Massachusetts Medical Reserve Corps Capacity Gap Analysis

April 2019

Prepared by Regina Villa Associates on behalf of the Massachusetts Department of Public Health Office of Preparedness and Emergency Management

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2 EXECUTIVE SUMMARY

In 2018, the Massachusetts Department of Public Health's Office of Preparedness and Emergency Management (MDPH OPEM) requested that Regina Villa Associates (RVA) conduct a Capacity Gap Analysis of the Medical Reserve Corps (MRC) program in Massachusetts. The purpose of this effort was to determine current perceptions of the MRC program in Massachusetts, examine desired outcomes (by region) of the MRC program, and supplement this information with existing objective data (collected from information submitted via MDPH OPEM quarterly reports). This analysis is intended to help each region generate strategic plans as they work to take MRC units from the current state to the desired outcome.

RVA conducted an online survey of regional stakeholders, including MRC unit leaders, in March 2018. There were 207 respondents to this survey, distributed across all Massachusetts public health emergency preparedness regions. About 15% of all respondents were MRC unit leaders – either unit directors or coordinators. The online survey included questions about MRC priorities and services, volunteer skillsets and populations, volunteer retention, deployment, unit coordination with non-MRC stakeholders, and additional information.

2.1 MRC PRIORITIES AND SERVICES

Across all regions, similar priorities emerged for unit leaders and non-unit leaders: community partnerships; volunteer engagement; responding to emergencies; and volunteer training. However, there was slight differentiation among what they considered most important.

When asked about MRC services, there were more differences between unit leaders and non-unit leaders across all regions. The ability to deploy volunteers within the MRC coverage area was seen as "extremely" important to both sets of respondents. While 83% of unit leaders said providing staffing support at shelters was "extremely" important, only 58% of non-unit leaders rated it as such. MRC unit leaders placed a high priority on services such as providing staffing support at flu clinics and EDS clinics, but non-unit leaders rated this service – especially staffing at flu clinics – as a lower priority. These differences suggest that there should be more coordination and communication between unit leaders and non-unit leaders in each region to better align their expectations of the MRC.

The survey also illuminated the fact that there needs to be more education on the issue of setting up and managing shelters for both sets of respondents. 75% of non-unlit leaders said it was an "extremely" or "very" important service, and 92% of unit leaders said it was an "extremely" or "very" important service. This numbers are surprisingly high considering this service is not in the purview of MRC units.

Respondents were also asked about the services MRC units are currently able to provide. In general, non-unit leaders believe the ability of MRC units to provide desired services is much more limited than unit leaders think. The ability to deploy volunteers within the unit coverage area in an emergency is the service seen as most desired by unit leaders and non-unit leaders. The majority of unit leaders believe that the unit either exceeds (17%) or meets (54%) this demand. The majority of non-unit leaders, though, believe this service is either "available but limited" (40%) or not available (17%).

Both unit leaders and non-unit leaders pointed to a lack of volunteers – either through recruitment, retention or availability during an actual emergency – as a barrier to providing desired services. Non-unit leaders also pointed to

a lack of integration of the MRC program with local emergency management. In some cases, this lack of integration was attributed to the isolation of the MRC program, lack of awareness of what MRC units do, and in some cases, cultural barriers with integration to town EMS/fire. Unit leaders pointed to state liability issues for volunteers and lack of transportation to disaster sites during poor weather conditions.

2.2 Volunteer Recruitment

Unit leaders and non-unit leaders have similar priorities for the type of skill sets they are looking for among MRC volunteers.

More detailed questions were asked of MRC unit leaders about their volunteer populations. Based on the responses to the questions, it seems that MRC volunteers are not very diverse. They are mostly made up of baby boomer (55 and older) and older adults (30-54). Some regions, notably Region 3 and Region 4C, have volunteers who can speak and/or write in languages other than English, but those numbers are very low in other regions.

Recruitment methods vary widely across regions. For example, while outreach to colleges and universities is very important in some regions, it is not seen as important in others.

2.3 Volunteer Retention

The survey demonstrated that there is variance among units – even within the same regions – about how often they engage with their volunteers to find out about their satisfaction levels and training interests. Some MRC units survey their volunteers on their satisfaction levels at least annually. Others have no record of ever surveying volunteer satisfaction. Similarly, some units survey their volunteers regarding their training interests at least annually. Others have no record of ever surveying on this topic.

Both unit leaders and non-unit leaders were also asked several questions about "active" volunteers, defined as someone who volunteers for a unit in some capacity (including via emails and drills) at least annually. An emerging theme in the responses is that non-unit leaders did not have a clear sense of how many "active" volunteers are even needed in the region.

2.4 Volunteer Deployment

Transportation seems to be a major indicator for the ability of MRC volunteers to respond in a disaster. Under normal driving conditions, unit leaders believe over 90% of their volunteers will travel up to 10 minutes, but do not believe that more that 30% of their volunteers will travel over 2 hours. Almost 20% of unit leaders believe *none* of their volunteers will travel more than 2 hours.

Under inclement weather conditions, these numbers drop more significantly. 45% of unit leaders believe none of their volunteers will travel two or more hours, and over 40% of unit leaders believe none of their volunteers will travel 1-2 hours in inclement weather. No unit leaders believe that more that 30% of their volunteers will travel 1-2 hours in inclement conditions.

2.5 Unit Coordination with Non-MRC Stakeholders

Responses to the survey also illuminated that additional coordination is needed between MRC unit leaders and other stakeholders. Increased communication between the two groups within each region would be beneficial. Through these discussions, unit leaders could understand more clearly the expectations placed on MRC units in their region. The other stakeholders could also have a more accurate view of MRC capacity.

2.6 ADDITIONAL INFORMATION

Additional key information about MRC units was also analyzed for this report, including:

- A regional overview featuring the number of units, communities covered, and total population covered
- The number of credentialed volunteers by unit
- Mission and Purpose of units
- Information about how units set priorities
- Barriers to providing services
- Existing MOUs with MRC units

2.7 CONCLUSION

Analysis of this detailed information shows that a key issue for all units is the ability to recruit the type of volunteer who will remain engaged and deploy in a disaster. Responses show that unit leaders may be able to learn from each other, as all have similar goals, but differ in terms of recruitment and retention strategies. Generating best practices on topics such as volunteer recruitment, retention, and training would increase MRC capacity statewide.

A secondary issue to address is the transportation needs of volunteers that may be required during a deployment (this can take the form of driving during inclement weather). Many volunteers are not willing to drive those distances

The analysis also suggests that increased communication between unit leaders and non-unit leaders in each region will be beneficial. This would allow unit leaders to understand more clearly the expectations of MRC units in their region by other stakeholders, and for those stakeholders to have a more accurate picture of MRC capacity.

3 BACKGROUND

3.1 MASSACHUSETTS PUBLIC HEALTH EMERGENCY PREPAREDNESS REGIONS

The Commonwealth of Massachusetts is composed of 351 cities and towns with a population of 6,547,629[1]. In 2013, the Massachusetts Department of Public Health (MDPH) Office of Preparedness and Emergency Management (OPEM) undertook a multiyear process to establish regional Health and Medical Coordinating Coalitions (HMCCs) across the state, one in each emergency preparedness region.

Massachusetts has six standalone public health emergency preparedness regions that include 15 distinct local public health coalitions, as well as the City of Boston. All healthcare entities in the state are geographically covered by one of the six HMCCs.

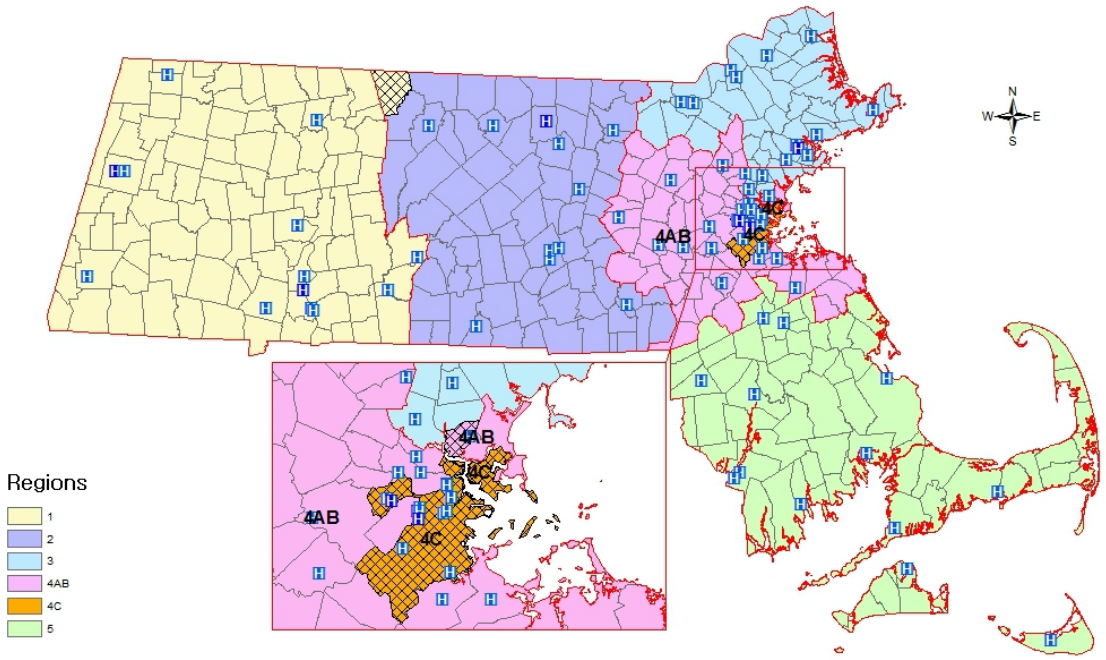
The six regions are:

- Region 1 – Western Massachusetts
- Region 2 – Worcester Regional
- Region 3 – North Shore
- Region 4AB – Boston Metro
- Region 4C – City of Boston
- Region 5 – Cape and Islands

Regions 4A and 4B only recently merged to form the Region 4AB region.

[1] U.S. Census (2010)

Figure 1 : Map of Massachusetts HMCCs



3.2 MASSACHUSETTS MRC PROGRAM

Massachusetts is host to 38 federally recognized Medical Reserve Corps (MRC) units found within local health departments and non-profit organizations. Spanning across seven[2] public health emergency preparedness (EP) regions, state funding is provided annually to sponsoring organizations of the regional health and medical coordinating coalitions (HMCC) to support the MRCs. State funding is equally provided to seven (7) regions: Region 1, Region 2, Region 3, Region 4A, Region 4B, Region 4C, and Region 5. Individual MRC Unit allocations are determined within the region and differ across the state.

Table 1: Number of MRC Units by Region in Massachusetts as of June 2018

Region	Number of MRC Units
Region 1	9
Region 2	3
Region 3	7
Region 4A	2
Region 4B	4
Region 4C	1
Region 5	11

In Massachusetts, there is a statewide MRC Coordination Steering Committee (Steering Committee) that includes one representative from each public health emergency preparedness region and representatives from MDPH's Office of Preparedness and Emergency Response (OPEM).

[2] Region 4A and Region 4B still receive separate allotments of funding, despite the recent merger.

The Steering Committee, facilitated by the MRC Statewide Coordinator, meets at least quarterly, either in person or by phone. Representatives solicit recommendations from the unit leaders in their region to be discussed at Steering Committee meetings. Additionally, they develop and implement an Action Plan to be revised on an annual basis to address recommendations and MRC deliverable requirements.

3.3 CAPACITY GAP PROJECT

In 2018, MRC Steering Committee members expressed a desire for a Regional Capacity Gap Analysis for MRC units to be conducted in Massachusetts. The results of this analysis are intended to assist the units in conducting future strategic planning. As federal funding for the program has decreased over time, many Massachusetts units are in a state of flux.

The Steering Committee has three goals for this project:

- Provide MRC Regional Advisory Groups assistance in developing an organizational approach and funding structure for each region.
- Provide assistance to MRC unit leaders when developing annual workplans and budgets.
- Provide education to non-MRC stakeholders about the real-world capacity of the MRC program.

With the assistance of a vendor, Regina Villa Associates, MRC Steering Committee members developed an online survey for regional stakeholders, including MRC unit leaders. A link to this survey was distributed to MRC Unit Leaders on March 16, 2018. The survey link was distributed to other stakeholders (MEMA, HMCC lists) on March 16, 2018. Recipients of this link were encouraged to forward it to other key stakeholders.

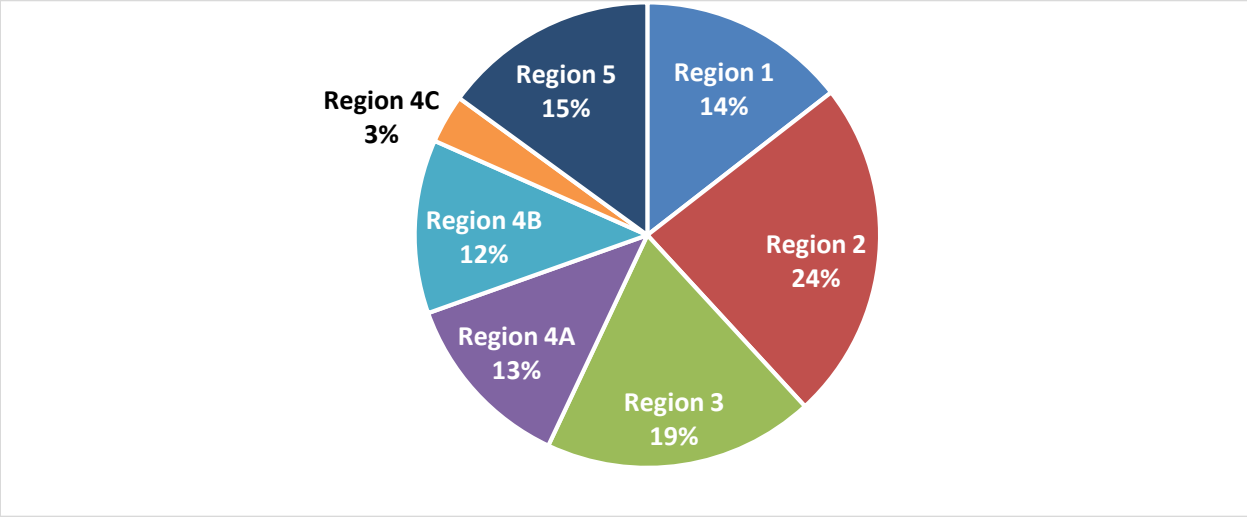
The survey closed on March 30, 2018.

4 RESPONSES – ALL REGIONS

4.1 EMERGENCY PREPAREDNESS REGION

There were 207 respondents to the survey, though not every respondent answered all the questions. Each respondent was asked to select the emergency preparedness region in which he or she worked.[3] Due to the varying number of MRC units in each region, it is not surprising that responses were not consistent throughout each region. Figure 2 shows the percentage of overall survey responses by region.

Figure 2: Responses by Region



4.2 RESPONDENT ROLE

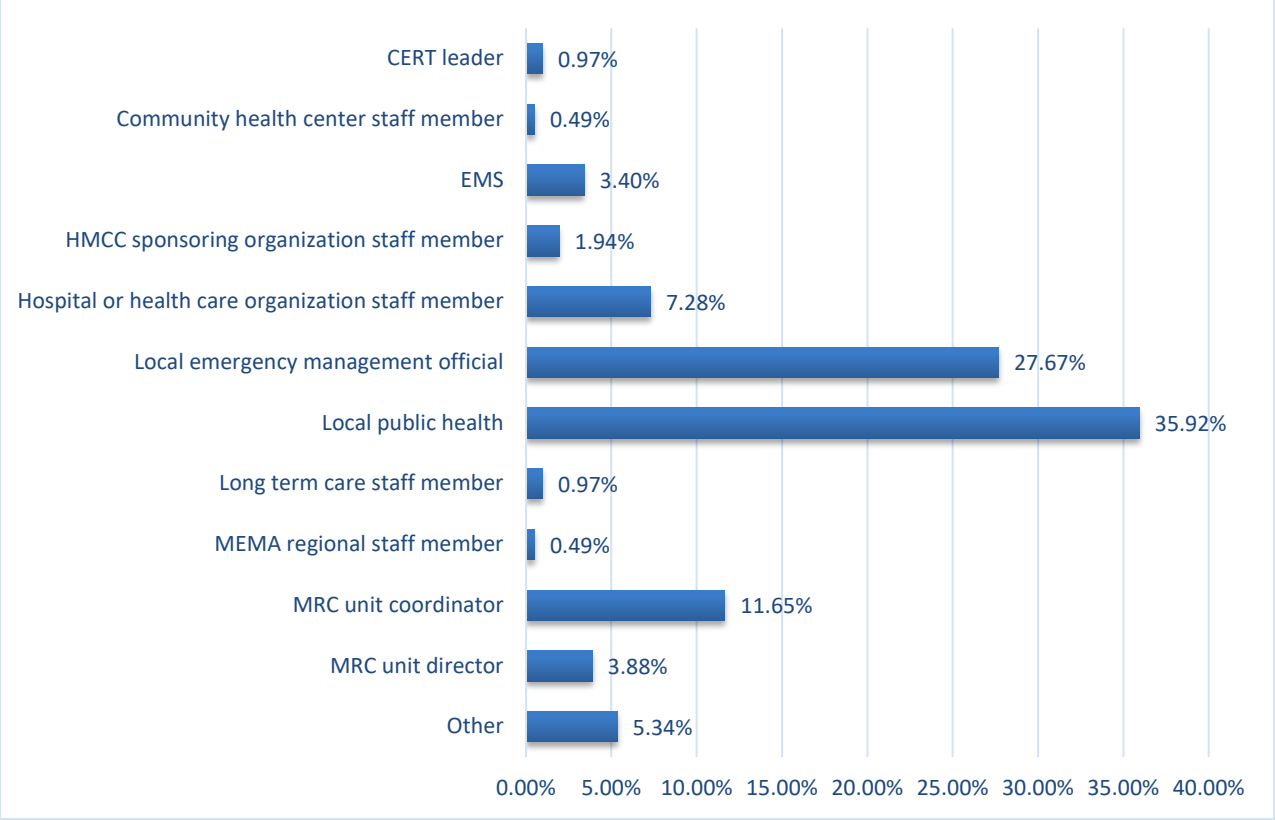
Each respondent was also asked to categorize their role. Figure 3 categorizes those responses. The largest category of respondents was "Local Public Health" with 36%. The second largest category was "local emergency management official" reaching 28%. Combined, MRC unit coordinators and directors were slightly over 15% of the total respondents.

For the "Other" category, responses included coalition planner, local public health administration assistant, among others.

For the purposes of analysis, the MRC unit coordinator and MRC unit director categories were combined to form a "unit leaders" category while other respondents were combined to form a "Non-Unit Leaders" category. In some cases, unit leaders were asked different questions than non-unit leaders in the online survey.

[3] Due to the way MRC units are funded by region, Regions 4A and 4B were left separate for this question.

Figure 3: Role of the Respondent



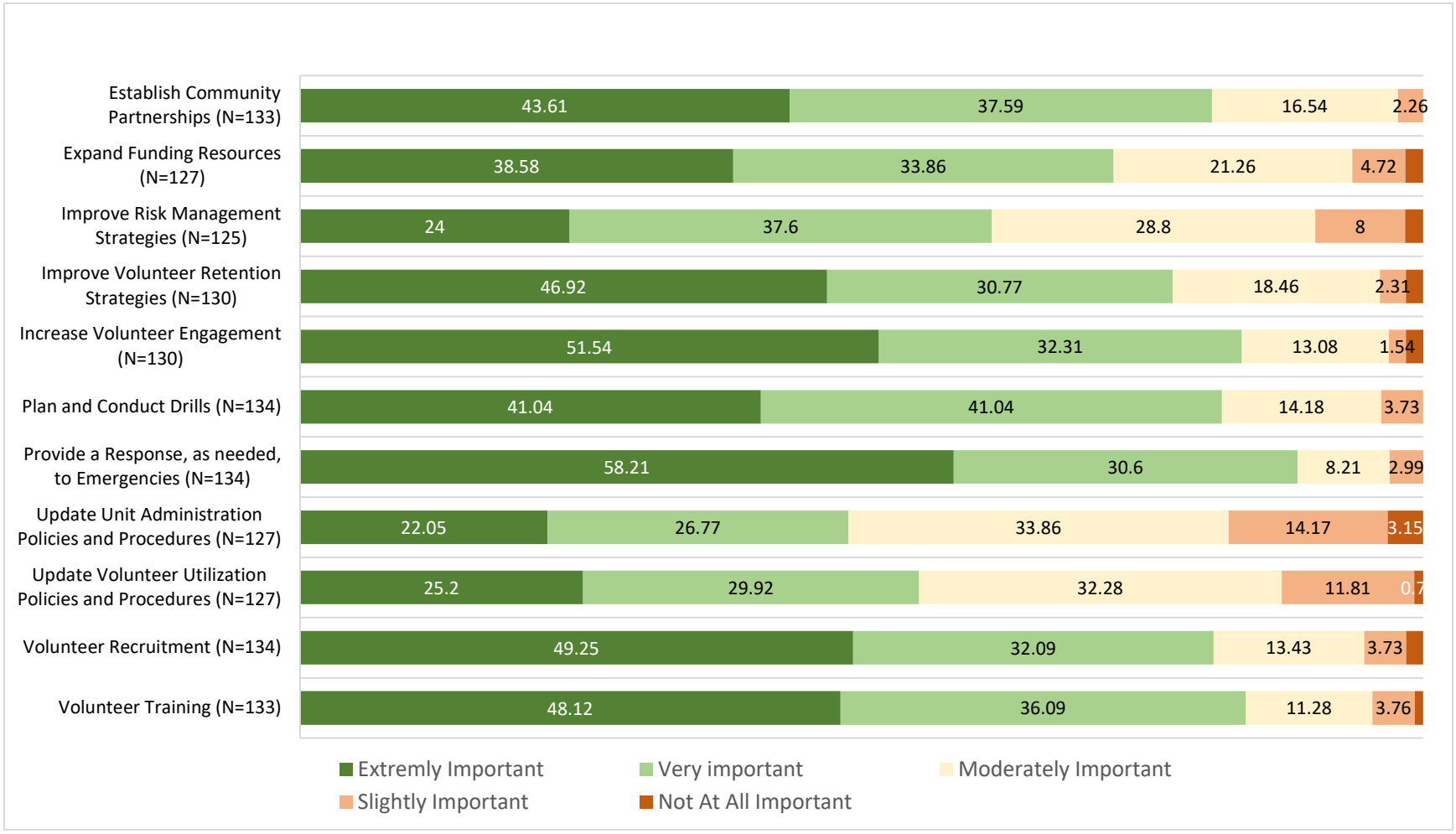
4.3 MRC Priorities

Both MRC Unit Leaders and Non-Unit Leaders were asked to rank possible MRC priorities on a 5-point scale from "Extremely Important" to "Not at all Important." Interestingly, similar priorities emerged for both groups, though there was some differentiation in the order of importance. The most important priorities for unit leaders and non-unit leaders were:

