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

13-06

STATEMENT OF POLICY

Medical Reserve Corps

Policy

The National Association of County and City Health Officials (NACCHO) supports the full integration of the Medical Reserve Corps (MRC) into local public health emergency readiness, response, and recovery activities to support community resiliency. NACCHO urges local health departments to sponsor or partner with an MRC unit to build their capacity and integrate MRC units in public health emergency readiness, response, and recovery planning efforts, as well as day-to-day public health activities. NACCHO urges Congress and the Administration to provide adequate funding to ensure MRC units have the resources to build, sustain, and improve their capacity and capability to support their local communities.

NACCHO also supports the legislation that establishes and authorizes funding for the MRC program through the Pandemic and All-Hazards Preparedness and Advancing Innovation Act (PAHPAI) (S. 1379.).

Justification

The MRC program is a national, community-based corps of medical and non-medical volunteers with a mission to strengthen public health, emergency response, and community resiliency. It is housed within the Department of Health and Human Services, Office of the Assistant Secretary for Preparedness and Response (ASPR). The program has more than 186,000 volunteers in 885 units across the United States.[1] This is a decrease from 2017, when the MRC strength was almost 200,000 volunteers within almost 1,000 units. This decrease in MRC volunteers and units aligns with the multi-year decrease of funding from $9 million in 2015 to $6 million in 2016 and consecutive years.

Local MRC unit volunteers have the potential to expand the workforce within their local communities and fill critical public health emergency response resource gaps. These resources support the tiered model of emergency responses being supported first at the local level, and help to offset resource requirements from the state or federal level. The economic value of MRC volunteers contributing to the historic 2017 hurricane season was almost $4 million (not including the value of other emergency responses that year.)[2] Without appropriate funding levels to sustain MRC unit operations and capabilities, communities may need to rely more heavily on state or federal resources.

These units are committed to strengthening public health; reducing vulnerabilities; improving local preparedness, response and recovery capabilities; and building community resilience. MRC units have supported numerous community public health missions, participated in local and regional exercises across the country, and responded during emergencies when called upon by local and state response agencies. MRC units' capabilities can vary according to community

needs, geographic region, and local investments, among other factors,[3] and each unit provides a unique set of capabilities to their communities – before, during, and after emergencies. Section 301 of PAHPAI reauthorized the MRC to provide for an adequate supply of volunteers in the case of a public health emergency. In addition, it cites local response capabilities to be coordinated with local MRC units.

MRC units train their volunteers to meet standardized core competencies, developed by NACCHO, that align with those of the National Center for Disaster Medicine and Public Health. Continuing efforts to support the integration of local MRC units into public health emergency readiness, response, and recovery activities further advances a unified and systematic approach to improve the health, safety, and resiliency of local communities, states, and the country, and reduces disaster risks by maximizing the whole of the community approach and all available resources. The *2016 National Profile of Local Health Departments* indicated that local health departments that used volunteers in an exercise in the past year were more than twice as likely to use volunteers during an event.[4]

The *2017 MRC Network Profile of the Medical Reserve Corps* highlights additional key metrics to demonstrate the readiness of MRC volunteers:[5]

- 96% of MRC units verify credentials of medical volunteers
- 83% have some type of liability coverage
- 74% perform criminal background checks
- 75% responded to an emergency
- 85% offered Intro to Incident Command System (ICS) Training
- 87% capable to provide mass vaccination/mass dispensing services
- 89% are integrated into their housing organization's emergency plans
- 92% train with another organization

Since the beginning of 2017, MRC units across the country have served as a valuable resource in combating the opioid crisis in local communities. Several MRC units are engaged in prevention activities to inform and aid communities in response to the recent increase in opioid abuse, enhance community education around opioid addiction, and reduce the number of individuals who die from opioid overdoses.[6]

Furthermore, the MRC is uniquely identified in several national emergency preparedness and planning guidelines. ASPR's 2017-2022 Health Care Preparedness and Response Capabilities document discusses 'Health Care Volunteer Management' as part of medical surge/alternate care site planning, including specific tasks to anticipate situations where hospitals would require volunteer support, identify processes to integrate volunteers, leverage existing registration programs such as the MRC, and develop rapid credential verification processes.[7]

The need to integrate volunteers as partners into public health planning and preparedness activities is also supported by the Centers for Disease Control and Prevention (CDC) in their Public Health Emergency Preparedness and Response Capabilities. MRC units are positioned to provide the additional staffing resources required to meet these CDC guidelines for Public Health Emergency Preparedness and Response Capabilities, specifically Capability 15-Volunteer Management requirements.[8]

The MRC as a network has a proven record of demonstrating its ability to perform these functions. In Fiscal Year 2018, MRC units nationwide participated in 17,396 total activities, contributing nearly 410,000 service hours. These activities had significant local impact: 580 responses to local emergencies; 9,488 activities in which MRC members strengthened the local public health system; 5,572 activities that served an at-risk/vulnerable population; 6,640 activities that supported non-emergency community events; 11,238 activities that developed or strengthened the MRC unit; 9,218 activities that improved community preparedness or resilience; and 6,461 activities that trained or exercised MRC members to improve individual, unit, or community response capability and capacity.[9]

MRC units also have the potential to deploy across and outside of their state. In 2017, 25% of units reported developing mission-ready packages or response teams. Some of the most common deployments include the following:[10]

- Local Deployment Activities: emergency community outreach (57%); first responder rehabilitation (55%); and, logistics (52%).
- Intra-State Deployment Activities: virtual operations support (20%); radiation response (20%); epidemiology (19%); and first responder rehabilitation (19%).
- Inter-State Deployment Activities: acupuncture (9%); behavioral health (4%); HAM radio (4%); and mass fatality (4%).

Public health and emergency preparedness and resiliency practices require that communities prepare for, withstand, and recover from both natural and manmade incidents. Public health and emergency response officials can further strengthen and augment their existing capabilities by engaging their local MRC units to help keep the public safe and healthy.

References

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Record of Action

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