

# N A C C H O Exchange

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## What's Inside...

6 Assessing Climate Change and Health in New Orleans

10 The MRC's Role in Promoting Community Health and Preventing Chronic Disease

14 Strengthening the Public Health Response Infrastructure by Empowering Community Partners and Volunteers

19 Until Help Arrives: The MRC's Role in Building Community Resiliency

## The Medical Reserve Corps – An Interview with Leaders Captain Rob Tosatto and Commander Skip Payne



*Captain Rob Tosatto, Director of the Medical Reserve Corps Program*

By Brennan J. Leddy, M.A.Ed (Ctr), Communications Specialist, Medical Reserve Corps Program, Partner Readiness and Emergency Programs Division, Office of Emergency Management, Assistant Secretary for Preparedness and Response, U.S. Department of Health and Human Services

The Medical Reserve Corps (MRC) is a national network of volunteers, organized locally to improve the health and safety of their communities. This year, the MRC celebrates its 15-year anniversary!

The idea for the MRC began forming following the Sept. 11, 2001, terrorist attacks when thousands of spontaneous volunteers, many health care professionals, offered their services in support of response and recovery efforts. Unfortunately, many could not be utilized because emergency managers did not have the capability at the time to verify their backgrounds, training, or credentials. The anthrax incidents that occurred in October and November of that same year further confirmed that health and medical volunteers could be instrumental in assisting with large-scale disaster or public health emergency responses.

In 2002, President Bush's State of the Union Address called on all Americans to volunteer in support of their country. From that call to action, the MRC Demonstration Project was created. The project began with 42 community-based units of medical, public health, and other volunteers. The mission then was the same as it is now—to engage local communities to strengthen public health, reduce vulnerability, build resilience, and improve preparedness, response, and recovery capabilities.

In 2006, the Pandemic All-Hazards Preparedness Act authorized, in law, the Medical Reserve Corps program. Since those early beginnings, the MRC network has evolved to over 200,000 volunteers—from youth to seniors—in almost 1,000 units nationwide.

The MRC Program, originally housed in the Office of the Surgeon General, functions as the national program office of the MRC. It is responsible for supporting local efforts to establish, implement, and sustain MRC units so they can achieve their local visions for public health and emergency preparedness. In 2013, Congress reauthorized the Pandemic All-Hazards Preparedness Act, placing the MRC Program under the purview of the Department of Health and Human Services Office of the

*continued on page 2*

## The Medical Reserve Corps – An Interview with Leaders Captain Rob Tosatto and Commander Skip Payne

*continued from page 1*

Assistant Secretary for Preparedness and Response.

NACCHO recently sat down with Captain Rob Tosatto, Director of the Medical Reserve Corps Program, and Commander Skip Payne, Deputy Director, to discuss and reflect on the program's history, its mission, and the resilient strength of its network.

**NACCHO:** You each followed a unique path to your leadership role within the MRC Program. Can you briefly share a bit about your background and how you arrived in your current position?

**Captain Tosatto:** I joined the U.S. Public Health Service (USPHS) in 1988 while I was still a pharmacy student. After several tours with the Indian Health Service as a Clinical Pharmacist, I decided to pursue graduate degrees in public health and business administration (MPH/MBA) with a focus on health care organization and policy. Subsequent USPHS positions helped to hone my organizational and leadership capabilities, especially as I was tasked with developing new programs. Deployments gave me experience in the preparedness and response realm.

**Commander Payne:** I started my public health career in the state of Ohio as a local public health epidemiologist and bioterrorism readiness coordinator. It was there that in 2005, I had the fortune of starting a local Medical Reserve Corps unit. Feeling the pull to serve at a national level, I commissioned in the USPHS in 2007 and served as a Consumer Safety Officer in the U.S. Food and Drug Administration (FDA) Detroit District

Office for a couple of years. While serving at the FDA, I joined the USPHS Rapid Deployment Force Team 3, a team comprised of USPHS Commissioned Corps Officers who are prepared to respond during a disaster or other public health emergencies. During one of our training rotations, I had the opportunity to reengage with the local Medical Reserve Corps members who were in attendance and shortly after, applied and accepted a program officer position within the MRC National Program Office.

**NACCHO:** Captain Tosatto, you took the leadership helm in 2003. What was the program's vision and growth plan at that time?

**Captain Tosatto:** It's fun for me to think back to those early years, particularly the excitement and innovation we felt as we worked to build the program and create our vision together as a network. The demonstration project in 2002 and that initial cadre of MRC units really sought to prove a concept—that communities could establish a mechanism to credential, train, and activate local health professionals and volunteers to meet public health and emergency needs.

At the time, we felt that concept was both viable and sustainable, but there were certainly a lot of "what if?" questions that we were asking ourselves. I think those first two years of the demonstration project, when the number of communities awarded grants to form MRC units quickly grew from 42 to 166, helped to solidify our vision and proved that the MRC model would work. We were building a national program with a national mission, carried out at the local level.

Regarding a specific growth plan, we set fairly modest goals in the beginning and wanted to focus more on building capabilities and the strength of each unit. As the network grew, we began to see what at one point seemed like dream goals come to fruition. I will say, it was pretty awesome when we reached 1,000 units in 2014.

**NACCHO:** Building on that initial vision and plan for the program, what are your thoughts on where the MRC stands today?

**Commander Payne:** Our MRC program and network continue to be strong and sustainable. I say this not only because of the sheer number of units across the country, but because of the partnerships, initiatives, and capabilities that our units have built and continue to grow. I like to think that we, at the Program Office, are really leading "a network of networks." Essentially, we're bending the network back on itself so that our seasoned units and mentors can help lead by example.

Using the four stages of group development, forming, storming, norming, and performing, individual units may be in various stages themselves—ranging from new to more seasoned units—but our program as a whole is in the norming stage. Our mission remains unchanged and we're standardizing our capabilities. For example, we're currently in the process of building mission ready packages (MRPs) for specific MRC preparedness and response capabilities. Sharing these across the network, which also include templates and training plans, will help with standardization and best practice replication while still allowing units to be customizable to their communities' needs. We want to ensure that an MRP that one unit has built to showcase their mass vaccination capabilities need not have to be recreated by others hoping to demonstrate and offer the same services in their communities.

**NACCHO:** Has MRC volunteer recruitment strategy changed over the years as units have grown in numbers and size?

*continued on page 3*

## The Medical Reserve Corps – An Interview with Leaders Captain Rob Tosatto and Commander Skip Payne

*continued from page 2*

**Captain Tosatto:** We offer best practices and technical assistance at the national level, but volunteer recruitment is carried out primarily at the local level and it can vary widely. A lot of MRC units look first to their medical associations and societies, professional schools, and other similar organizations for volunteers. Being able to offer medical professionals with continuing education credits as part of their volunteer service and training is a huge plus. Other units choose to place ads and commercials in local media. Many units recruit while conducting local public health activities in the community.

**Commander Payne:** I will say that what we've found is that the best way to recruit is through word of mouth. That direct referral from a friend or family member seems to attract volunteers who both understand the personal commitment and are committed to the program mission.

**NACCHO:** As the MRC celebrates its 15th anniversary this year, what have been some of the largest or most impactful responses in which units have participated?

**Captain Tosatto:** In the early years, the 2004 and 2005 hurricane seasons really stand out. Florida was hit especially hard with Hurricanes Charley, Frances, Ivan, and Jeanne in 2004. And then Hurricanes Katrina and Rita hit Louisiana and Texas in 2005. During each event, local MRC units stepped up immediately and showed their value. And what I think may have been initially surprising to many that early on was that the units were not only able to supplement local emergency response capabilities, but that they were able to assist the states, federal government, and non-governmental organization partners like the Red Cross in their response efforts. These hurricanes were really the first large-scale emergency responses for the MRC and our success showed that the demonstration project was worth it.

I also think of the MRC's response during the H1N1 outbreak in 2009–2010 as a pivotal time for our program. Before the H1N1 vaccine was developed, our units were extremely active in health education and outreach, teaching the public proper hand-washing techniques and cough etiquette. Then, when the vaccine came out, units quickly organized and assisted with mass vaccination clinics in communities across the country.

**Commander Payne:** There are two additional events that come to mind for me: the Reno Air Races in 2011 when a plane crashed into the crowd during the air show, and the Boston Marathon bombing in 2013 where MRC members were volunteering under the Boston Athletic Association. In both circumstances, MRC units were working the events in their traditional capacities, leading and working in first aid stations, managing traffic and crowd control, etc. As soon as tragedy struck, they were able to switch gears immediately and assist emergency responders with a mass casualty event. We often say that MRC volunteers are “ready, willing, and able,” and I think the circumstances of both of these events speak to those abilities.

**Captain Tosatto:** It's also important to point out that while we just listed a few high-profile responses, when you think about the real impact of MRCs over time, it is more likely the public health initiatives that have a far greater reach. It's the physical activity and healthy eating initiatives, the vaccination clinics, the blood pressure screenings—all of the things that local health departments would love to do if they had sufficient money and staffing. MRCs can help fill those gaps and I believe that impact on the community is significant.