- Community partnerships
- Volunteer engagement
- Responding to emergencies
- Volunteer training

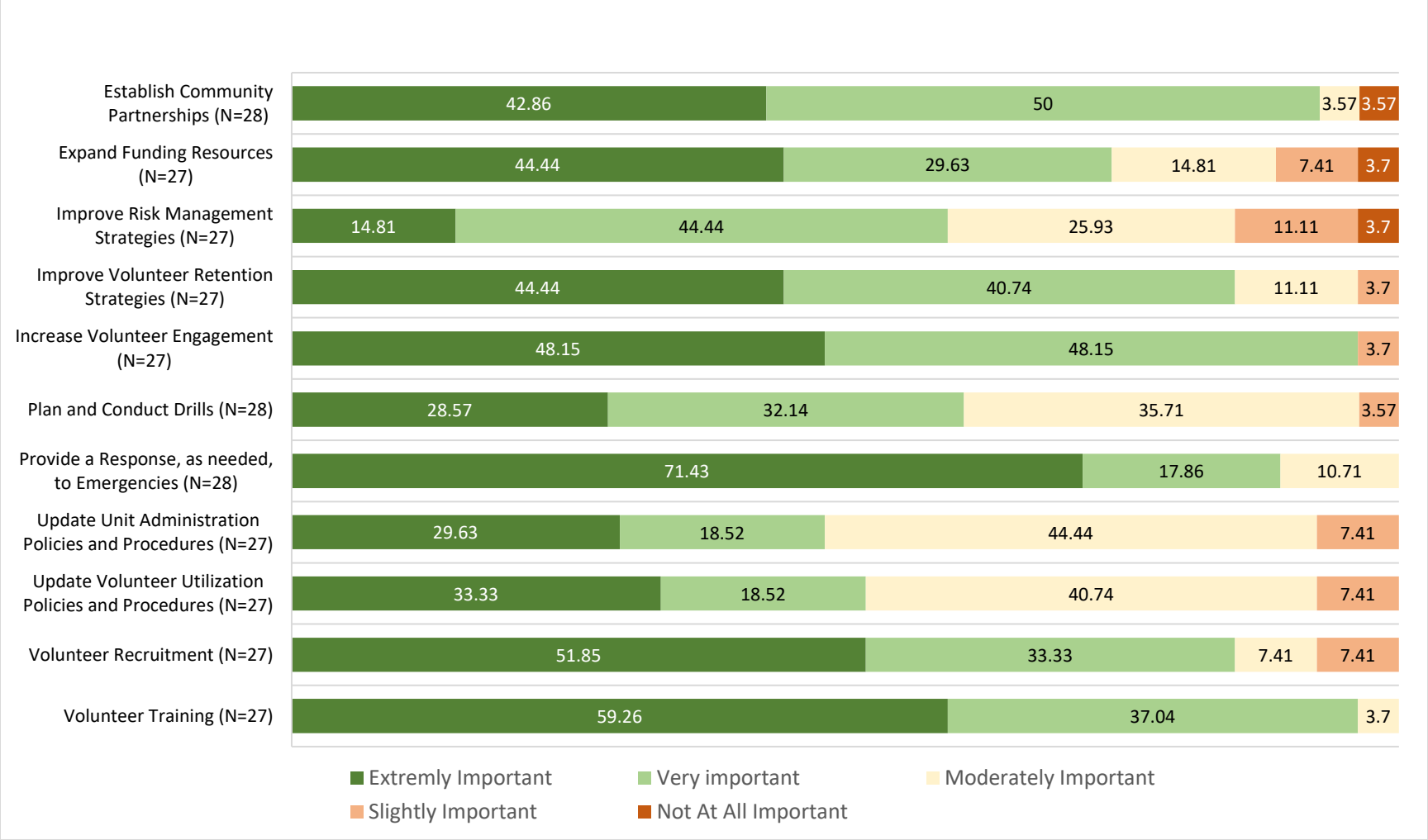
Figure 4 summarizes the priorities of Non-Unit Leaders. Figure 5 summarizes the priorities of Unit Leaders.

Figure 4: MRC Priorities – Non-Unit Leaders



Responses – All Regions

Figure 5: MRC Priorities – Unit Leaders



4.4 MRC SERVICES

4.4.1 Desired Services

All respondents were asked to further define what services they would like to see MRC units provide. The figures on the following pages show the responses of unit leaders and non-unit Leaders.

Among both sets of respondents, it is clear that the ability to deploy volunteers within the MRC coverage area is an extremely important service. Interestingly, MRC unit leaders also place providing staffing support at shelters as a high priority, with 83% rating it as "extremely" important, while 58% of non-unit leaders rate it as "extremely" important.

Providing staffing support at flu clinics and EDS clinics are also services that MRC unit leaders consider a high priority. This is less true for non-unit leaders – especially for flu clinics. 68% of non-unit leaders say this service is "extremely" or "very" important, compared to 87% of unit leaders.

Both unit leaders and non-unit leaders had respondents that indicated setting up and managing shelters is an "extremely" or "very" important service for MRC units to provide (75% of non-unit leaders and 92% of unit leaders). This indicates that there needs to be education on the fact that MRC units are not tasked with this service.[4]

[4] The Massachusetts Civil Defense Act requires that every city and town establish a local emergency management program and to appoint an official to oversee the program (typically known as the Emergency Management Director or EMD). The EMD and other local officials will direct evacuations, open shelters, coordinate the actions of local departments and agencies, mobilize local resources, activate mutual aid agreements with other cities and towns, and request state assistance in accordance with the plans and procedures developed by the local emergency management program. Additional information can be found in the Massachusetts Emergency Management Agency's (MEMA's) Commonwealth of Massachusetts Comprehensive Emergency Management Plan Base Plan (February 2017) and Commonwealth of Massachusetts Statewide Mass Care and Shelter Coordination Plan (June 2018).

Figure 6: Desired MRC Services – Non-Unit Leaders

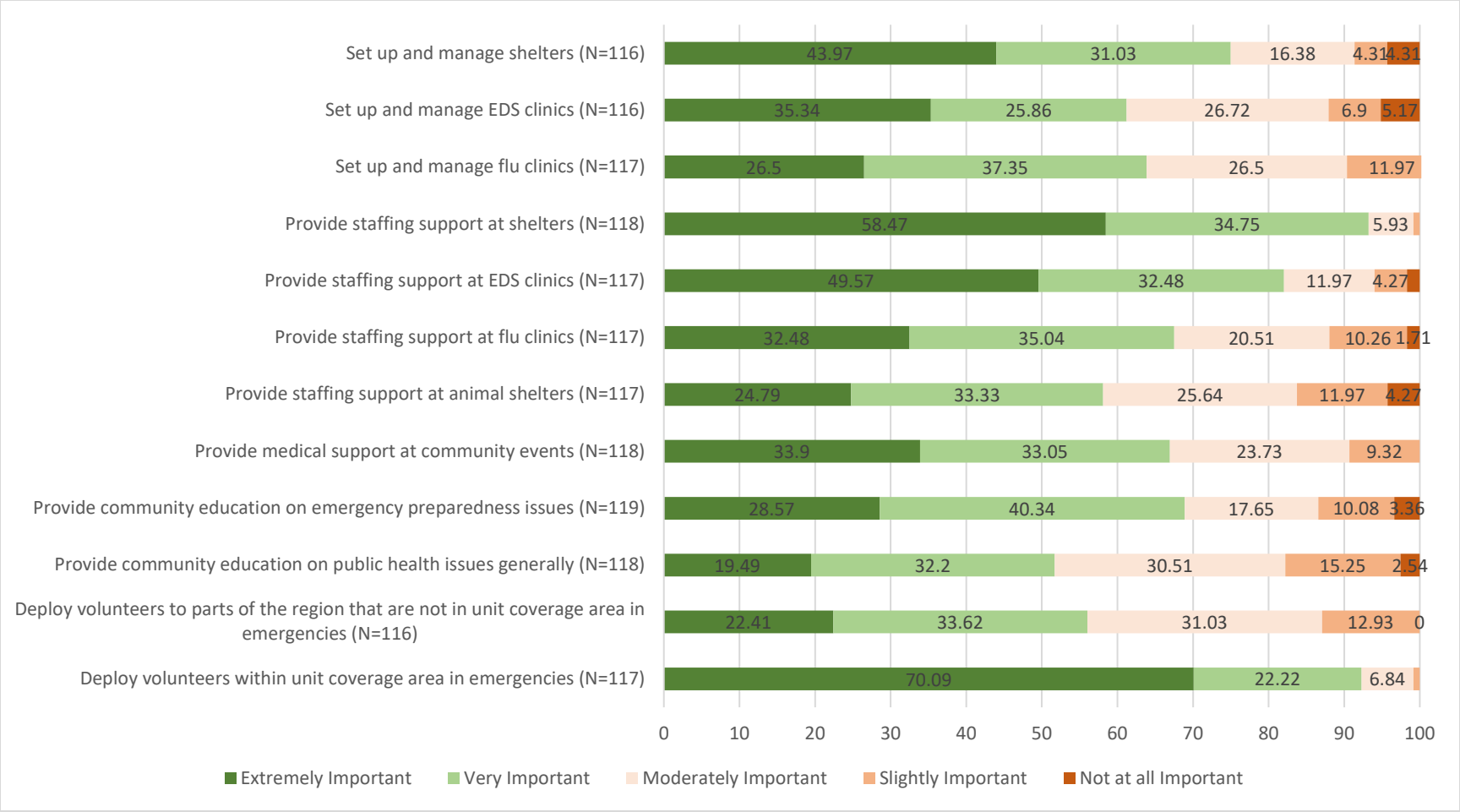
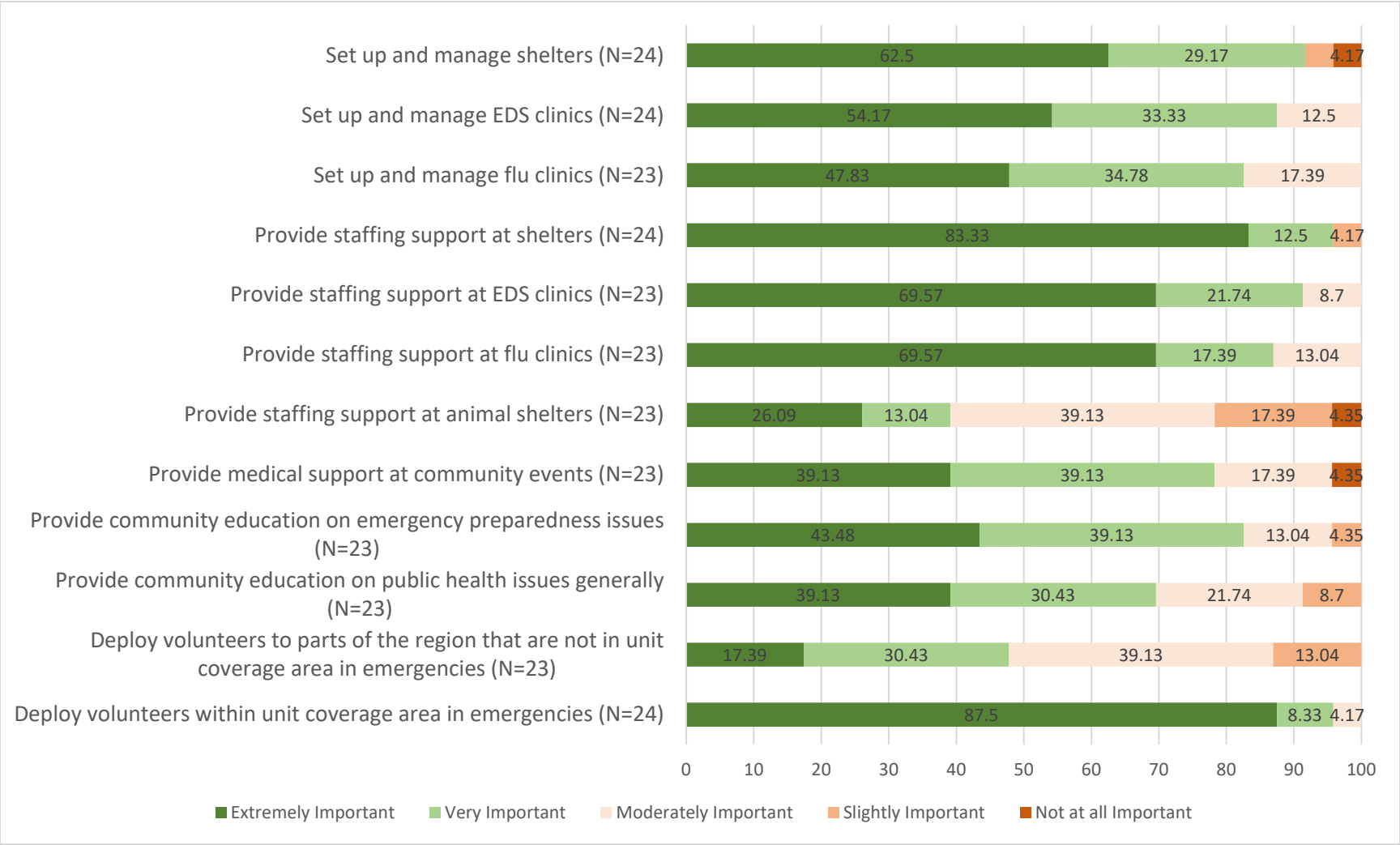


Figure 7: Services Desired from MRC Units – Unit Leaders



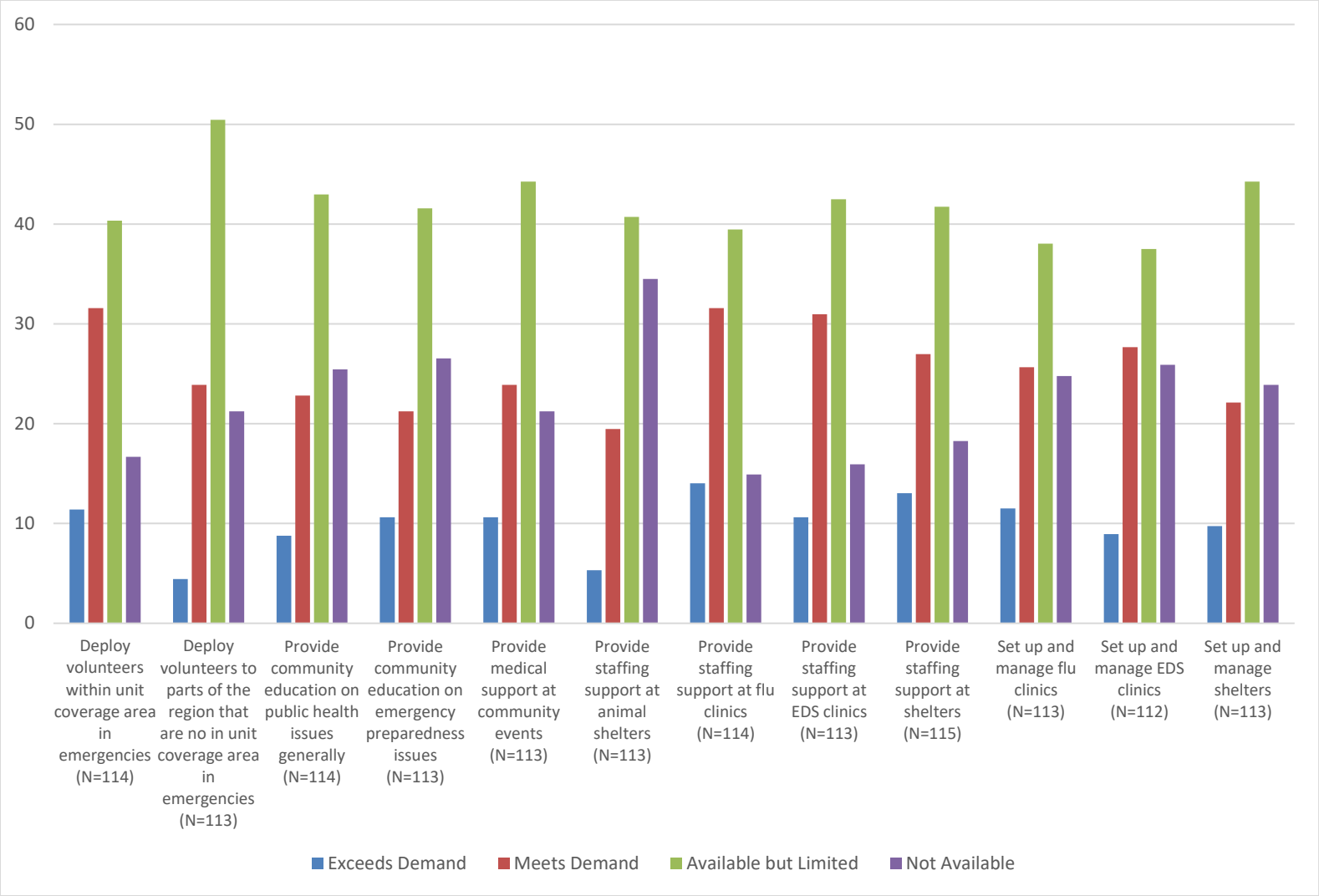
4.4.2 Actual Services Provided

When it comes to the actual services MRC units can provide, respondents were asked how well MRC units could currently meet the regional demand for those services. The figures below summarize the responses by unit leaders and non-unit leaders.

In terms of the service that is most important to unit leaders and non-unit leaders – the ability to deploy volunteers within the unit coverage area in an emergency – the majority of unit leaders believe that the unit either exceeds (17%) or meets (54%) this demand. The majority of non-unit leaders, though, believe this service is either "available but limited" (40%) or not available (17%).

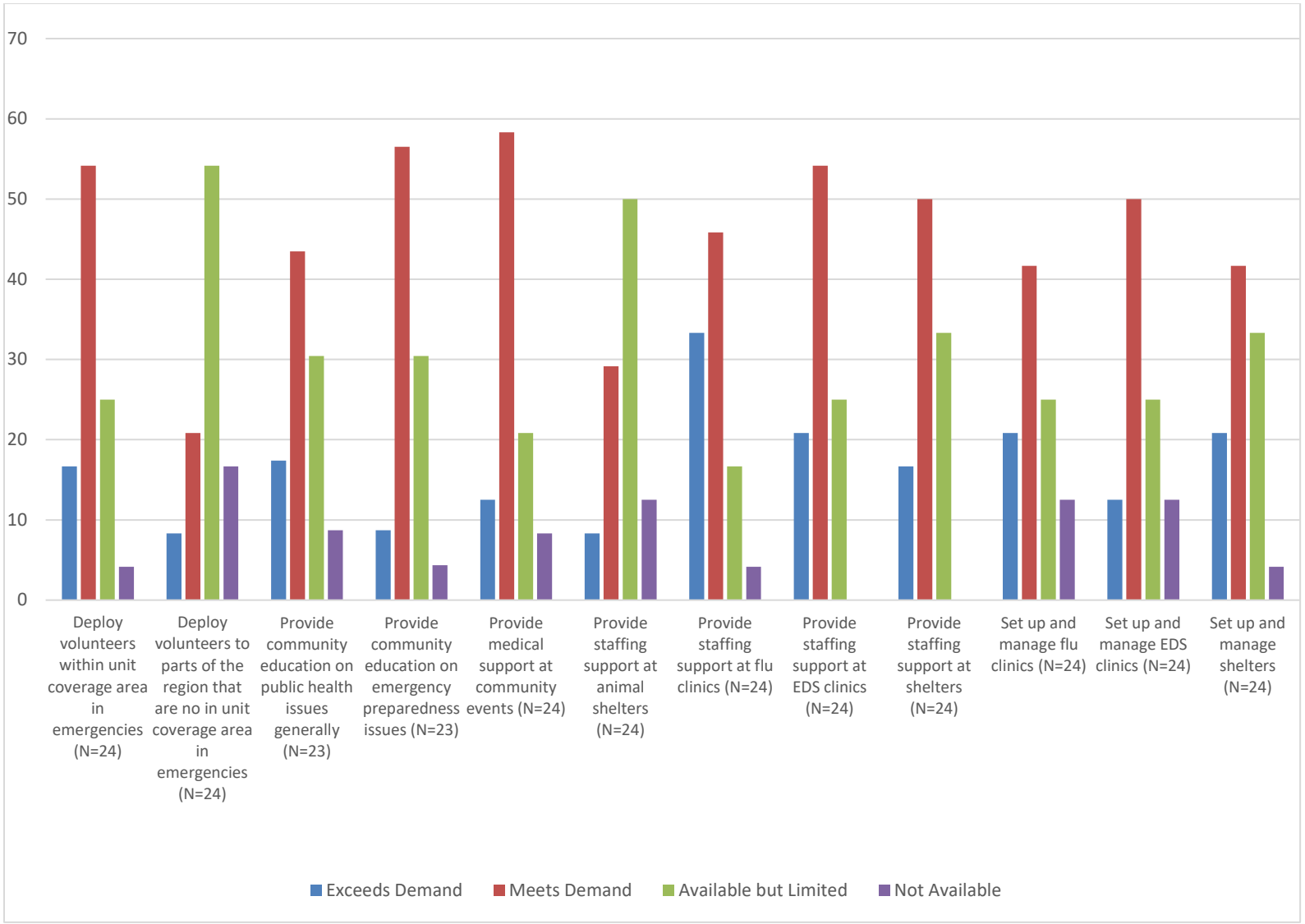
In general, non-unit leaders believe the ability of MRC units to provide desired services is much more limited than the perception of unit leaders.

Figure 8: MRC Services Provided – Non-Unit Leaders



Responses – All Regions

Figure 9: MRC Services Provided – Unit Leaders



4.4.3 Barriers

Unit leaders and non-unit leaders were also asked to share perceived barriers to service priorities for the region, as an open-ended response.

Although in previous questions, most unit leaders believed units could deploy volunteers in an emergency, both unit leaders and non-unit leaders pointed to a lack of volunteers – either through recruitment, retention or availability during an actual emergency – as a barrier. Specifically, unit leaders pointed to state liability issues for volunteers and lack of transportation to disaster sites during poor weather conditions as barriers to emergency deployment.

Non-unit leaders pointed to a lack of integration of the MRC program with local emergency management. In some cases, this lack of integration was blamed on the isolation of the MRC program and a lack of awareness and complete understanding of what MRC units do, and in other cases, cultural barriers with integration to town EMS/fire were blamed.

4.5 VOLUNTEERS

4.5.1 About MRC Volunteers

MRC unit leaders provide quarterly reports to MDPH OPEM, in which they share information about their unit, including the current number of credentialed volunteers[5] (see table below).

