

# WORKING P A P E R

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## Enhancing Public Health Preparedness: Exercises, Exemplary Practices, and Lessons Learned, Phase III

### Task E: Approaches for Developing a Volunteer Program to Respond to Public Health Emergencies

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## Summary

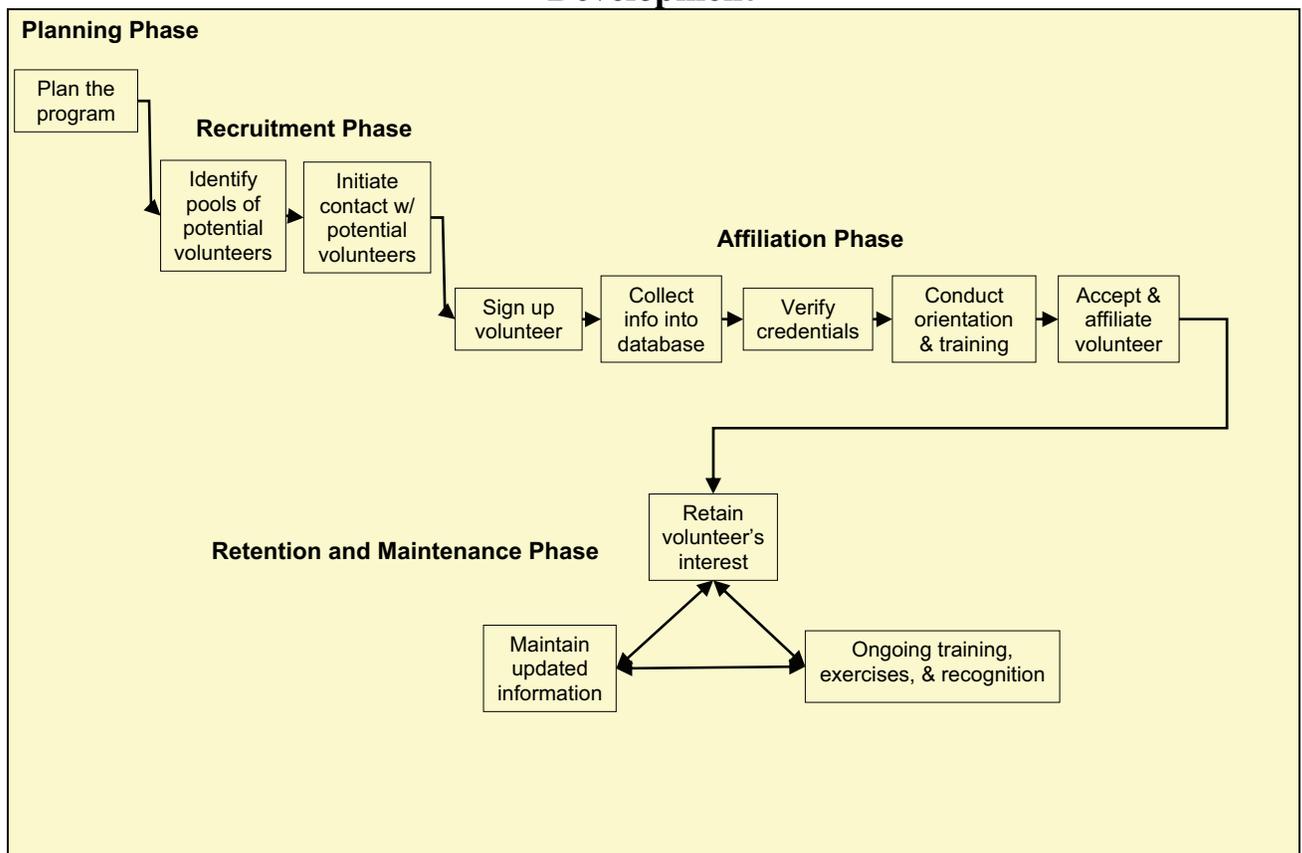
Although the need to prepare for public health emergencies has always been a concern, the events of September 11th, the devastating tsunami in Asia, Hurricane Katrina, and the emergence of avian influenza have all brought the potential for a large-scale disaster to the forefront of public awareness. These and other catastrophic events have drawn attention to the need for a “surge” of additional health care workers and other volunteers to assist public health agencies, emergency management organizations, first responders, and health care facilities with disaster response and recovery efforts. However, while experience has shown that many volunteers, including health professionals, are typically willing to help in the wake of a natural disaster or other emergency, in many cases, the spontaneous arrival of large numbers of volunteers at the scene of an emergency can hinder an efficient response. As a result, emergency responders, including public health organizations, have recognized the need for a pre-planned and coordinated volunteer effort during a public health emergency.

