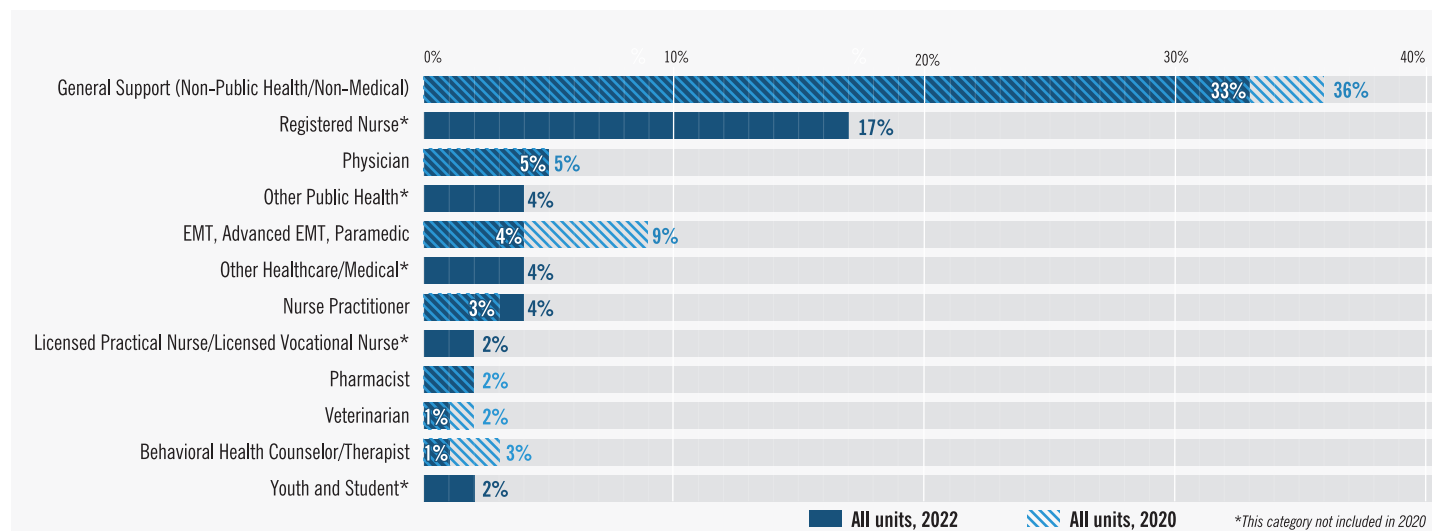


FIGURE 12: Volunteer hours reported

Size of Population	Total Non-emergency	Average Non-emergency	Total Emergency (including COVID-19)	Average Emergency (including COVID-19)	Total COVID-19 only	Average COVID-19 only
<25,000	4,738	108	7,470	174	7,060	160
25K-49,999	8,856	158	9,092	160	8,619	154
50K-99,999	19,934	246	43,471	530	37,969	469
100K-499,999	66,744	388	112,072	648	108,974	616
500,000+	343,010	2,812	499,230	4,231	440,964	3,737
Total	443,283	933	671,335	1,419	603,587	1,268

FIGURE 13: Legal protections by activity

Type of Legal Protection	Declared Emergencies <i>n</i> = 493	Training Activities <i>n</i> = 488	Public Health Activities <i>n</i> = 488	Activities Outside Jurisdiction <i>n</i> = 479
Professional Liability Coverage/ Malpractice	44.8%	27.3%	32.6%	18.0%
Other Liability Coverage	40.0%	32.8%	35.0%	18.2%
Workers compensation	29.6%	22.1%	23.2%	12.5%
Reemployment rights	2.0%	0.8%	1.0%	0.8%
Other	2.8%	2.3%	3.1%	1.9%
No legal protections	2.2%	13.3%	10.9%	18.4%
Do not know	24.1%	30.3%	27.7%	47.0%

Legal protections

Legal protection for MRC unit volunteers varies between states and jurisdictions; the following data helps unit leaders and stakeholders identify gaps locally. Almost one-third (30%) of respondents stated they either had no protections or that they did not know what protection they had beyond federal protections. Another 41% stated they had state legislation, a department, or agency regulation in place beyond federal protections.

A majority (91%) of units reported not purchasing any additional legal protections for their volunteers besides existing statutory protections. Of the units that did purchase additional legal protections, the most common type was other liability coverage and professional liability coverage/malpractice.

Declared emergencies and public health activities were the circumstances under which a higher percentage of respondents were covered by legal protections for professional liability, malpractice, and other liabilities. **FIGURE 13** (page 13) highlights the circumstances in which volunteers are covered by their available legal protections.

Key findings

Collecting and analyzing demographic information ensures that MRC units represent the communities they serve. The COVID-19 response highlighted the importance of having a diverse and representative volunteer base that can create trust and rapport within the community. Currently 25% of

units collect race/ethnicity data of volunteers. To ensure that MRC units represent the communities they serve, units should collect and monitor race/ethnicity data among volunteers and adapt recruitment strategies to ensure units are representative of their communities.

A quarter (24%) of volunteers are aged 66 or older while only 7% are under the age of 25. This highlights an opportunity to recruit younger volunteers among high schools, colleges, and universities.

While most units are led by paid staff, 52% of unit leaders devote nine hours or less per week to the MRC, and 66% devote 14 hours or less per week. As will be seen later in this report, this limited amount of paid time devoted to MRC support limits a unit's operational abilities.

Among unit leaders, a quarter (23%) have served in their position for one year or less. This highlights a need to ensure that training and resources are readily available and accessible to leaders who are new in their role. At the same time, 36% of unit leaders have served for six or more years. This presents opportunities for knowledge sharing and mentorship with newer unit leaders and increased efforts can be made to facilitate this form of collaboration.

Legal protections varied considerably by activity type and type of legal protection, with fewer than half of the units reporting professional malpractice or other liability coverage for declared emergencies. This shows a need for more resources and education in this area to provide MRC volunteers the protection that they require.

LORAIN COUNTY MRC, OHIO



INFOGRAPHIC

MRC unit snapshot

UNIT DEMOGRAPHICS

70% of MRCs are affiliated with their local health department (an increase compared to 64% in 2020)



30% of units had none or did not know what legal protections they had beyond federal protections for their volunteers



UNIT LEADERS



COMMUNITIES SERVED BY MRC UNITS



38% **SMALL** serving fewer than 100,000

21% **MEDIUM** serving 100,000–250,000

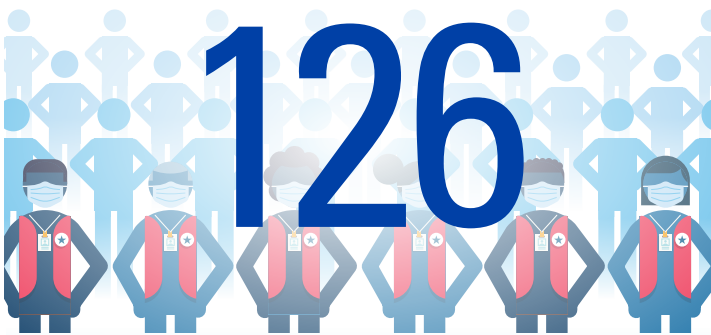
41% **LARGE** serving more than 250,000

83% hold paid positions

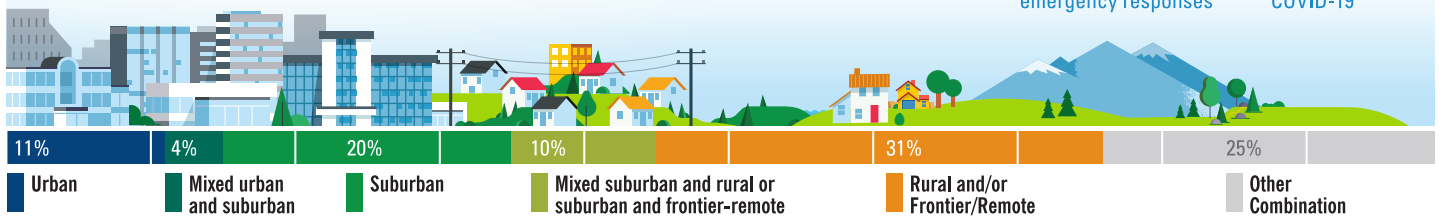
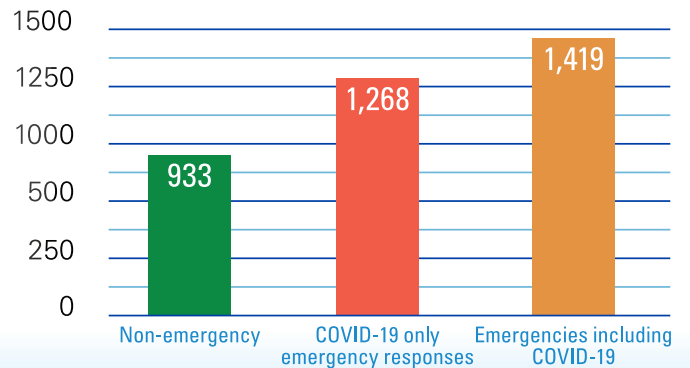
65% have less than five years of experience in their role as MRC unit leader

14% serve 35-40 hours to MRC work per week

AVERAGE NUMBER OF VOLUNTEERS PER UNIT



AVERAGE NUMBER OF VOLUNTEER HOURS PER MRC UNIT




*DISTRIBUTION OF UNITS

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

Volunteer Management



 58% OF MRC UNITS INDICATED WORD OF MOUTH AS THE MOST EFFECTIVE FORM OF RECRUITMENT.

 83% OF MRC UNITS CONDUCTED BACKGROUND CHECKS FOR AT LEAST SOME OF THEIR VOLUNTEERS.

Volunteer management is the ability to coordinate with emergency management and partner agencies to identify, recruit, register, verify, train, and engage volunteers to support the jurisdictional public health agency's preparedness, response, and recovery activities during pre-deployment, deployment, and post-deployment.⁴

Vetted, trained, and engaged volunteers bring the skills needed to support the mission of their communities and are empowered to gain new skills to meet a diversity of emergency and non-emergency roles. Volunteer training helps to develop skills and education through increasing knowledge and application, ensuring volunteers are equipped to respond to emergencies.

This section provides information on effective methods of recruitment, barriers to recruitment efforts, background screening, credentials, use of MRC core competencies, and types and formats of trainings offered.

Volunteer recruitment, screening, and communications

Recruitment methods

Recruiting volunteers is an essential and ongoing activity for unit leaders and largely affects the unit's ability to deploy and support their communities in emergencies.