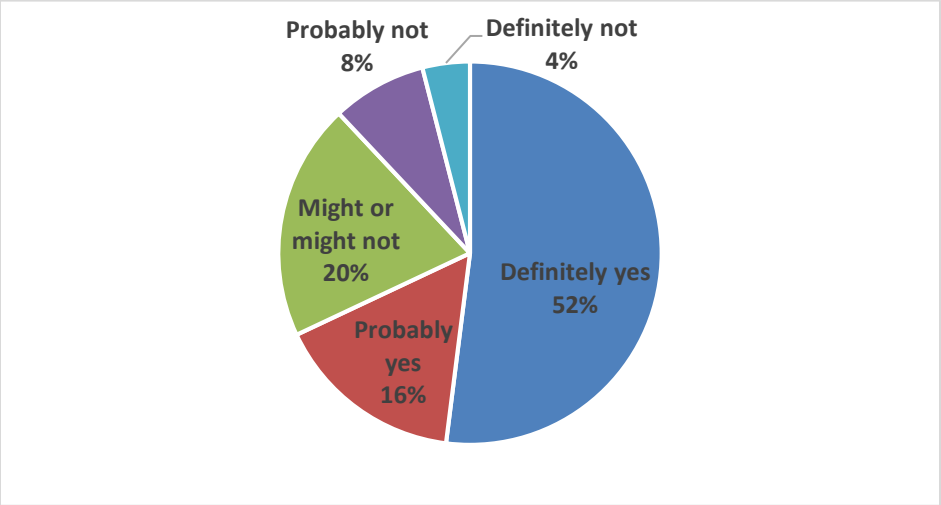
Table 2: Credentialed Volunteers by Region

Region	Number of Credentialed Volunteers (BP1 Q4 Reporting)
Region 1[6]	1,470
Region 2	878
Region 3	1,807
Region 4A[7]	1,390
Region 4B[8]	1,330
Region 4C	1,117
Region 5[9]	2,002

[5] Each MRC unit in MA Responds has pre-established standards, including submission of valid CORI and VSOS checks. Units not in MA Responds must submit copies of written policies and procedures, including credentialing sources and frequency. Non-MA Responds units must also include a process for verifying medical licenses when appropriate, as well as CORI, and VSOS/SORI checks for all volunteers.
[6] Springfield MRC and Greater Westfield MRC unit's numbers are based on Q3 reporting.
[7] Region 4A MRC unit's numbers are based on Q2 reporting.
[8] Region 4B MRC unit's numbers are based on Q2 reporting.
[9] Bridgewater MRC unit's numbers are based on Q3 reporting.

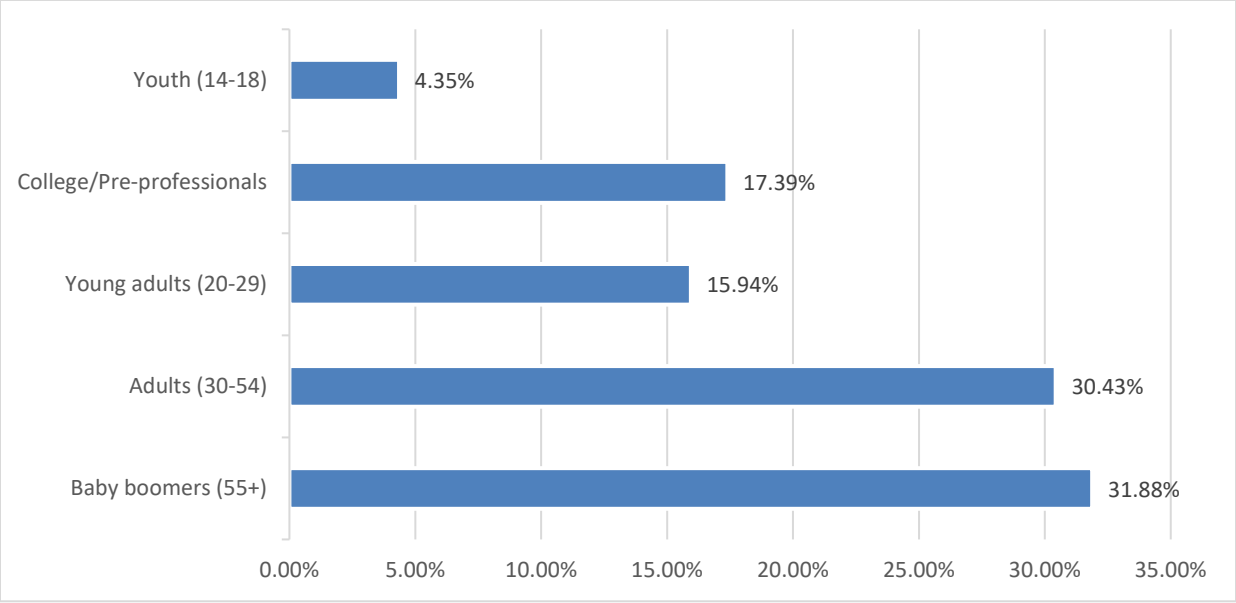
Unit leaders were then asked to determine their capacity to manage additional volunteers. A majority of unit leaders say they would "definitely" be able to manage additional volunteers. (See Figure 10)

Figure 10: Capacity to Manage Additional Volunteers



Unit leaders were also asked to describe the demographics of their volunteers. Based on their responses, it is clear that the largest category of MRC volunteers is aged 55 or more. With the exception of youth volunteers, young adults (aged 20-29) remain the smallest category. (See Figure 11)

Figure 11: MRC Volunteer Population Statewide



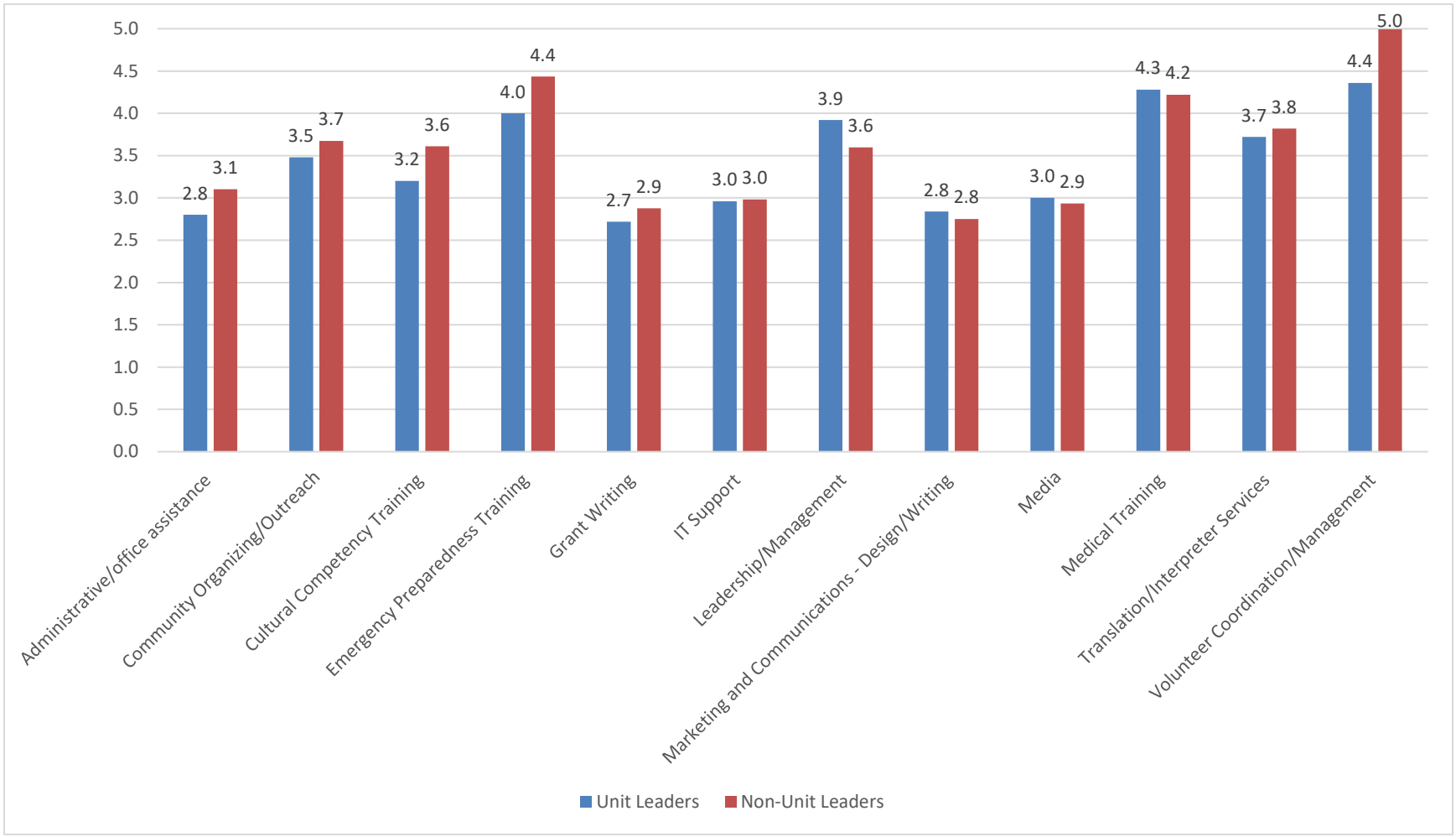
4.5.2 Skill Sets - Desired

Unit leaders and non-unit leaders were both asked to share their opinions on what skill sets were most important for MRC volunteers to possess. They were asked to rank each skill on a 5-point scale from "Extremely important" to "Not at all important." Figure 12 summarizes the mean responses from unit leaders and non-unit leaders.

The responses of unit leaders and non-unit leaders to these questions were relatively consistent with one another. For both sets of respondents, they pointed to volunteer coordination/management, emergency preparedness training, and medical training as the most important volunteer skill sets, although non-unit leaders rated emergency preparedness training slightly more highly than non-unit leaders.

In general, non-unit leaders rated each skill set more highly than unit leaders, with the exception of leadership/management skills, media and medical training (though those differences were slight). While volunteer coordination/management was the most important skill set for both groups, non-unit leaders rated it 0.6 points higher than unit leaders.

Figure 12: Average Rating of Desired Volunteer Skill Sets for Unit Leaders and Non-Unit Leaders



4.5.3 Actual Volunteer Skill Sets

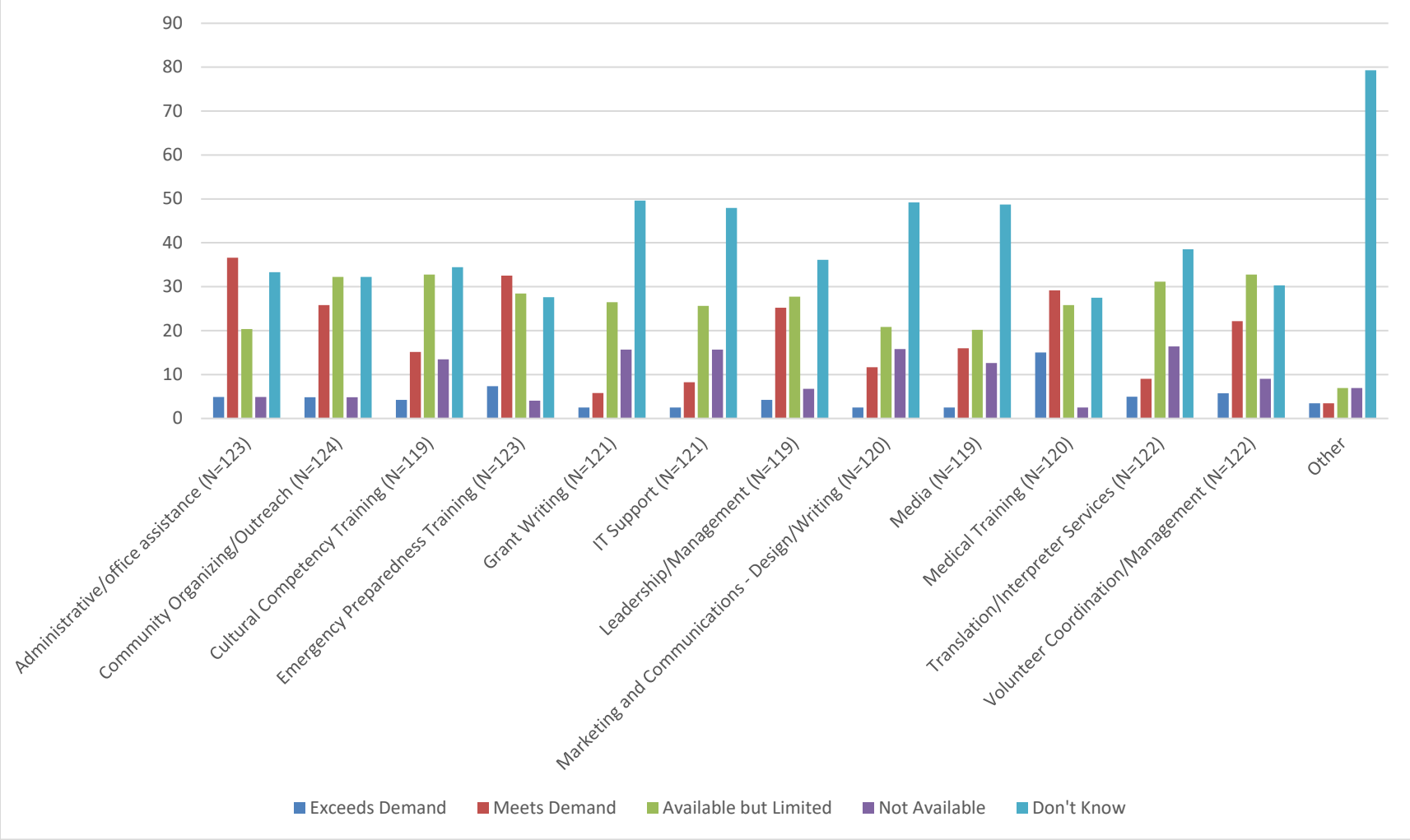
Respondents were then asked to what degree existing MRC volunteers possess these skill sets. Figures 13 and 14 summarize the responses by unit leaders and non-unit leaders.

In terms of skill sets that are most important to unit leaders and non-unit leaders –medical training and emergency preparedness training – most unit leaders seemed satisfied with the capacity of their volunteers to meet demand.

The skill sets that were identified with the most gaps – categorized as "available but limited" or "not available" include grant writing (94%), IT support (80%), Marketing and Communications (72%), Media (76%), and Translation and Interpreter Services (82%).

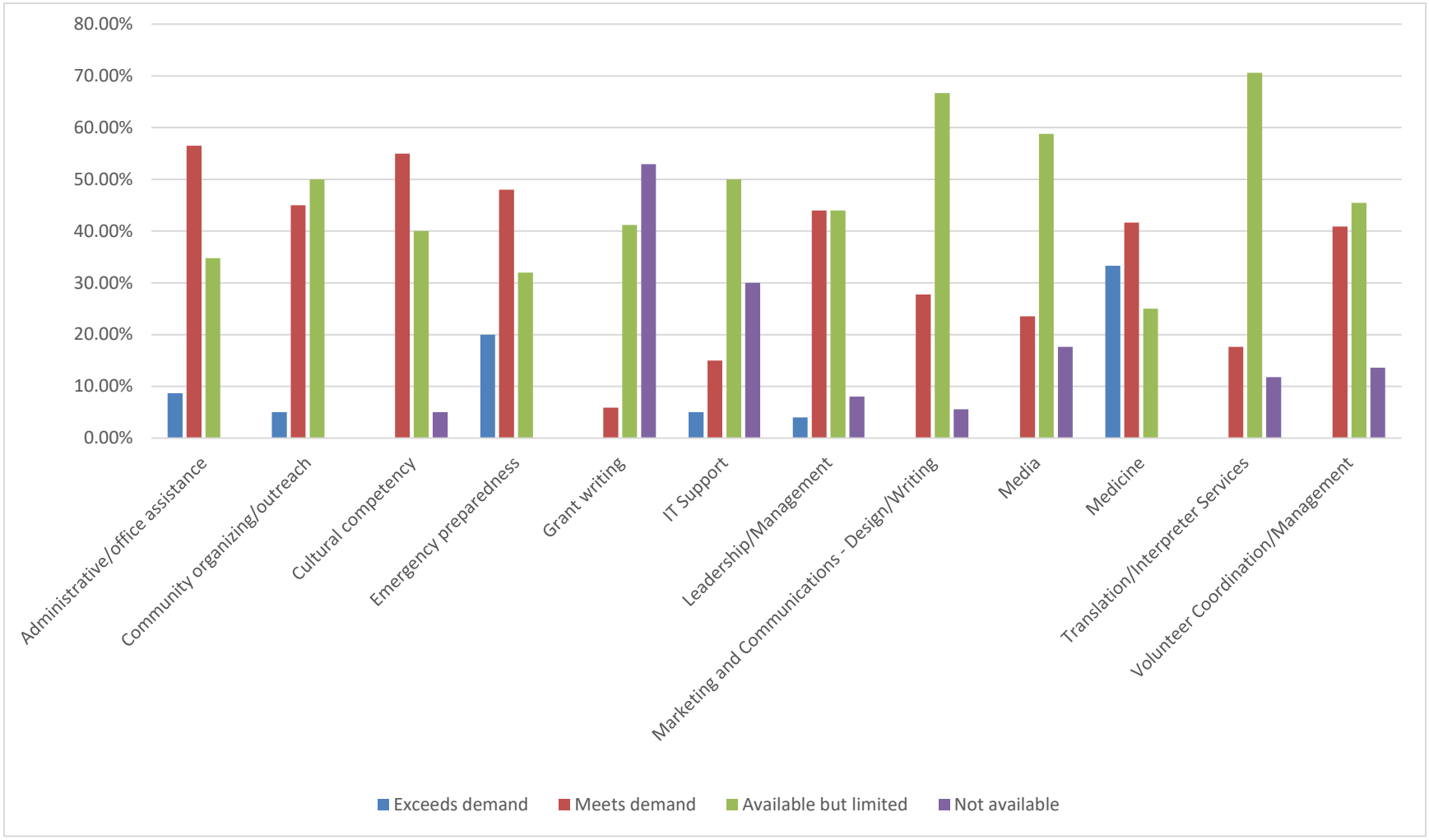
In general, non-unit leaders were unfamiliar with the actual skill sets of MRC volunteers. In near all cases, over 30% of respondents said they "Don't Know" about these skills. This suggests that MRC unit leaders could engage with their stakeholder partners to educate them on these issues.

Figure 13: Actual Volunteer Skill Sets – Non-Unit Leaders



Responses – All Regions

Figure 14: Actual Volunteer Skill Sets – Unit Leaders

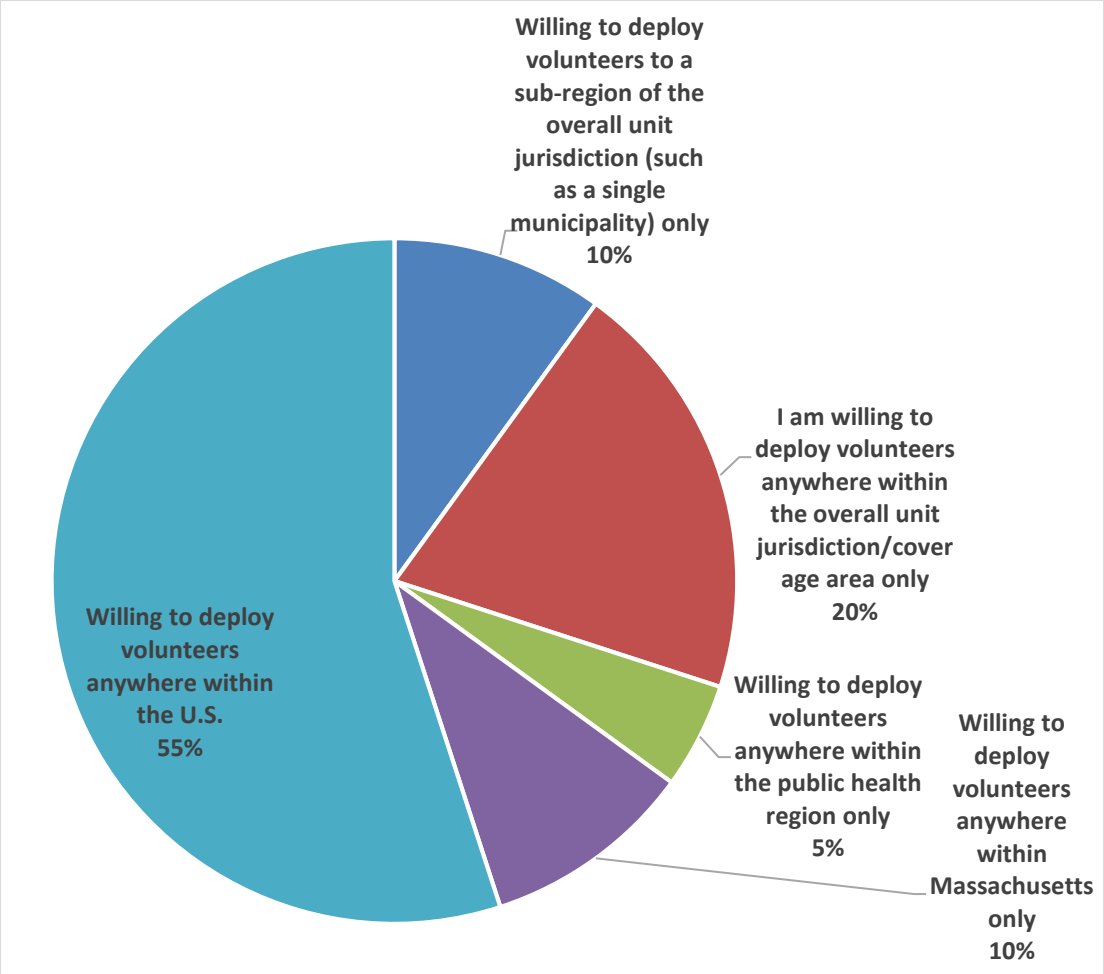


4.6 DEPLOYMENT

Unit leaders were also asked a series of questions about volunteer deployment. (See Figure 15)

The majority of unit leaders (55%) indicated that they would be willing to deploy their volunteers anywhere in the United States. 30% of unit leaders are willing to deploy volunteers ***only*** within the unit jurisdiction or a sub-region of the overall jurisdiction (such as a municipality).