**NACCHO:** Are there any emerging public health challenges or initiatives in which you see the MRC taking a lead role?

**Commander Payne:** I think we've already seen the MRC begin to play a significant role in combating the opioid crisis locally, primarily because our volunteers live in these communities and have seen the devastating impact first-hand. They also

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*continued on page 4*

## The Medical Reserve Corps – An Interview with Leaders Captain Rob Tosatto and Commander Skip Payne

*continued from page 3*

“Every single unit is different based on community need, funding resources, and a host of other variables, yet the mission of improving public health and safety remains constant.”

understand the value the MRC can bring to help. From outreach and education, to hosting drug take-back events, to training law enforcement on the use of nasal naloxone, units have really been at the forefront of this issue for a few years now.

Another initiative that I see the MRC starting to take a lead role on is the recently launched “You are the Help Until Help Arrives” curriculum. This program, spearheaded by a number of federal partners, aims to educate and empower the public to take action in an emergency situation before professional help arrives. Many MRC units have already begun to promote the program locally and host training events for the community. I’m excited to see it take off!

**Captain Tosatto:** Not necessarily a public health challenge, but an initiative where I’ve seen a lot of growth in recent years is youth engagement. MRCs are working with local schools and organizations like HOSA-Future Health Professionals to channel the energy and enthusiasm of young people and make them better informed peer educators. It’s really inspiring to watch.

**NACCHO:** What are some of the more innovative responses or initiatives you’ve seen MRC units undertake?

**Captain Tosatto:** That’s a tough one, as there is so much innovation amongst the MRCs. Some units have established community gardens. It’s an initiative that I wouldn’t have thought of myself, but I love the idea. Local, healthy food made available to the community, and even distributed through the Women, Infants, and Children program and food banks, which I know at least one of the units has done, certainly has a positive impact on public health.

I also think about the MRC’s role during the Ebola response, and the unit in Minnesota that created a Cultural Services Unit to reach the community’s West African population. Through their creativity and sensitivity, the MRC really became a trusted messenger and knowledge source. This was especially important at the time when there was

a lot of mistrust and misinformation circulating around Ebola.

**Commander Payne:** When I think of innovation, some of our alternative MRC units come to mind as well. For example, there is an acupuncture unit in Colorado that has provided services to first responders and survivors after traumatic events. They established their unit based on community need and are doing a wonderful job sharing resources and success stories within the network. In fact, just this spring, the unit developed an Acupuncture Mission Ready Package.

We also have units that are dedicated to animal health issues. Particularly in rural areas with a lot of farm animals, those units meet the unique needs of their communities. This spring, the Oklahoma MRC’s Animal Response Team was critical during a tornado response in Elk City.

That’s one of the things that I love so much about the MRC Program as a whole. Every single unit is different based on community need, volunteer capabilities, funding resources, and a host of other variables, yet the mission of improving public health and safety remains constant.

**NACCHO:** What have been some of the hardest challenges the program has encountered over the years?

**Captain Tosatto:** To piggy-back on Commander Payne’s answer to the previous question, I’ve also found that sometimes the differences and non-uniformity of units have posed a challenge. This happens particularly when I’m trying to talk broadly about the network, but find myself having to caveat that one unit may offer a capability while another unit may not. I always end my conversations with “it’s best to talk to your local MRC unit leader!”

**Commander Payne:** The MRC model isn’t reflected anywhere else in federal government. When we talk about assets and capabilities that we don’t technically own, nor that we have command and control over, that makes folks—particularly within government—

*continued on page 5*

## The Medical Reserve Corps – An Interview with Leaders Captain Rob Tosatto and Commander Skip Payne

*continued from page 4*

uncomfortable. While we are very comfortable with it from the MRC Program Office perspective, it's often a challenge to convince others that the model works and that you don't always need "command and control" in order to effectively lead.

Effective advocacy and turnover are also challenges that we face. Effective advocacy requires the network to do a lot of educating at the local level. Due to being mistakenly classified as lobbying efforts, appropriate and effective advocacy efforts seemed to be overlooked by housing organizations, making it a tough area to gain traction. And then, when there's financial instability, there's often turnover among MRC unit leaders. As a Program Office, I think we've been able to mitigate some of these challenges by ensuring we're able to provide an array of technical assistance and support the spectrum of transitions that we see—from brand new units coming onboard, to turnover in unit leaders, to making sure that we are continuing to encourage and engage our seasoned leaders.

**NACCHO:** On the flip side, what do you think are the top reasons the MRC has been so successful over its 15-year history?

**Captain Tosatto:** We would not be where we are today without the highest levels of support we received early on, including true champions in the Surgeon General and White House administration. Their unwavering commitment and support—and belief that this would work back in 2002—were the reasons the MRC was able to realize that early growth. As a leader, I knew that I had their trust to meet challenges head-on, discard what may not be working, and perfect and replicate what was.

Our success is also attributable to our early stakeholders outside of the DC Beltway. Understanding that I only had a small program office in Washington, DC, I approached the Regional Health Administrators (RHAs) back in 2004 to gauge their willingness and support for MRC regional staff to sit within

their RHA offices. I knew we needed champions outside of headquarters at the regional level and went to the RHAs for their thoughts. The idea was met with overwhelmingly positive feedback and that was really the start of what is currently our MRC Regional Liaison role—a critical component of our structure today.

Along those same stakeholder lines, we showed the states very early on that we were willing and eager to work with them. And because of that early partnership, we now have a designated MRC State Coordinator from each state. The states did not have to designate those folks, but because of their willingness to do so and understanding of the value it brings, our network is undoubtedly stronger.

**Commander Payne:** I would echo Captain Tosatto's thoughts. The speed of innovation was not restricted early on by the highest levels of leadership and that sent an important message—the MRC was not going to be led by a top-down hierarchy. We are a successful program because our network often leads the way. This is their program just as much as it is ours.

**NACCHO:** Finally, Captain Tosatto, we understand you are retiring this summer. Any parting words of wisdom?

**Captain Tosatto:** I am not sure if this is wisdom, but I would encourage all to stay positive. There will be challenges in any work, but optimism can usually be found. Most of all, have fun!

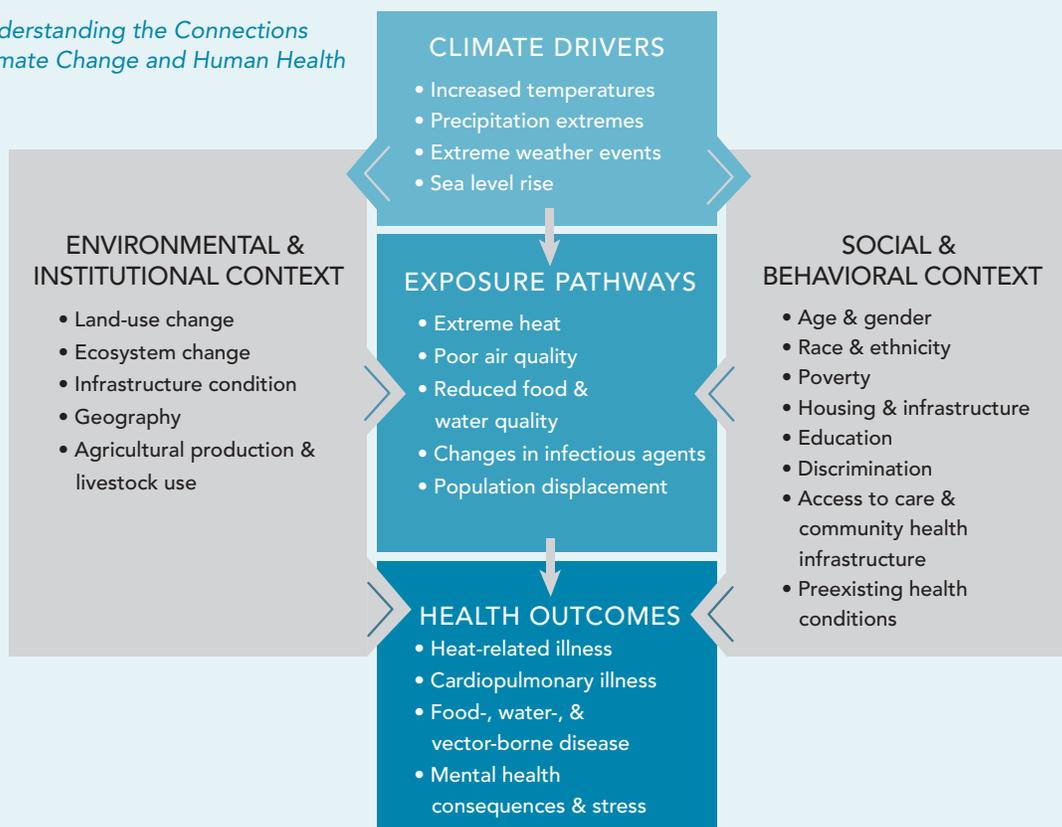
I am extremely grateful for the opportunity I have been given to grow and lead this amazing program. I leave knowing that it is in the good hands of Commander Payne and the MRC Program team. The MRC network is strong, the unit leaders are very capable, and the volunteers are dedicated to the health and safety of their communities. What more could I ask for as I turn over the reins? 🍷

*For more information about the Medical Reserve Corps, visit <https://mrc.hhs.gov>.*

"We are a successful program because our network often leads the way. This is their program just as much as it is ours."