MRC units across all jurisdiction sizes indicated that their most effective form of recruitment continues to be through word of mouth (58%), MRC booth at community events (30%), or social media (28%), **FIGURE 14** (page 18). The least effective forms of recruitment included paid media platforms such as newspapers, radios, and mass mailings.

Barriers to recruitment

Unit leader time constraints were the largest barrier in recruitment of volunteers, with 58% of MRC units reporting it as a limitation. Funding (42%) was also a large barrier in recruitment and may impact the staffing needed to manage the MRC program. About one quarter (24%)

AT RIGHT: PASSAIC COUNTY MRC, NEW JERSEY



**“WE HAVE A WONDERFUL
TEAM HERE AND A
WONDERFUL SYSTEM.”**

DAWN WILKES-BRIGHT, MPH
Unit Leader, Bergen County MRC (NJ)

of units reported volunteers are not highly utilized in their jurisdiction. Lack of volunteer legal protections (8%), liability coverage (12%), and workers compensation (11%), pose limited impact to recruitment efforts, **FIGURE 15**.

Background screening and verification of volunteer professional credentials

The mission of the MRC requires vetted and qualified volunteers to meet both medical and non-medical roles.

In 2022, 83% of units conducted background screening for at least some of their volunteers. Background checks continue to increase for MRC units in comparison to 66% in 2020 and 64% in 2017. The primary reason reported for not conducting background screening is the cost, and to a lesser degree, limited staff to coordinate background screenings. Nearly all (97%) of MRC units verify medical credentials, and 79% of those verified are done through the state registry or ESAR-VHP system, **FIGURES 16-18**.

83% OF MRC UNITS CONDUCTED BACKGROUND CHECKS FOR AT LEAST SOME OF THEIR VOLUNTEERS.

Communications with volunteers and methods of information exchange

Communication is vital to both internal MRC volunteers and external MRC stakeholders. Although MRC units utilize multiple communication channels with volunteers, the primary method of communicating for emergencies and non-emergencies is through email, 74% and 92% respectively, **FIGURE 19**.

Many units use virtual meeting options for communications with volunteers during non-emergency activities (64%). Most MRC units indicated that they do not use social media channels such as LinkedIn (91%), YouTube (88%), Twitter (85%), and Instagram (81%) for communications with volunteers, not shown in figures. The exception for using social media is Facebook, with almost 50% indicating they use it for non-emergency use. MRC units cited lack of time to devote to social media and housing unit limitations as barriers to using social media.

The top two barriers cited for using social media (e.g., Facebook, Twitter, etc.) that units reported were "lack of time to devote to social media," 39% and "health department limits use of those sites" 30%. About a third, 31%, of MRC units also report "no barriers" using social media, **FIGURE 20**.

FIGURE 14: Top recruitment methods

	2022 All units	2020 All units
Word of mouth	58%	62%
MRC booth at community events	30%	22%
Social media (organic/unpaid)	28%	42%
In-person presentations	18%	21%
Trainings open to community members	16%	13%
PSA/call to action from State or Local Government leadership	11%	25%
	n=504	n=461

FIGURE 15: Barriers to recruitment

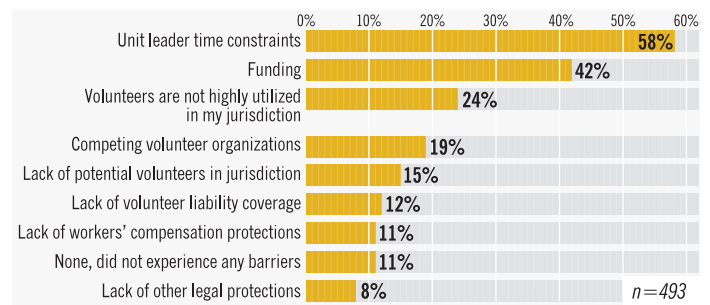


FIGURE 16: Background checks on volunteers

	All Units
Yes, for all volunteers	70%
Yes, for selected volunteers	10%
Yes, but only during an emergency response	3%
No	17%

n=503

FIGURE 17: Barriers to conducting background screening on volunteers

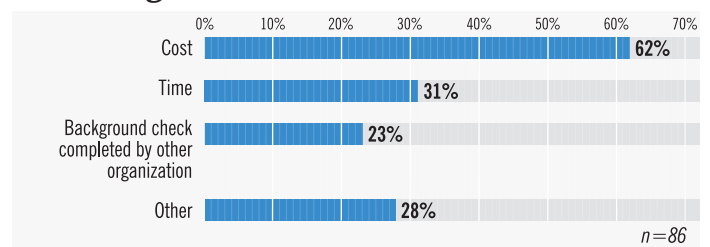


FIGURE 18: Verification of volunteer medical credentials

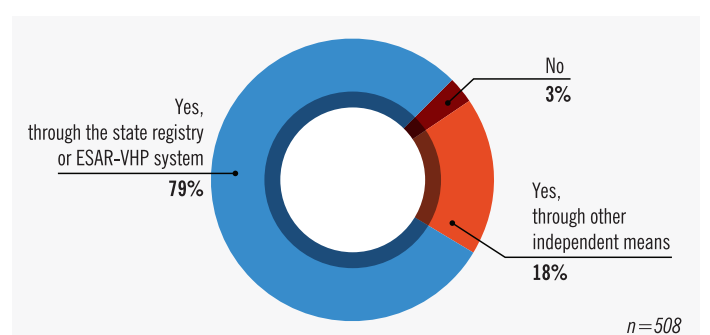


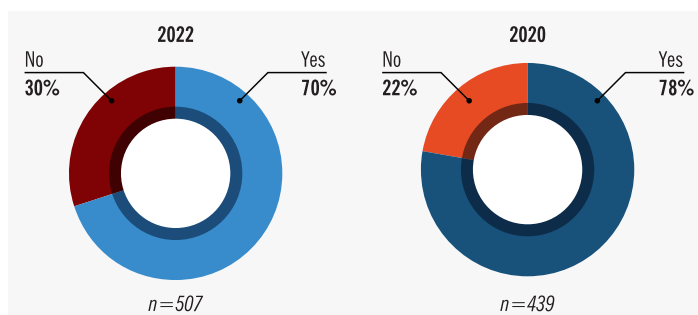
FIGURE 19: Most common communication channels used to communicate with volunteers

Communication channel	(n)	Non-Emergency	Emergency	Do not use
Email	470	92%	74%	5%
Zoom, Teams, Google Meet, or other virtual meeting platforms	410	64%	35%	34%
Facebook	393	47%	19%	52%
Text msg via ESAR-VHP or state volunteer management system	442	39%	56%	41%
Custom volunteer management system	391	39%	37%	57%
SignUpGenius or other sign-up platforms	396	38%	30%	56%
Group Communication Tools (e.g., Google Suite, Outlook 365/Teams)	376	35%	26%	64%
Automated calling via ESAR-VHP or state system	424	32%	51%	47%
MRC unit level website	410	32%	15%	56%
Email Listservs	373	32%	24%	67%
Instagram	365	18%	7%	81%
Twitter	354	15%	7%	85%
YouTube	352	12%	5%	88%
LinkedIn	348	9%	2%	91%

FIGURE 20: What barriers does your MRC unit face when using social media technologies?

All Units (n=492)	(n)	%
Do not have time to devote to social media	191	39%
No barriers using social media	153	31%
Housing department limits use of those sites	150	30%
Other	76	15%
Not familiar with using the technologies	35	7%
Do not see value in participating in social media	10	2%

FIGURE 21: MRC units with a written volunteer training plan



CASE STUDY

Partners in community response: Universities and the MRC



UNIVERSITY OF MINNESOTA MRC, MINNESOTA

The University of Minnesota MRC serves as a regional and state resource in addition to serving the university community. The unit's 1,800 active volunteers include students, staff, and faculty from the health sciences.

The unit is organized into a variety of strike teams to align with volunteers' interests and expertise. For example, the Logistics Strike Team helps set-up for deployments and drills and consists of about 60 volunteers. Other teams include pharmaceutical response, veterinary medicine response, and a behavioral response strike team that comprises practicing faculty including therapists and counselors who are licensed professionals. Faculty members serve as strike team leads and trainings are specialized to meet the needs of the strike team.

"We also have a student advisory group that makes us so much stronger," said MRC Director Kathy Berlin. "Inclusion of the students brings [their] energy and point of view."

During COVID-19, the unit worked 32 separate deployments simultaneously. This included medical triage, screenings at the university health center, community outreach, and testing and vaccination on campus and with community partners. Examples of other unit deployments include behavioral health assessments for newly arriving Afghan refugees, staffing support at a nursing facility whose seniors were displaced due to flooding, and veterinary medical support at a shelter in Iowa supporting 900 displaced companion animals following massive flooding.

FIGURE 22: How training plans were developed

<i>n</i> =351	All Units	
Informed by the MRC Volunteer Core Competencies	149	43%
Created by a previous coordinator at my unit	140	40%
Informed by local needs/gaps assessments	100	29%
Supplied by our sponsoring organization (all or part)	87	25%
Utilized my unit's MRC-TRAIN account	61	17%
Adopted a plan provided from my State or Regional Coordinator	57	16%
A collaborative effort with local partners (i.e., Red Cross, Hospitals, another MRC Unit)	54	15%
Adopted from one posted by a peer on the MRC listserv or other communication method	50	14%
Other	42	12%
Adopted State Training Matrix	20	6%

FIGURE 23: Assessment of volunteer skills

<i>n</i> =503a	All Units	
Request certificate of completion	287	57.1%
Initial volunteer application process	270	53.7%
Direct observation during training exercises	243	48.3%
Proficiency demonstration	132	26.2%
Surveys after training exercise	121	24.1%
Pre/post training test	112	22.3%
Self-assessment tools	84	16.7%
MRC-TRAIN evaluations	71	14.1%
We do not assess volunteers' skills or competencies	48	9.5%
Other (please specify)	35	7.0%

FIGURE 25: Training offered in-person or in the field

	In-person or In Field
Basic Life Support	71%
Until Help Arrives/Active Bystander	69%
Core Disaster Life Support (CDLS)	60%
Stop the Bleed	59%
CPR/first aid/automated external defibrillator (AED)	47%
Medical/First Aid	36%
Personal and Family Preparedness	36%
MRC 101/Unit Orientation	34%
HIPAA	28%
Psychological First Aid (PFA) or Disaster Behavioral Health	27%
Risk Communication	21%
Bloodborne Pathogens	20%
Animal Emergency Preparedness	17%
Mass Dispensing/Mass Vaccination/PODs	14%
Introduction to the Incident Command System (IS-100)	13%
Radiological Emergency Response/Community Reception Centers (IS-301)	13%
Disaster Responder Health and Safety	13%
Introduction to CERTs (IS-317)	12%
National Incident Management System (ICS-700)	11%
HAZMAT for Healthcare Providers	11%
Basic Disaster Life Support (BDLS)	11%
ICS for Single Resources and Initial Action Incidents (IS-200)	10%
National Response Framework, An Introduction (IS-800)	9%