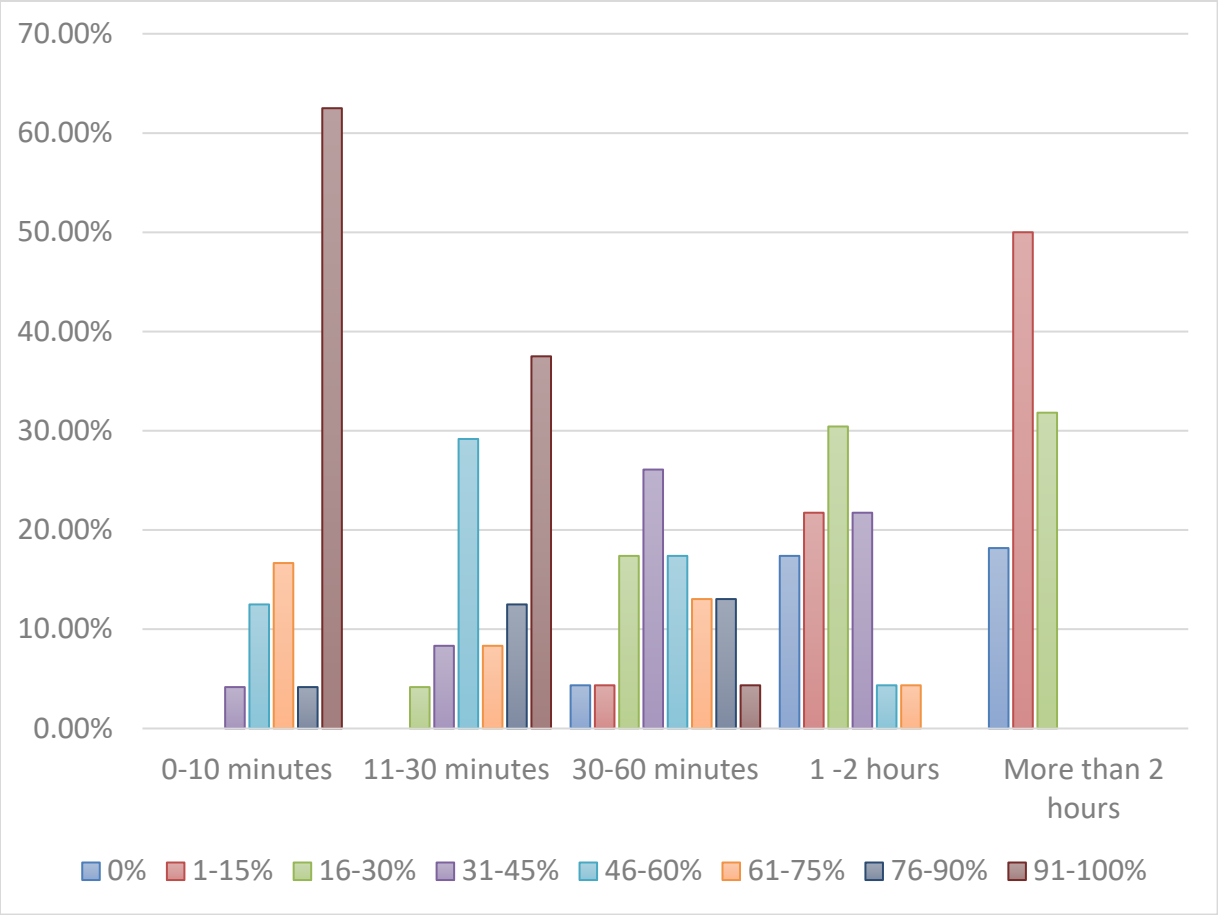
Figure 15: Volunteer Deployment by Unit Leaders



Unit leaders were also asked how willing their volunteers would be to travel in a deployment – both during normal driving conditions and during inclement weather.

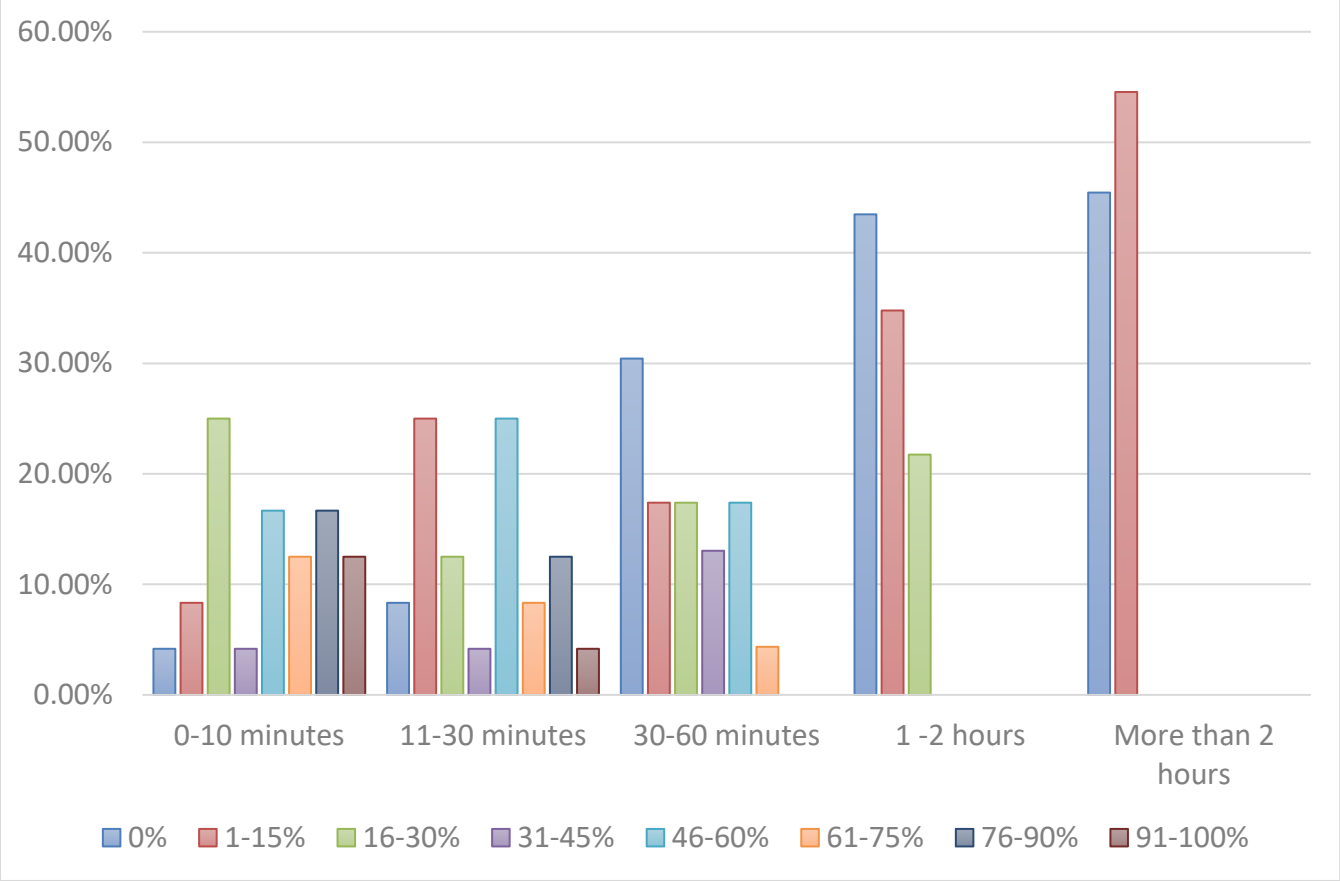
In normal driving conditions, unit leaders believe over 90% of their volunteers will travel 0-10 minutes. No unit leaders believe that more that 30% of their volunteers will travel over 2 hours. Almost 20% of unit leaders believe none of their volunteers will travel more than 2 hours. (See Figure 16)

Figure 16: Volunteer Driving Distance (Normal Conditions)



In inclement weather, 45% of unit leaders believe none of their volunteers will travel two or more hours. Over 40% of unit leaders believe none of their volunteers will travel 1-2 hours in inclement weather. No unit leaders believe that more that 30% of their volunteers will travel 1-2 hours in inclement conditions. (See Figure 17)

Figure 17: Volunteer Driving Distance (Inclement Weather)



4.7 Additional Comments

All respondents were also encouraged to share any additional feedback they had about the MRC program in Massachusetts. Those open-ended responses can be found in Appendix A.

5 REGION 1

5.1 Overview

The total population for Region 1 is 807,404[10], covering 96 communities. In Region 1, there are three county-based units – Hampshire County MRC, Berkshire MRC, and Franklin Regional Council of Governments MRC[11].

The fourth county in Region 1, Hampden County, is home to seven units. Two communities in Hampden County, Ludlow and Palmer, are not covered by MRC units. The total population of these two communities is 33,243.

Table 3: MRC Units in Region 1

Unit Name	Number of Communities	Total Population
Berkshire	31	130,467
Central Hampden County	4	152,007
East Longmeadow	1	15,720
Franklin	24	62,543
Greater Westfield and Western Hampden County	8	57,830
Hampden/Wilbraham	2	19,358
Hampshire	21	158,832
Longmeadow	1	15,784
Monson	1	8,560
Springfield	1	153,060

Thirty respondents from Region 1 answered at least some of the Capacity Gap survey, 8 were affiliated with the MRC unit (either as a unit director or coordinator).

5.2 Volunteers in Region

Based on the BP1 Q4 reports, there are 1,470 credentialed volunteers in the region[12].

[10] U.S. Census 2010

[11] In 2018, this MRC unit's name was changed to Franklin County MRC.

[12] While the National MRC Program Office does not require credentialing of volunteers, MDPH OPEM requires credentialing of volunteers for MRC units to receive state funding. The current credentialing standard for Massachusetts units includes, at minimum: CORI checks, including a written CORI policy; a method of checking the sex offender status of volunteers (either a VSOS or SORI check), including a written sex offender check policy; a method of checking medical license information for medical volunteers, including a policy about the frequency of checks.

Table 4: Credentialed Volunteers in Region 1

Unit Name	Credentialed Volunteers	% of Unit's Population
Berkshire	182	0.14%
Central Hampden County	57	0.04%
East Longmeadow	0	0.0%
Franklin	39	0.06%
Greater Westfield; Hampden County[13]	72	0.12%
Hampden/Wilbraham	47	0.24%
Hampshire	709	0.45%
Longmeadow	65	0.41%
Monson	49	0.57%
Springfield[14]	250	0.16%

5.3 Role of Respondent

As mentioned earlier, 8 of the respondents were affiliated with MRC units in the region.

Table 5: Respondents from Region 1

Role of Respondent	%	Count
MRC unit director	6.67%	2
MRC unit coordinator	20.00%	6
HMCC sponsoring organization staff member	6.67%	2
Local emergency management official	43.33%	13
Local public health	20.00%	6
Hospital or health care organization staff member	0.00%	0
Community health center staff member	0.00%	0
EMS	0.00%	0
Long-term care staff member	0.00%	0
MEMA regional staff member	0.00%	0
CERT leader	0.00%	0
Other, please describe	3.33%	1
Total	100%	30

[13] Based on Q3 data; did not complete Q4 report.
[14] Based on Q3 data; did not complete Q4 report.

5.4 Mission and Purpose of Units in Region 1

MRC Unit Leaders were asked to share what they believe to be the mission and purpose of units in Region 1 (see table below).

Table 6: Stated Mission and Purpose of MRC Units in Region 1

Build healthy and resilient communities!
The mission of the Monson MRC is to establish a pool of volunteers, both medical and non-medical, as part of the Public Health Preparedness initiatives. The primary focuses being the ability to respond to public health emergencies and provide support to the local community in a timely and organized manner working with the Board of Health and the Local Emergency Management Committee.
To provide volunteer support to our communities during emergency and non-emergency events with pre-credentialed, trained and engaged members of our unit.
To build strong, healthy and prepared communities by establishing teams of volunteers who can contribute their skills and expertise during times of need.

5.5 Unit Priorities

Section 4.3 summarized the information about MRC unit priorities from both unit leaders' and non-unit leaders' perspectives for the entire Commonwealth. As noted there, there were similar priorities for both groups, including community partnerships, volunteer engagement, responding to emergencies, and volunteer training.

This section provides more detail about unit priorities in Region 1, including how the unit leaders set priorities and if they perceive any barriers to achieving those priorities.

5.5.1 Setting Priorities

The table below provides more detailed information about how unit leaders in Region 1 set unit priorities.

Table 7: How Unit Leaders Set Priorities in Region 1

Which of the following describes how your unit sets priorities annually (in order to develop a workplan and budget)?	%	Count[15]
The unit coordinator develops the workplan and budget independently.	10.00%	1
A Steering Committee or Advisory Group with representatives from the covered communities meets to set priorities/develop the workplan.	30.00%	3
The unit leader meets with other unit leaders in the region to develop shared priorities/workplans.	30.00%	3
The unit leader works with the HMCC sponsoring organization to develop budget and workplan.	20.00%	2
Currently the unit coordinator meets with the housing agency liaison and develops the plan and budget based on identified objectives during the existing fiscal year	10.00%	1
Total	100%	10

[15] Respondents were permitted to select multiple responses to the question.

5.5.2 Barriers to Providing Services

Non-unit leaders were asked to share any barriers they believe MRC units face, preventing the units from providing the services that are priorities for the region. Their open-ended responses are summarized in the table below. Most identified either a lack of volunteers of a lack of reliable volunteers who will be present in an emergency.

Table 8: Barriers to MRC Services – Non-Unit Leaders (Region 1)

What barriers (if any) do you see for MRC units to provide the services that are priorities in the region?
People don't want to commit their time or to go to other towns for emergencies.
Funding, volunteers & volunteer availability, liability coverage.
The volunteers lose interest.
Adequate quantity of medically-trained volunteers.
Lack of experience in real events. Lack of recognition from public officials.
The lack of trained volunteers.
Volunteers.
Our volunteers are often seen as unreliable or, even worse, that they go rogue when invited to participate in exercises and events. Many local officials don't know about the MRC and those that do, don't trust them.

Unit leaders were also asked to share any barriers they believe their units face, preventing them from providing priority services for the region. The open-ended responses are summarized in the table below.

Table 9: Barriers to MRC Services – Unit Leaders (Region 1)

What barriers (if any) do you see for your unit to provide the services that you prioritize?
Have no veterinarians or animal care experts.
Number of volunteers, availability of volunteers, availability of unit leader, quantity of supplies, costs of all of the above.
Volunteer availability and dedication to the mission.
Supplies and training.

5.6 VOLUNTEERS

Respondents were asked a series of detailed questions about their current volunteers.

5.6.1 "Active" Volunteers

Both unit leaders and non-unit leaders were asked several questions about "active" volunteers, defined as someone who volunteers for a unit in some capacity (including via emails and drills) at least annually.

Non-unit leaders were asked to estimate the number of active volunteers in the region. In Region 1, 70% of those respondents estimated that there were 100 or fewer active volunteers in the region. One respondent believed there were between 750 and 1000 active volunteers in the region.

Non-unit leaders were then asked to share the number of "active" volunteers they would like to see in the region. Over half of the respondents (56%) wanted to see between 51 and 500 active volunteers in the region. 44% wanted to see between 51 and 250 active volunteers.

Unit leaders were also asked to estimate the number of active volunteers in their unit, as well as the desired number of active volunteers in their unit. Unfortunately, since we did not ask respondents to identify their unit name, it is difficult to link these responses to the appropriate units. We would suggest that during regional planning discussion, unit leaders discuss these figures with the other leaders in their regions to get a sense of overall regional capacity.

5.6.2 Translation/Interpreter Skills

Unit leaders were asked to share information about the number of volunteers in their units with translation and interpretation skills.[16] The results were summarized for all of Region 1 (see Table 10).

Table 10: Total Number of Volunteers in Region 1 with Translation and Interpretation Skills

Language	Writes Fluently	Speaks Fluently
Spanish	29	29
Portuguese	1	1
Chinese	0	0
French Creole	0	0
Vietnamese	1	1
Russian	2	2
Arabic	3	3
Mon-Khmer, Cambodian	0	0
French	16	16
Italian	1	1

5.6.3 Recruitment

Unit leaders were asked about the most important volunteer recruitment methods for their units (see Figure 18). These responses varied demonstrably by region.

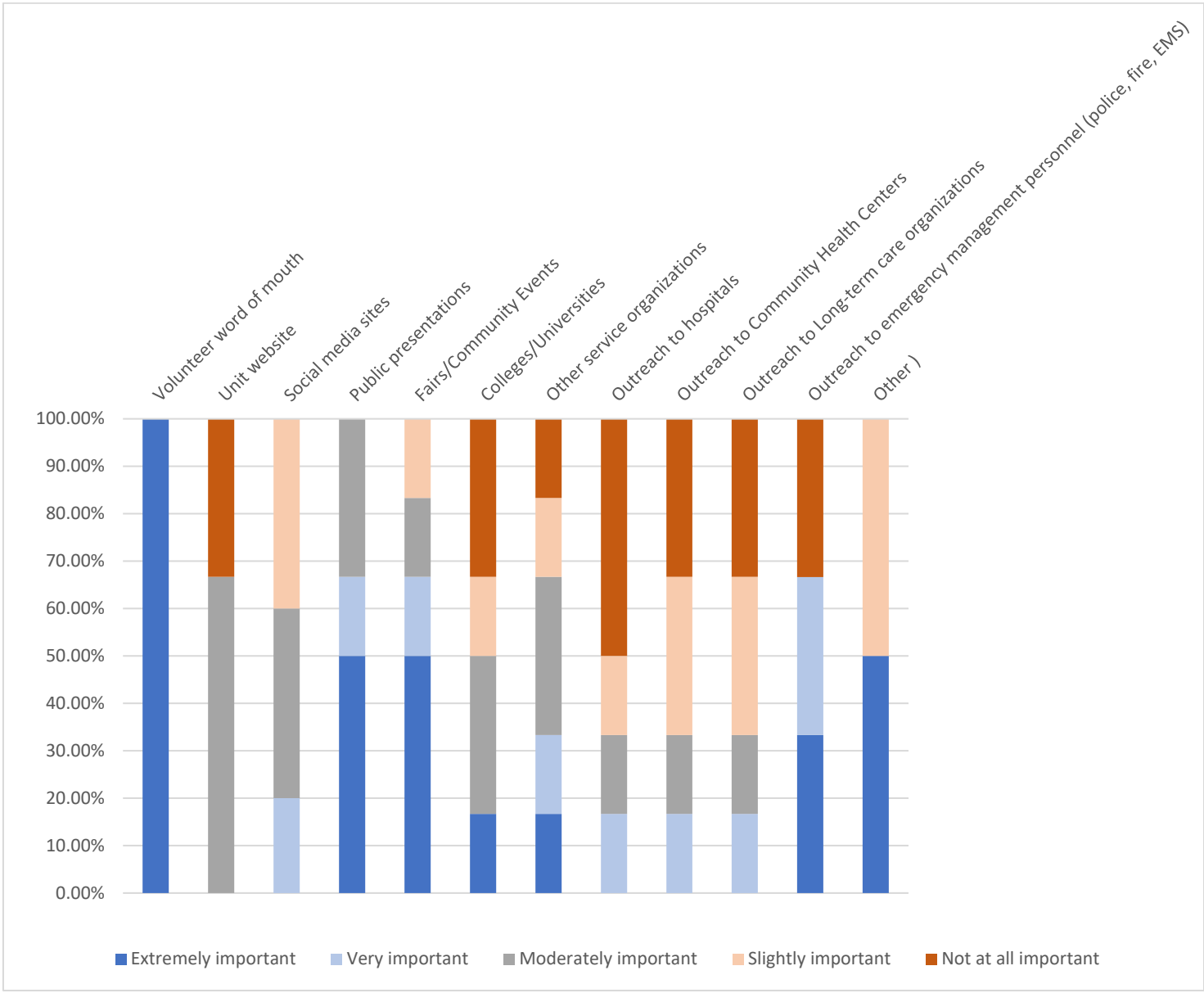
In Region 1, the most important methods were Volunteer Word of Mouth (100% of respondents rated it as "Extremely Important.") Public presentations, Fairs/Community Events, and Outreach to Emergency Management Personnel were also seen as important recruitment methods.

In Region 1, the unit website and outreach to colleges and universities, hospitals and community health centers were not seen as important.

[16] This information is requested as part of a volunteer's profile in MA Responds. For units in the MA Responds system, this data can be easily sorted and exported into a report.

Region 1

Figure 18: Most Important Volunteer Recruitment Methods in Region 1



5.6.4 Tracking

Unit leaders were asked if they compiled each volunteer's hours across multiple activities or events. The majority of unit leaders in Region 1 said they do not compile volunteer hours for individual volunteers across multiple activities and events.

Table 11: Tracking Volunteer Participation in Region 1

For each volunteer in your unit, do you compile their volunteer hours across multiple activities/events?	%	Count
Yes - more than once a year	16.67%	1
Yes - once a year	16.67%	1
Yes - every few years	0.00%	0

My unit does not compile volunteer hours for individual volunteers across multiple activities/events.	66.67%	4
Total	100%	6

5.6.5 Volunteer Satisfaction

Unit leaders were asked if they surveyed their volunteers to get a sense of their satisfaction (see Table 12). At most, unit leaders said they survey volunteers once a year.

Table 12: Frequency of Volunteer Satisfaction Surveys in Region 1

Frequency of Volunteer Satisfaction Surveys	%	Count
More than once a year	0.00%	0
Once a year	33.33%	2
Every few years	33.33%	2
To the best of my knowledge, my unit has never surveyed volunteer satisfaction.	33.33%	2
Total	100%	6

5.6.6 Volunteer Training Interests

Unit leaders were asked if they survey volunteers to get a sense of their training interest (see table below). In Region 1, half of the respondents said they survey volunteers once a year. One unit leader does not believe the unit's volunteers have ever been surveyed about training interests.

Table 13: Frequency of Training Interest Surveys in Region 1

Frequency of Training Interest Surveys	%	Count
More than once a year	0.00%	0
Once a year	50.00%	3
Every few years	33.33%	2
To my knowledge, my unit has never surveyed existing volunteers about training interests.	16.67%	1
Total	100%	6

5.6.7 Barriers to Provide Training to Volunteers

Unit leaders were asked to describe any perceived barriers to providing training to volunteers as open-ended responses. The complete list of responses is shared in Table 14. Scheduling and availability of volunteers are named as issues.

Table 14: Possible Barriers to Volunteer Training in Region 1 (Open-Ended)

Please describe any barriers you see in providing training to your volunteers.
Availability of trainers and volunteers to be trained.
The biggest issue seems to be the volunteer's willingness to come out to trainings, finding a time and date that is acceptable for a large enough number of people to make it worthwhile for the speaker, venue, etc.
Scheduling to maximize volunteer response.
Funding, food incentive (dinner or lunch) to draw additional volunteers, staff time.
Volunteers are working full time.

5.6.8 Barriers to Volunteer Engagement

Unit leaders were asked to share the biggest challenges their units face in their efforts to engage volunteers. They were asked to rank seven challenges (including "other") on a scale to determine what the biggest challenge was. The list of possible challenges included: lack of volunteer recruitment; volunteer availability; staff does not have time to manage volunteers; no planning and strategy for engaging volunteers; no staff time to develop volunteer positions; mis-match of volunteers with skills needed; and other.

In Region 1, volunteer availability was identified as the biggest challenge. The second biggest challenge was a mismatch of volunteers with skills needed.

5.7 MOUs

Unit leaders were asked to share any existing Memoranda of Understanding (MOUs) their units have in place.

Table 15: Current MOUs in Place for MRCs in Region 1

Please list all of the organizations with which your MRC has current MOUs in place.
None beyond the home municipalities Boards of Selectmen.
None.
None.
Health departments/local boards of health, service agencies and pharmacies are pending.
Town of Longmeadow Board of Health.