# Assessing Climate Change and Health in New Orleans

Figure 1. Understanding the Connections between Climate Change and Human Health



Source: Environmental Protection Agency (<https://www.epa.gov/climate-indicators/understanding-connections-between-climate-change-and-human-health>)

## Introduction

By Kathy Deffer, Senior Program Analyst, Medical Reserve Corps, NACCHO

The influences of weather and climate on human health are significant and varied. Exposure to health hazards related to climate change affects people and communities to different degrees. While often assessed individually, exposure to multiple climate change threats can occur simultaneously, resulting in compounding or cascading health impacts (see Figure 1).

Because of climate change, the frequency, severity, duration, and location of weather and climate phenomena—rising temperatures, heavy rains and droughts, and some other kinds of severe weather—are changing. This means that areas already experiencing health-threatening weather and climate phenomena, such as severe heat or hurricanes, are likely to experience worsening impacts, such as higher temperatures and increased storm intensity, rainfall rates, and storm surge. It also means that some locations will experience new climate-related health threats. For example, areas previously unaffected by toxic algal blooms or waterborne diseases because of cooler water temperatures may face these hazards in the future as increasing water temperatures allow the organisms that cause these health risks to thrive. Even areas that currently experience these health threats may see a shift in the timing of the seasons that pose the greatest risk to human health.

The impacts of climate can affect human health in two main ways: first, by changing the severity or frequency of health problems that are already affected by climate or weather factors; and second, by creating unprecedented or unanticipated health problems or health threats in places where they have not previously occurred.<sup>1</sup>

The City of New Orleans is an example of one city that has been impacted by global warming. Recognizing the need to take action, the New Orleans Health Department took key findings from a climate vulnerability assessment and identified ways that the Medical Reserve Corps (MRC) could be trained and mobilized to respond to climate threats and conduct outreach related to climate change.

## Assessing Climate Change and Health in New Orleans

*continued from page 6*

### **The City of New Orleans**

*By Marsha Broussard, DrPH, MPH, Health Director, New Orleans Health Department*

Since Hurricane Katrina, rebuilding the City of New Orleans has been an arduous task. Even with over 50 years of experience dealing with adverse weather and its long-lasting consequences, we continue to develop and refine collaborative and inclusive approaches to finding long-term solutions to the impending issues our city faces in the near future. Taking climate change into consideration, we are developing mitigation and adaptation strategies to protect our families from rising sea levels, hurricanes, and flooding. But water is only one of our concerns. According to the Third National Climate Assessment, the Southeast of the United States is already experiencing the imminent threats of climate change. Observed and projected climate change impacts include (1) increased temperatures and extreme heat events; (2) sea level rise leading to coastal erosion, salt water intrusion, and subsidence; and (3) changes in precipitation patterns and increased severe weather events such as hurricanes.<sup>2</sup>

As Mayor Mitch Landrieu said, “For New Orleans, and many coastal cities, climate change is a matter of life and death. We cannot wait for global action,

we are adapting our city and our lives to the risks ahead.”

In 2015, the Public Health Institute (funded by the Kresge Foundation) selected the New Orleans Health Department (NOHD) to be one 13 local health departments to participate in a climate change and health learning collaborative. With this opportunity, our Healthy Environments and Emergency Preparedness programs conducted a climate vulnerability assessment using the Centers for Disease Control and Prevention’s Building Resilience Against Climate Effects framework as a guide. The potential impacts of climate change and extreme weather on our community highlighted the health effects on our most vulnerable populations and neighborhoods. Our research focused on increased heat, decreased air quality, and increased mosquito populations. In order to determine solutions to potential climate change impacts, we mapped vulnerability data by census tracts and identified the three most susceptible neighborhoods in Orleans Parish.

We utilized local sources to collect health information and climate specific data relative to health, such as emergency room visits due to heat stroke. Health information included hospitalization



*continued on page 8*



## Assessing Climate Change and Health in New Orleans

*continued from page 7*



surveillance for chronic illnesses such as diabetes, kidney disease, and cardiovascular disease. The Louisiana Public Health Institute retrieved data on chronic health conditions from the local health information exchange system. This system tracks people on Medicaid and Medicare using a community health center or Federally Qualified Health Center. Finally, we used 911 call data to examine heat-related calls. We are currently in the process of comparing the 911 call data to historical weather data. Results will be analyzed to identify call location patterns and at-risk populations. For example, if heat-related calls come from elderly residents within a specific neighborhood, we will respond with targeted community outreach to provide education on methods to stay safe during hot days and how to stay cool in their homes.

In partnership with the Gulf Coast Center for Law and Policy, the NOHD recently held community meetings within the three most susceptible neighborhoods. Our focus was to provide education on the health impacts of climate change and involve the residents in the conceptualization process to create innovative solutions based on community needs to better adapt, mitigate, prepare for, and respond to climatic changes.

The ideas that resulted from these meetings were classified into six categories:

- 1. Trust:** Local governmental officials should communicate information early and often. Transparency is paramount.
- 2. Education:** Residents would like to have information on affordable methods to prepare their homes against adverse weather and how to protect themselves.
- 3. Incentives:** City Council and City departments should offer incentives for companies and residents to make climate mitigation and adaptation investments such as installing solar panels, energy-efficient appliances, low-flow toilets and shower heads, purchasing zero emission vehicles, and planting trees and community gardens. They could also provide low-interest loans for energy-saving home renovations and solar panels. For policies and incentives for renewables and efficiency throughout the U.S., visit <http://www.dsireusa.org/>.
- 4. Public Spaces:** City facilities should meet multiple needs of the community. For example, recreation centers and libraries could be advertised as cooling stations and parks should have more trees for shade.

*continued on page 9*



## Assessing Climate Change and Health in New Orleans

*continued from page 8*

**5. Infrastructure:** Improve infrastructure to address climate change projections. This includes everything from improved drainage to bus stop canopies to protect from weather.

**6. Services:** Provide services to vulnerable residents such as checking on them during extreme temperatures and severe weather events or offering transportation to cooling stations and other sites where services are provided.

The community meetings also helped our Emergency Preparedness program update the emergency operation plans and develop procedures for issuing heat advisories, air quality alerts, and mosquito-borne illness cases.

Based on this assessment and the community conversations, the NOHD is developing a climate change and health report that highlights the actions our department will take and suggestions for other city departments to improve health outcomes related to climate change. Over the past year, we conducted internal climate change training and examined methods to integrate climate change into our programs. The 2017 Community Health Improvement Plan has already established climate change objectives that will remain a focus of our work for the next five years.

To expand on the initial project, the New Orleans Medical Reserve Corps (NOMRC), sponsored by the NOHD, received a Challenge Award from NACCHO to train its members to respond to climate change threats and conduct climate change outreach. Over the past year, we have trained the NOMRC members to participate in warming and cooling stations, conduct community outreach, respond to mosquito-borne illnesses (focused on Zika virus and West Nile), and contact vulnerable residents enrolled in the Special Needs Registry.

In preparation for hurricane season, we held eight meetings with local health care providers to provide guidance on how to update emergency operation plans and how to inform patients about the impacts of climate change.

This project has given our department a voice in the climate change and resilience conversations occurring throughout the city and across other city departments. As a result, the city's overall climate adaptation and resilience plan has added health as a main priority and considers the NOHD an essential partner. For example, the Department of Public Works is now proposing to add more bike lanes to increase environmentally friendly transportation and mobility options, and to plant more trees throughout the city to decrease flooding and improve air quality. The Sewerage and Water Board is designing natural drainage systems to avoid water stagnation and prevent mosquito breeding sites.

With these departments on our team, the NOHD is in a better place to prepare for and respond to the impacts of climate change. 📧

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For more information, visit <https://www.nola.gov/health/emergency-preparedness/new-orleans-regional-medical-reserve-corps/> or e-mail [healthdepartment@nola.gov](mailto:healthdepartment@nola.gov).

"This project has given our department a voice in the climate change and resilience conversations occurring throughout the city and across other city departments."

# The MRC's Role in Promoting Community Health and Preventing Chronic Disease

By James Randall, Yale School of Public Health, Intern, Medical Reserve Corps, NACCHO, and Mahlet Moges, Tufts University, Intern, Medical Reserve Corps, NACCHO



2016–2017 Farmington farmers market vendor Xong Lee

With the rising cost of health care, chronic disease prevention and health promotion are more critical than ever. Chronic diseases are responsible for seven of 10 deaths in the United States each year, and treating people with chronic diseases accounts for most of the nation's health care costs.<sup>1</sup> Many uninsured individuals end up seeking care for untreated chronic diseases at emergency departments (EDs) instead of through primary care physicians. For example, in 2013, almost 20 million uninsured individuals used EDs; 6.7% of those ED visits were for non-emergencies.<sup>2</sup> While health care reform has resulted in a decrease in the use of EDs for non-emergencies as an increasing number of patients have become insured, preventive public health programs remain vitally important. To further bridge the gap in access to preventive care, many communities have increased their community primary care and screening activities. MRC units in particular have begun implementing preventative programs that address chronic diseases in vulnerable populations, ultimately lowering health care costs for the uninsured and the health care system as a whole.