FIGURE 26: Training offered online

	Offered Online
Introduction to the Incident Command System (IS-100)	78%
National Incident Management System (ICS-700)	77%
ICS for Single Resources and Initial Action Incidents (IS-200)	75%
National Response Framework, An Introduction (IS-800)	70%
Personal and Family Preparedness	55%
MRC 101/Unit Orientation	49%
Psychological First Aid (PFA) or Disaster Behavioral Health	46%
Disaster Responder Health and Safety	46%
CPR/First Aid/Automated External Defibrillator (AED)	44%
HIPAA	44%
Animal Emergency Preparedness	44%
Risk Communication	43%
Core Disaster Life Support (CDLS)	38%
Medical/First Aid	35%
Introduction to CERTs (IS-317)	35%
HAZMAT for Healthcare Providers	33%
Radiological Emergency Response/Community Reception Centers (IS-301)	32%
Mass Dispensing/Mass Vaccination/PODs	28%
Until Help Arrives/Active Bystander	19%
Stop the Bleed	18%
Bloodborne Pathogens	17%
Basic Life Support	15%
Basic Disaster Life Support (BDLS)	14%

FIGURE 27: Areas in which NACCHO could better support MRC units

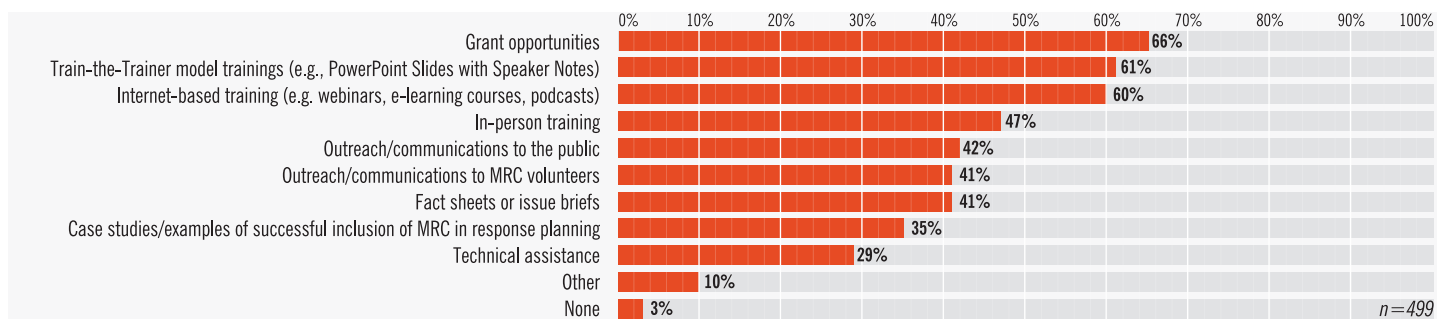


FIGURE 24: Mandatory volunteer trainings offered or made available

	Mandatory
MRC 101/Unit Orientation	48%
Introduction to the Incident Command System (IS-100)	45%
National Incident Management System (ICS-700)	38%
Psychological First Aid (PFA) or Disaster Behavioral Health	30%
ICS for Single Resources and Initial Action Incidents (IS-200)	19%
Personal and Family Preparedness	18%
HIPAA	17%
National Response Framework, an Introduction (IS-800)	14%
Basic Life Support	10%
CPR/First Aid/Automated External Defibrillator (AED)	10%
Core Disaster Life Support (CDLS)	8%
Stop the Bleed	6%
Risk Communication	5%
Until Help Arrives/Active Bystander	4%
Disaster Responder Health and Safety	4%
Introduction to CERTs (IS-317)	3%
Radiological Emergency Response/Community Reception Centers (IS-301)	2%
Bloodborne Pathogens	2%
HAZMAT for Healthcare Providers	2%
Medical/First Aid	2%
Animal Emergency Preparedness	1%
Basic Disaster Life Support (BDLS)	1%
Mass Dispensing/Mass Vaccination/PODs	0%

Volunteer training

Volunteer training and competencies

Volunteer training helps to develop skills and education through increasing knowledge and application, ensuring volunteers are equipped to respond to emergencies. In 2022, 70% of units said they had developed a volunteer training plan, 8% lower than in the 2020 MRC Network Profile, **FIGURE 21** (page 19). Units that had a formal training plan developed them through multiple sources; the most common source reported was MRC Core Competencies (43%) and training plans created by the previous coordinator of the unit (40%), **FIGURE 22**.

FIGURE 22.

Although not shown in the figures, large jurisdictions were more likely to use the MRC Core Competencies and smaller jurisdictions favored utilizing a previously established training plan. MRC-TRAIN was used by 17% of units. The MRC-TRAIN learning management system provides a training plan based on the MRC Core Competencies and includes recommended trainings to meet the competencies.

Volunteer skills are mostly assessed through requesting certificate of completion (57%), and least commonly assessed by MRC-TRAIN evaluations (14%), **FIGURE 23**.

Volunteer training plans

Units were asked about the trainings offered and made available to their volunteers, and the responses were categorized as online, in-person, field setting, not offered, and mandatory.

Nearly half (48%) of units selected having MRC 101/Unit Orientation

CASE STUDY

Nurturing volunteers through 20 years of service



BERGEN COUNTY MRC, NEW JERSEY

The Bergen County MRC in New Jersey serves a county that includes 70 towns and well over one million people located 17 minutes from New York City. Its 238 volunteers are a “beautiful mix from the community,” said Dawn Wilkes-Bright and includes doctors, veterinarians, nurses, LPNs, phlebotomists, and dentists.

Unit #9 was one of the first units formed in the county. Volunteers have provided shelter assistance for medical needs during Hurricane Sandy, education during Hurricane Ida and the SARS outbreak, and flu vaccinations. During the COVID-19 response, they supported drive-through points of dispensing (PODs), worked with FEMA, and supported children’s vaccination clinics doing “anything you asked them to do.” As mpox emerged, volunteers were already asking to help before the formal request was made.

To help keep volunteers engaged, the unit holds monthly trainings year-round, except for July and August. Trainings are geared toward topics such as bloodborne pathogens, CPR, Narcan, tourniquets, mental health (including taking care of yourself), and respiratory illness. Every December, the unit hosts an appreciation dinner.

Dawn Wilkes-Bright advises other unit leaders to “Keep pushing and keep your MRC active. Always appreciate and acknowledge them. We have a wonderful team here and a wonderful system.”

as a mandatory training, followed by Introduction to the Incident Command System (IS-100) 45%, and National Incident Management System (ICS-700) 38%, **FIGURE 24**.

Popular in-person or in the field trainings were Basic Life Support (71%), Until Help Arrives/Active Bystander (69%), and Core Disaster Life Support (CDLS) (60%), **FIGURE 25**.

The most common online trainings were Introduction to the Incident Command System (IS-100) (78%), National Incident Management System (ICS-700)(77%), ICS for Single Resources and Initial Action Incidents (IS-200) (75%), and National Response Framework, An Introduction (IS-800) (70%), **FIGURE 26**.

Areas to better support MRC units

When respondents were asked for ways in which NACCHO could better support the MRC units, they selected grant opportunities (66%), train-the-trainer model trainings (61%), and internet-based training, including webinars, e-learning courses, and podcasts (60%), **FIGURE 27**.

Key findings

The ability to effectively manage volunteers is paramount to the success of an MRC unit. Ensuring that units are equipped with skills needed by communities begins with recruitment and building robust training opportunities to keep volunteers engaged and excited about the service they provide. Since 2015, word-of-mouth has consistently been the most effective method of recruitment. This is followed by MRC booths at community events. This points to a need for easily customizable communications materials like brochures and handouts as well as social media templates to encourage peer-to-peer sharing by existing volunteers and effective promotional materials for use by volunteers individually and at community events. MRC units should maximize opportunities for their volunteers to be involved in the recruitment process and include recruitment of new volunteers as a part of trainings, especially those held jointly with external partners.

A key barrier to recruitment, unit leader time constraints, was reported by 58% of respondents. This is an important finding when considered with data from Part One in the report, which indicates that 66% of leaders devote 14 hours or less per week to the MRC. Funding ranked second as a barrier, reported by 42% of units, which will be further discussed in Part Five of this report.

About one quarter (24%) of units reported volunteers are not highly utilized in their jurisdiction. This is a barrier that can be addressed through a community needs assessment to better understand the resource gaps and identify support roles for the MRC. Effective communication of unit capabilities to key community stakeholders can also support increased utilization of volunteers.

In terms of training, most units (70%) do have a written training plan. However, with less than half of the overall units utilizing the MRC Volunteer Core Competencies, there are opportunities to strengthen the use of national standards to develop volunteer capabilities that can be supplemented by local mission training requirements.

MARICOPA COUNTY DEPARTMENT OF PUBLIC HEALTH MRC, ARIZONA



INFOGRAPHIC

MRC volunteer management

RECRUITMENT

58%

of MRC indicated word-of-mouth as the most effective form of recruitment.



VERIFICATION



83%

of MRC units conducted background checks for at least some of their volunteers



97%

of units verify medical credentials

79%

of units verify medical credentials through the state registry or ESAR-VHP system

RECRUITMENT BARRIERS



58% of MRC units report unit leader time constraints as the largest barrier to recruitment.

Barriers to using social media for volunteer recruitment:

39% do not have time to devote to social media

31% reported no barriers using social media

30% of MRC units' housing departments limit use of social media sites

TRAINING



57%

of units request certificate of completion to assess volunteer skills



70%

of units have a written training plan

TOP IN THE FIELD/IN-PERSON TRAININGS OFFERED



Basic Life Support



Core Disaster Life Support (CDLS)



Until Help Arrives/Active Bystander



Stop the Bleed



**“NEVER UNDERESTIMATE
THE WILLINGNESS OF
VOLUNTEERS OR PEOPLE
WHO WANT TO HELP.”**

JENNIFER FREELAND, MA
Former Virginia MRC State Coordinator

Unit Capabilities and Responsiveness



89% OF UNITS DEVELOPED MEDICAL POINT OF DISPENSING OR MASS VACCINATION CAPABILITIES.



96% OF RESPONDENTS DEPLOYED TO COVID-19 BETWEEN JANUARY 1, 2020–DECEMBER 31, 2022.

The findings from the MRC Network Profile survey provide a picture of the emergency and non-emergency capabilities of the MRC. MRC units are involved in a variety of emergency and non-emergency activities throughout the year supporting their communities' needs. The results show that MRC units can develop capabilities to meet the needs of the communities they serve.