6 REGION TWO

6.1 Overview

The total population for Region 2 is 918,221[17], covering 74 communities. In Region 2, there are 3 units – Greater Grafton MRC, Wachusett MRC and Worcester Regional MRC.

Table 16: MRC Units in Region 2

Unit Name	Number of Communities	Total Population
Greater Grafton	4	60,707
Wachusett	22	206,034
Worcester Regional	48	651,480

6.2 Volunteers in Region

Based on the BP1 Q4 reports, there are 878 credentialed volunteers[18] in the region.

Table 17: Credentialed Volunteers in Region 2

Unit Name	Credentialed Volunteers	% of Unit's Population
Greater Grafton	136	0.22%
Wachusett	307	0.15%
Worcester Regional	435	0.07%

6.3 Role of Respondent

As mentioned earlier, there were 49 respondents from this region. Five of the respondents were affiliated with MRC units in the region.

Table 18: Respondents from Region 2

Role of Respondent	%	Count
MRC unit director	2.04%	1
MRC unit coordinator	8.16%	4
HMCC sponsoring organization staff member	0.00%	0
Local emergency management official	26.53%	13
Local public health	46.94%	23
Hospital or health care organization staff member	2.04%	1

[17] U.S. Census 2010

[18] While the National MRC Program Office does not require credentialing of volunteers, MDPH OPEM requires credentialing of volunteers for MRC units to receive state funding. The current credentialing standard for Massachusetts units includes, at minimum: CORI checks, including a written CORI policy; a method of checking the sex offender status of volunteers (either a VSOS or SORI check), including a written sex offender check policy; a method of checking medical license information for medical volunteers, including a policy about the frequency of checks.

Community health center staff member	2.04%	1
EMS	2.04%	1
Long-term care staff member	4.08%	2
MEMA regional staff member	0.00%	0
CERT leader	0.00%	0
Other, please describe	6.12%	3
Total	100%	49

6.4 Mission and Purpose of Units in Region 2

MRC Unit Leaders were asked to share what they believe to be the mission and purpose of units in Region 2 (see table below).

Table 19: Stated Mission and Purpose of MRC Units in Region 2

Please describe the mission of your MRC unit.
To unify towns in preparation of a small- or large-scale incident.
Our mission is to be dedicated to establish teams of local medical and public health professionals and lay volunteers to contribute their skills and expertise throughout the year as well as during times of community need. Our vision is to use the skills, knowledge and abilities of the Wachusett Medical Reserve Corps membership to meet an identified public health need or emergency response.
We are a committed group of volunteers who keep their communities safe by promoting public health, by responding to emergencies, by supplementing existing resources and by fostering the well-being of residents.
Public health outreach and emergency preparedness training.

6.5 Unit Priorities

Section 4.3 summarized the information about MRC unit priorities from both unit leaders' and non-unit leaders' perspectives for the entire Commonwealth. As noted there, there were similar priorities for both groups, including community partnerships, volunteer engagement, responding to emergencies, and volunteer training.

This section provides more detail about unit priorities in Region 2, including how the unit leaders set priorities and if they perceive any barriers to achieving those priorities.

6.5.1 Setting Priorities

The Table 20 provides more detailed information about how unit leaders in Region 2 set priorities.

Table 20: How Unit Leaders Set Priorities in Region 2

Which of the following describes how your unit sets priorities annually (in order to develop a workplan and budget)?	**%**	**Count[19]**
The unit coordinator develops the workplan and budget independently.	33.33%	1

[19] Respondents were permitted to select multiple responses to the question.

A Steering Committee or Advisory Group with representatives from the covered communities meets to set priorities/develop the workplan.	0.00%	0
The unit leader meets with other unit leaders in the region to develop shared priorities/workplans.	0.00%	0
The unit leader works with the HMCC sponsoring organization to develop budget and workplan.	33.33%	1
"Though we have not made an Advisory Group official, the Unit Coordinator/Director engages covered communities to request feedback on how the workplan/budget should look. By 2019, we are hoping to have established a formal Advisory Board."	33.33%	1
Total	100%	3

6.5.2 Barriers to Providing Services

Non-unit leaders were asked to share any barriers they believe MRC units face, preventing the units from providing the services that are priorities for the region. The open-ended responses are summarized in the table below. Most identified a lack of volunteers as a barrier.

Table 21: Barriers to MRC Services – Non-Unit Leaders (Region 2)

What barriers (if any) do you see for MRC units to provide the services that are priorities in the region?
Home & work responsibilities.
New to this position.
Uxbridge does not have a go to person for this plan - no one in charge.
Numbers active.
Lack of volunteers.
Lack of volunteers, leadership and organization.
Contracts are not in place in the summer to provide vital staffing.
Lack of volunteers.
Having enough volunteers when and where needed.
They must work with local public safety officials.

Unit leaders were also asked to share any barriers their units face, preventing them from providing priority services for the region. The open-ended responses are summarized in Table 22.

Table 22: Barriers to MRC Services – Unit Leaders (Region 2)

What barriers (if any) do you see for your unit to provide the services that you prioritize?
MRC Coordinators time limitations due to payroll constraints to fully coordinate services.
Volunteers do not seem to prioritize responding to requests.

6.6 VOLUNTEERS

Respondents were asked a series of detailed questions about their current volunteers.

6.6.1 "Active" Volunteers

Both unit leaders and non-unit leaders were asked several questions about "active" volunteers, defined as someone who volunteers for a unit in some capacity (including via emails and drills) at least annually.

Non-unit leaders were asked to estimate the number of active volunteers in the region. In Region 2, almost 70% (68.4%) of those respondents estimated that there were 100 or fewer active volunteers in the region. Two respondents believed there was between 501-750 active volunteers in the region.

Non-unit leaders were then asked to share the number of active volunteers that they would like to see in the region. There was a wide range of responses to this question. For example, 3 respondents answered "50 or fewer" while 4 respondents answered, "More than 1000." Five respondents answered "Don't Know" to the question. This suggests that among non-unit leaders, there is not a clear sense of how many volunteers are needed in the region.

Unit leaders were also asked to estimate the number of active volunteers in their unit, as well as the desired number of active volunteers in their unit. Unfortunately, since we did not ask respondents to identify their unit name, it is difficult to link these responses to the appropriate units. We would suggest that during regional planning discussion, unit leaders discuss these figures with the other leaders in their regions to get a sense of overall regional capacity.

6.6.2 Translation/Interpreter Skills

Unit leaders were asked to share information about the number of volunteers in their units with translation and interpretation skills[20]. These results were summarized for Region 2 (see table below).

Table 23: Total Number of Volunteers in Region 2 with Translation and Interpretation Skills

Language	Writes Fluently	Speaks Fluently
Spanish	1	1
Portuguese	0	0
Chinese	0	0
French Creole	0	0
Vietnamese	0	0
Russian	0	0
Arabic	0	0
Mon-Khmer, Cambodian	0	0
French	0	0
Italian	0	0

6.6.3 Recruitment

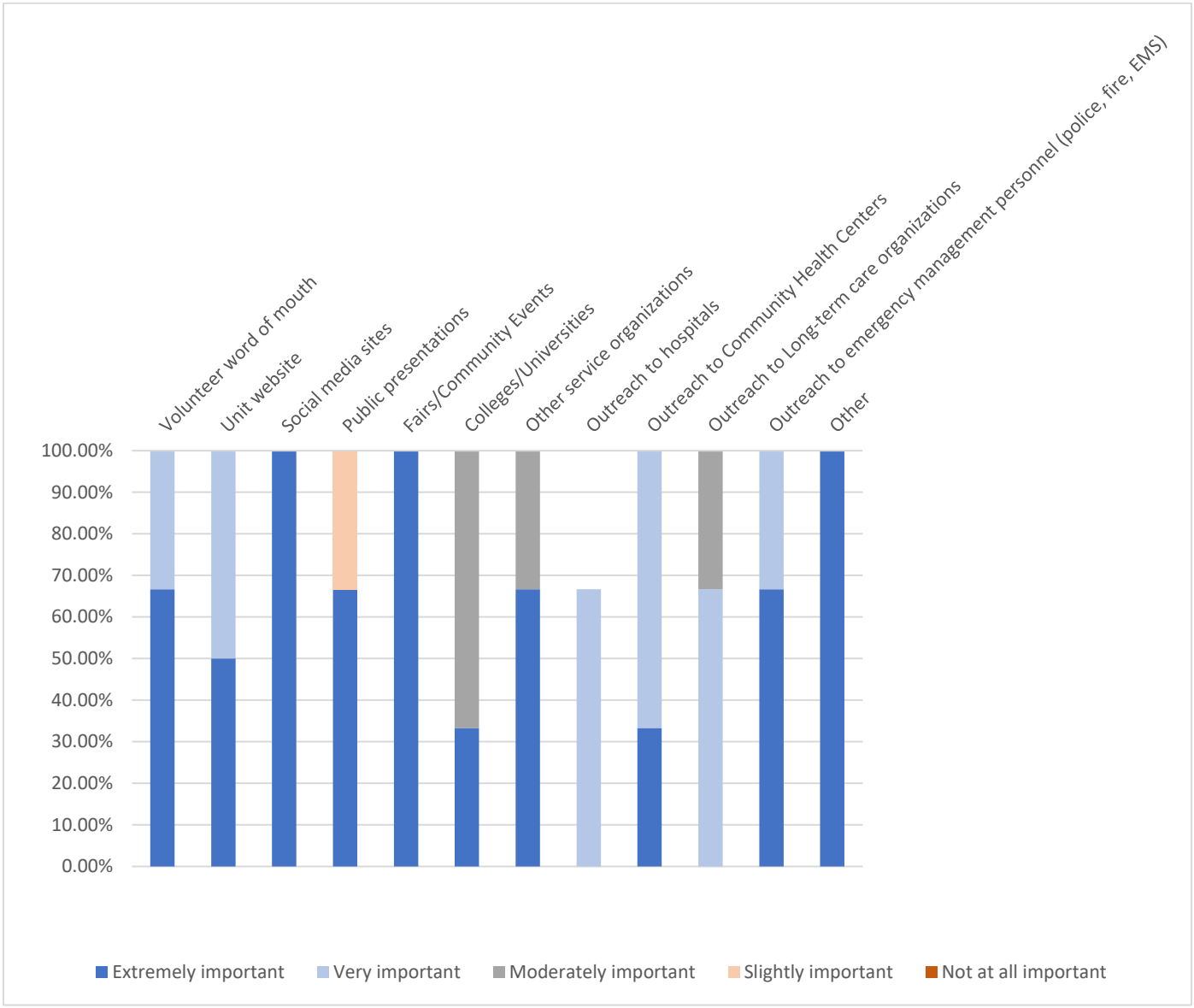
Unit leaders were asked about the most important volunteer recruitment methods for their units (see Figure 19). These responses varied demonstrably by region.

[20] This information is requested as part of a volunteer's profile in MA Responds. For units in the MA Responds system, this data can be easily sorted and exported into a report.

Region Two

In Region 2, the most important methods were Social Media Sites and Fairs/Community Events (100% of respondents rated them as "extremely important"). Other important recruitment methods included Volunteer Word of Mouth, Unit Website, and Outreach to Emergency Management Personnel. One respondent included the "Other" category as extremely important, naming outreach to faith-based communities.

Figure 19: Most Important Volunteer Recruitment Methods in Region 2



6.6.4 Tracking

Unit leaders were asked if they compiled each volunteer's hours across multiple activities or events. The majority of unit leaders in Region 2 said they do not compile volunteer hours for individual volunteers.

Table 24: Tracking Volunteer Participation in Region 2

For each volunteer in your unit, do you compile their volunteer hours across multiple activities/events?	%	Count
Yes - more than once a year	33.33%	1
Yes - once a year	0.00%	0
Yes - every few years	0.00%	0
My unit does not compile volunteer hours for individual volunteers across multiple activities/events.	66.67%	2
Total	100%	3

6.6.5 Volunteer Satisfaction

Unit leaders were asked if they surveyed their volunteers to get a sense of their satisfaction (see Table 25 below). In Region 2, unit leaders said they survey volunteers at least once a year.

Table 25: Frequency of Volunteer Satisfaction Surveys in Region 2

Frequency of Volunteer Satisfaction Surveys	%	Count
More than once a year	33.33%	1
Once a year	66.67%	2
Every few years	0.00%	0
To the best of my knowledge, my unit has never surveyed volunteer satisfaction.	0.00%	0
Total	100%	3

6.6.6 Volunteer Training Interests

Unit leaders were also asked if they surveyed their volunteers to get a sense of their training interests (see Table 26 below). In Region 2, unit leaders said they survey volunteers at least once a year about training.

Table 26: Frequency of Training Interest Surveys in Region 2

Frequency of Training Interest Surveys	%	Count
More than once a year	33.33%	1
Once a year	66.67%	2
Every few years	0.00%	0
To my knowledge, my unit has never surveyed existing volunteers about training interests.	0.00%	0
Total	100%	3

6.6.7 Barriers to Provide Training to Volunteers

Unit leaders were asked to describe any perceived barriers to providing training to volunteers as open-ended responses. The complete list of responses is shared in Table 27.

Table 27: Possible Barriers to Volunteer Training in Region 2 (Open-Ended)

Please describe any barriers you see in providing training to your volunteers.
The Training Request Form process with HMCC and State/DPH is unclear, time-consuming, and ineffective. Individual MRC units know what training gaps exist in their local communities. Having the State dictate what trains are allowable is frustrating for the MRC leaders, guest speakers, and volunteers who are constantly informed the trainings are subject to cancellation if the state does not see it tying in directly to 'Emergency Preparedness.' The Medical Reserve Corps was designed to address public health initiatives and medical emergencies; however, MRC units are limited to use funding towards what OPEM deems 'emergency preparedness.' I would much rather utilizing my time doing focus-groups with volunteers or working hands-on in the community than filling out Training Request Forms 3x to receive approval.
Barrier is in willingness of volunteers to attend, participate in training.

6.6.8 Barriers to Volunteer Engagement

Unit leaders were asked to share the biggest challenges their units face in their efforts to engage volunteers. They were asked to rank seven challenges (including "other") on a scale to determine what the biggest challenge was. The list of possible challenges included: lack of volunteer recruitment; volunteer availability; staff does not have time to manage volunteers; no planning and strategy for engaging volunteers; no staff time to develop volunteer positions; mis-match of volunteers with skills needed; and other.

In Region 2, lack of volunteer recruitment and volunteer availability were tied as the biggest challenges named. A lack of staff time to develop volunteers was also identified as a challenge.

6.7 MOUs

Unit leaders were asked to share any existing Memoranda of Understanding (MOUs) their units have in place.

Table 28: Current MOUs in Place for MRCs in Region 2

Please list all of the organizations with which your MRC has current MOUs in place.
There were none known upon my on-boarding. We currently have an MOU in place with Stop and Shop, Koopman's Lumber, Pepperoni Express Pizza, and various faith-based organizations throughout Greater Grafton who have agreed to use their facilities as warming shelters. More MOUs are pending per the business plan.
None that I am aware of.
Wachusett.

7 REGION THREE

7.1 Overview

The total population for Region 3 is 1,266,323[21], covering 49 communities. In Region 3, there are seven units – Greater River Valley MRC, Mass Task Force (MATF), Mystic Valley MRC, Northeast MRC (NEMRC), North Shore Cape Ann MRC, Topsfield Regional MRC, and Upper Merrimack Valley MRC. MATF has some overlap with other units in the region, but for the purposes of Table 29 (see below), it includes all the communities in Essex County. No community has been double-counted.

Table 29: MRC Volunteers in Region 3

Unit Name	Number of Communities	Total Population
Greater River Valley	8	258,745
MATF	2	13,411
Mystic Valley	5	188,975
NEMRC	1	60,879
North Shore Cape Ann	14	362,616
Topsfield Regional	12	109,472
Upper Merrimack Valley	7	272,225

7.2 Volunteers in Region

Based on the BP1 Q4 reports, there are 1,807 credentialed volunteers[22][23] in the region.

Table 30: Credentialed Volunteers in Region 3

Unit Name	Credentialed Volunteers	% of Unit Population
Greater River Valley	247	0.10%
MATF[24]	N/A	N/A
Mystic Valley	75	0.04%
NEMRC	37	0.16%
North Shore Cape Ann	569	0.16%
Topsfield Regional	329	0.30%
Upper Merrimack Valley	550	0.20%

[21] U.S. Census 2010

[22] While the National MRC Program Office does not require credentialing of volunteers, MDPH OPEM requires credentialing of volunteers for MRC units to receive state funding. The current credentialing standard for Massachusetts units includes, at minimum: CORI checks, including a written CORI policy; a method of checking the sex offender status of volunteers (either a VSOS or SORI check), including a written sex offender check policy; a method of checking medical license information for medical volunteers, including a policy about the frequency of checks.

[23] This number does not include the number of credentialed volunteers in MATF, as that unit does not share volunteer data with MA DPH.

[24] MATF does not accept MDPH OPEM funding and does not complete quarterly reports.

7.3 Role of Respondent

As mentioned earlier, 7 of the respondents were affiliated with MRC units in the region.

Table 31: Respondents from Region 3

Role of Respondent	%	Count
MRC unit director	5.13%	2
MRC unit coordinator	12.82%	5
HMCC sponsoring organization staff member	2.56%	1
Local emergency management official	7.69%	3
Local public health	48.72%	19
Hospital or health care organization staff member	10.26%	4
Community health center staff member	0.00%	0
EMS	0.00%	0
Long-term care staff member	0.00%	0
MEMA regional staff member	0.00%	0
CERT leader	0.00%	0
Other, please describe	12.82%	5
Total	100%	39

7.4 Mission and Purpose of Units in Region 3

MRC unit leaders were asked to share what they believe to be the mission and purpose of units in Region 2 (see Table 32 below).

Table 32: Stated Mission and Purpose of MRC Units in Region 3

Please describe the mission of your MRC unit.
Recruit, train and deploy members for disaster preparedness / surge capacity in three areas: public health emergencies, mass casualty events, and community service activities.
Recruit, organize, train, and mobilize volunteers to strengthen public health and emergency response utilizing MRC Core Competencies as benchmarks.
The MRC was formed to promote public health and safety across the region, in three key areas: 1. Public Health Emergencies – Events that threaten public health, such as a disease outbreak or toxic chemical release. 2. Mass Casualty Incidents – Disasters that cause injury or threats to large numbers of people. These can include a building collapse, fire, storm, flood, or other event that displaces groups of residents that must be moved to emergency shelters. 3. Community Service Activities – Opportunities to foster the well-being of local residents, such as health fairs, blood pressure clinics, or training programs.
The MRC was formed to promote public health and safety across the region, in three key areas: 1. Public Health Emergencies – Events that threaten public health, such as a disease outbreak or toxic chemical release. 2. Mass Casualty Incidents – Disasters that cause injury or threats to large numbers of people. These can include a building collapse, fire, storm, flood, or other event that displaces groups of residents that must be moved to emergency shelters. 3. Community Service Activities – Opportunities to foster the well-being of local residents, such as health

fairs, blood pressure clinics, or training programs.
Mission: The mission of the MRC is to provide public health volunteer medical services that supplement existing resources in case of disaster. Purpose: The Region 4A MRC [25]was formed to promote public health and safety across the region, in three key areas: 1. Public Health Emergencies – events that threaten public health, such as a disease outbreak or toxic chemical release. 2. Mass Casualty Incidents – disasters that cause injury or threats to large numbers of people. These can include a building collapse, fire, storm, flood, or other event that displaces groups of residents that must be moved to emergency shelters. 3. Community Service Activities – opportunities to foster the well-being of local residents; such as health fairs, blood pressure clinics, or training programs.
The mission of the Greater River Valley MRC is to provide volunteer services, both medical and non-medical, that supplement existing resources in a public health event, emergency or disaster.
The mission of the Greater River Valley MRC is to provide public health volunteer medical services that supplement existing resources in a public health emergency or disaster.

7.5 Unit Priorities

Section 4.3 summarized the information about MRC unit priorities from both unit leaders' and non-unit leaders' perspectives for the entire Commonwealth. As noted there, there were similar priorities for both groups, including community partnerships, volunteer engagement, responding to emergencies, and volunteer training.

This section provides more detail about unit priorities in Region 3, including how the unit leaders set priorities and if they perceive any barriers to achieving those priorities.

7.5.1 Setting Priorities

Table 33 (see below) provides more detailed information about how unit leaders in Region 3 set priorities.

Table 33: How Unit Leaders Set Priorities in Region 3

Which of the following describes how your unit sets priorities annually (in order to develop a workplan and budget)?	%	Count[26]
The unit coordinator develops the workplan and budget independently.	50.00%	6
A Steering Committee or Advisory Group with representatives from the covered communities meets to set priorities/develop the workplan.	8.33%	1
The unit leader meets with other unit leaders in the region to develop shared priorities/workplans.	25.00%	3
The unit leader works with the HMCC sponsoring organization to develop budget and workplan.	8.33%	1
Unit director and coordinator develop workplan and budget but also incorporates region unit leaders to develop shared priorities and projects	8.33%	1
Total	100%	12

7.5.2 Barriers to Providing Services

Non-unit leaders were asked to share any barriers they believe MRC units face, preventing the units from providing the services that are priorities for the region. The open-ended responses are summarized in Table 34. Most identified a lack of active volunteers who can be relied upon.

[25] This response for Region 3 included this reference to the Region 4A MRC, which may have been a mistake by the respondent. No open-ended survey responses were edited by the report's authors.

[26] Respondents were permitted to select multiple responses to the question.

Table 34: Barriers to MRC Services – Non-Unit Leaders (Region 3)

What barriers (if any) do you see for MRC units to provide the services that are priorities in the region?
We don't know if we can count on them.
lack of active members
not enough regular activities throughout the year to engage them.
Number of volunteers
The age of volunteers. We need new / younger members.
MRC is not a household name.
Coordinating with local jurisdictions will be a barrier. What is the process to identify the training and skill set of MRC members responding to incidents in a local jurisdiction. Just in time training to support their role in a local response will be very challenging.

Unit leaders were also asked to share any barriers they believe their units face, preventing them from providing priority services for the region. The open-ended responses are summarized in Table 35 (see below).

Table 35: Barriers to MRC Services – Unit Leaders (Region 3)

What barriers (if any) do you see for your unit to provide the services that you prioritize?
Complete inconsistency across the region for the way they manage shelters!!!
State liability.
State liability.
Liability.
Power outages can cause problem with contacting volunteers.
Difficult during power outages.

7.6 VOLUNTEERS

Respondents were asked a series of detailed questions about their current volunteers.

7.6.1 "Active" Volunteers

Both unit leaders and non-unit leaders were asked several questions about "active" volunteers, defined as someone who volunteers for a unit in some capacity (including via emails and drills) at least annually.

Non-unit leaders were asked to estimate the number of active volunteers in the region. In Region 3, 67% of those respondents estimated that there were 100 or fewer active volunteers in the region. No respondents believed there were 750 or more active volunteers in the region.