Many public health agencies have never developed such a program before, and are not familiar with the approaches available for recruiting, managing, and retaining volunteers. This report aims to provide hands-on strategies and approaches that can be used by public health agencies and other community organizations to establish or expand a volunteer program for building workforce surge capacity in the event of a public health emergency. Because the evidence base in public health emergency preparedness is still being developed, we do not attempt to rate the approaches or to identify “best” practices. Rather, the report provides examples of how various organizations (including local and state public health authorities; Medical Reserve Corps units (MRCs); national disaster relief organizations; local, state, and national volunteer organizations; and faith-based organizations) are attempting to resolve common challenges in recruiting, affiliating, managing and retaining volunteers, especially health professionals. The study draws upon the published academic, public health, and lay practitioner literatures on volunteering as well as interviews with key program staff in health departments, MRCs, and other local and national volunteer organizations.

## KEY FINDINGS

We began our study by developing a process map to illustrate the major steps involved in. Figure S.1 outlines the processes involved in recruiting and retaining volunteers for public health emergencies, which typically include four phases: planning, recruitment, affiliation, and retention/maintenance. Although individual volunteer programs will vary in their design, our work indicates that these steps are common to many programs.

**Figure S.1 Process Diagram for Volunteer Program Development**



### Planning

Careful planning is critical to the success of any volunteer program (Forsyth, 1999; McCurley and Lynch, 2006; Maryland Governor's Office on Service and Volunteerism, 2006). In public health, a volunteer program to expand the workforce in the event of an emergency requires that program goals are aligned with the broader public health emergency planning goals. When elements of the public health emergency plan

accurately reflect what the volunteer program can (and cannot) provide, it will be easier to align personnel and resources.

**Determining volunteer roles is an important planning step.** Public health departments will want to establish the roles of volunteers and determine whether they will be called upon only in emergency situations or also to assist with routine public health functions such as conducting immunization clinics. Many of the public health departments interviewed for this study are focusing their initial planning efforts solely on the recruitment of volunteer health professionals (VHPs), particularly physicians and nurses, although some health departments are also partnering with local volunteer organizations to recruit non-health professional volunteers.

**Estimating the number of volunteers needed is difficult.** Representatives of many programs we studied report that it is challenging to estimate the number of volunteers needed; hence many programs seek to recruit as many volunteers as they can. No matter how many volunteers are recruited, additional volunteers may be required during an emergency, since some affiliated volunteers may be unavailable, unwilling, or unable to serve when the need arises.

**It can be useful to plan for the potential influx of spontaneous unaffiliated volunteers (SUVs).** As does much of the literature, most of the interviewees for this study acknowledged that unsolicited SUVs *will* arrive during an emergency (Volunteer Florida, 2005, no date; Fernandez et al., 2006; California Office of Emergency Services, 2001; Marshall, 1995; California Service Corps, 2004). Further, their services could be critical, especially if an event extends for longer than anticipated. Some organizations actively plan strategies for managing SUVs and using them effectively. Strategies include developing “just-in-time training” to prepare SUVs for service, partnering with other volunteer organizations such as the American Red Cross to assist with SUV intake and staging logistics, and establishing a Volunteer Reception Center (VRC), where large numbers of volunteers can be quickly processed and deployed (California Office of Emergency Services, 2001; Fernandez, et al., 2006; Illinois Terrorism Task Force Committee on Volunteers and Donations, 2005; California Service Corps, 2004).

Spontaneous unaffiliated licensed VHPs present a unique challenge in that verifying their professional credentials during an emergency can be daunting, especially

if power and internet resources are compromised. Ideally, VHPs who volunteer their professional services during an emergency will be affiliated with an established volunteer organization or registry that has already verified their licenses. Although there is agreement that the presence of SUVs can create problems in an emergency, their relevance should be noted and ideally the volunteer management strategy will include both the management of affiliated and non-affiliated volunteers in the event that they are needed.

**Legal issues impact the use of VHPs.** State laws govern the licensing of health professionals and are thus important to consider when recruiting licensed health professionals as volunteers. Further, these laws may be affected by an emergency declaration. For example, license reciprocity regulations could be relaxed if VHPs are needed from another state. A legal issue of major concern is the risk of liability should a disaster victim become ill, injured, or killed as a result of a volunteer's actions. All states have Good Samaritan Laws, which protect volunteers from liability to some degree; however, many states have recognized the need for broader protections for volunteers, especially VHPs. Another legal issue of concern is the availability of worker's compensation should a volunteer become ill or injured in the course of service. States vary in the degree to which they have determined, in advance, how workers' compensation may apply to volunteers. Volunteer programs should be prepared to explain liability risks and the extent to which workers' compensation benefits are available (if any).