The COVID-19 pandemic showed the resilience and dedication of the MRC volunteers that tirelessly served their communities. Utilizing the capabilities previously developed, local MRC units provided workforce surge capacity and supported and engaged their communities through collaboration and partnership with entities, including LHDs and state health departments.

COVID-19 response activities

The 2020 MRC Network Profile captured rich data from the MRC units' response at the beginning and during the COVID-19 pandemic. In 2022, we asked the units about their continued response as the pandemic was ongoing.

Capabilities developed or adapted

MRC units were asked about capabilities developed or adapted to respond to COVID-19. Not shown in a table, 76% developed or adapted clinic or drive-through COVID-19 testing/vaccination capabilities and 72% developed or adapted mass vaccination or POD capabilities. The least common capability developed or adapted was medical surge—hospital-based, 7%, and medical surge alternate care sites, 8%. Nearly all (99%) of units who responded to COVID-19 developed or adapted at least one capability.

Capabilities deployed

A number of units deployed clinic or drive-through COVID-19 testing/vaccination (82%) from January 1, 2020, to December 31, 2022, **FIGURE 28** (page 26). The second most common capability deployed was mass vaccination or POD, 77%.

Overall trends for capabilities deployed during the COVID-19 response remained the same. However, more units were deployed to COVID-19 activities over the course of the pandemic from 2020–2022 than in 2020 alone, with 4% not supporting COVID-19 response or mitigation activities compared to 16% (2020 Network Profile) of units not participating in 2020.

AT LEFT: NAUGATUCK VALLY MRC, CONNECTICUT

FIGURE 28: Capabilities deployed in response to COVID-19 from January 2020 through December 2022

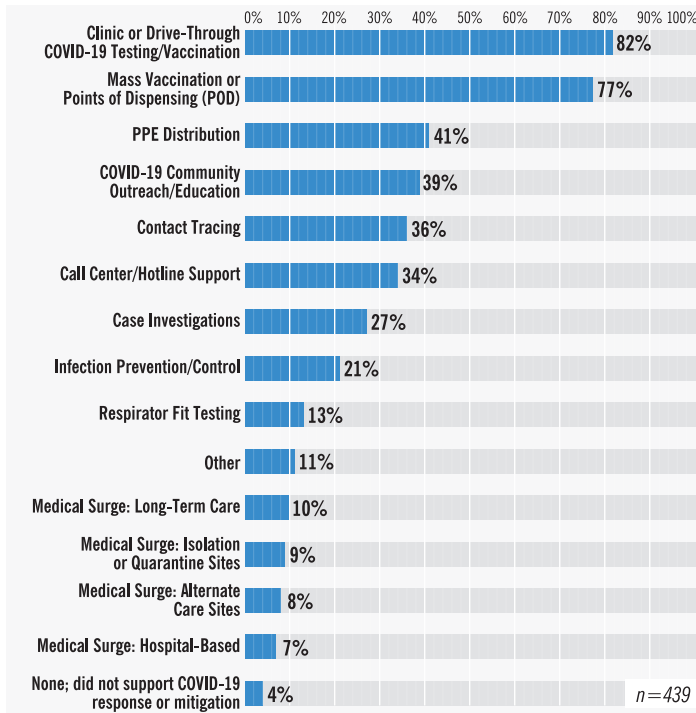
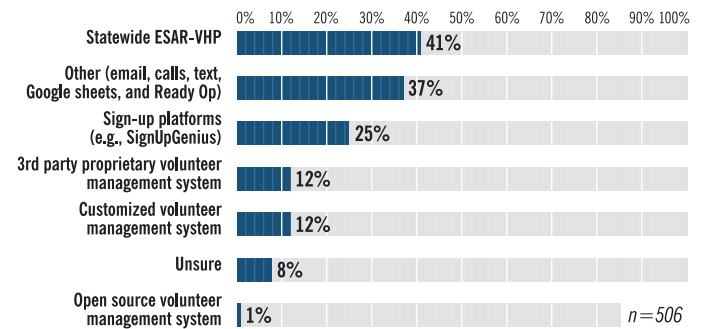


FIGURE 29: Volunteer management systems used to alert, activate, and deploy during the COVID-19 response

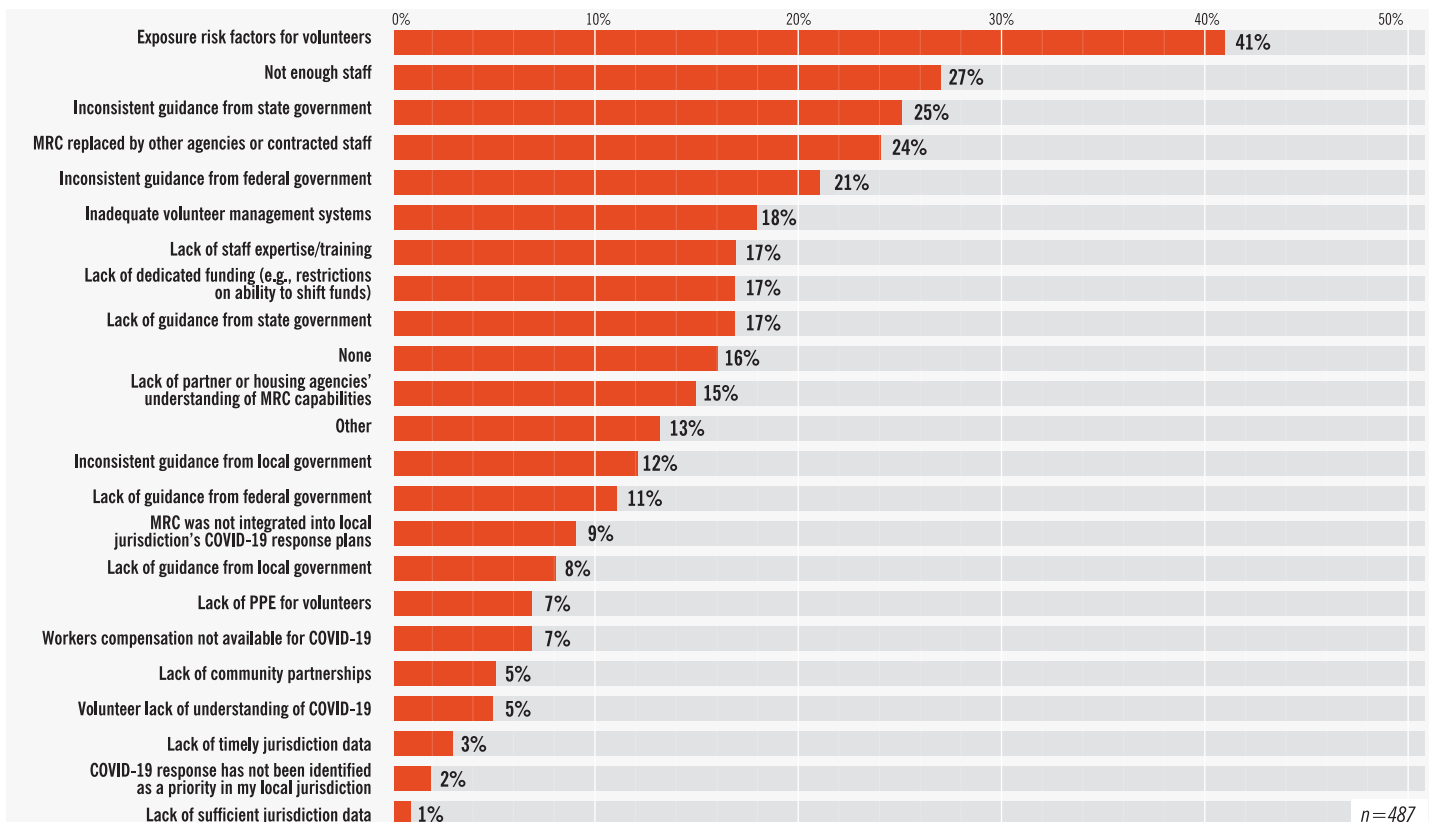


“THE MRC STAFF VOLUNTEERS FACILITATED OUR IMMEDIATE RESPONSE UPON SUPPLY ARRIVAL AND HAVE CONTINUED TO BE A KEY INGREDIENT IN OUR ABILITY TO STAFF THE LARGE-SCALE CLINICS WE HAVE HOSTED.”

TOM THEES

Executive Director of the VNA of Central Jersey, Inc.

FIGURE 30: Barriers on Effectiveness of the MRC’s COVID-19 Response



FIGURES 31-38: Emergency response capabilities

Figure 31. Points of Dispensing (POD) Operations (Non-COVID)

	Developed or Adapted	Deployed
Medical POD or Mass Vaccination	281 71.0%	232 58.6%
Non-Medical POD	107 27.0%	71 17.9%
Seasonal flu vaccination	256 64.6%	214 54.0%

Figure 32. Medical Surge Support

	Developed or Adapted	Deployed
Alternate Care Site/Medical Surge	74 18.7%	37 9.3%
Patient Reception Center	43 10.9%	22 5.6%
Mass Casualty Support	68 17.2%	29 7.3%
Pharmacy Support	46 11.6%	27 6.8%
Health Clinic Support/Staffing/Medical/First Aid Booth	247 62.4%	201 50.8%

Figure 33. Non-Medical Surge Support

	Developed or Adapted	Deployed
Family Assistance Center	65 16.4%	33 8.3%
Radiological Community Reception Center	41 10.4%	9 2.3%
Volunteer Reception Center	72 18.2%	36 9.1%

Figure 34. Mental Health and Behavioral Support

	Developed or Adapted	Deployed
Behavioral/Mental Health Services	101 25.5%	66 16.7%
Substance Use Services	68 17.2%	43 10.9%
Disaster Resilience (Psychological First Aid, Acupuncture, Disaster Mental/Behavioral Health)	139 35.1%	67 16.9%

Figure 35. Evacuation and Shelters Support

	Developed or Adapted	Deployed
Evacuation Support	69 17.4%	35 8.8%
Medical Shelter Support	135 34.1%	74 18.7%
General Shelter Support (Human and/or Animal)	134 33.8%	78 19.7%

Figure 36. Epidemiology Emergency Support

	Developed or Adapted	Deployed
Epidemiology/Contact Tracing (Non-COVID)	79 19.9%	42 10.6%
Emergency Surveillance/Population Monitoring	72 18.2%	48 12.1%
Communicable Disease Outbreaks (MPOX, Measles, RSV, or Other)	65 16.4%	42 10.6%

Figure 37. Responder Safety and Health Support

	Developed or Adapted	Deployed
Respirator Fit Test	87 22.0%	58 14.6%
First Responder Rehabilitation	51 12.9%	27 6.8%

Figure 38. General Emergency Response Support

	Developed or Adapted	Deployed
Emergency Operations Center Support	123 31.1%	82 20.7%
Virtual Operation Support	53 13.4%	35 8.8%
Emergency Communications Support (Call Center, HAM Radio, Social Media)	136 34.3%	92 23.2%
Logistics	129 32.6%	92 23.2%
Recovery Support Services	34 8.6%	25 6.3%
Search and Rescue	34 8.6%	15 3.8%
Veterinary/Animal Response	53 13.4%	25 6.3%

Volunteer management systems

The most used management system to alert, activate, and deploy volunteers during the COVID-19 response was the statewide ESAR-VHP (41%), followed by "other" (37%), and sign-up platforms such as SignUpGenius (26%). Other management systems used during the response are listed in **FIGURE 29**.