Non-unit leaders were then asked to share the number of active volunteers that they would like to see in the region. There was a wide range of responses to this question. For example, 3 respondents answered "50 or fewer" while 2 respondents answered, "More than 1000." Seven respondents answered "Don't Know" to the question. This suggests that among non-unit leaders, there is not a clear sense of how many volunteers are needed in the region.

Unit leaders were also asked to estimate the number of active volunteers in their unit, as well as the desired number of active volunteers in their unit. Unfortunately, since we did not ask respondents to identify their unit name, it is difficult to link these responses to the appropriate units. We would suggest that during regional planning discussion, unit leaders discuss these figures with the other leaders in their regions to get a sense of overall regional capacity.

7.6.2 Translation/Interpreter Skills

Unit leaders were asked to share information about the number of volunteers in their units with translation and interpretation skills[27]. These results were summarized for all of Region 3 (see table below).

Table 36: Total Number of Volunteers in Region 3 with Translation and Interpretation Skills

Language	Writes Fluently	Speaks Fluently
Spanish	75	75
Portuguese	12	12
Chinese	30	30
French Creole	2	2
Vietnamese	5	5
Russian	0	0
Arabic	0	0
Mon-Khmer, Cambodian	3	3
French	7	7
Italian	0	0

7.6.3 Recruitment

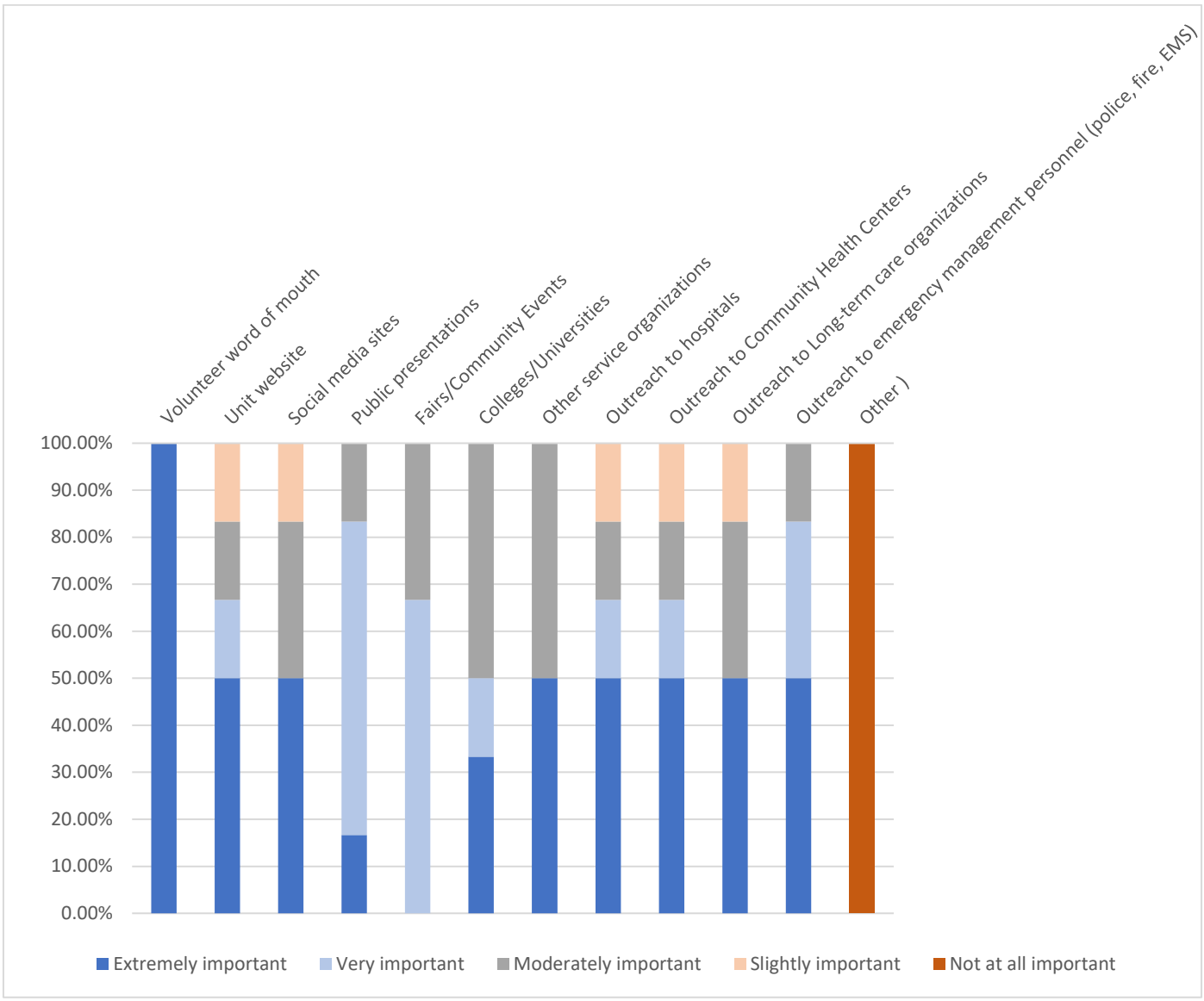
Unit leaders were asked about the most important volunteer recruitment methods for their units (see Figure 20). These responses varied demonstrably by region.

In Region 3, the most important methods were Volunteer Word of Mouth (100% of respondents rated it at "Extremely Important"). Outreach to emergency management personnel, hospitals, and community health centers were also seen as important recruitment methods.

[27] This information is requested as part of a volunteer's profile in MA Responds. For units in the MA Responds system, this data can be easily sorted and exported into a report.

Region Three

Figure 20: Most Important Volunteer Recruitment Methods (Region 3)



7.6.4 Tracking

Unit leaders were asked if they compiled each volunteer's hours across multiple activities or events (see Table 37 below). The majority of unit leaders in Region 3 said that compile volunteer hours for individual volunteers across multiple activities and events.

Table 37: Tracking Volunteer Participation in Region 3

For each volunteer in your unit, do you compile their volunteer hours across multiple activities/events?	%	Count
Yes - more than once a year	83.33%	5
Yes - once a year	16.67%	1
Yes - every few years	0.00%	0

My unit does not compile volunteer hours for individual volunteers across multiple activities/events.	0.00%	0
Total	100%	6

7.6.5 Volunteer Satisfaction

Unit leaders were asked if they surveyed their volunteers to get a sense of their satisfaction (see Table 38 below). All respondents said they survey their volunteers at least once a year.

Table 38: Frequency of Volunteer Satisfaction Surveys in Region 3

Frequency of Volunteer Satisfaction Surveys	%	Count
More than once a year	66.67%	4
Once a year	33.33%	2
Every few years	0.00%	0
To the best of my knowledge, my unit has never surveyed volunteer satisfaction.	0.00%	0
Total	100%	6

7.6.6 Volunteer Training Interests

Unit leaders were asked if they survey volunteers to get a sense of their training interest (see Table 39 below). In Region 3, all respondents said they survey their volunteers at least once a year.

Table 39: Frequency of Training Interest Surveys in Region 3

Frequency of Volunteer Training Interest Surveys	%	Count
More than once a year	66.67%	4
Once a year	33.33%	2
Every few years	0.00%	0
To my knowledge, my unit has never surveyed existing volunteers about training interests.	0.00%	0
Total	100%	6

7.6.7 Barriers to Provide Training to Volunteers

Unit leaders were asked to describe any perceived barriers to providing training to volunteers as open-ended responses. The complete list of responses is shared in Table 40. State liability was an issue raised by multiple respondents. We presume that this is in reference to the fact that the Commonwealth of Massachusetts does not have a statute providing state liability protections to MRC volunteers.[28]

[28] Some MRC volunteers receive special volunteer protections through their host municipalities. A summary, developed by MDPH, of liability protections available for MRC and other health care professional volunteers is available here: https://bit.ly/2zmcFoR. MDPH also developed a summary of liability protections available for non-health care volunteers that is available here: https://bit.ly/2CWR7m9.

Table 40: Possible Barriers to Volunteer Training in Region 3 (Open-Ended)

Please describe any barriers you see in providing training to your volunteers.
Both questions about 'frequency of surveying' are misleading. We ask for feedback after EVERY service activity and ask training opinions with each evaluation. We don't send surveys because that method doesn't work.
State liability.
State liability
State liability.
Funding.
Time for training that works for variety of volunteer's life schedules.

7.6.8 Barriers to Volunteer Engagement

Unit leaders were asked to share the biggest challenges their units face in their efforts to engage volunteers. They were asked to rank seven challenges (including "other") on a scale to determine what the biggest challenge was. The list of possible challenges included: lack of volunteer recruitment; volunteer availability; staff does not have time to manage volunteers; no planning and strategy for engaging volunteers; no staff time to develop volunteer positions; mis-match of volunteers with skills needed; and other.

In Region 3, volunteer availability was seen as the biggest challenge by a large margin. Lack of volunteer recruitment and no staff time to develop volunteer positions were also seen as challenges.

7.7 MOUs

Unit leaders were asked to share any existing Memoranda of Understanding (MOUs) their units have in place.

Table 41: Current MOUs in Place for MRCs in Region 3

Please list all of the organizations with which your MRC has current MOUs in place.
We have informal agreements and partnerships, but any official MOUs are established by our housing agent, not our unit.
Fire, Police, Hospitals, CERT, Senior Centers.
Fire, Police, Senior Centers, CERT, Hospitals.
Local Health, Senior Centers, Hospitals, Closed PODs, CERT.
All public health departments of the 8 communities, Clergy covenant, amateur radio group.

8 REGION 4A

8.1 Overview

The total population for Region 4A is 619,879[29], covering 33 communities. In Region 4A, there are two units – Region 4A MRC and Burlington Volunteer Reserve Corps.

Table 42: MRC Units in Region 4A

Unit Name	Number of Communities	Total Population
Burlington	1	24,498
Region 4A MRC	32	595,381

8.2 Volunteers in Region

Based on the BP1 Q4 reports, there are 1390 credentialed volunteers[30] in the region.

Table 43: Credentialed Volunteers in Region 4A

Unit Name	# Credentialed Volunteers	% of Unit Population
Burlington	165	0.67%
Region 4A MRC[31]	1225	0.21%

8.3 Role of Respondent

As mentioned earlier, 4 of the respondents were affiliated with MRC units in the region.

Table 44: Respondents from Region 4A

Role of Respondent	%	Count
MRC unit director	3.85%	1
MRC unit coordinator	11.54%	3
HMCC sponsoring organization staff member	0.00%	0
Local emergency management official	19.23%	5
Local public health	46.15%	12
Hospital or health care organization staff member	15.38%	4
Community health center staff member	0.00%	0
EMS	3.85%	1

[29] U.S. Census 2010

[30] While the National MRC Program Office does not require credentialing of volunteers, MDPH OPEM requires credentialing of volunteers for MRC units to receive state funding. The current credentialing standard for Massachusetts units includes, at minimum: CORI checks, including a written CORI policy; a method of checking the sex offender status of volunteers (either a VSOS or SORI check), including a written sex offender check policy; a method of checking medical license information for medical volunteers, including a policy about the frequency of checks.

[31] Based on Q2 reporting.

Long-term care staff member	0.00%	0
MEMA regional staff member	0.00%	0
CERT leader	0.00%	0
Other, please describe	0.00%	0
Total	100%	26

8.4 Mission and Purpose of Units in Region 4A

MRC unit leaders were asked to share what they believe to be the mission and purpose of units in Region. None of the respondents in Region 4A shared that information.

8.5 Unit Priorities

Section 4.3 summarized the information about MRC unit priorities from both unit leaders' and non-unit leaders' perspectives for the entire Commonwealth. As noted there, there were similar priorities for both groups, including community partnerships, volunteer engagement, responding to emergencies, and volunteer training.

This section provides more detail about unit priorities in Region 4A, including how the unit leaders set priorities and if they perceive any barriers to achieving those priorities.

8.5.1 Setting Priorities

The table below provides more detailed information about how unit leaders in Region 4A set unit priorities.

Table 45: How Unit Leaders Set Priorities in Region 4A

Which of the following describes how your unit sets priorities annually (in order to develop a workplan and budget)?	%	Count[32]
The unit coordinator develops the workplan and budget independently.	50.00%	1
A Steering Committee or Advisory Group with representatives from the covered communities meets to set priorities/develop the workplan.	50.00%	1
The unit leader meets with other unit leaders in the region to develop shared priorities/workplans.	0.00%	0
The unit leader works with the HMCC sponsoring organization to develop budget and workplan.	0.00%	0
Other (please describe)	0.00%	0
Total	100%	2

8.5.2 Barriers to Providing Services

Non-unit leaders were asked to share any barriers they believe MRC units face, preventing the units from providing the services that are priorities for the region. The open-ended responses are summarized in Table 46. Most identified either a lack of volunteers with the appropriate skill sets or a lack of reliable volunteers.

[32] Respondents were permitted to select multiple responses to the question.

Table 46: Barriers to MRC Services – Non-Unit Leaders (Region 4A)

What barriers (if any) do you see for MRC units to provide the services that are priorities in the region?
Not sure.
Staffing.
Sole reliance on volunteers without compensation.
Need more volunteers with skill sets & most importantly need MRC Regional Coordinator to assist.
Volunteer retainment.
Cannot depend on volunteers for actual emergency events--impossible to know how many will assist and what their training level will be.
Volunteers not wanting to participate outside their designated community. Not a lot of opportunities for volunteers to utilize their skills.

Unit leaders were also asked to share any barriers their units face, preventing them from providing priority services for the region. The open-ended responses are summarized in the table below.

Table 47: Barriers to MRC Services – Unit Leaders (Region 4A)

What barriers (if any) do you see for your unit to provide the services that you prioritize?
Additional recruitment is needed to support positions.
Lack of local unit Leadership support.

8.6 VOLUNTEERS

Respondents were asked a series of detailed questions about their current volunteers.

8.6.1 "Active" Volunteers

Both unit leaders and non-unit leaders were asked several questions about "active" volunteers, defined as someone who volunteers for a unit in some capacity (including via emails and drills) at least annually.

Non-unit leaders were asked to estimate the number of active volunteers in the region. In Region 4A, 60% of respondents estimated that there was between 101-750 active volunteers in the region.

Non-unit leaders were then asked to share the number of active volunteers they would like to see in the region. There was a wide range of responses to this question. About one-third wanted to see between 51-250, while another one-third wanted to see 750 or more volunteers. The final third indicated that they didn't know the desired number. Three respondents answered "Don't Know" to the question. This suggests that among non-unit leaders, there is not a clear sense of how many volunteers are needed in the region.

Unit leaders were also asked to estimate the number of active volunteers in their unit, as well as the desired number of active volunteers in their unit. Unfortunately, since we did not ask respondents to identify their unit name, it is difficult to link these responses to the appropriate units. We would suggest that during regional planning discussion, unit leaders discuss these figures with the other leaders in their regions to get a sense of overall regional capacity.

8.6.2 Translation/Interpreter Skills

Unit leaders were asked to share information about the number of volunteers in their units with translation and interpretation skills[33]. These results were summarized for all of Region 4A.

Table 48: Total Number of Volunteers in Region 4A with Translation and Interpretation Skills

Language	Writes Fluently	Speaks Fluently
Spanish	2	2
Portuguese	1	1
Chinese	0	0
French Creole	0	0
Vietnamese	0	0
Russian	0	0
Arabic	0	0
Mon-Khmer, Cambodian	0	0
French	0	0
Italian	0	0
Other (South Asian languages)	6	6

8.6.3 Recruitment

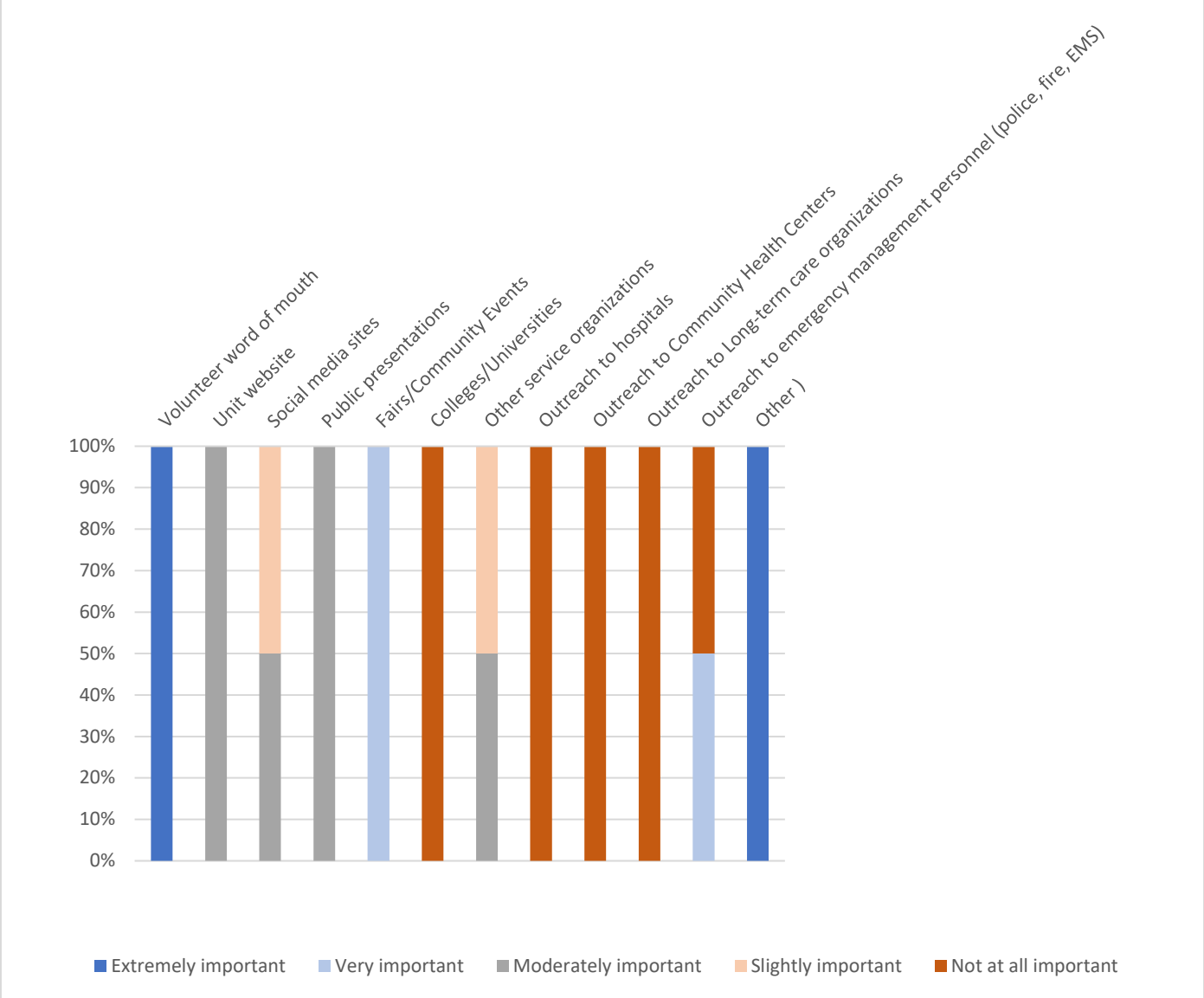
Unit leaders were asked about the most important volunteer recruitment methods for their units (see Figure 21). These responses varied demonstrably by region.

In Region 4A, the most important methods were Volunteer Word of Mouth and "Other," described as a postal mailing to nurses and EMTs (100% of respondents rated these as "Extremely Important").

In Region 4A, outreach to colleges and universities, hospitals, community health centers, and long-term care facilities were not seen as important.

[33] This information is requested as part of a volunteer's profile in MA Responds. For units in the MA Responds system, this data can be easily sorted and exported into a report.

Figure 21: Most Important Volunteer Recruitment Methods (Region 4A)



8.6.4 Tracking

Unit leaders were asked if they compiled each volunteer's hours across multiple activities or events. One unit leader in 4A tracks participation more than once a year, the other tracks every few years (see Table 49 below).

Table 49: Tracking Volunteer Participation in Region 4A

For each volunteer in your unit, do you compile their volunteer hours across multiple activities/events?	%	Count
Yes - more than once a year	50.00%	1
Yes - once a year	0.00%	0
Yes - every few years	50.00%	1
My unit does not compile volunteer hours for individual volunteers across multiple	0.00%	0

activities/events.		
Total	100%	2

8.6.5 Volunteer Satisfaction

Unit leaders were asked if they surveyed their volunteers to get a sense of their satisfaction (see Table 50 below). At most, unit leaders survey volunteers once a year.

Table 50: Frequency of Volunteer Satisfaction Surveys in Region 4A

Frequency of Volunteer Satisfaction Surveys	%	Count
More than once a year	0.00%	0
Once a year	50.00%	1
Every few years	50.00%	1
To the best of my knowledge, my unit has never surveyed volunteer satisfaction.	0.00%	0
Total	100%	2

8.6.6 Volunteer Training Interests

Unit leaders were asked if they survey their volunteers to get a sense of their training interests (see Table 51 below). In Region 4A, one unit leader says he/she conducts surveys once a year. The other unit leader does not believe his/her volunteers have ever been surveyed about training interests.

Table 51: Frequency of Training Interest Surveys in Region 4A

Frequency of Volunteer Training Interest Surveys	%	Count
More than once a year	0.00%	0
Once a year	50.00%	1
Every few years	0.00%	0
To my knowledge, my unit has never surveyed existing volunteers about training interests.	50.00%	1
Total	100%	2

8.6.7 Barriers to Provide Training to Volunteers

Unit leaders were asked to describe any perceived barriers to providing training to volunteers as open-ended responses. The complete list of responses is shared in the table below. Funding was named by both unit leaders in the region as a barrier.

Table 52: Possible Barriers to Volunteer Training in Region 4A (Open-Ended)

Please describe any barriers you see in providing training to your volunteers.
Barriers include a list of approved and available trainers and funding. There should be a designated list of pre-approved trainers that MRC units can work with. In addition, training is expensive (i.e. psychological first aid) and funding is limited for my unit (5K/year).
Lack of monetary and time resources.

8.6.8 Barriers to Volunteer Engagement

Unit leaders were asked to share the biggest challenges their units face in their efforts to engage volunteers. They were asked to rank seven challenges (including "other") on a scale to determine what the biggest challenge was. The list of possible challenges included: lack of volunteer recruitment; volunteer availability; staff does not have time to manage volunteers; no planning and strategy for engaging volunteers; no staff time to develop volunteer positions; mis-match of volunteers with skills needed; and other.

In Region 4A, lack of staff time to manage volunteers was identified as the biggest challenge. Volunteer availability and "other," identified as funding for programs, were also seen as big challenges.

8.7 MOUs

Unit leaders were asked to share any existing Memoranda of Understanding (MOUs) their units have in place.

Table 53: Current MOUs in Place for MRCs in Region 4A

Please list all of the organizations with which your MRC has current MOUs in place.
None. Templates are needed for MOUs as well as legal counsel.

