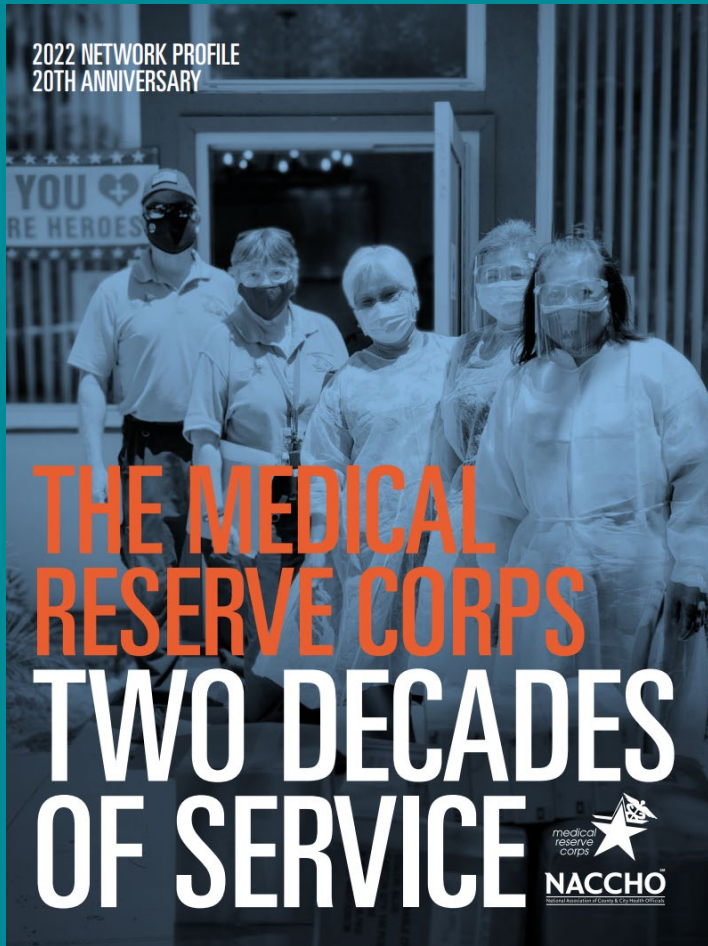


2022 NETWORK PROFILE
20TH ANNIVERSARY



**THE MEDICAL
RESERVE CORPS**
**TWO DECADES
OF SERVICE**



The Medical Reserve Corps 2022 Network Profile

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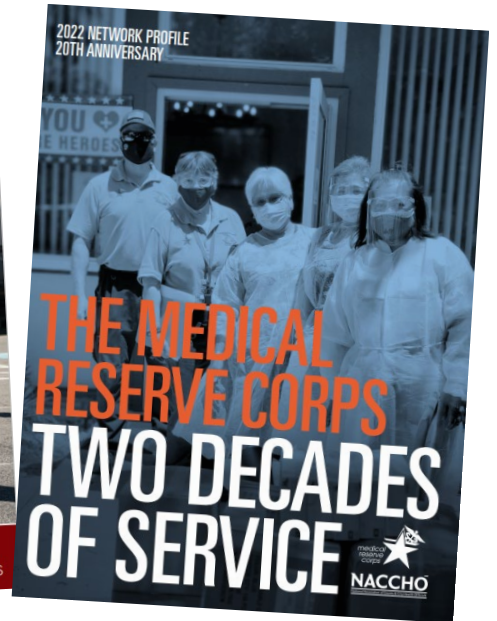
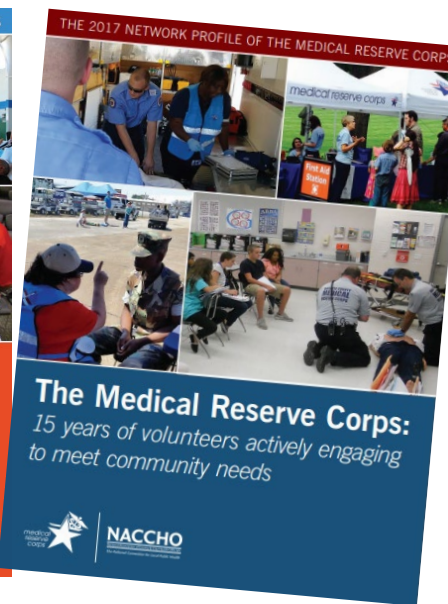
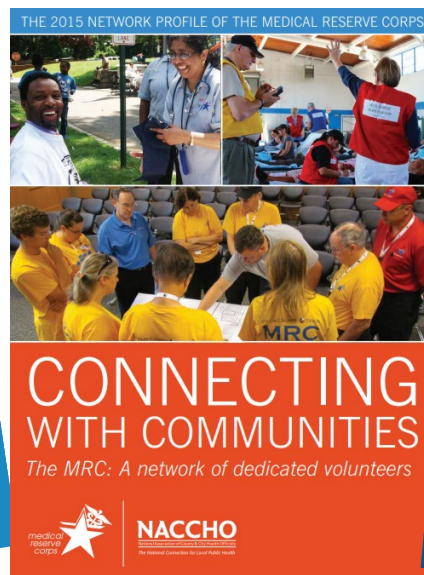
MRC Program Office