Barriers to deploying MRC volunteers

The largest barrier that hindered the effectiveness, scale, or quality of the MRC unit's COVID-19 response was exposure to risk factors in both 2022 and 2020, **FIGURE 30**. In 2020, 42% of units reported "not having enough staff" as a large barrier that hindered the effectiveness of the response; this decreased significantly in 2022 to 27%. Other barriers that had somewhat of a hindrance on the effectiveness of the MRC unit's response were inconsistent guidance from the state government (25%), MRC being replaced by other agencies or contracted staff (24%), and inconsistent guidance from the federal government (21%), **FIGURE 30**.

Emergency and non-emergency capabilities

The use of MRC volunteers in emergency and non-emergency activities builds community resilience, establishes relationships with community partners, increases volunteer knowledge of their roles, provides opportunities to engage and retain volunteers, and demonstrates unit abilities to partners.

Emergency capabilities

Respondents were asked to report their non-COVID-19 capabilities and deployments for 2022. **FIGURES 31-38** illustrate the types of emergency response capabilities that MRC units have developed or adapted during 2022.

Nearly three-quarters (71%) of units reported they have developed medical POD or mass vaccination capabilities, **FIGURE 31**. This hallmark capability of the MRC continues to be the top capability since the 2017 Network Profile.

Non-emergency capabilities

FIGURES 39-41 (page 28) illustrate the type of non-emergency capabilities that units developed. Capabilities can be developed through formal training, just-in-time training, or through in-person activities with supervision. The top findings for non-emergency capabilities indicate that 75% of MRC units provide community education training. Community training may include "Until Help Arrives," CPR and Community First Aid, "Stop the Bleed," Personal and Family Preparedness Planning, Countering Opioid Overdoses through Administration of Naloxone, and other public health priorities, **FIGURE 39** (page 28). Approximately 62% of units participate in personal/family preparedness campaigns or promote National Preparedness Month to build community resilience.

FIGURES 39-41: Non-emergency response capabilities

Figure 39. Community Outreach Missions				
	Developed or Adapted		Deployed	
Community Education Trainings (Until Help Arrives, CPR/First-aid, Naloxone Administration, etc.)	295	74.5%	210	53.0%
Personal/Family Preparedness Information Campaigns/ National Preparedness Month	246	62.1%	174	43.9%
Figure 40. Epidemiology Non-Emergency Support				
Epidemiology and Surveillance Services	122	30.8%	85	21.5%
Communicable Disease (HIV/AIDS, Other STDs, TB) Testing, Treatment Services	75	18.9%	54	13.6%
Figure 41. General Public Health Support				
Environmental	38	9.6%	22	5.6%
Vector Control	47	11.9%	32	8.1%
Other	40	10.1%	32	8.1%

FIGURE 42: Deployment Readiness Guide usage and awareness

	(n)	2022			2020		
		Aware of Resource	Have Used Resource	Unaware of Resource	Aware of Resource	Have Used Resource	Unaware of Resource
MRC Volunteer Tier Levels	492	56%	27%	25%	50%	18%	29%
MRC Unit Leader Deployment Readiness Checklists	489	66%	22%	18%	58%	19%	21%
MRC Core Competencies Volunteer Training Plan	489	60%	36%	17%	51%	32%	18%
Mission Sets	485	58%	21%	28%	52%	18%	26%

MRC LOS ANGELES, CALIFORNIA



FIGURES 43-49: Emergency response mission sets

Figure 43. Points of Dispensing (POD) Operations			Developed or Adapted	
Medical POD or Mass Vaccination	169	38.3%		
Clinic/Drive-Through COVID-19 Testing/Vaccinations	132	29.9%		
COVID-19 Testing	101	22.9%		
Non-medical POD	65	14.7%		
Figure 44. Medical Surge Support				
Medical Surge – Hospital Based	22	5.0%		
Medical Surge – Long Term Care	20	4.5%		
Medical Surge – Alternate Care Sites	22	5.0%		
Medical Surge – Isolation or Quarantine	21	4.8%		
Clinical & Non-Clinical Healthcare Setting Support	24	5.4%		
Figure 45. Non-Medical Surge Support				
Family Assistance Centers	33	7.5%		
Volunteer Reception Center	58	13.2%		
Medical Volunteer Coordination/Liaison	55	12.5%		
Radiological Community Reception Centers/ Population Monitoring	19	4.3%		
Figure 46. Mental Health and Behavioral Support				
Disaster Behavioral Resilience (Psychological First Aid (PFA), Acupuncture, Disaster Mental/Behavioral Health)	45	10.2%		
Figure 47. Evacuation and Shelters Support				
Evacuation Support	37	8.4%		
Medical Shelter Support	91	20.6%		
General Shelter Support (Human and/or Animal)	102	23.1%		
Figure 48. Responder Safety and Health Support				
Personal Protective Equipment (PPE) Fit Testing	46	10.4%		
Respirator Fit Testing	41	9.3%		
First Responder Rehabilitation	27	6.1%		
Responder Rehab Support	15	3.4%		
Figure 49. General Emergency Response Support				
Emergency Operations Center Support	86	19.5%		
Virtual Operation Support	19	4.3%		
Emergency Communications Support (Call Center, Ham Radio, Social Media)	83	18.8%		
COVID-19 Hotline – Phone Call Triage/Assessment	63	14.3%		
Veterinary/Animal Response	33	7.5%		
Risk Communications	43	9.8%		
Search and Rescue	19	4.3%		
Recovery Support Services	11	2.5%		

MRC GEM, GEORGIA



FIGURES 50-52: Non-emergency response mission sets

Figure 50. Community Outreach Missions		Developed or Adapted	
Community Outreach/Education	74	16.8%	
Wellness Checks	34	7.7%	
Senior Citizen Resiliency	21	4.8%	
Figure 51. Epidemiology Non-Emergency Support			
Epidemiology/Contact Tracing (Non-COVID-19 activities)	43	9.8%	
Case Investigations	37	8.4%	
Infection Prevention/Control	33	7.5%	
Figure 52. General Public Health Support			
Environmental	20	4.5%	
Vector Control	12	2.7%	
Other	33	7.5%	

More than half of responding MRC units report being aware of both the 2019 and 2021 MRC Deployment Readiness Guide resources such as volunteer tier levels (56%), unit leader deployment readiness checklists (66%), core competencies volunteer training plan (60%) and mission sets (58%). When asked if the units have used these resources, 36% used core competencies volunteer training plan (a 5% increase from 2020), 27% used volunteer tier levels (a 9% increase from 2020), 22% used unit leader deployment readiness checklists, and 21% used mission sets, **FIGURE 42.**

Mission sets and capabilities developed

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

Deployment Readiness Guide

The Deployment Readiness Guide is a comprehensive guide aimed at increasing MRC units' deployment readiness. It provides a common set of tools for MRC unit leaders to develop the capabilities of their volunteers to support medical and public health emergency responses. The tools included in the guides provide recommended standards that can be modified to fit the unique missions of individual MRC units. These standards can also be shared with emergency response partners to demonstrate the capabilities of MRC volunteers.

Both the 2019 and 2021 guides, along with any future guides and novel deployment readiness resources, are available at www.naccho.org/mrc

Mission Sets

The concept of "mission sets" was first introduced in the 2019 MRC Deployment Readiness Guide to provide a common set of tools for MRC unit leaders to develop the capabilities of their volunteers to support medical and public health emergency responses. A mission set describes a scalable response and recovery capability for MRC units and volunteers that is organized, developed, trained, and exercised prior to an emergency or disaster for local, state, and/or regional deployment purposes. Mission sets are a planning tool that allow units to compile basic information using a standard template for response missions or activities that can be shared with volunteers, partner organizations, or other MRC units to provide an understanding of the unit capabilities for that response or activity.

More information on mission sets can be found at www.naccho.org/mrc

MRC units to provide an understanding of the unit capabilities for that response or activity. *The 2019 and 2021 MRC Deployment Readiness Guides* provide templates and examples of mission sets that have been developed by MRC units for response planning.

MRC units develop mission sets to support medical and public health emergencies such as PODs, shelter operations, medical surge support, community outreach, communications, and other emergency response missions. In 2022, the most common type of mission set developed were those that supported the COVID-19 response. Also prevalent were mission sets that support emergency shelter operations.

FIGURES 43-52 display the percentage of units that developed a mission set grouped according to response category.

NAUGATUCK VALLEY MRC, CONNECTICUT



Partnerships

Partners often have a relationship with MRC units who operate locally and share a common goal of public health and emergency response.

MRC Units were asked about the type of support received from their sponsoring agency. Of the units who receive support from their sponsoring agency, 71% received support for material resources, 71% received leadership support, 68% received staff assistance, and 63% received training support, as shown in **FIGURE 53**.

Over two in five (43%) MRC unit respondents said they received no support from local government agencies. About one-third (34%) who partner with local government agencies receive support in training; 24% receive support for material resources; and 22% receive leadership support. Of the 442 MRC units who partner with local government agencies, only 12% receive support in funding.

Units who partner with state agencies receive the most support from these agencies through training, 62%. Nearly half (49%) of units receive leadership support from state agencies, 46% receive material resources, and 13% of units said they do not receive state agency support.

When asked about MRC support from state or local non-governmental organizations, 54% reported receiving no support, 29% received support for training, 20% received support in material resources, and 11% received support in funding.

Support to MRC units from federal agencies was primarily through training (43%) and funding (42%). A little over a quarter (28%) reported that they received no support from federal agencies. Among those who did receive support from federal agencies, the least common type of support was in staffing assistance: just 10% reported receiving this type of support.