Increasing access to healthy food is one proven way to lower the prevalence of chronic disease. Many local health departments and MRC units are strategically targeting "food deserts," low-income areas in which residents do not have access to a supermarket or large grocery store.<sup>3</sup> Food deserts restrict disproportionately vulnerable communities, such as rural populations, from accessing healthy and nutritious food and put them at increased risk for developing negative health outcomes. Some studies found that predominantly black neighborhoods had 48% fewer chain supermarkets than predominantly white neighborhoods.<sup>4</sup> In addition to environmental factors that may lead to the creation of food deserts, sociodemographic factors such as income, education, and ethnicity remain important contributory factors to the presence of obesity in children and adults.<sup>5</sup>

Some communities affected by food deserts and high rates of obesity have tackled the inaccessibility to healthy living options through effective integration of primary care-based interventions.<sup>5</sup> Many MRC units have focused on increasing physical activity and access to nutritious foods in their communities. By empowering

## The MRC's Role in Promoting Community Health and Preventing Chronic Disease

*continued from page 10*

volunteers to offer primary health services and referrals to secondary services, in addition to providing healthier food options, chronic disease rates and health care costs in populations adversely affected by health disparities as a result of food deserts could dramatically decrease.<sup>6</sup> The following stories highlight the experiences of several MRC units in delivering programs to prevent chronic disease and promote community health.

### **La Crosse, Wisconsin**

*By Brenda Lutz-Hanson, MPH, Health Educator, Preparedness Coordinator, and Greater La Crosse Area MRC Coordinator, La Crosse County Health Department*

The La Crosse County Health Department (LCHD) is the housing organization for the Greater La Crosse Area Medical Reserve Corp (MRC). The MRC unit coordinator is employed by LCHD as a health educator/preparedness coordinator. LCHD's 2016 community health assessment identified the town of Farmington (population 2,061) as a food desert. The closest grocer/convenience store is more than 10 miles away on secondary roads with steep grades and severe curves. The larger grocers and all farmers markets are located more than 20 miles away from Farmington residents.

In 2016, the MRC unit obtained a Challenge Award from NACCHO to provide nutrition education from May through December on the Get Active La Crosse website (<http://www.getactivelacrosse.org>) and set up a farmers market to sell fresh produce at the town hall from June through October. The unit provided education in established newspapers, through the health department's Farm2School and Foot Steps to Health programs, and in monthly on-site presentations at the town hall.

When developing the Farmington town hall market, the MRC unit faced several challenges, including (1) learning about the local farmers market rules, practices, and logistics; (2) identifying community members to

support implementation in the town of Farmington; (3) communicating with and marketing to the community; (4) recruiting vendors; and (5) logistical issues such as undesirable weather and road construction that impeded easy access from surrounding areas.

MRC unit members interviewed LCHD staff who worked on farmers market and nutrition programs and gathered information and resources to aid the implementation of the Farmington market. Local community members, whom the unit identified through prospecting, attended initial informational meetings and recruits attended monthly meetings to monitor market performance and practices. The unit developed marketing materials such as posters, signs, a webpage, and a local command board. The unit also scheduled monthly programs and hosted random drawings for pertinent educational materials, such as cookbooks, cutting sheets, and knives, for market attendees. A local youth trio played music on two market nights to accompany an event to promote the sale of tacos made with onions and salsa from the market vendors, which benefitted the local garden club. The event attracted the greatest volume of market visitors in one night.

Three vendors attended most of the 16 weeks of the market. One produce vendor missed one market night due to illness, so customers that night were all provided with a \$5 voucher to visit again. Two other vendors who participated sold jams, jellies, salsa, and hand-sewn fabric products. For the initial year, vendors were provided with stipends for attending as an incentive to return each week and stay the entire two-and-a-half hours the market was open.

The MRC unit established a monthly drawing to track visitors. Attendees were encouraged to place their name and number in a drawing each week they attended; each month, four people were selected to win a preparedness item or a produce-related cookbook. The unit established a weekly schedule for "market monitors," who ran the

drawings and provided educational and promotional handouts to encourage visitors to return for upcoming programs. Monitors collected customer satisfaction feedback during the last several weeks of the market. Committee members were enthusiastic about continuing the market in 2017. Additionally, the produce farmer secured land with a local farmer, so now the produce is grown in the Farmington Township. Local MRC volunteers will continue to monitor the market and provide produce-related education.

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### **Orleans County, New York**

*By Albert A. Cheverie, Public Health Emergency Preparedness Coordinator and Orleans County VALOR Medical Reserve Corps Unit Director, Orleans County Public Health*

Evolution of purpose is the key to longevity. The original mission of the Medical Reserve Corps (MRC) was to provide a means to manage both spontaneous and registered volunteers in a time of disaster and other public health emergencies. MRC units are now very skilled at the original mission and have expanded beyond that mission to support community health initiatives. MRC units can be actively engaged in supporting preventive activities for healthy communities as well as supporting preparedness response plans.

According to the 2015 County Health Rankings for New York State counties, Orleans County ranked overall 47th of 62 for Health Outcomes and 59th of 62 for Health Factors. Premature deaths occur at a rate of 6,435 per 100,000 people for Orleans County residents as compared to 5,457 per 100,000 people for New York State. For Orleans County resident health behaviors, 29% of adults reported they currently smoke, 31% of adults reported being obese (BMI of 30 or more), and 27% adults reported being physically inactive.

Personal fitness and well-being have been shown to tie directly into individuals' ability to sustain themselves and build community resilience during

*continued on page 12*

## The MRC's Role in Promoting Community Health and Preventing Chronic Disease

*continued from page 11*

"Of the original 40 participants, 36 completed all the requirements for the program. Several of the graduates have continued their fitness regime and joined the Run for God program, while many others continue to walk or run on their own."

a crisis. In 2016, the Orleans County VALOR (Volunteer Alliance Linking Orleans Resources) MRC in New York partnered with the Albion Running Club (ARC) to promote community fitness and nutrition. ARC is a local non-profit in Orleans County that focuses on improving health through movement and fitness programs; its programs include Run for God, Fit in Fifty, and Metro 10 Road Race. The organizations also had an existing relationship as several health department employees were members of two, and in some cases, all three groups.

The project was open to all Orleans County adults interested in improving their health, losing weight, or quitting smoking. Prospective participants completed an application to be considered for the program. Selections were made based on BMI, current health state, current fitness state, and smoker/non-smoker status. The 40 selected participants received a professional sneaker fitting by a local fitness outlet and a discount on the sneakers that was weighted based on their individual fitness level. Other members of ARC mentored and encouraged participants during the weekly group runs. The participants were also encouraged to run at least twice per week on their own or with other members of the cohort.

The program mentored participants through a 20-week program, which culminated in a 5K walk/run event. Valor MRC members assisted with recording initial, mid-point, and final vitals for all participants. Members of the VALOR MRC also provided safety and preparedness information to the participants. A former health department intern taught four nutrition lessons, two in lecture format and two in a hands-on instructional format using the local Cornell Cooperative Extension kitchen. Participants sampled the healthy choices that were prepared and received copies of the recipes for future use. The hands-on nutrition lessons were received very favorably by all. The ability to see, touch, and taste the food encouraged participants to try healthy recipes with their own families.



The end goal of the program was a sustained increase in healthy habits among participants. In addition to the original discounted pair of sneakers, the cohort received further incentives throughout. All those who completed the course, including the fun run event, received a fitness tracking device. All those who maintained an 80% attendance, including at least two of the nutrition classes, also received a coupon for \$40 off a new pair of sneakers at a participating retailer. The health department also purchased slip-on ice cleats to allow outdoor exercise in inclement weather.

Of the original 40 participants, 36 completed all the requirements for the program. Several of the graduates have continued their fitness regime and joined the Run for God program, while many others continue to walk or run on their own. With the success of this collaboration of partners, the VALOR MRC looks forward to partnering again with the ARC and continues to promote health and wellness in the county and the value that it brings to community resiliency.

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*continued on page 13*

## The MRC's Role in Promoting Community Health and Preventing Chronic Disease

*continued from page 12*

### Richmond, Virginia

*By Kate Bausman, CVA, MRC and Clinical Linkages Coordinator, the Virginia Department of Health*

As of 2014, 48% of the city of Richmond, VA, qualifies as a food desert. Because of the impact food deserts have on instances of obesity and chronic disease, in late 2015, the Richmond City Medical Reserve Corps (MRC), in partnership with Richmond City Health District (RCHD), identified a need to bring healthier lifestyle education and health screenings to underserved, vulnerable populations in under-resourced areas of the city. Previously, MRC volunteers provided only blood pressure screenings at community events to which they had been invited. The initial plan for this project was to both expand the scope of the health screenings to include blood sugar, cholesterol, height, weight, and BMI readings, and proactively seek out opportunities to provide these screenings to the community.