9 REGION 4B

9.1 Overview

The total population for Region 4B is 1,008,027[34], covering 27 communities. In Region 4B, there are four units – Brookline MRC, Norfolk County 7 MRC (NC-7), Newton MRC, and Region 4B MRC.

Table 54: MRC Units in Region 4B

Unit Name	Number of Communities	Total Population
Brookline	1	58,732
NC-7	7	173,381
Newton	1	85,146
Region 4B MRC	18	690,768

9.2 Volunteers in Region

Based on the BP1 Q4 reports, there are 1,330 credentialed volunteers[35] in the region.

Table 55: Credentialed Volunteers in Region 4B

Unit Name	# Credentialed Volunteers	% of Unit Population
Brookline	275	0.47%
NC-7	633	0.37%
Newton	118	0.14%
Region 4B MRC[36]	304	0.04%

9.3 Role of Respondent

As mentioned earlier, 2 of the respondents were affiliated with MRC units in the region.

Table 56: Role of Respondent in Region 4AB

Role of Respondent	%	Count
MRC unit director	0.00%	0
MRC unit coordinator	8.00%	2
HMCC sponsoring organization staff member	0.00%	0
Local emergency management official	32.00%	8

[34] U.S. Census 2010

[35] While the National MRC Program Office does not require credentialing of volunteers, MDPH OPEM requires credentialing of volunteers for MRC units to receive state funding. The current credentialing standard for Massachusetts units includes, at minimum: CORI checks, including a written CORI policy; a method of checking the sex offender status of volunteers (either a VSOS or SORI check), including a written sex offender check policy; a method of checking medical license information for medical volunteers, including a policy about the frequency of checks.

[36] Based on Q2 reporting.

Local public health	44.00%	11
Hospital or health care organization staff member	4.00%	1
Community health center staff member	0.00%	0
EMS	0.00%	0
Long-term care staff member	0.00%	0
MEMA regional staff member	0.00%	0
CERT leader	4.00%	1
Other, please describe	8.00%	2
Total	100%	25

9.4 Mission and Purpose of Units in Region 4B

MRC unit leaders were asked to share what they believe to be the mission and purpose of units in Region 4B (see table below).

Table 57: Stated Mission and Purpose of MRC Units in Region 4B

Please describe the mission of your MRC unit.
The mission of our MRC unit is to establish a group of medical and non-medical volunteers that can assist local public health as we prepare for and respond to public health threats and/or emergencies that may arise in our community(ies), region, or state. In addition, our mission also includes utilizing these medical and non-medical volunteers for flu clinics, health fairs, and/or when the need arises.

9.5 Unit Priorities

Section 4.3 summarized the information about MRC unit priorities from both unit leaders' and non-unit leaders' perspectives for the entire Commonwealth. As noted there, there were similar priorities for both groups, including community partnerships, volunteer engagement, responding to emergencies, and volunteer training.

This section provides more detail about unit priorities in Region 4B, including how the unit leaders set priorities and if they perceive any barriers to achieving those priorities.

9.5.1 Setting Priorities

The table below provides more detailed information about how unit leaders in Region 4B set unit priorities.

Table 58: How Unit Leaders Set Priorities in Region 4B

Which of the following describes how your unit sets priorities annually (in order to develop a workplan and budget)?	%	Count[37]
The unit coordinator develops the workplan and budget independently.	0.00%	0
A Steering Committee or Advisory Group with representatives from the covered communities meets to set priorities/develop the workplan.	25.00%	1

[37] Respondents were permitted to select multiple responses to the question.

The unit leader meets with other unit leaders in the region to develop shared priorities/workplans.	25.00%	1
The unit leader works with the HMCC sponsoring organization to develop budget and workplan.	25.00%	1
Other (please describe)	25.00%	1
Total	100%	4

9.5.2 Barriers to Providing Services

Non-unit leaders were asked to share any barriers they believe MRC units face, preventing the units from providing the services that are priorities for the region. The open-ended responses are summarized in the table below. Most identified recruitment and engagement of volunteers as barriers.

Table 59: Barriers to MRC Services – Non-Unit Leaders (Region 4B)

What barriers (if any) do you see for MRC units to provide the services that are priorities in the region?
MRC in our community wants to be a stand alone instead of working with emergency management. That doesn't work!
Staffing. Availability of members to break away from their primary job.
The MRC volunteers are not properly trained and may not attend training if it was offered.
An aging volunteer base that is not as mobile, diversified and available as we would wish. More recruitment and engagement is necessary.
It is very difficult for local health departments to recruit, maintain, and train MRC volunteers. We need better support from our regional planners. Also, the MRC database is a very useful resource, if this is discontinued local public health will not have access to MRC's.
Difficulty getting people to give up their time.
Keeping volunteers engaged.
Local EMs are not always aware of / willing to use the many resources available via MRCs.
I know nothing about the MRC in my region.
Flu Clinics are an issue because of the various training and qualifications of volunteers to perform a clinical function.
Sign up but don't engage when needed.
lack of state wide coordination, standardization of the plan, individual community and regional MRC's, database not up to date and information spread between databases, credentialing not completed.

Unit leaders were also asked to share any barriers their units face, preventing them from providing priority services for the region. The open-ended responses are summarized in the table below.

Table 60: Barriers to MRC Services – Unit Leaders (Region 4B)

What barriers (if any) do you see for your unit to provide the services that you prioritize?
Lack of transportation to other communities.

9.6 VOLUNTEERS

Respondents were asked a series of detailed questions about their current volunteers.

9.6.1 "Active" Volunteers

Both unit leaders and non-unit leaders were asked several questions about "active" volunteers, defined as someone who volunteers for a unit in some capacity (including via emails and drills) at least annually.

Non-unit leaders were asked to estimate the number of active volunteers in the region. In Region 4B, 67% of those respondents estimated that there was 50 or fewer active volunteers in the region.

Non-unit leaders were then asked to share the number of active volunteers they would like to see in their region. About half of respondents would like to see between 51 and 250 active volunteers. Two respondents wanted to see more than 750 active volunteers.

Unit leaders were also asked to estimate the number of active volunteers in their unit, as well as the desired number of active volunteers in their unit. Unfortunately, since we did not ask respondents to identify their unit name, it is difficult to link these responses to the appropriate units. We would suggest that during regional planning discussion, unit leaders discuss these figures with the other leaders in their regions to get a sense of overall regional capacity.

9.6.2 Translation/Interpreter Skills

Unit leaders were asked to share information about the number of volunteers in their units with translation and interpretation skills[38]. These results were summarized for all of Region 4B (see table below).

Table 61: Total Number of Volunteers I Region 4B with Translation and Interpretation Skills

Language	Writes Fluently	Speaks Fluently
Spanish	0	0
Portuguese	0	0
Chinese	0	0
French Creole	0	0
Vietnamese	0	0
Russian	0	0
Arabic	0	0
Mon-Khmer, Cambodian	0	0
French	0	0
Italian	0	0

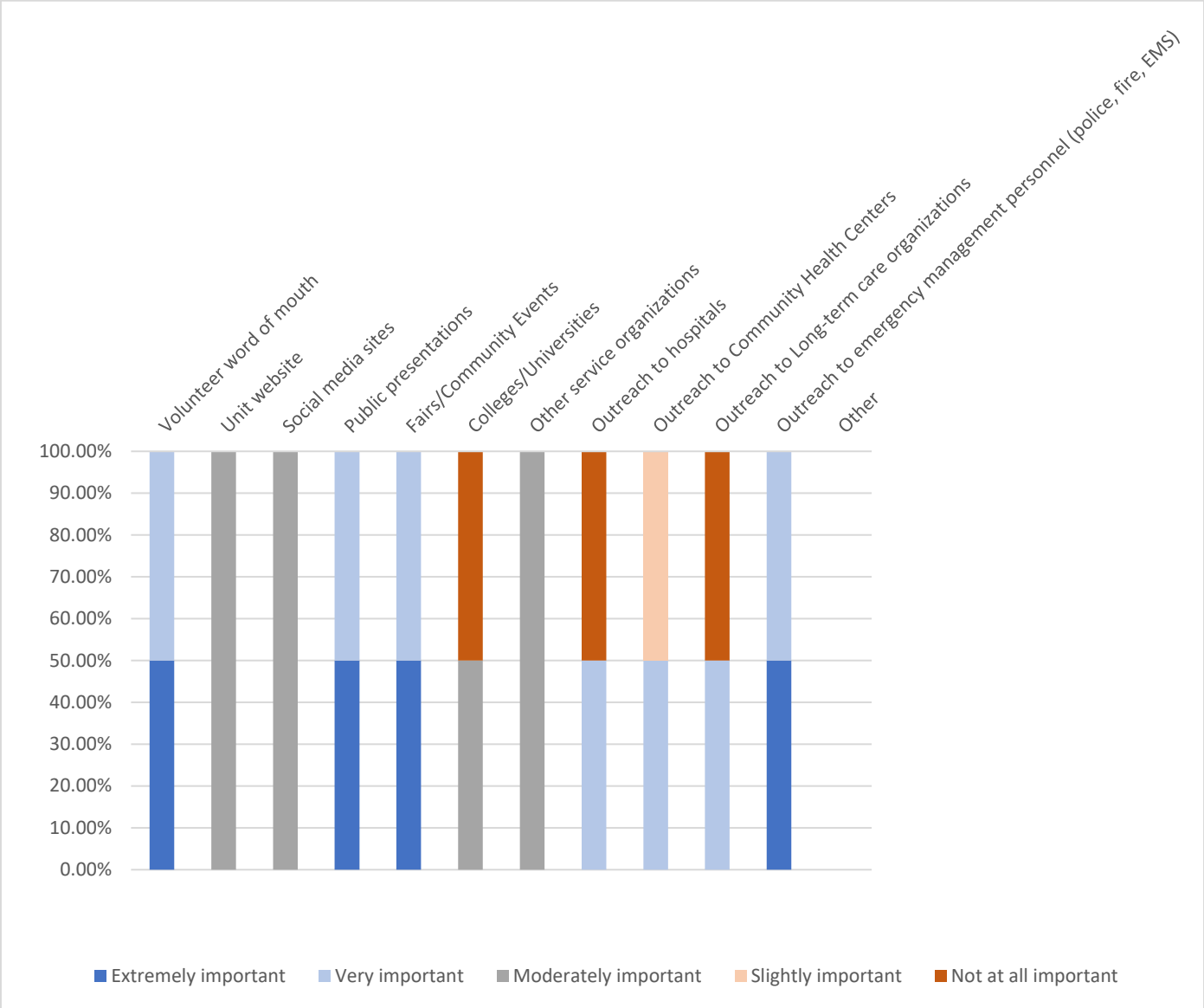
9.6.3 Recruitment

Unit leaders were asked about the most important volunteer recruitment methods for their units (see Figure 22). These responses varied demonstrably by region.

In Region 4B, the most important methods were Volunteer Word of Mouth, Public presentations, Fair/Community Events, and Outreach to emergency management personnel. Outreach to colleges and universities and long-term care facilities were seen as least important in the region. 100% of respondents ranked Volunteer Word of Mouth, Fair/Community Events and Colleges/Universities as extremely important."

[38] This information is requested as part of a volunteer's profile in MA Responds. For units in the MA Responds system, this data can be easily sorted and exported into a report.

Figure 22: Most Important Volunteer Recruitment Methods (Region 4B)



9.6.4 Tracking

Unit leaders were asked if they compiled each volunteer's hours across multiple activities or events. All unit leaders in Region 4B who responded said they do not compile volunteer hours for individual volunteers across multiple activities and events.

Table 62: Tracking Volunteer Participation in Region 4B

For each volunteer in your unit, do you compile their volunteer hours across multiple activities/events?	%	Count
Yes - more than once a year	0.00%	0
Yes - once a year	0.00%	0
Yes - every few years	0.00%	0
My unit does not compile volunteer hours for individual volunteers across multiple activities/events.	100.00%	2
Total	100%	2

9.6.5 Volunteer Satisfaction

Unit leaders were asked if they surveyed their volunteers to get a sense of their satisfaction (see table below). One unit leader said that he/she surveys more than once a year. The other unit leader who responded said that the unit never surveys volunteer satisfaction.

Table 63: Frequency of Volunteer Satisfaction Surveys in Region 4B

Frequency of Volunteer Satisfaction Surveys	%	Count
More than once a year	50.00%	1
Once a year	0.00%	0
Every few years	0.00%	0
To the best of my knowledge, my unit has never surveyed volunteer satisfaction.	50.00%	1
Total	100%	2

9.6.6 Volunteer Training Interests

Unit leaders were asked if they survey volunteers to get a sense of their training interest (see table below). In Region 4B, one unit leader surveys volunteers more than once a year. The other unit leader who responded said he/she surveys volunteers every few years.

Table 64: Frequency of Training Interest Surveys in Region 4B

Frequency of Volunteer Training Interest Surveys	%	Count
More than once a year	50.00%	1
Once a year	0.00%	0
Every few years	50.00%	1
To my knowledge, my unit has never surveyed existing volunteers about training interests.	0.00%	0
Total	100%	2

9.6.7 Barriers to Provide Training to Volunteers

Unit leaders were asked to describe any perceived barriers to providing training to volunteers as open-ended responses. No unit leader in Region 4B responded to this question.

9.6.8 Barriers to Volunteer Engagement

Unit leaders were asked to share the biggest challenges their units face in their efforts to engage volunteers. They were asked to rank seven challenges (including "other") on a scale to determine what the biggest challenge was. The list of possible challenges included: lack of volunteer recruitment; volunteer availability; staff does not have time to manage volunteers; no planning and strategy for engaging volunteers; no staff time to develop volunteer positions; mis-match of volunteers with skills needed; and other.

In Region 4B, volunteer availability was identified as the biggest challenge. The second biggest challenge was lack of volunteer recruitment.

9.7 MOUs

Unit leaders were asked to share any existing Memoranda of Understanding (MOUs) their units have in place (see table below).

Table 65: Current MOUs in Place for MRCs in Region 4B

Please list all of the organizations with which your MRC has current MOUs in place.
School, grocery stores, gas stations, police, restaurants.

10 REGION 4C

10.1 Overview

The total population for Region 4C is 617,594[39], covering the City of Boston. In Region 4C, there is one unit, the Boston MRC.

10.2 Volunteers in Region

Based on the BP1 Q4 reports, there are 1,117 credentialed volunteers[40] in the region, 0.18% of the Boston's total population.

10.3 Role of Respondent

As mentioned earlier, one of the respondents was affiliated with the Boston MRC.

Table 66: Respondents from Region 4C

Role of Respondent	%	Count
MRC unit director	0.00%	0
MRC unit coordinator	14.29%	1
HMCC sponsoring organization staff member	0.00%	0
Local emergency management official	14.29%	1
Local public health	0.00%	0
Hospital or health care organization staff member	71.43%	5
Community health center staff member	0.00%	0
EMS	0.00%	0
Long-term care staff member	0.00%	0
MEMA regional staff member	0.00%	0
CERT leader	0.00%	0
Other, please describe	0.00%	0
Total	100%	7

10.4 Mission and Purpose of Boston MRC

MRC unit leaders were asked to share what they believe to be the mission and purpose of their units. In Boston, the MRC unit coordinator described the mission and purpose as, "To recruit, organize, and train volunteers who are committed to improving the overall health of Boston neighborhoods by engaging in public health preparedness, response, and recovery efforts."

[39] U.S. Census 2010

[40] While the National MRC Program Office does not require credentialing of volunteers, MDPH OPEM requires credentialing of volunteers for MRC units to receive state funding. The current credentialing standard for Massachusetts units includes, at minimum: CORI checks, including a written CORI policy; a method of checking the sex offender status of volunteers (either a VSOS or SORI check), including a written sex offender check policy; a method of checking medical license information for medical volunteers, including a policy about the frequency of checks.

10.5 UNIT PRIORITIES

Section 4.3 summarized the information about MRC unit priorities from both unit leaders' and non-unit leaders' perspectives for the entire Commonwealth. As noted there, there were similar priorities for both groups, including community partnerships, volunteer engagement, responding to emergencies, and volunteer training.

This section provides more detail about unit priorities in Region 4C, including how the unit leaders set priorities and if they perceive any barriers to achieving those priorities.

10.5.1 Setting Priorities

When asked how the Boston MRC sets priorities, the Boston unit leader respondent said that, "The unit leader works with the HMCC sponsoring organization to develop budget and workplan."

10.5.2 Barriers to Providing Services

Non-unit leaders were asked to share any barriers they believe MRC units face, preventing the units from providing the services that are priorities for the region. In Region 4C, only one non-leader responded to this open-ended question, answering "Engagement."

Unit leaders were also asked to share any barriers their units face, preventing them from providing priority services for the region. In Region 4C, the unit leader for Boston MRC did not respond to this question.

10.6 VOLUNTEERS

Respondents were asked a series of detailed questions about their current volunteers.

10.6.1 "Active" Volunteers

Both unit leaders and non-unit leaders were asked several questions about "active" volunteers, defined as someone who volunteers for a unit in some capacity (including via emails and drills) at least annually.

Non-unit leaders were asked to estimate the number of active volunteers in the region. The answers from the three respondents to this question varied widely: one estimated less than 50, one estimated between 251-500, and one estimated between 501-750.

Non-unit leaders were then asked to share the number of active volunteers they would like to see in the region. Over half the respondents to this question said between 51 and 250 volunteers. One indicated that he/she didn't know the desired number. This suggests that among non-unit leaders, there is not a clear sense of how many volunteers are needed in the region.

Unit leaders were asked to estimate the number of active volunteers in their unit, as well as the desired number of active volunteers in their unit. The unit leader in Boston estimated that there were between 101 and 200 active volunteers in the unit, which is also the range of desired volunteers in the unit.

10.6.2 Translation/Interpreter Skills

Unit leaders were asked to share information about the number of volunteers in their units with translation and interpretation skills[41]. These results were summarized for Region 4C (see Table 67):

[41] This information is requested as part of a volunteer's profile in MA Responds. For units in the MA Responds system, this data can be easily sorted and exported into a report.

Table 67: Total Number of Volunteers in Region 4C with Translation and Interpretation Skills

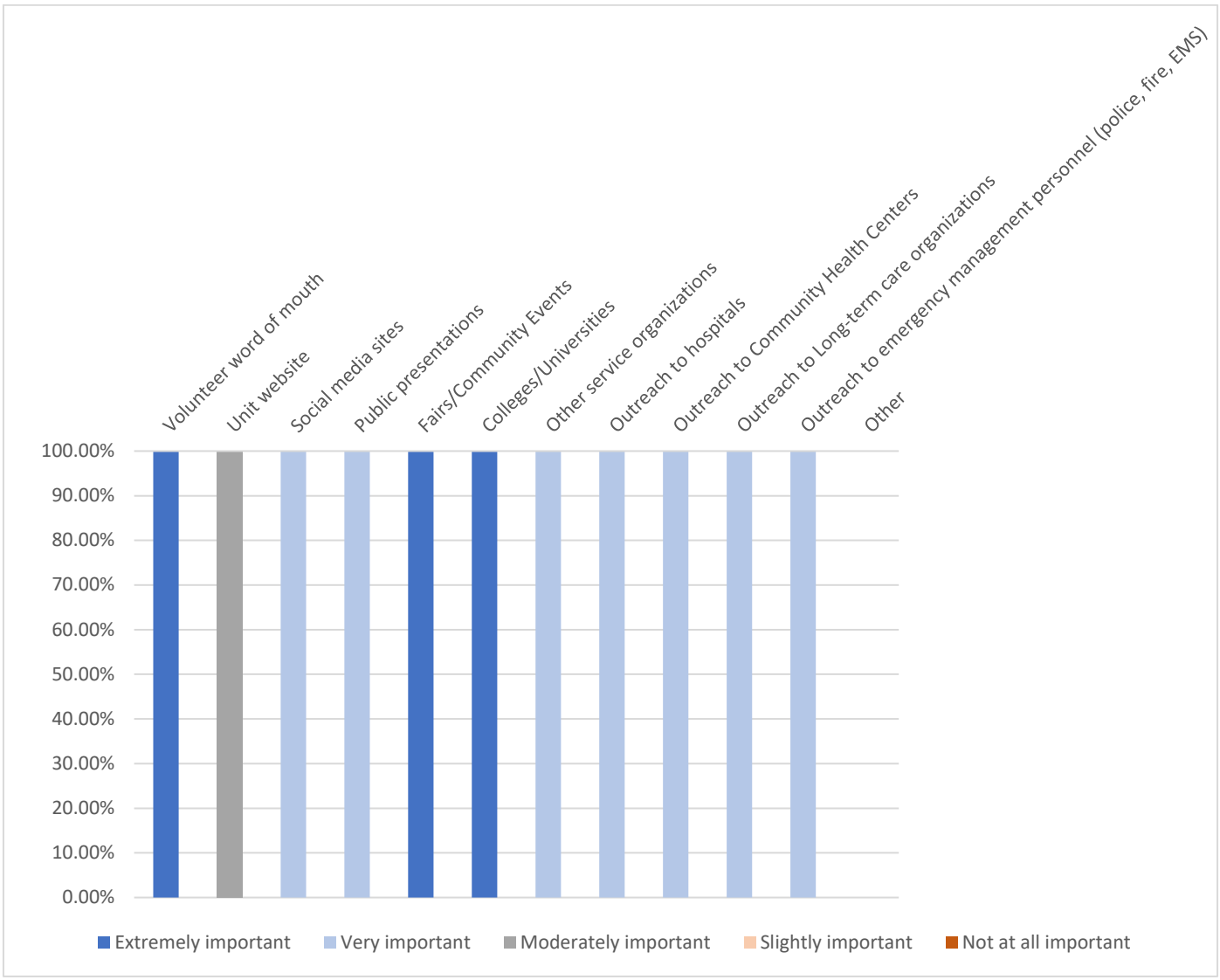
Language	Writes Fluently	Speaks Fluently
Spanish	130	130
Portuguese	5	5
Chinese	21	21
French Creole	3	3
Vietnamese	15	15
Russian	12	12
Arabic	11	11
Mon-Khmer, Cambodian	DK	DK
French	50	50
Italian	0	0

10.6.3 Recruitment

Unit leaders were asked about the most important volunteer recruitment methods for the Boston MRC (see Figure 23). These responses varied demonstrably by region.

In Region 4C, the most important methods identified were Volunteer Word of Mouth, Fairs/Community Events, and Outreach to Colleges and Universities. The unit website was seen as the least important.

Figure 23: Most Important Volunteer Recruitment Methods in Region 4C



10.6.4 Tracking

Unit leaders were asked if they compiled each volunteer's hours across multiple activities and events. In Boston, the unit leader said they compile the volunteer hours more than once a year.

10.6.5 Volunteer Satisfaction

Unit leaders were asked if they surveyed their volunteers to get a sense of their satisfaction. In Boston, the unit leader said they survey volunteers once a year.

