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 and other public health entities to create, 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 and sustained funding to ensure MRC units have the resources to build, sustain, and improve their capacity and capability to support their local communities. Additionally, NACCHO supports maintaining the cooperative agreement with the Administration for Strategic Preparedness and Response (ASPR), under which NACCHO has distributed MRC awards directly to local MRC, ensuring timely and efficient receipt and use of resources.

Justification

The MRC program is a national, community-based corps of medical and non-medical volunteers with a mission to strengthen public health, healthcare delivery, medical skills and surge capacity, emergency response, and community resiliency, housed within ASPR. The program has more than 200,000 volunteers in roughly 800 units across the United States.[1] Although the number of volunteers has continued to grow, there has been a decrease in the number of units from 2017, when the MRC network was almost 1,000 units strong.

The decrease in the number of MRC units aligns with the multi-year decrease of annual funding from $9 million in 2015 to approximately $3 million in 2020 to support building MRC unit infrastructure and capacity. Given MRC volunteers' primary role as emergency public health workforce expanders, the reduction of sustainable annual funding for MRC programs directly impacts the resiliency of local health departments and the communities that they serve to provide a trained and ready workforce. In fact, the 2020 Network Profile of the MRC report found that 33% of MRC units operated without any funding.[2] Recent one-time funding from ASPR in the amount of $20 million from the American Rescue Plan Act will serve to rebuild the capacity of MRC units who have actively worked to respond to COVID-19, but additional sustained funding is needed to ensure the longevity of the MRC program's ability to respond to the public health needs each jurisdiction that they serve.[3]

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. Without appropriate annual funding levels to sustain MRC unit operations and capabilities, communities will 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 fostering community resiliency. 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, state, and federal response agencies. ASPR reported that MRC units throughout the United States served approximately 3 million hours in response to the COVID-19 pandemic, which equates a workforce savings of over $85 million dollars according to Independent Sector estimates. [1, 4]

MRC units' capabilities can vary according to community needs, geographic region, and local investments, among other factors,[2] and each unit provides a unique set of capabilities to their communities – before, during, and after emergencies. Section 301 of the Pandemic and All-Hazards Preparedness and Advancing Innovation Act of 2019 reauthorized the MRC to provide 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 2019 National Profile of Local Health Departments indicated that 55% of local health departments used MRC volunteers to prepare for public health emergency activities. [4] The 2020 MRC Network Profile of the Medical Reserve Corps highlights additional key metrics to demonstrate the readiness of MRC volunteers:[2]

- 97% of MRC units verify credentials of medical volunteers
- 86% have some type of liability coverage
- 66% perform criminal background checks
- 84% of MRC units responded to the COVID-19 emergency
- 96% offered Intro to Incident Command System (ICS) Training
- 89% capable to provide mass vaccination/mass dispensing services
- 91% are integrated into their housing organization's emergency plans

In addition to responding to the COVID-19 pandemic and other local arising emergencies, MRC units across the country have served as a valuable resource in combating the opioid crisis in local communities since 2017. Numerous 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.[5]

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.[6] NACCHO created the Deployment Readiness Guide in 2019 with its most recent update in 2021 to assist units in meeting these goals by providing structured mechanisms such as mission sets to assist MRC units in successfully deploying in a variety of emergency situations.[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 the MRC Factors for Success and 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 2020 alone, MRC units nationwide participated in 16,584 total activities, contributing nearly 820,000 service hours. MRC units also have the potential to deploy across, outside of their state, and even assist at the federal level. A key example of this multi-level MRC response can be found in the Afghanistan repatriation and refugee emergency in 2021.[10] MRC units worked locally and with their state and federal partners. Some of the most common emergency capabilities include the following:[2]

- Local Deployment Activities: Medical POD or mass vaccination (89%); alternate care site/medical surge (54%); and mass casualty support (54%).
- Intra-State Deployment Activities: volunteer reception center (52%); radiation response (25%); epidemiology (37%); and first responder rehabilitation (33%).
- Inter-State Deployment Activities: disaster resilience including Psychological First Aid, acupuncture, and disaster mental/behavioral health (71%); HAM radio (4%); and mass fatality (54 %).

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.

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Record of Action

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