*A member of the Richmond City Medical Reserve Corps provides a health screening to a member of the community.*

To prepare for the project's launch, the Richmond City MRC Coordinator initiated external partnerships with local non-profits, businesses, and safety-net providers. She also became an active member and sub-group co-chair of Northside Strong, a collective impact group working to better understand and address needs of residents living in Richmond's underserved Northside neighborhoods. In addition to developing external partnerships, she strengthened internal linkages with the Richmond City MRC's existing Healthy Corner

Stores Initiative and Resource Centers. The Healthy Corner Stores Initiative is a partnership between the Virginia Department of Health, corner store owners, and local farmers working together to bring fresh fruits and vegetables into neighborhood stores. The Resource Centers offer a variety of services to satellite RCHD locations in public housing neighborhoods.

Richmond City MRC has been able to go above and beyond its original goal of participating in events twice a month. The internal partnership with Resource Centers to provide support to their staff during their regular community outreach events has enabled an exceptional increase in event participation, in addition to its work with Healthy Corner Stores and other community activities. Since beginning the program in earnest in September 2016, 100 Richmond City MRC volunteers have provided health screenings to hundreds of residents and delivered healthy living education to thousands of residents at more than 90 individual events. As the program grew, it became clear that the unit had a responsibility to address other medical needs.

Richmond City MRC expanded its services from offering medical screenings to providing referrals to medical services. Because of previous barriers to health care, these referrals often served as the first connection community members had to access life-saving health care. Partnerships with local safety-net providers have enabled people to connect with low- or no-cost medical services (in some cases including no-cost specialty care) within days of their screenings. In a few cases, community members were able to make an appointment while at the event. This was the most significant accomplishment of the project thus far. In addition to connecting community members to medical services, unit members also provided referrals to other community resources, including housing and financial assistance, thereby helping the community recognize that a person's health is connected to the resources available to them.

The Richmond City MRC program

flourished from a trained group of emergency response volunteers to a robust community health and community engagement program. The Richmond City MRC develops skills of compassionate community members to then holistically serve the needs of the community through health screenings, education, and connections to valuable resources in the community. Through the passion and talents of MRC volunteers, community members, and service providers, the MRC will continue to provide relevant and critical services to aid in eliminating health disparities and creating a healthier Richmond. 

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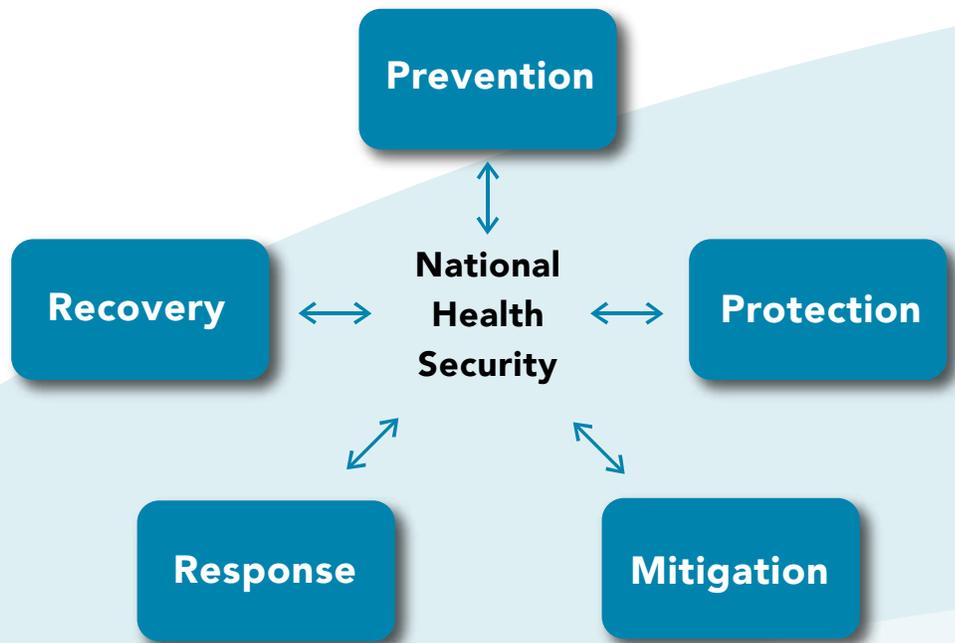
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# Strengthening the Public Health Response Infrastructure by Empowering Community Partners and Volunteers

By Kathy Deffer, Senior Program Analyst, Medical Reserve Corps, NACCHO

Figure 1. Mission Areas Relevant to National Health Security



Source: Office of the Assistant Secretary for Preparedness and Response, U.S. Department of Health and Human Services

Developing solid relationships among community stakeholders is critical prior to an emergency to ensure a synchronized and collaborative response to a public health emergency. Medical Reserve Corps (MRC) units recognize the need for community collaboration and the important role they play in their local community health security strategy. Building and understanding the nuances of community partners takes time and effort to be successful, but is an important aspect that should not be overlooked.

The 2015–2018 National Health Security Strategy (NHSS) Implementation Plan provides the strategic direction to increase national health security and drives actions that communities must take to address five key mission areas before, during, and after an incident (Figure 1).

The NHSS provides a foundation on which the whole community can contribute to the common goal of national health security. The implementation plan is supported by five strategic objectives requiring stakeholders to collaborate on many of the activities to support these objectives. The MRC plays a critical role in supporting these strategic objectives—in particular, Strategic Goal 4: Enhance the integration and effectiveness of the public health, health care, and emergency management systems.

The Snohomish County MRC and the Philadelphia MRC recognize the importance of their role in supporting their local community response plans, while also addressing the unique challenges of a volunteer force. Through their stories, they demonstrate how they have tackled gaps in their ability to meet their emergency response goals and how they have built their community collaboration to support the NHSS model.

## Strengthening the Public Health Response Infrastructure by Empowering Community Partners and Volunteers

*continued from page 14*

### Supporting Hospitals with Surge Capacity in Snohomish County, Washington

*By Therese Quinn, Medical Reserve Corps Coordinator, Snohomish Health District*

In Snohomish County, the mission of the Medical Reserve Corps (MRC) is to provide surge support in times of disaster. The Snohomish MRC has supported points of dispensing, mass vaccination, and Red Cross shelters. However, when it came to providing surge support to local hospitals and shelters, it faced a unique set of challenges—and, ultimately, successes.

MRC unit volunteers—many of whom are volunteer nurses, physicians, EMTs, and other health care professionals—expressed an interest in training to use their professional expertise in a health care setting during local emergency response situations. Before extensively exploring the possibility of providing hospital and shelter surge support, MRC volunteers participated in hospital exercises but primarily as patient role-players. Additionally, many volunteers were unfamiliar with Red Cross protocols and forms, so there was reluctance on the part of some hospitals and shelters to use volunteers during a surge.

To overcome these challenges, it became clear that hospitals and Red Cross shelters needed to identify specific credential and training requirements for MRC volunteers. The Snohomish MRC and other response organizations regularly participated in the Region 1 Healthcare Coalition, making it an ideal venue in which to work through some of these issues. The coalition comprises organizations from Snohomish, Skagit, Whatcom, Island, and San Juan Counties. Hospitals, clinics, Tribal Nations, public health, emergency management, and other health care organizations also belong to the Coalition. Its mission is to develop and promote emergency preparedness and response capabilities throughout the health care community.

The Snohomish MRC first called together the emergency managers from the hospitals in the county to discuss the

needs of the hospital during a disaster in which there were more patients than could be treated with available hospital staff. Hospitals identified four teams that would need assistance during such a scenario: Triage, Decontamination, Logistics, and Communications. The Triage Team would consist of nurses, physicians, and EMS professionals who would work under hospital staff supervision in the emergency department. The Decontamination Team would be trained to work under hospital staff supervision to set up and run decontamination operations. Logistics Team members would act as runners to deliver messages, records, and supplies throughout the facility. The Communications Team would consist of amateur radio operators who could work in the Emergency Operations Center to supplement emergency communications.

The hospitals immediately identified trainings for the Decontamination Team. It was decided that MRC volunteers could be credentialed for the Decontamination Team if they completed one classroom training and one training exercise per year, in addition to being an MRC volunteer in good standing. Communications Team members would need to have a current Technician License or higher from the Federal Communications Commission. Additionally, Communications Team members would be encouraged to participate in weekly radio tests at one of the hospitals. The trainings for the Triage and Logistics team are still in development.

Despite the establishment of these training requirements, hospitals remained concerned about having volunteers in the hospital who had not gone through the hospital volunteer process. The largest hospital in the county, which is also part of a hospital system, worked with the MRC to credential MRC volunteers so they could work within the hospital's scope of practice in a disaster. The MRC volunteers went through the hospital volunteer online portal and applied as other volunteers would. The MRC Coordinator provided the Hospital Volunteer Coordinator with the names of the MRC volunteers who went through the

“The Snohomish County MRC and the Philadelphia MRC recognize the importance of their role in supporting their local community response plans, while also addressing the unique challenges of a volunteer force.”

*continued on page 16*

## Strengthening the Public Health Response Infrastructure by Empowering Community Partners and Volunteers

*continued from page 15*

portal each time. Those volunteers were given instructions so they could more easily complete all of the other processes with a single visit to the hospital, rather than several visits. Approximately 10 MRC volunteers have become MRC hospital volunteers and been badged through the hospital. This badge allows MRC volunteers to quickly access the hospital and provide needed services.