10.6.6 Volunteer Training Interests

Unit leaders were asked if they survey volunteers to get a sense of their training interests. In Boston, the unit leader said survey volunteers once a year.

10.6.7 Barriers to Provide Training to Volunteers

Unit leaders were asked to describe any perceived barriers to providing training to volunteers as open-ended response. In Boston, the unit leader said that the largest barrier in providing training to volunteers is a lack of funding.

10.6.8 Barriers to Volunteer Engagement

Unit leaders were asked to share the biggest challenges their units face in their efforts to engage volunteers. They were asked to rank seven challenges (including "other") on a scale to determine what the biggest challenge was. The list of possible challenges included: lack of volunteer recruitment; volunteer availability; staff does not have time to manage volunteers; no planning and strategy for engaging volunteers; no staff time to develop volunteer positions; mis-match of volunteers with skills needed; and other.

In Boston, the unit leader identified the biggest challenge as a mis-match of volunteers with skills needed. The second biggest challenge identified is volunteer availability.

10.7 MOUs

Unit leaders were asked to share any existing Memoranda of Understanding (MOUs) their units have in place. No MOUs were shared for Region 4C.

11 REGION 5

11.1 Overview

The total population for Region 5 is 1,310,181[42], covering 67 communities. In Region 5, there are ten units (see Table 68 below). The Plymouth Area MRC, which covered 4 communities, had disbanded – leaving those communities uncovered. New leadership in Plymouth applied for reinstatement in 2018.

Table 68: MRC Units in Region 5

Unit Name	Number of Communities	Total Population
Bridgewater MRC	3	47,273
Bristol Norfolk MRC	9	178,362
Brockton Area MRC	3	127,284
Cape Cod MRC	15	215,888
Duxbury Bay MRC	5	82,726
Greater Fall River MRC	5	147,289
Greater New Bedford MRC	4	155,280
Greater Taunton MRC	5	103,085
Martha's Vineyard MRC	8	26,707
Middleborough MRC	6	68,640
Plymouth Area (in application process)[43]	4	83,426

11.2 Volunteers in Region

Based on the BP1 Q4 reports, there are 2,002 credentialed volunteers[44] in the region[45].

Table 69: Credentialed Volunteers in Region 5

Unit Name	# Credentialed Volunteers	% of Unit Population
Bridgewater[46]	326	0.69%
Bristol Norfolk	100	0.06%
Brockton Area	125	0.10%
Cape Cod	269	0.12%
Duxbury Bay	80	0.10%

[42] U.S. Census 2010
[43] Plymouth Area became a registered unit in November 2018.
[44] While the National MRC Program Office does not require credentialing of volunteers, MDPH OPEM requires credentialing of volunteers for MRC units to receive state funding. The current credentialing standard for Massachusetts units includes, at minimum: CORI checks, including a written CORI policy; a method of checking the sex offender status of volunteers (either a VSOS or SORI check), including a written sex offender check policy; a method of checking medical license information for medical volunteers, including a policy about the frequency of checks.
[45] This total does not include Martha's Vineyard and Plymouth Area MRC units.
[46] Based on Q3 reporting.

Greater Fall River	421	0.29%
Greater New Bedford	261	0.17%
Greater Taunton	127	0.12%
Martha's Vineyard[47]	N/A	N/A
Middleborough	293	0.43%
Plymouth Area (in application process)[48]	N/A	N/A

11.3 Role of Respondent

As mentioned earlier, 5 of the respondents were affiliated with MRC units in the region.

Table 70: Respondents from Region 5

Role of Respondent	%	Count
MRC unit director	6.45%	2
MRC unit coordinator	9.68%	3
HMCC sponsoring organization staff member	3.23%	1
Local emergency management official	45.16%	14
Local public health	9.68%	3
Hospital or health care organization staff member	3.23%	1
Community health center staff member	0.00%	0
EMS	16.13%	5
Long-term care staff member	0.00%	0
MEMA regional staff member	3.23%	1
CERT leader	3.23%	1
Other, please describe	0.00%	0
Total	100%	31

11.4 Mission and Purpose of Units in Region 5

MRC unit leaders were asked to share what they believe to be the mission and purpose of units in Region 5 (see table below).

Table 71: Stated Mission and Purpose of MRC Units in Region 5

Please describe the mission of your MRC unit.
To better serve the Brockton community during public health crisis and strengthen volunteer base.

[47] Martha's Vineyard MRC did not receive DPH OPEM funding in BP1 so the unit did not submit a quarterly report.
[48] Plymouth Area MRC is currently applying to become a unit.

Volunteers are called upon to provide disaster assistance in the event existing resources are overwhelmed.
Provide MRC volunteers for public health emergencies and upon request of local emergency management officials.

11.5 Unit Priorities

Section 4.3 summarized the information about MRC unit priorities from both unit leaders' and non-unit leaders' perspectives for the entire Commonwealth. As noted there, there were similar priorities for both groups, including community partnerships, volunteer engagement, responding to emergencies, and volunteer training.

This section provides more detail about unit priorities in Region 5, including how the unit leaders set priorities and if they perceive any barriers to achieving those priorities.

11.5.1 Setting Priorities

The table below provides more detailed information about how unit leaders in Region 5 set priorities.

Table 72: How Unit Leaders Set Priorities in Region 5

Which of the following describes how your unit sets priorities annually (in order to develop a workplan and budget)?	%	Count[49]
The unit coordinator develops the workplan and budget independently.	25.00%	1
A Steering Committee or Advisory Group with representatives from the covered communities meets to set priorities/develop the workplan.	25.00%	1
The unit leader meets with other unit leaders in the region to develop shared priorities/workplans.	25.00%	1
The unit leader works with the HMCC sponsoring organization to develop budget and workplan.	0.00%	0
Other (please describe)	25.00%	1
Total	100%	4

11.5.2 Barriers to Providing Services

Non-unit leaders were asked to share any barriers they believe MRC units face, preventing the units from providing the services that are priorities for the region. The open-ended are summarized in the table below. Most identified a lack of volunteer retention or a lack of integration of MRC units with other groups in the region.

Table 73: Barriers to MRC Services – Non-Unit Leaders (Region 5)

What barriers (if any) do you see for MRC units to provide the services that are priorities in the region?
Volunteer retention.
Not enough volunteers or ways to get them there in the case of weather emergencies.
Confused as to if this is current MRC unit place or possible MRC development, we currently have no MRC
Volunteers
Not enough volunteers in general and not enough younger volunteers.

[49] Respondents were permitted to select multiple responses to the question.

MRC cannot continue to operate in a vacuum. They must integrate into the Emergency Response plans and become another tool in the Emergency Management Mitigation, Response and Recovery for emergencies.
I don't know anything about them. There has been no outreach, so what I know is second and third hand. There is also a cultural barrier within the fire/EMS community that would discourage use of these resources.
Recruitment/retention.
Lack of coordination within the group, too much attention by town EMD is required.
Younger folks are not volunteering, we are seeing retired folks as volunteers and many leave the region for the winter months or are very reluctant to travel in inclement weather. Many cannot do extended stays at the shelters which then requires more volunteers.
If there are emergencies throughout the region and we barely have enough volunteers for our own sites, it is near impossible to try to help others at the same time.
Our unit is isolated and difficult/expensive for other units to reach. We have just begun building our local unit.
lack of state wide coordination, standardization of the plan, individual community and regional MRC's, database not up to date and information spread between databases, credentialing not completed.
Volunteers.
Insufficient staff.

Unit leaders were also asked to share any barriers their units face, preventing them from providing priority services for the region. The open-ended responses are summarized in the table below.

Table 74: Barriers to MRC Services – Unit Leaders (Region 5)

What barriers (if any) do you see for your unit to provide the services that you prioritize?
Based on location of a disaster being able to get people on site at a shelter due to bad weather conditions within the state.
Ongoing volunteers, clinical and non-clinical.
Lack of time, staff, funding.
Many volunteers work full time and others are snow birds ... move to Florida for winter. Other volunteers unable to deploy in snow with help shoveling out and being provided transportation.

11.6 VOLUNTEERS

Respondents were asked a series of detailed questions about their current volunteers.

11.6.1 "Active" Volunteers

Both unit leaders and non-unit leaders were asked several questions about "active" volunteers, defined as someone who volunteers for a unit in some capacity (including via emails and drills) at least annually.

Non-unit leaders were asked to estimate the number of active volunteers in the region. In Region 5, 67% of those respondents believe that there are less than 50 active volunteers in the region.

Non-unit leaders were then asked to share the number active volunteers they would like to see in the region. 26% would like to see between 51 and 250 active volunteers, while another 26% indicated that they would like to see between 251 and 500 volunteers. 22% of respondents indicated that they didn't know the desired number. This suggests that among non-unit leaders, there is not a clear sense of how many volunteers are needed in the region.

Unit leaders were also asked to estimate the number of active volunteers in their unit, as well as the desired number of active volunteers in their unit. Unfortunately, since we did not ask respondents to identify their unit name, it is difficult to link these responses to the appropriate units. We would suggest that during regional planning discussion, unit leaders discuss these figures with the other leaders in their regions to get a sense of overall regional capacity.

11.6.2 Translation/Interpreter Skills

Unit leaders were asked to share information about the number of volunteers in their units with translation and interpretation skills[50]. Two unit leaders in the region indicated that they did not know this information about their volunteers. The rest of the results are summarized for all of Region 5 (see table below).

Table 75: Total Number of Volunteers in Region 5 with Translation and Interpretation Skills

Language	Writes Fluently	Speaks Fluently
Spanish	4	4
Portuguese	0	0
Chinese	0	0
French Creole	2	2
Vietnamese	0	0
Russian	0	0
Arabic	0	0
Mon-Khmer, Cambodian	0	0
French	0	0
Italian	0	0
Japanese	1	1

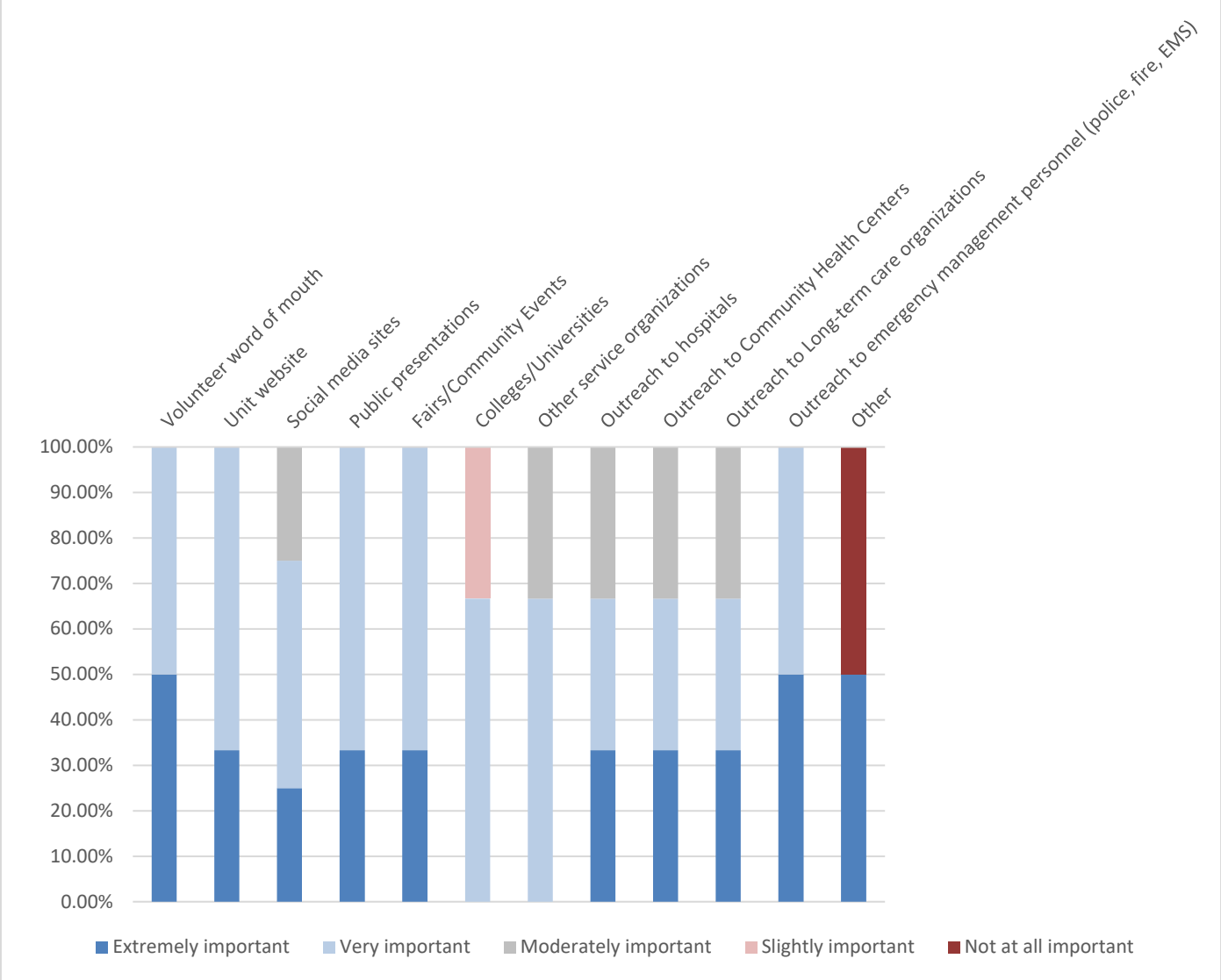
11.6.3 Recruitment

Unit leaders were asked about the most important volunteer recruitment methods for their units (see Figure 24). These responses varied demonstrably by region.

In Region 5, the most important methods were Volunteer Word of Mouth and Outreach to emergency management personnel. The least important method was outreach to colleges and universities.

[50] This information is requested as part of a volunteer's profile in MA Responds. For units in the MA Responds system, this data can be easily sorted and exported into a report.

Figure 24: Most Important Volunteer Recruitment Methods (Region 5)



11.6.4 Tracking

Unit leaders were asked if they compiled each volunteer's hours across multiple activities or events. Half the unit leaders in Region 5 said that they do not compile volunteer hours.

Table 76: Tracking Volunteer Participation in Region 5

For each volunteer in your unit, do you compile their volunteer hours across multiple activities/events?	%	Count
Yes - more than once a year	25.00%	1
Yes - once a year	25.00%	1
Yes - every few years	0.00%	0
My unit does not compile volunteer hours for individual volunteers across multiple activities/events.	50.00%	2

Total	100%	4

11.6.5 Volunteer Satisfaction

Unit leaders were asked if they surveyed their volunteers to get a sense of their satisfaction (see table below). Unit leaders were split evenly in terms of responses, ranging from surveys more than once a year to never surveying volunteers.

Table 77: Frequency of Volunteer Satisfaction Surveys in Region 5

Frequency of Volunteer Satisfaction Surveys	%	Count
More than once a year	25.00%	1
Once a year	25.00%	1
Every few years	25.00%	1
To the best of my knowledge, my unit has never surveyed volunteer satisfaction.	25.00%	1
Total	100%	4

11.6.6 Volunteer Training Interests

Unit leaders were asked if they survey volunteers to get a sense of their training interests (see table below). In Region 5, three-quarters of respondents said they survey volunteers about training interests at least once a year.

Table 78: Frequency of Training Interest Surveys in Region 5

Frequency of Volunteer Training Interest Surveys	%	Count
More than once a year	25.00%	1
Once a year	50.00%	2
Every few years	0.00%	0
To my knowledge, my unit has never surveyed existing volunteers about training interests.	25.00%	1
Total	100%	4

11.6.7 Barriers to Provide Training to Volunteers

Unit leaders were asked to describe any perceived barriers to providing training to volunteers as open-ended responses. Only one respondent answered this question and identified, “lack of time, funding and resources.”

11.6.8 Barriers to Volunteer Engagement

Unit leaders were asked to share the biggest challenges their units face in their efforts to engage volunteers. They were asked to rank seven challenges (including “other”) on a scale to determine what the biggest challenge was. The list of possible challenges included: lack of volunteer recruitment; volunteer availability; staff does not have time to manage volunteers; no planning and strategy for engaging volunteers; no staff time to develop volunteer positions; mis-match of volunteers with skills needed; and other.

In Region 5, Volunteer Availability was named as the biggest challenge. The second biggest challenge identified was Lack of Volunteer Recruitment.

11.7 MOUs

Unit leaders were asked to share any existing Memoranda of Understanding (MOUs) their units have in place (see table below).

Table 79: Current MOUs in Place for MRCs in Region 5

Please list all of the organizations with which your MRC has current MOUs in place.
4 Nursing Homes and 1 Neighborhood Health Center and looking to 12 more Long-Term Care Facilities.
The regional coordinator would be able to answer this question.

12 APPENDIX A – ADDITIONAL COMMENTS (ALL REGIONS)

We are thrilled to grow at such a rapid pace. As a unit, we believe partnering with community organizations who have their own volunteers is equally important. Many surrounding faith-based organizations have volunteers they CORI check on their own. We believe working with them as a team for sheltering situations, etc. builds invaluable rapport in the event they are needed in a large-scale incident. Continual changes on a State level are not often tricked down/communicated to local MRCs and this can be very frustrating, particularly because I will dedicate significant time preparing certain reports/etc. only to learn the extra leg work that was necessary/required 3 months ago is no longer necessary. The HMCC is not consistent with e-mail replies yet still hold me and the Town accountable for meet timely deadlines.... despite not having all the information. The Training Request Form needs to explicitly state what is or is not allowed as it pertains to MRC trainings. The Opioid Crisis Emergency is not being deemed by OPEM/DPH as 'emergency' that relates to 'emergency preparedness' which leaves me and our volunteers very confused/perplexed when trying to plain trainings about how to respond to the opioid crisis. It feels like MRC units were initially established to be a grassroots/local effort among communities and it is now becoming more and more controlled by the State which takes away some of the MRC charm it was designed to have.
The MRC concept is great, but some take their importance way to high and don't want to or think they have to work with their own community too.
We truly appreciate connections made at the biannual MA MRC meetings!!! Per decisions being made that affect unit operations, please do your best to involve 'boots on the ground' unit leaders. Folks in offices have no clue what it's like to serve in this capacity, so certain funding restrictions are crazy!!! They'd allow funds to pay speakers and facility usage, but our speakers donate their time and we use free municipal meeting space. We're not allowed to use funds on uniforms, but need that immediate professional recognition for every flu clinic and emergency shelter. They'd pay for jackets, but we don't operate outdoors. They won't let us use funds for meals unless meetings are 4 hours, but think about volunteers coming straight from a full day's work to an ICS/EDS training from 6 to 9P; what are they supposed to do for dinner??? They're VOLUNTEERS!!! They feel more welcome and supported if we can spring for salad and pizza at such times, and the cost isn't prohibitive. Thanks for asking!
I answered these questions as a locally based MRC unit. Some of these questions were based on Regional MRC replies, but I answered as a single MRC unit.
I am new in Northborough. My town has an interest in dealing with animals at shelters and sheltering in general due to constant storms.
We desperately need more support at emergency shelters during weather and natural disaster events. Oftentimes the guests are the most vulnerable populations and need assistance from everything from using the bathroom to aid in taking medication. Behavioral health volunteers are desperately needed at shelters, too. This was witnessed first hand at a recent shelter activation with at least 4 guests with this need.
No. Thanks
Not at this time.
Uxbridge needs to get "someone" to head and co-ordinate this effort.
None
Hoping that funding will increase for the administration tools to help increase our volunteer base.
I am responding as the unit leader/director for a small community of 6500 that is part of a regional MRC.
Emergency Management especially on the South Coast of Region 5 have little to no contact with MRC.
I have general knowledge of our MRC, I do not believe it is an active group.
MRC at the local community level is very important, to be part of the total emergency preparedness team by sticking to the total community wide emergency medical training and offering this free training to all, at times in

order to obtain maximum saturation, to include biological chemical and radiation along with wilderness and home emergencies is needed
CERT Teams and MRC's can work well together especially in a Shelter environment. Flu clinics, EDS, and PODS, are also missions where our complimenting Skill Sets can be used as force multipliers. As we continue to define roles in Active Shooter scenarios, we will find a place for MRC and CERT in Reunification Centers, EOCs and other Cold Zone activities.
MRC's need continued training and a continuation of on call hours with commitment.
With time restrains on public health job duties, really need many Regional Coordinators to help with all these emergencies. Send Registration forms, set up deployments, manage deployments while feet on ground public health is at shelter or EDS coordinating volunteers. During Emergencies need more Regional Coordinators sent to then help at emergencies while one of the Regional Coordinators does Admin or technical stuff.
Share survey results with unit leaders.
A fair and consistent method for funding distribution within MRCs is needed. A unit that covers a smaller geographical area still needs to meet the requirements of the program. Some suggestions for state resources to support MRCs include: an attorney to consult on legal matters; a list of DPH approved trainers and costs for services; statewide recruitment efforts (i.e. billboards, tv commercials, outreach to hospitals and medical centers - why do we need to do this individually??); state efforts to arrange MOUs with larger companies (Wegman's, Market Basket) done on behalf of MRC units.
MRCs are extremely valuable assets - both in emergencies & every day. The more MRC volunteers are active in the community - assisting at community events, raising awareness about community preparedness - the more resilient a community can be. We need to raise awareness of MRC resources with local Emergency Management.
I have heard a lot of good things about the MRCs and I am on the Regional MRC's distribution list but I still believe communications between MRCs and local emergency management need to be improved. I have never sat with our Regional MRC to understand their goals, objectives and plan for response. The Regional MRC seems to be a "small town" organization but maybe that is where the needs are largest.
The MRC is very important to Hampshire County and we have a very good working relationship. Without them, it would be difficult to support our regional shelters, flu vaccinations, EDS sites and the many large events in the county.
Needs to be strike teams that created through state resources and funding. MRC funding use is so limited it would be better to have strike teams developed that would cross regions to help set up and provide needs.
I am sorry for the lack of input. I am new to the position and have not yet been involved in the Region 3 HMCC.
None.
A few of the survey questions and answers were confusing. Not sure what was being asked or how to answer. Did the best I could. Thank you.
Thank you for doing this gap analysis - it is timely and much needed.
1) Funding to provide volunteers quality training opportunities 2) Initial training, orientation and retainment for volunteers.
How does a vacation resort community that has MANY medical people here for three months, communicate with them to see if they will volunteer? This isn't their home county and we don't have a list of them from the state.
We have seen on more than one occasion a need to establish a regional medical needs shelter. There is a population of individuals that require medical support during widespread power outages and other impacts that affect this population of people with chronic medical needs. The hospitals are beginning to know this population as they arrive following power outages and sometimes take shelter for hours to days. As hospitals are already full and patients boarding in our Emergency Departments already this population of people coming to the hospital to seek shelter makes it challenging to support their needs and continue to operate as an acute care facility. The MRC could be a huge driver to establish regional medical needs shelters to support this vulnerable population.

13 APPENDIX B: LIST OF TABLES

Appendix B: List of Tables

14 APPENDIX C: LIST OF FIGURES