FIGURE 53: Types of support received from agencies/organizations

Type of Support	Sponsoring Organization	Local Government Agencies	State Agencies	State or Local NGOs	Federal Agencies
Material Resources	71.3%	24.2%	45.8%	19.9%	28.2%
Funding	51.3%	12.4%	36.7%	10.7%	42.4%
Staff assistance	68.0%	19.9%	32.5%	12.6%	9.6%
Training	63.0%	33.7%	62.4%	29.1%	43.3%
Leadership	70.5%	21.9%	48.9%	14.0%	25.2%
No support	9.2%	43.4%	13.3%	54.3%	27.8%
	n=478	n=442	n=474	n=422	n=436

Community partnerships

In 2022, more than half of MRC unit respondents said they were a response partner with the police, local health departments, healthcare coalitions, hospitals/health systems, fire/EMS, and state emergency management. A range of 29%–49% of units were a response partner with pharmacies, long-term care facilities (LTCFs), federal agencies, faith-based organizations, education organizations, citizen corps/Community Emergency Response Teams (CERT), American Red Cross, and another MRC unit. When community organizations worked with MRC units, they were primarily response partners or held joint trainings.

CASE STUDY

Combating the opioid epidemic

Preliminary data from the Centers for Disease Control and Prevention (CDC) predicts that over 100,000 people in the U.S. died in 2021 from a drug overdose.⁵ The New Mexico Integrative Wellness MRC has taken steps to combat the opioid epidemic in their community. The unit comprises about 20 acupuncturists and behavioral health therapists and is cross-trained to work in critical incidents across New Mexico and Region 6. Most of their work is in the northern part of the state.

The unit has been teaching Acudetox, an auricular acupuncture for the prevention and treatment of drug use, for more than two years. They heard from local partner Barrios Unidos,

a community center in Chimayo, NM, that, in addition to the community experiencing a high incidence of overdose deaths, local drug users were not getting the care they needed. To help divert trips to the emergency room and prevent deaths from sepsis, the unit developed a wound kit and accompanying Wound Care Zine.

The wound kit includes dressings, antibiotic cream, normal saline, wraps, and two doses of Naloxone. Naloxone for the kits is provided free of charge from the Statewide Overdose Prevention Education Coordinator. An initial distribution of over 100 kits was conducted through community centers, behavioral health clinics, and the local COVID hotel.



NEW MEXICO INTEGRATIVE WELLNESS MRC, NEW MEXICO

FIGURE 54: Community partnerships and type of relationship

Type of Support	(n)	Response partner	Written agreement	Joint training	No relationship	Does not exist within community
American Red Cross	467	45.8%	13.5%	24.0%	34.9%	4.5%
Animal Health Agencies	448	21.2%	4.2%	10.0%	62.7%	8.9%
Another MRC Unit	468	42.5%	11.8%	41.2%	20.3%	16.9%
Citizen Corps/CERT	453	37.5%	5.5%	33.6%	30.0%	19.0%
Local Emergency Mgmt Agency	477	75.1%	16.6%	46.8%	12.2%	0.6%
State Emergency Mgmt Agency	457	57.1%	7.7%	33.9%	25.8%	2.4%
Education Organizations	452	37.4%	15.7%	27.9%	38.5%	3.8%
Faith-based Organizations	450	36.4%	6.2%	17.1%	47.3%	4.4%
Federal Agencies	427	33.7%	2.6%	22.2%	44.5%	9.1%
Fire/EMS	461	62.9%	8.5%	37.5%	21.7%	1.5%
Future Health Professionals (HOSA)	426	53.0%	11.9%	30.3%	29.2%	4.8%
Hospitals/Health System	455	53.0%	11.9%	30.3%	29.2%	4.8%
Healthcare Coalitions	449	57.2%	10.5%	36.7%	24.1%	4.2%
LHDs	470	82.1%	21.5%	47.7%	6.8%	1.7%
Long-Term Care Facilities (LTCF)	435	35.6%	8.3%	15.4%	48.3%	7.1%
National Disaster Management Systems (NDMS)	419	11.7	0.5%	7.2%	58.9%	25.8%
Pharmacies	432	29.2%	6.9%	8.6%	59.7%	7.4%
Police	455	57.4%	9.7%	27.5%	30.8%	2.4%
Tribal Health Department	415	9.6%	2.2%	3.1%	37.6%	51.3%

Joint trainings primarily occurred among local emergency management agency (47%), another MRC unit (41%), and local health departments (48%), **FIGURE 54**.

About two in five MRC unit respondents (40% or more) reported no relationship with animal health agencies, federal agencies, future health professionals (HOSA), long-term care facilities, National Disaster Medical System (NDMS), and pharmacies. Other organizations that units did not have relationships with include education organizations (39%), tribal health departments (38%), police (31%), the American Red Cross (35%), citizen corps/CERT (30%), hospitals/health systems (29%), state emergency management agencies (26%), and healthcare coalitions (24%), **FIGURE 54**.

Key findings

As noted in Part One, volunteers within the MRC unit respondents dedicated 603,587 hours to COVID-19 response in 2022. Nearly all units developed or adapted their capabilities to respond to COVID-19. From January 1, 2020 through December 31, 2022, nearly all also deployed capabilities in response to COVID-19. Developing and maintaining these capabilities provides opportunities to prepare and familiarize volunteers for future response roles. For example, 82% of units deployed in support of Clinic or Drive-Through COVID-19 Testing and 77% deployed in support of Mass Vaccination or PODs. These are capabilities that can be adapted to other emergency and non-emergency settings. This demonstration of surge capacity staffing presents an opportunity to leverage success stories from the COVID-19 response, especially by those quarter of units who see underutilization of volunteers within their jurisdictions as a barrier to recruitment, as noted in Part Two.

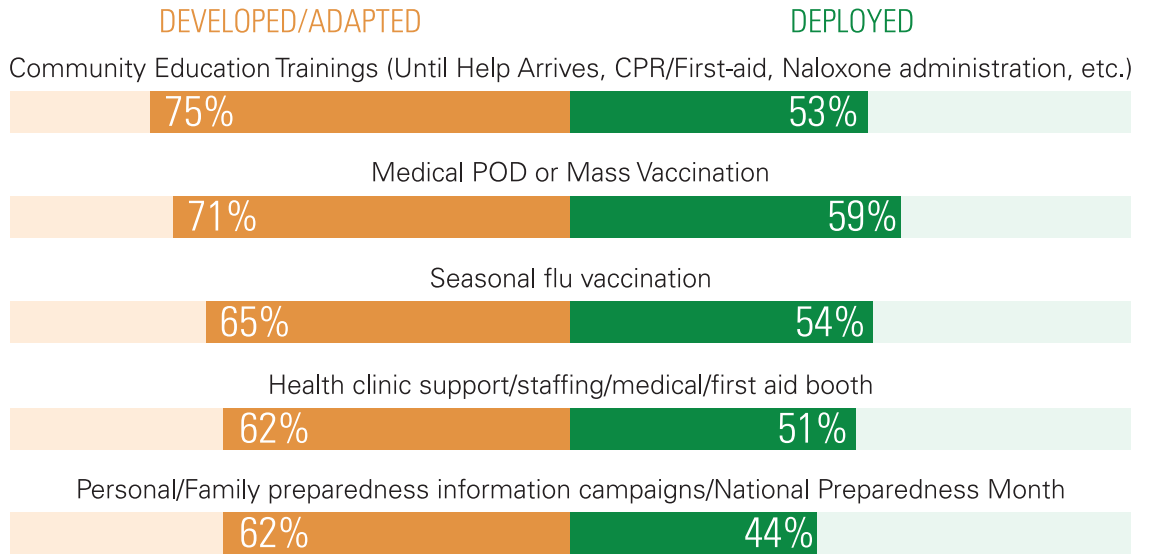
While continuing with COVID-19 response, units also developed and deployed a range of emergency and non-emergency capabilities, contributing 1,114,618 hours in 2022. This demonstrates the versatility of response capabilities and can be leveraged in future volunteer recruitment and partnership building activities. Sustainment of these capabilities is vital to ensure units continue to be prepared for future all-hazard responses.

In terms of resources to support unit deployment, the 2022 survey assessed usage of Deployment Readiness Guides and missions sets. While use of the 2019 and 2021 Deployment Readiness Guides has increased overall, many are still unaware of these resources. This presents an opportunity for NACCHO to continue to refine the resources in partnership with unit leaders and promote the guide to improve and support MRC capabilities and deployments.

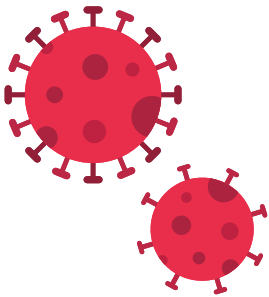
The number and diversity of mission sets developed helps to demonstrate the capabilities of units to support their communities. They also present a peer learning opportunity among units, with the sharing of such resources contributing to capacity building. Unit leaders can also use this data as part of their own needs assessment, identifying opportunities for further capability building.

It is vital for MRC units to engage and collaborate with local stakeholders to promote public health and respond to public health emergencies. The data presented helps communities to assess their own partnerships in relation to those across the network. As utilized by almost half of respondents, joint training with partners provides opportunities to build relationships and exercise together before emergencies occur. This also presents an opportunity for those not currently participating in joint trainings to build this into their training plans in alignment with capabilities and mission sets.

MRC unit capabilities



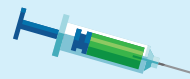
COVID-19



96%

of respondents deployed to COVID-19 between Jan 1, 2020–Dec 31, 2022

TOP 3 MISSION SETS DEVELOPED



38% Medical POD or mass vaccination



30% Clinic/Drive-Through COVID-19 Testing/Vaccinations



23% General Shelter Support (Human and/or Animal)



TOP COVID-19 CAPABILITIES DEPLOYED

- Clinic or Drive-Through COVID-19 Testing/Vaccination
- Mass Vaccination or Points of Dispensing (POD)
- PPE Distribution



SYSTEMS USED TO ALERT, ACTIVATE, AND DEPLOY VOLUNTEERS DURING COVID-19 RESPONSE

- 41% statewide ESAR-VHP
- 37% "other" (email, calls, text, Google Sheets, and ReadyOP)
- 26% Sign-Up Platforms (e.g. SignUpGenius)



BARRIERS TO DEPLOYING MRC VOLUNTEERS DURING COVID-19 RESPONSE

- 41% Exposure to risk factors for volunteers
- 27% Not enough staff
- 25% Inconsistent guidance from state government
- 24% MRC replaced by other agencies or contracted staff

Funding



THE LARGEST SOURCE OF FUNDING TO SUPPORT MRC UNITS CAME FROM NACCHO'S MRC COVID-19 RESPOND, INNOVATE, SUSTAIN, AND EQUIP (RISE) AWARD.



46% OF UNITS INDICATED THEY DID NOT RECEIVE DONATED FUNDS OR RESOURCES.