In June 2016, the MRC practiced activation and check-in procedures at the hospital as part of a regional exercise. Volunteers checked in through the processes that were developed and worked as role players for the exercise.

As more MRC volunteer programs go through this process, the Snohomish



MRC will work with other hospitals in the county to implement similar processes, with the goal of being integrated into hospital surge capacity response plans. The Snohomish MRC will continue to identify and train additional MRC volunteers for the Communications and Decontamination teams. Additionally, the unit will work with the hospitals to expand training opportunities so volunteers can also join the Logistics and Triage teams. Plans are underway to have MRC volunteers trained on these teams so that they can be integrated into the next regional exercise.

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### **Understanding MRC Volunteers' Willingness to Respond in Southeast Pennsylvania**

*By Beau Sanchez, MPH, MRC Coordinator, Philadelphia Department of Public Health*

Research and real responses have shown that it is important to consider Medical Reserve Corps (MRC) volunteers' willingness to respond to public health emergencies, such as pandemic influenza, weather-related disasters, and radiological and bioterrorism incidents. Contrary to common assumptions, enrollment with an MRC unit is not automatically predictive of willingness to respond.

The MRC deployment during the 2015 World Meeting of Families and Papal Visit in Philadelphia offers an interesting case study of volunteer show rates. Because volunteer participation for this planned event was much lower than expected, MRC unit coordinators in southeastern Pennsylvania decided to further assess volunteer willingness to deploy for both planned and no-notice events. There are five MRC units in the southeast Pennsylvania region: Bucks County MRC, Chester County MRC, Delaware County MRC, Montgomery County MRC, and Philadelphia MRC. For the Papal Visit, the Philadelphia MRC, which is managed by the Philadelphia Department of Public Health, successfully activated the Pennsylvania Intrastate MRC Volunteer Deployment Plan to engage MRC volunteers throughout the state. Given the statewide reach of this activation, volunteer participation was lower than expected. Altogether, 169 volunteers were deployed, which accounts for only 2.8% of the total number of registered volunteers in all these units. In addition, the 169 volunteers who did deploy accounted for only 64% of 263, the total number of volunteers who were confirmed for this event. To improve volunteers' willingness to respond, the MRC unit coordinators in southeastern Pennsylvania applied for and received a Challenge Award from NACCHO.

The 2016 Challenge Award project, a collaborative effort among these five MRC units, aimed to increase volunteer

*continued on page 17*

## Strengthening the Public Health Response Infrastructure by Empowering Community Partners and Volunteers

*continued from page 16*

willingness to respond to emergencies by better understanding and addressing the barriers volunteers encounter when asked to respond to different events. The MRC unit coordinators worked with Johns Hopkins School of Public Health to deliver the Public Health Infrastructure Training, specifically the Extended Parallel Process Model to Willingness-to-Respond in the Public Health System. This training was geared toward MRC coordinators, first responders, and leaders of other community volunteer groups. The Philadelphia MRC partnered with Drexel University to coordinate the delivery of the training. Two six-hour trainings were held in October and November of 2016 with over 30 participants. The five-module, train-the-trainer program focused on three objectives: (1) describe the influences of perceived threat and efficacy on volunteers' willingness to respond in public health emergencies; (2) describe emergency scenario-specific patterns of response willingness; and (3) identify potential interventions to enhance response willingness within the public health emergency preparedness system. Activities included facilitated discussions and group and individual activities. Once the participants of the training are skilled in the five modules, they are able to deliver the training to volunteers, ideally over the course of six months.

The MRC coordinators originally intended to use the Challenge Award funds to pay for the training; however, Drexel University covered the costs, which provided an opportunity to use the funds for a follow-up training for volunteers. The MRC coordinators used knowledge from the Public Health Infrastructure Training to design and conduct a one-day regional training open to all five units in the region. The purpose of the training was to further explore issues that may deter volunteers from responding, such as volunteers' perceived risk and concern for safety in emergencies.

The training consisted of team-building activities, a panel facilitated

discussion, and a keynote speaker, Dr. Susan B. Connors—an expert in volunteers' willingness to respond. Dr. Connors's presentation included an interactive disaster bingo game and a presentation on the barriers and facilitators of volunteer willingness. She identified communication as a barrier and resources as a facilitator when volunteers respond to emergencies. In addition, volunteers having the support and approval of colleagues and friends increases their drive to respond in emergencies. The MRC coordinators also participated in a facilitated panel discussion, which gave volunteers the opportunity to understand current planning initiatives, gaps, successes, and previous deployment experiences from each unit. Most importantly, the training offered a forum for volunteers to provide feedback, which the MRC coordinators can use to further refine plans and procedures. Moving forward, the MRC coordinators in southeast Pennsylvania plan to build on this foundation by delivering all five modules of the Public Health Infrastructure Training over the course of six months.

The MRC is a skilled, trained workforce that serves as a critical resource during emergencies. MRC coordinators across the nation should evaluate how volunteers' willingness to deploy may affect their operations during a public health emergency and should consider providing similar trainings to understand and address the issues that may deter volunteers from responding. 

*Learn more about the Johns Hopkins School of Public Health's Public Health Infrastructure Training at <http://bit.ly/2tJgX8r>.*

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"Most importantly, the training offered a forum for volunteers to provide feedback, which the MRC coordinators can use to further refine plans and procedures."

# The MRC Core Competencies: Setting the Standard for Excellence

By Betty Duggan, Director, New York City Medical Reserve Corps, New York City Department of Health and Mental Hygiene

A challenge for many local health departments is the limited staff available to perform the community outreach, education, and preparedness planning needs of their jurisdictions. Medical Reserve Corps (MRC) volunteers continue to be an invaluable resource for local health departments to support these initiatives. Because of the important role MRC volunteers serve, it is critical that they receive training and opportunities to build their skills to prepare them for success. A set of MRC Core Competencies is the foundation for the development of both medical and non-medical MRC volunteers.

First developed in 2006, the MRC Core Competencies provide a baseline level of skills and knowledge for all MRC volunteers. The Core Competencies are national standards that strengthen the MRC brand and each unit's overall response capability. In 2012, NACCHO formed the MRC Core Competencies Workgroup to review and revise the 2006 Core Competencies. This group evaluated the current standards, considered what MRC volunteers needed to be successful, and discussed recent key shifts in emergency management and public health trends.

The workgroup included regional, state, and local MRC coordinators and representatives from academia, the Medical Reserve Corps Program Office, and NACCHO. The workgroup found that while the MRC network had evolved, the competencies had not. The 2006 competencies covered three areas: Health, Safety, and Personal Preparedness; Roles and Responsibilities of Individual Volunteers; and Public Health Activities and Incident Management. However, the competencies did not include standards for cultural humility, ethics, and public health and did not address the changing role of MRC in the community.

After the workgroup's review, MRC aligned its Core Competencies with the Society for Disaster Medicine and Public Health's (DMPH) Competencies. There were many benefits to adopting the DMPH Competencies: They are considered industry standard and are used across various health professions engaged in disaster medicine and public health. The workgroup organized the 11 DMPH Competencies into four accessible learning paths: Volunteer Preparedness, Volunteer Response, Volunteer Leadership, and Volunteer Support for Community Resiliency. These learning paths make the competencies easier to understand and implement. The paths are action-oriented, set learning goals for volunteers, guide the creation of training curricula, and provide ways for unit leaders to evaluate volunteer performance.



Since the revised competencies were published in 2015, several resources have been developed to supplement the use of the MRC Core Competencies. A training plan with suggested training courses is available on MRC-TRAIN, which MRC unit leaders can modify for their local requirements. A self-assessment tool allows the volunteers to assess their knowledge of the competencies, which can be used as part of a new volunteer orientation or periodically throughout their service to update their records. An Excel spreadsheet is also available for MRC unit leaders to capture competency levels of their volunteers, giving them a snapshot of individual versus unit capabilities.

*To learn more about the MRC Core Competencies, visit <http://www.naccho.org/programs/public-health-preparedness/medical-reserve-corps>.*

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# Until Help Arrives: The MRC's Role in Building Community Resiliency

By Kathy Deffer, Senior Program Analyst, Medical Reserve Corps, NACCHO



*Participants in the Northeast Tennessee MRC's active bystander pilot training, now called Until Help Arrives*

During a mass casualty event, immediate first response measures are critical to saving lives. Although first responders, law enforcement, hospitals, and emergency planners have prepared coordinated response plans, there is still the golden window of time until help arrives that can make the difference in saving a life. Recent events, such as the Boston Marathon bombings, have shown the impact that bystanders can make in saving lives and assisting first responders by providing first aid to those who are critically injured in the immediate moments after an incident happens.