All units

Tremendousness and DCG One

MRC Network Profile Overview

- Began in 2013
- Since then, 5 reports have been published



- <https://www.naccho.org/programs/public-health-preparedness/medical-reserve-corps/mrc-network-profile>

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- The report has five parts, each part is presented in a different color, to the right.
- Colors corresponding to each part's heading run along the bottom of the page.

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Graphs, Tables, Charts

- Within the text are references presented in a color that corresponds to the heading in its graphic representation.

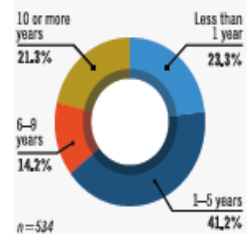
Overall, 23% of respondents reported serving less than one year as unit leaders, and 41% have served between one and five years. About one-third (36%) of unit leaders had served six years or more, **FIGURE 7**.

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 7: Years as leader



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 9: Volunteer race/ethnicity

n=49*	Overall mean	US Average ¹
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

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

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Key findings

- 2 or 3 key findings from each section are highlighted at the beginning of the Part in orange.

PART 2

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

Future Directions and Recommendations

PART 5

- Part 5: Future Directions
 - Highlights overall findings and recommendations from the 2022 MRC Network Profile.
 - These recommendations can be used to spark conversations with stakeholders and other important partners.

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

Infographics

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

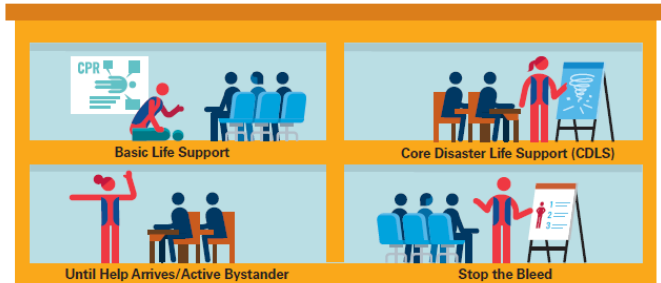
TRAINING



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



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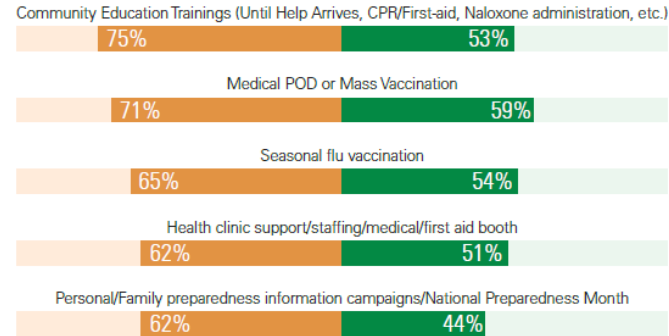
INFOGRAPHIC

MRC Unit Capabilities



DEVELOPED/ADAPTED

DEPLOYED

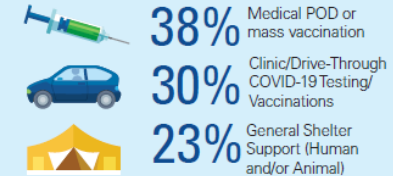


COVID-19



96% of respondents deployed to COVID-19 between Jan 1, 2020-Dec 31, 2022

TOP 3 MISSION SETS DEVELOPED



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



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More infographics

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

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TIMELINE

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 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.

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.

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 Wado 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 900 units and 300,000+ volunteers.

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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

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

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

AVERAGE NUMBER OF VOLUNTEERS PER UNIT

126

AVERAGE NUMBER OF VOLUNTEER HOURS PER MRC UNIT

933 (Non-emergency)

1,268 (COVID-19 only emergency responses)

1,419 (Emergencies including COVID-19)

*DISTRIBUTION OF UNITS

11% Urban

4% Mixed urban and suburban

20% Suburban

10% Mixed suburban and rural or suburban and frontier-remote

51% Rural and/or Frontier/Remote

2% Other Combination

*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.

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Webpage Demonstration

- <https://www.naccho.org/>
- <https://www.naccho.org/programs/public-health-preparedness/medical-reserve-corps>
- <https://www.naccho.org/programs/public-health-preparedness/medical-reserve-corps/mrc-network-profile>