Funding is imperative for the day-to-day emergency and non-emergency operations of MRC units. Funding is used for equipment, supplies, uniforms, background screenings, training, management systems, staffing, deployments, and much more.

Funding sources and budgets

In 2022, responding MRC units received a total of \$21,497,102 from the sources listed in **FIGURE 55** (page 36). The largest source of funding to support units came from one-time funding through the American Rescue Plan Act of 2021, a portion of which was distributed through NACCHO's MRC COVID-19 Respond, Innovate, Sustain, and Equip (RISE) Award. This funding accounted for \$7,093,410 or 33% of the total funding sources reported in 2022. This was followed by Public Health Emergency Preparedness (PHEP) funding in the amount of \$4,281,902 or 20% of the total sources of funding and NACCHO's Operational Readiness Award (ORA) funding as \$993,734 or 5% of the total sources of funding. The least amount of funding came from fundraising, State Homeland Security Program (SHSP) funding, local grant funding, and corporate sponsor funding. **FIGURE 55** details the funding and funding sources for 2022.

When looking at the funding sources by size of population served, units serving 100,000–499,999 received the most RISE award funding, followed by units serving 500,000+ people. Units serving populations with less than 25,000 people received the least amount of RISE funding. Overall, units serving larger population sizes received more funding than those serving smaller jurisdictions, with the exception of units serving 100,000–499,999 populations. A total of 62% of the MRC units served populations of 100,000 or more. Units serving larger jurisdictions overall receive more funding from all sources in comparison to units serving jurisdictions smaller than 100,000 people.

Donations

Nearly half (46%) of units indicated they did not receive donated funds or resources. Over one quarter (28%) received in-kind donations, 18% received cash donations, and 17% reported they did not know whether donations were accepted. In comparison to 2020 (37%) more MRC units were not able to accept donations in 2022 (46%), **FIGURE 56** (page 37).

As reported in previous years, MRCs sponsored by local health districts serving larger jurisdictions were less able to accept donations than those units serving smaller jurisdictions. The number of units accepting cash and in-kind donations decreased from 2020 to 2022, 9% and 10% respectively.

AT RIGHT: SAN BERNARDINO COUNTY MRC, CALIFORNIA



**“THIS SHOWS VOLUNTEERS
THAT WE CARE ABOUT
THEM AND WANT THEM
TO DO WELL.”**

TRACI HOLT, BA, CNA, EMT
MRC Coordinator, Ventura County MRC (CA)

Units were asked if funding changed (either increased or decreased), which areas would be impacted most significantly. Units ranked training, supplies/equipment, followed by staffing and payroll, as the top three areas. Training would be most impacted if units had more funding, secondly supplies/equipment, and third, staffing and payroll.

Operational Readiness Awards

The Operational Readiness Awards (ORA) were designed to build the operational readiness capabilities of volunteers and units to meet the emergency preparedness and response needs of local, regional, and statewide stakeholders.

NACCHO distributes MRC Operational Readiness Awards through a cooperative agreement with the Medical Reserve Corps Office, Administration of Strategic Preparedness and Response, Department of Health and Human Services.

In 2022, NACCHO awarded a total of 128 ORAs, totaling over \$1.065 million, through two funding tiers. Tier 1 awards provided 43 units with \$5,000 to fund projects designed to strengthen MRC volunteer capabilities and Tier II awards provided 85 units with \$10,000 to fund projects designed to strengthen MRC units' response capabilities.

A total of 114 units or 89% of all awardees completed the final evaluation survey, providing outcomes and impacts of their award activities. Their responses highlighted the broad successes of the ORAs. For example, 82% of the respondents evaluated the impact and outcomes of their ORA activities and 94% felt that their ORA activities improved the capability or capacity of their MRC unit, thanks to the service of 7,691 volunteers across 29 states. The monetary value of the 2022 ORA activities totaled over \$5 million, or nearly \$49,000 per awardee.

Highlights from 2022 ORA activity

Volunteer training

Twenty-two percent of Tier I and 21% of Tier II awardees used their ORA funds to participate in and offer virtual and in-person training to their volunteers.

"I believe this award improved our capabilities. It increased Medical Expertise. Medical training can enhance the skills and knowledge of MRC volunteers, allowing them to provide a broader range of medical services to their communities. With additional training in areas such as emergency medicine, infectious disease control, and mental health support, MRC volunteers can respond more effectively to public health emergencies and provide higher-quality care to their communities..."

—Stanislaus County Medical Reserve Corps, Tier I Awardee

Volunteer recruitment

Nineteen percent of Tier I and 17% of Tier II awardees used their ORA funds to participate in recruiting events for their volunteers.

"MRC volunteers were recruited from collegiate healthcare partnerships, conferences, and other meetings throughout the state. Many of these volunteers assisted us with non-emergency health events and with our Alternative Care Site, providing much-needed care to over 400 vulnerable patients across the state."

—North Carolina Baptist Men MRC, Tier I Awardee

Community outreach/education

14% of Tier I and 16% of Tier II awardees used their ORA funds to participate in community outreach and education efforts.

"Our Street Outreach team went to our local homeless encampments to provide support and evaluation assistance to the men and women of the community. One man was in critical need of medical attention. With the help of our volunteers, they were able to get him into a shelter to get the help he needed and saved his life."

—Pierce County MRC (WA), Tier II Awardee

FIGURE 55: Funding sources for 2022

Type of Support	Units reporting this source	Median 2022	Mean 2022	Total 2022
ORA	127	\$10,000	\$7,812	\$993,734
RISE	144	\$50,000	\$48,343	\$7,093,410
Public Health Emergency Preparedness (PHEP)	187	\$6,000	\$32,377	\$4,281,902
Hospital Preparedness Program (HPP)	29	\$9,125	\$15,178	\$283,057
Local Health Department (LHD)	47	\$3,260	\$2,273	\$1,157,579
County Government	17	\$3,821	\$28,555	\$315,886
State Health Department	34	\$12,000	\$10,287	\$354,401
State Homeland Security Program (SHSP)	6	\$10,487	\$13,930	\$83,579
Cities Readiness Initiative (CRI)	30	\$240,770	\$33,088	\$919,543
Urban Area Security Initiative (UASI)	8	\$98,500	\$90,394	\$723,148
Fundraising Funding	8	\$2,206	\$3,667	\$29,339
Corporate Sponsor Funding	3	\$39,350	\$2,187	\$6,560
Local Grant Funding	14	\$1,509	\$3,046	\$42,096
Other/Unknown	29	--	--	\$5,212,868
Total budget	366	\$29,550	\$75,903	\$21,497,102
Total budget EXCLUDING RISE AWARDS	366	\$10,000	\$38,262	\$14,403,692

Figure 55 includes median, mean, and total funding by funding category. However, units may have provided incomplete responses or made entry errors. During data cleaning, prior to analysis, individual funding amounts within a category were coded as missing within that category if they were extreme outliers, though an overall total may not have been removed. Thus, there is an "other/unknown" category that reflects amounts from total funding that cannot be ascribed to a particular category.



BUCKS COUNTY MRC, PENNSYLVANIA

MAG MRC, GEORGIA



FIGURE 56: MRC acceptance of donations

2022	Type of Support	2020
18%	Yes, cash and/or check donations	27%
28%	Yes, in kind (e.g., goods, services, expertise, or cash equivalents)	38%
46%	No	37%
17%	Do not know	17%

Mass vaccination

Thirteen percent of Tier I and 11% of Tier II awardees used their ORA funds to participate in mass vaccination activities.

“Notably, we were invited to send medical volunteers to the first-ever ‘medical camp’ to screen immigrants and impoverished residents for health care, with referrals for endocrine and other issues. This invitation to our members drew excited offers to help from our most seasoned nurse practitioners — even those who’d been so busy running their clinical practices that their time available for volunteering was limited. We established a strong partnership with the hosts in the process: a group of volunteer physicians in their “Love All Serve All” LASA Foundation programs. Through this effort we supported 24 clinics in 5 of our 7 communities; 226 volunteers served 736.5 hours, valued \$28,410.49.”

—Upper Merrick Valley MRC, Tier II Awardee

Readiness, Impact, Sustain, Equip Award

With support from ASPR and funding from the American Rescue Plan Act of 2021, NACCHO provided \$15.2 million to MRC units and state coordinators through the MRC COVID-19 Respond, Innovate, Sustain, and Equip (RISE) award. NACCHO’s MRC COVID-19 RISE awards sought to provide MRC units and state coordinators funding to support the immediate needs of the MRC network, increase capacity to address the ongoing COVID-19 response efforts, and ensure units are resourced for future mission requirements.

This funding prioritized building capacity for the MRC to respond, innovate to evolving requirements, sustain staffing requirements, and equip MRC units and state coordinators with resources needed to support their mission.

In 2022, NACCHO awarded a total of 182 units through a first round of RISE award funding, totaling over \$9.37 million, through three funding tiers. Tier I awards provided 62 units with \$25,000; Tier II awards provided 47 units with \$50,000; and Tier III provided 73 units with \$75,000. The

three tier distinctions were based on MRC unit and state coordinator capacity to achieve certain objectives. For example: Tiers I and II were intended for MRC units or state coordinators that demonstrated the capacity to effectively develop and implement a program plan at \$25,000 and \$50,000 level, respectively, to address their needs to support COVID-19 response efforts.

Additionally, NACCHO offered an extra funding opportunity to these award recipients and awarded an additional \$2.1 million to 108 units across the country. This brought the total first round of RISE funding awards to \$11.4 million. Simultaneously, through a second round of RISE award funding, NACCHO awarded \$3.7 million in RISE funds to 71 units. Tier I awards provided 30 units with \$25,000; Tier II awards provided 23 units with \$50,000; and Tier III provided 18 units with \$75,000.

Given that the grant period for RISE awards funding was ongoing in 2022, final evaluation data is not yet available. In the interim, budget information from 60 units participating in the first round of RISE award funding was randomly selected for analysis, with 20 budgets sampled from each of the award’s three tier levels. Of those units sampled, funds were allocated in the following primary budget categories:

Personnel/staffing needs

During COVID-19, 36% of RISE funds were utilized to sustain operations by addressing staffing needs to include full- or part-time staff to support ongoing readiness and operational requirements. This budget category included retirement, insurance, workers compensation, and other staffing-related expenses for MRC units.

Training/volunteer recruitment

As part of COVID-19 response efforts, RISE awardees also budgeted and utilized 15% of funds for volunteer training, recruitment efforts to expand volunteer capacity, and onboarding expenses to build their capacity of trained and ready corps of volunteers. This budget category included expenses related to training events, website development, background checks, volunteer recruitment tools, and computer software subscriptions.