The Centers for Disease Control and Prevention (CDC) recognized the need to develop a training for volunteers and community members to give them the skills to be able to provide lifesaving measures until professional help arrives.<sup>1</sup> As a result of research on the actions of bystanders at mass casualty events, the CDC convened a workgroup to develop the training course *Becoming an Active Bystander*, which included the Federal Emergency Management Agency (FEMA), the American Red Cross, the American Heart Association, and the U.S. Department of Health and Human Services' Office of the Assistant Secretary for Preparedness and Response. The CDC then further collaborated

with FEMA to produce the training materials and worked with six Medical Reserve Corps (MRC) units to pilot the course. The MRC units were tasked with reviewing the course content and materials, conducting training sessions using the materials, and providing feedback and recommendations to enhance the materials. The CDC and FEMA then used that information, along with science, to inform the reviews and modifications and released the final training platform, *Until Help Arrives*, in March 2017.<sup>1</sup>

Throughout the process, leveraging partnerships at the local and federal level helped to ensure buy-in and applicability of the curriculum. The goal of the training is to empower volunteers and the general public, give them the skills to be the local preparedness component, and ensure they are prepared to respond. The MRC will play a critical role in promoting the *Until Help Arrives* program and educating the public in communities nationwide. This article highlights the experiences of two of the MRC units involved in the pilot training, explores how they plan to integrate the training into their community preparedness outreach efforts, and shares their plans to deploy trained MRC volunteers during disasters.

*continued on page 20*

## Until Help Arrives: The MRC's Role in Building Community Resiliency

*continued from page 19*



### The Northeast Tennessee Medical Reserve Corps

*By Chad R. Bruckman, Emergency Response Coordinator, Tennessee Department of Health -Northeast Region*

In a disaster, immediate action can mean the difference between life and death. Recent experiences at home and around the world have taught us the value of educating the public on how to move from just standing by to being an active bystander.

The Northeast Tennessee Medical Reserve Corps (MRC) Unit #1340 was selected as one of six pilot regions in the country for the active bystander pilot training in 2014. Becoming an Active Bystander, now called *Until Help Arrives*, is a four-hour course developed by FEMA following recent mass casualty events such as the Boston Marathon bombings. The goal of the course is to train and motivate members of the public to save lives by acting. Participants learn to manage bleeding, provide care to the injured, and communicate with emergency responders when they arrive at the scene. Most important, it trains participants to assess a scene safety before acting.

The Northeast Regional Health Office, Sullivan County Regional Health Office, and MRC volunteers participated in an instructor train-the-trainer course on June 11, 2014. The active bystander pilot course was then delivered to 30 Northeast Region MRC members on July 23, 2014. The course received rave reviews from participating volunteers. Participants especially enjoyed the hands-on activities and the encouragement to act when disaster strikes.

The Northeast Tennessee MRC presented a poster about the pilot training, "On Becoming an Active Bystander," at the 2015 Preparedness Summit in Atlanta. The poster brought a lot of attention and questions about the training program and allowed the Northeast Tennessee MRC to showcase this lifesaving training.

In 2016, the Northeast Tennessee MRC received a \$15,000 Challenge Award from NACCHO to support the active bystander course. Through this grant, the unit purchased 150 bleeding control kits, which it assigned to MRC volunteers who attended the training.

On Jan. 25, 2017, the unit held another course that trained an additional 16 MRC volunteers. The 45 MRC volunteers who have received the training have been identified for potential deployment in the event of a local disaster where these skills could help mitigate injuries.

With the March 2017 release of the *Until Help Arrives* course, the Northeast Tennessee MRC instructors plan on using the national curriculum to teach additional classes to continue to expand the number of trained individuals and MRC volunteers in the community.

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### The Southwest Virginia Medical Reserve Corps

*By Kristina K. Morris, MA, Unit Coordinator, Southwest Virginia Medical Reserve Corps*

In May 2014, the Southwest Virginia (SWVA) Medical Reserve Corps (MRC) was honored to pilot test the Centers for Disease Control and Prevention's (CDC's) *Becoming an Active Bystander* training curriculum. The SWVA MRC serves a rural population with primarily volunteer-based EMS services. Travel time to area hospitals can be extensive. Additionally, local events can bring in as many as 100,000 visitors per year. This new CDC training provided an excellent opportunity to empower citizens to help those around them during an unexpected emergency while awaiting first responders.

SWVA MRC was asked to recruit trainers and attendees from unit members. These members would conduct or complete one training session and provide feedback to CDC personnel at the conclusion of the training. SWVA MRC encouraged volunteer health care professionals to serve as trainers and non-medically trained volunteers to complete the course. The recommended training time was either one four-hour session or two two-hour sessions.

On July 22, 2014, 18 students, seven instructors, and a representative from the

*continued on page 21*

## Until Help Arrives: The MRC's Role in Building Community Resiliency

*continued from page 20*

CDC completed two two-hour sessions. The session began with a testimonial from a volunteer who had been involved in an active bystander response earlier in the spring, bringing to life the need for everyone to have skills and abilities to help fellow citizens when faced with an emergency.

Fortunately, all in attendance understood that with pilot projects, some things would work well and other areas would need improvement. At the conclusion of the training, attendees were very forthcoming with suggestions and comments, which included the following:

1. Use a large room to allow attendees to move around and practice skills, such as bleeding control, abdominal thrusts, CPR compressions, and the recovery position;
2. Use teaching stations for hands-on instruction;
3. Shorten the course to two hours;
4. Find shorter embedded videos for the presentation; and
5. Use one or two instructors throughout instead of many to conserve the flow of the course.

The community was very interested in additional active bystander classes, so the SWVA MRC submitted and was awarded a 2016 NACCHO Challenge Award to offer additional trainings. Because the course was still in development, the SWVA MRC modified the pilot presentation to meet its needs. Taking into consideration comments from the pilot presentation, the unit used health care professionals to team-teach the course. It edited the slide deck and trainer manual for redundancy and to allow the course to be condensed into one two-hour training session. It also edited the student manual and provided it electronically so students could use laptops, tablets, and smartphones. The SWVA MRC held classes in large rooms with plenty of space to set up hands-on stations and found different artwork to better illustrate the recovery position.

To date, over 125 citizens have

completed the training. Trainers work as teams of two for each session and customize their class based on location, students, and their comfort-level with the material.

In the spring of 2017, the new and updated course was released as *Until Help Arrives*. The course is offered (1) as an interactive video for school-age children; (2) as an online webinar; or (3) by in-person instruction. The SWVA MRC transitioned to the new curriculum in July 2017.

Based on initial review of *Until Help Arrives*, it may be possible for the instructors to be non-medically trained volunteers if fewer medical interventions are taught. The course teaches personal preparedness, when and how to call 9-1-1, and how to control bleeding and provide comfort care. The time needed for the course has been shortened considerably. Students must go online to submit evaluations and receive their certificate of completion.

The SWVA MRC believes that it is extremely important that local citizens know how to provide care and save the lives of family, friends, and visitors when at the scene of an unexpected emergency. We should all aspire to provide care until help arrives. 📧

*For more information, contact Kristina Morris at 276-274-0555 or [kristina.morris@vdh.gov](mailto:kristina.morris@vdh.gov).*

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"Recent events, such as the Boston Marathon bombings, have shown the impact that bystanders can make in saving lives and assisting first responders by providing first aid to those who are critically injured in the immediate moments after an incident happens."

# Until Help Arrives Training Tools



Three main training tools are available as part of the Until Help Arrives program online at <http://www.ready.gov/untilhelparrives>:

■ **Interactive video.**

An interactive animated video that educates the public on what to do when their day takes a dangerous twist. Set in an amusement park, this interactive experience puts viewers in control of making lifesaving decisions for injured amusement park patrons.

■ **Web-based training.**

A 25-minute video tutorial explaining the steps people should take to help someone with life-threatening injuries. The video covers five main topics: call 9-1-1, protect the injured from harm, stop bleeding, position people so they can breathe, and provide comfort.

■ **Instructor-led curriculum.**

Materials for a hands-on, instructor-led course that covers all five topics in-depth and includes videos and activities. There are no specific certification requirements for the instructors who teach the classroom training; however, instructors must be knowledgeable and comfortable teaching the content and answering questions.

## MRC's Role Promoting Until Help Arrives in Local Communities

The MRC will play a critical role in promoting the Until Help Arrives program and educating the public in communities nationwide. To help promote the program, the MRC Program Office has posted the following outreach resources on the MRC website (<http://bit.ly/2tLJkmi>):

■ **Program launch message, promotional toolkit, and shareable images.**

Resources include program description, FAQs, social media posts, and shareable images to help promote the program within local communities.

■ **Promotion video.**

A brief, two-minute video that can be shared with stakeholders to introduce and promote the program.

■ **MRC TRAIN courses.**

Trainings that can be incorporated into MRC volunteer training plans.

# Educating Policymakers about the Importance of the MRC

By Ian Goldstein, Senior Specialist, Government Affairs, NACCHO



Federal funding is critical to maintaining the strength of the Medical Reserve Corps (MRC) program. The MRC is vital to public health preparedness and is funded well below many other preparedness programs. For pennies on the dollar, the MRC can be used as a force multiplier to supplement local health department staffing.

In recent years, funding for the MRC program has been cut significantly. In FY2013, the MRC was funded at \$11 million; in FY2017, the program received just \$6 million. To ensure Members of Congress understand the critical importance of the MRC, NACCHO's Government Affairs staff regularly meet with Congressional staff to educate them about the value of the MRC program and explain the vital role MRC units play in public health preparedness, especially in rural and under-resourced communities. NACCHO has also shared the experience and impact of the MRC volunteers during the 2013 Boston Marathon and the difference they made in saving lives that day.

There is more work to be done, as many policymakers may still not be aware of the MRC program or why it matters to local communities. NACCHO encourages MRC volunteers and program coordinators to educate Members of Congress about the MRC program and the ways in which it supports preparedness and community health.

There are many ways MRC leaders and volunteers can educate policymakers about this vital community program.

NACCHO's Government Affairs team created an advocacy toolkit to help NACCHO members better understand their role in advocacy and provide resources to help them build relationships with Members of Congress and their staff. To help guide efforts of MRC leaders and volunteers, the toolkit contains a section that outlines the difference between advocacy and lobbying and describes how to get involved without portraying bias or partisanship. The toolkit also contains resources and information; congressional calendars; budget and appropriations timelines; effective communication techniques; instructions for scheduling a meeting; and customizable fact sheets and talking points.

Building support for public health programs takes extra effort on the part of public health professionals, but without it, public health may face further funding decreases. NACCHO encourages MRC members to learn more about how they can raise awareness about the important role they play in protecting their communities. [📄](#)

*Learn more about the NACCHO Advocacy Toolkit at <http://www.naccho.org/advocacy>. For more information, contact Ian Goldstein at 202-507-4273 or [igoldstein@naccho.org](mailto:igoldstein@naccho.org).*



FOUNDATION FOR  
THE PUBLIC'S HEALTH

## The Foundation for the Public's Health Supports MRC Funding Opportunities

In 2015, NACCHO formed the Foundation for the Public's Health to mobilize dollars and partnerships to support the public's health through the work of local health departments, other nonprofit organizations, and the private sector. In developing the mission and priorities of the Foundation, its board of trustees voted to focus its philanthropic efforts on three key programs of public health, one of which is the MRC program. Working with the MRC Advisory Group, the Foundation committed to finding additional funding at the national and state levels to ensure that local MRC units can serve their citizens in times of crisis.

For more information, visit <http://www.tfph.org> or contact Paul Alagero, President and CEO of the Foundation of the Public's Health, at 202-507-4213 or [palagero@naccho.org](mailto:palagero@naccho.org).

# The MRC Network Profile: Capturing the Impact of Medical Reserve Corps Units Nationwide

By Kabaye Diriba, MPH, Program Analyst, Medical Reserve Corps, NACCHO, and James Randall, Yale School of Public Health, Intern, Medical Reserve Corps, NACCHO

The 2017 edition of the *MRC Network Profile* arrives Oct. 31. This year's *Network Profile* will be the third installment in a series of comprehensive analyses of the Medical Reserve Corps (MRC) network. It features the cross-cutting impact of local MRC units throughout the country, including tribal and territorial units. The *Network Profile* also provides aggregated data on a number of public health preparedness and response activities and capabilities, including strengths, local collaborations, training and core competencies, public health preparedness activities, and unit characteristics. With an 82% response rate from surveys distributed to all active MRC units from January through March 2017, the publication is a useful resource for older and newer MRC units alike.

This hard-hitting, up-to-date snapshot of the current functionality of local MRC units builds on the 2013 and 2015 reports and provides stakeholders with valuable information on trainings, volunteer management, impact of the 2016 NACCHO Challenge Award projects, and local health department perspectives. With over two-thirds of MRC units housed in local health departments, this report allows established units and local health departments to compare their activities with national averages. Newer MRC units can use the report to learn tips, tricks, and established methods from other units to ensure success in their local communities.

The *Network Profile* is a valuable resource that provides the tools MRC units and local health departments need to highlight the impact of the MRC at the local and national levels. For those health departments that aspire to advocate on behalf of their MRC unit(s) but have not had the data to do so, the *Network Profile* is the solution. The *Network Profile* is also beneficial as a tool for disseminating best practices that



medical reserve corps

**MRC CHALLENGE AWARD**

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

CONNECTING WITH COMMUNITIES: THE 2015 NETWORK PROFILE OF THE MEDICAL RESERVE CORPS

## MRC innovation through the Challenge Award

"The unique partnerships created through our MRC Challenge Award project [have] allowed for the pooling of materials, resources, best practices, and MRC person power to enact wide-reaching community change."

—Erin McDonough, MRC Unit Leader

- 100% of awardees report new or enhanced relationships with partners
- 40% of awardees report increased work with vulnerable or at-risk populations
- 70% of awardees report projects serve as a model for other units across the country

Challenge Award innovation projects serve as an incubator for ideas that can be implemented in communities nationwide.

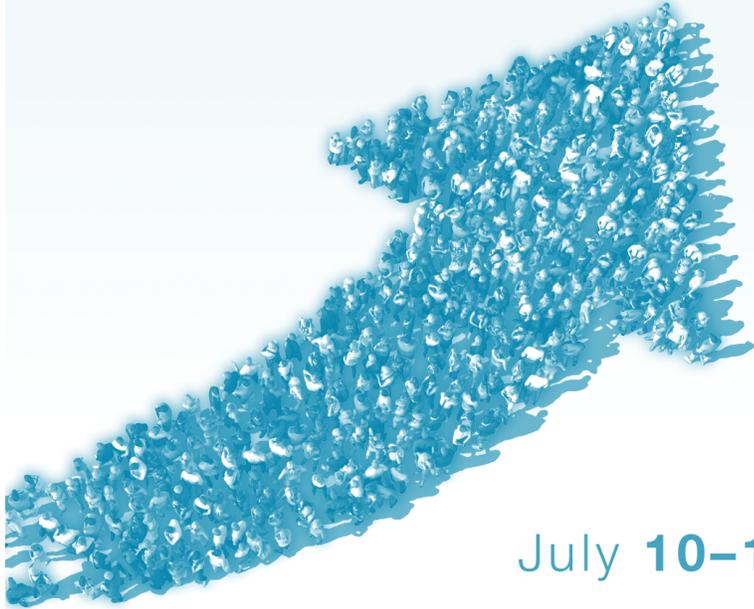
[www.medicalreservecorps.gov](http://www.medicalreservecorps.gov)  
[www.naccho.org](http://www.naccho.org)

have been successfully implemented by MRC units across the nation. According to the 2015 *Network Profile*, in 2015 alone, 70% of NACCHO Challenge Awardees reported that their projects served as templates for future programs (Figure 1). The *Network Profile* allows MRC units to evaluate other programs and help cultivate ways to expand their units. This year, the *Network Profile* includes baseline data on the awareness and use of the MRC Core Competences revised in 2015 and the development and deployment of Mission Ready Packages or mission-specific teams.

With preparedness funding at risk, obstacles to recruitment, and the uncertain future of technology, MRC units must remain vigilant, continuously striving to serve their communities through an innovative and community-driven approach. The *Network Profile* offers an opportunity for MRC units and health departments to explore new opportunities and gain valuable insight into MRC

capabilities. Moreover, the *Network Profile* is an important asset for community health organizers who need resources to demonstrate the effectiveness of their MRC units or to deduce what the future of the MRC may hold.

*The MRC Network Profile arrives Oct. 31 and can be acquired through NACCHO's MRC webpage at <http://bit.ly/MRCProfile>.*



*Unleashing*  
THE *Power* OF  
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## Roadmap to Ready

### A Training and Mentoring Program for New Preparedness Coordinators



2018 application cycle will open in mid-September

Share and gain knowledge that will make our communities safer. Join NACCHO's 2018 Roadmap to Ready training group.

Roadmap to Ready provides new preparedness coordinators with the knowledge, skills, connections, and tools they need to successfully lead public health preparedness planning and response activities at their local jurisdictions.

NACCHO is seeking both mentees and mentors to participate in the 2018 program year.

For eligibility requirements and program information, visit <http://www.naccho.org/programs/public-health-preparedness/roadmap-to-ready>.

**NACCHO**  
National Association of County & City Health Officials

### About NACCHO Exchange

*NACCHO Exchange*, the quarterly magazine of the National Association of County and City Health Officials (NACCHO), reaches every local health department in the nation. It presents successful and effective resources, tools, programs, and practices to help local public health professionals protect and improve the health of all people and all communities.

### Mailing and Contact Information

Please direct comments or questions about *Exchange* to Lindsay Tiffany, Lead of Publications, at [ltiffany@naccho.org](mailto:ltiffany@naccho.org). To report changes in contact information or to check membership status, please contact NACCHO's membership staff at 877-533-1320 or e-mail [membership@naccho.org](mailto:membership@naccho.org). Additional copies of *NACCHO Exchange* may be ordered at <http://www.naccho.org/pubs>.

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National Health Observances	
September:	National Preparedness Month
October:	National Breast Cancer Awareness Month
November:	American Diabetes Month

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#### ENVIRONMENTAL IMPACT STATEMENT

1225 LBS OF PAPER MADE WITH 25% POST CONSUMER RECYCLED FIBER SAVES...

-  1,242 lbs wood    A total of 4 trees that supplies enough oxygen for 2 people annually.
-  1,814 gal water    Enough water to take 105 eight-minute showers.
-  1min BTUs energy    Enough energy to power an average American household for 5 days.
-  377 lbs emissions    Carbon sequestered by 4 tree seedlings grown for 10 years.
-  110 lbs solid waste    Trash thrown away by 24 people in a single day.