Purchasing equipment/technology

RISE awardees also utilized their funds to purchase supplies and essential materials to equip their units to support volunteer deployments and meet mission requirements during COVID-19. This accounts for 45% of funding allocated. Examples of materials and equipment purchased include office electronic supplies, CPR supplies, medical supplies, volunteer response tools, outdoor response supplies, kits, outreach materials, and other.

Key findings

Historically and as noted previously, funding has been a barrier for MRC units. In 2020, the median operating budget overall reported by units was \$2,500, with 33% of units reporting they have no current source of funding for their operational activities. In 2022, the MRC network saw a large influx of one-time funding through the American Rescue Plan Act of 2021, a portion of which was distributed through NACCHO’s RISE award. This one-time funding for the MRC accounted for 53% of reported funding for units in 2022. The additional funding allowed units to replenish resources needed, increase temporary staffing levels, and expand training opportunities. Long-term sustainment of funding remains a priority to ensure the readiness of the MRC to support emergency response needs.



INFOGRAPHIC

MRC funding and resources

Estimated funding from all sources for 2022

\$21,497,102



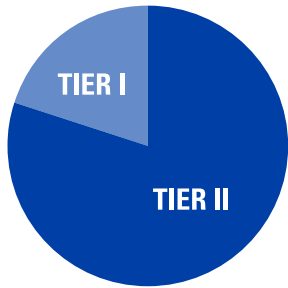
The largest source of funding to support MRC units came from NACCHO's MRC COVID-19 Respond, Innovate, Sustain, and Equip (RISE) award.



46% of units indicated they did not receive donated funds or resources

OPERATIONAL READINESS AWARDS

NACCHO awarded a total of 128 Operational Readiness Awards, totaling over **\$1.065 million**.



TIER I AWARDS

Provided 43 units with **\$5K** to fund projects designed to strengthen MRC volunteer capabilities

TIER II AWARDS

Provided 85 units with **\$10K**

94%

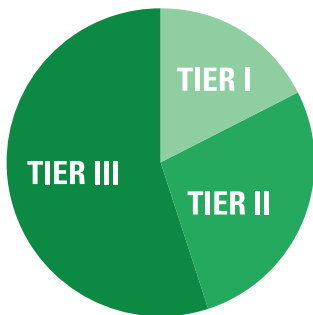
of respondents felt that their ORA activities improved the capability or capacity of their MRC unit

7,691

volunteers across 29 states

RISE FUNDS

In 2022, NACCHO awarded a total of 253 units with RISE funds totaling over **\$15.2M**, through three funding tiers.



TIER I AWARDS

\$2.667M

TIER II AWARDS

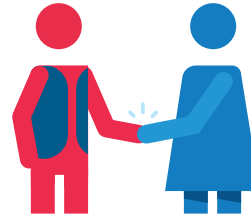
\$4.2M

TIER III AWARDS

\$8.347M

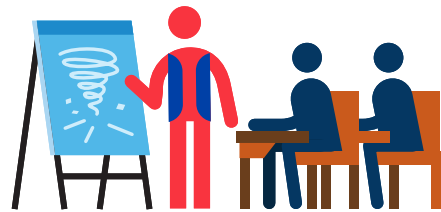
HOW WERE RISE FUNDS USED?

Based on a sampling of 60 randomly selected units



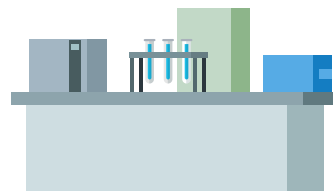
36%

Used funds for personnel/staffing needs



15%

for training/volunteer recruitment



45%

for purchasing equipment/technology



**"I'M IMMENSELY PROUD OF
THE WORK WE'VE DONE.
IT'S EXTRAORDINARY.
VOLUNTEERS ANSWERED
THE CALL EVERY TIME."**

SOFÍA PENDLEY, PH.D.

Unit Co-Director, Sacred Heart University MRC (CT)

Future Directions



THE LIMITED AMOUNT OF PAID STAFF TIME DEVOTED TO MANAGING AN MRC LIMITS A UNIT'S ABILITY TO OPERATE AT OPTIMUM LEVELS AND CAN IMPACT THEIR RESPONSE CAPABILITIES.



THE HISTORIC INVESTMENT IN THE MRC IN 2022 IS NOT GUARANTEED IN THE FUTURE.

Overall findings and recommendations

The year 2022 was historic for the Medical Reserve Corps. The network celebrated its 20th year of service to the country and saw an investment of \$100 million through the American Rescue Plan Act of 2021 (ARP). NACCHO distributed over \$15 million from ARP funding to local and state MRC units, via its cooperative agreement with ASPR.

At the same time, MRC units were also engaged in responding to the COVID-19 pandemic, supporting activities including testing, vaccination, PPE distribution, community outreach, and contact tracing. While responding to the pandemic, MRC units developed new capabilities, conducted recruitment and training activities, responded to local emergencies, and supported community health needs.

Examining how local and state MRC leaders utilized funds and applied lessons learned from pandemic response will help inform the direction of future investments. Based on information provided in the profile report, there are insights

from this pivotal time that can identify areas for continued investment. The following are recommendations that can be used to inform future MRC network activities.

Invest in personnel

The workforce surge capacity MRC units provided during the pandemic demonstrates the capabilities of units and their volunteers and points to the greater potential that can be achieved through further investment in personnel.

NACCHO recommends the following to further strengthen and grow MRC personnel:

Invest in unit leaders

NACCHO recommends a shared investment of funding at the local, state, and federal levels to sustain and grow unit leader staff positions that attract talent, foster diversity, and allow for dedicated time to support unit activities. NACCHO further recommends that new unit leaders are supported through training and resource sharing that increases their capabilities in volunteer management and unit response capacity.

AT LEFT: PHILADELPHIA MRC, PENNSYLVANIA

The findings in this report warrant a focus on sustainment of funding to adequately resource paid staff tasked with managing an MRC unit. While most units are led by paid staff, 66% of unit leaders devote 14 hours or less per week to the MRC. Smaller jurisdictions were especially impacted by limited paid staff support compared to larger jurisdictions. This limited amount of paid staff time devoted to managing an MRC limits a unit's abilities and can impact their response capabilities. For example, a key barrier to recruitment, unit leader time constraints, was reported by 58% of respondents, which presents challenges to ensure the unit has the number of volunteers it needs to meet response needs.

Data also points to a need to retain and foster professional development among unit leaders. A quarter of unit leaders (23%) have served in their position for one year or less. This highlights a need to ensure that training and resources are readily available and accessible to leaders who are new in their role. At the same time, 36% of unit leaders have served for six or more years. This presents opportunities for knowledge sharing and mentorship with newer unit leaders.

Invest in volunteers

NACCHO recommends a shared investment at the local, state, and federal levels to sustain and grow recruitment of volunteers who represent the communities they serve, especially as relates to race/ethnicity, and those who represent the next generation of the MRC. NACCHO further recommends establishment of uniform baseline standards for volunteers and the subsequent resources to support those standards. This includes administrative guidance for background screenings, legal protections, and establishment of a uniform standard of baseline training requirements for volunteers.

Unit demographic information highlights the range of professional skillsets volunteers bring to their communities. Conversely, it also illustrates opportunities for those in the network to better capture data, especially as relates to race/ethnicity, and to use this data to better target volunteer and leader recruitment to ensure units are representative of the communities they serve. It also points to an opportunity to recruit younger volunteers from high schools, colleges, and universities.

Volunteer training is a key component of unit activities, as it prepares volunteers to respond, fosters volunteer engagement and retention, and offers opportunities to nurture external partnership through joint training events. Continued investment in training activities is critical to unit success. As units look to develop or diversify their training offerings, this report's data can serve as a resource and benchmark. When looking at current volunteer training activities, most units (70%) do have a written training plan, yet less than half of the overall units are utilizing the MRC Volunteer Core Competencies. This highlights opportunities to strengthen the use of national standards to develop volunteer capabilities that can be supplemented by local mission training requirements.

It is also important to note that legal protection for MRC unit volunteers varies between states and jurisdictions. These protections were lacking and show a need for more resources and education in this area to provide MRC volunteers the protection that they require.

Champion value of MRC

In 2022, MRC volunteers contributed over 1,114,618 hours of service to communities across the country, 603,587 of which were dedicated



MRC LEADERS, REGIONS 4 AND 6

to COVID-19 response. This demonstration of surge capacity staffing presents an opportunity to leverage success stories from COVID-19. The number and diversity of capabilities and mission sets developed and deployed by units in 2022 also demonstrates the breadth and depth of units and their ability to respond to community needs. Clearly articulating the value of the MRC to key stakeholders and leaders will ensure this surge capacity workforce is trained and ready to meet future emergency response needs, and is integrated into response plans to ultimately contribute to community resiliency.

NACCHO recommends the following to champion the value of the MRC at local, state, and federal levels:

Strengthen community partnerships and integration of MRC into response plans

NACCHO recommends the development of tools to nurture local partnership building, including dedicating resources that further the integration of the MRC into local response plans. NACCHO further recommends leaders identify and invest in capabilities of MRC units to build community resilience outside of emergency response scenarios.

About one quarter (24%) of units reported that a barrier to recruitment is that volunteers are not highly utilized in their jurisdiction. This is a



barrier that can be addressed through a community needs assessment to better understand the resource gaps and identify support roles for the MRC. Volunteers that are engaged in building community resilience during non-emergencies develop experience and earn trust with community partners to support emergency responses.

It is vital for MRC units to engage and collaborate with local stakeholders to promote their capabilities to meet public health priorities and response needs for public health emergencies. The data presented helps communities to assess their own partnerships in relation to those across the network and illustrates opportunities for continued cultivation of partnerships at the local, state, and national levels.

Provide tools and training to help leaders articulate value of MRC

NACCHO recommends providing tools that equip leaders to educate state and local policymakers about the MRC's ability to respond to emergencies and foster community resiliency.

Effective communication of unit capabilities to key stakeholders can support increased utilization of volunteers. MRC leaders would benefit from additional tools, templates, and trainings to help them articulate and share the capabilities of their units with key stakeholders.

A Shared Investment in the Future of the MRC

In its first 20 years of service, the MRC network demonstrated its capabilities locally and collectively nationwide. To accomplish the above recommendations, an increased, shared investment at local, state, and federal levels is vital. While 2022 saw historic investment in the MRC, similar investment is not guaranteed in the future. It will be important to assess the impact of this one-time ARP funding and share broadly its impact on community resilience.

Further investments in the network will ensure a scalable public health workforce that fosters resilient communities while being trained and ready to respond to emergencies.

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2022 NETWORK PROFILE
20TH ANNIVERSARY

THE MEDICAL RESERVE CORPS TWO DECADES OF SERVICE

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