**Funding limitations are common and costs are substantial.** Public health and MRCs interviewed for this study consistently reported that developing, managing, and maintaining a volunteer program is costly and funding is scarce. Costs can be substantial and include, for example, staffing, program materials, and in some cases, sophisticated information technology (IT) systems for data management. Further, there is the additional cost of initially verifying VHP credentials and reverifying those credentials on a regular basis.

**Program evaluation is rare.** Only a few of the programs in our study currently track statistics to measure recruitment, training completion, or response to drills and exercises. However, meaningful program evaluation is important, and must rest on

appropriate measures. A reasonable starting point for program evaluation would be to set goals for recruitment and call-down drills and measure progress toward achieving those goals.

## **Recruitment**

Recruiting individuals for public health emergencies is especially challenging because of the specific skill sets that can be needed, as well as the difficulty of keeping volunteers engaged and practiced between events. There are three main approaches for recruiting volunteers. *Warm body* recruitment, as its name suggests, is useful for jobs that just about anyone can fill, and typically involves spreading the message about positions broadly through public service announcements (PSAs) and other media sources as well as community groups such as churches and colleges. *Word of mouth recruitment* targets individuals who are already connected to the recruiting organization. *Targeted recruitment* focuses on recruiting those with specific skills and special commitment (McCurley, 1995; McCurley and Lynch, 2006).

**Multiple pools of possible volunteers are needed.** There are many approaches for contacting potential pools of volunteers, including exhibits at professional conferences and community events; presentations at local businesses, hospitals, doctor's offices, schools, and community organizations; public service announcements on local radio and TV, and articles in the local newspaper. Networking is also an important approach, and organizations may want to review their current relationships with other community organizations and determine the extent to which they will need to expand existing networks to find volunteers. Several public health agencies reported that they had hired consulting firms to help them develop a sustainable marketing plan for volunteer recruitment. Some state public health departments have advertised in or submitted articles to professional association newsletters, and many are also collaborating with state licensing boards to include volunteer recruitment literature in professional license renewal mailings.

**Message development is important for encouraging people to volunteer.** Messages might focus on the particular volunteer groups being sought, the specific needs of the organization, the ways in which volunteers can alleviate these needs, and the potential benefits of volunteering. A variety of messages may be needed.

## **Affiliation**

Once an individual decides to volunteer, the recruit becomes officially affiliated with the volunteer program and undergoes a process of approval. Like other volunteer organizations, public health volunteer organizations must develop a database to keep track of their volunteers. An additional component of affiliation in public health is to identify and verify relevant credentials for VHPs.

**Ease of sign-up, and prompt response, help establish initial volunteer interest.** Responding promptly to a potential volunteer's initial display of interest is critical. Some health departments, MRCs and volunteer organizations use a two-step process whereby the volunteer initially indicates interest by sending back a simple tear-off postcard or filling out a short form online; the organization then follows up promptly with a phone call, letter or email. Interviewees emphasized the importance of having some form of prompt personal contact at this stage of recruitment.

**Collecting volunteer data is an important step in the affiliation phase.** At a minimum, contact information is needed, but organizations may also collect demographic or personal information depending on how volunteers will be used. Many public health and MRC volunteer programs also ask volunteers about other commitments that might interfere with emergency volunteering duties or about skills and previous volunteer experience, including completion of training. Some programs also conduct background checks on all potential volunteers to be sure they do not have a history of criminal offenses. If a prospective volunteer is a licensed health professional, the volunteer program typically collects information on the VHP's professional credentials, licenses, skills, and privileges at health care institutions.

**Data management systems vary widely.** Our interviews revealed that systems for collecting and managing volunteer data vary dramatically and range from paper-based files and simple spreadsheets to the use of sophisticated commercial systems. Some agencies use databases that can be accessed via the Internet. Such systems have the advantage of allowing prospective volunteers to input information themselves, and also allow access by MRC and health department officials to volunteer data in the field during an event. Some of the more sophisticated data systems have the ability to connect with other agency databases, automated credential checking systems, or automated calling

systems. However, these capabilities increase the complexity and the cost of a system and were noted more often in state health departments as opposed to local health departments and MRCs.

**Sharing data among volunteer organizations may be desirable, but can raise concerns.** Sharing volunteer data between local volunteer organizations, between local and state health departments, and between state health departments and the federal Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) program can minimize the “double-counting” of volunteers and also facilitate deployment to areas of need during an emergency. However, efficient data-sharing requires interoperability of data systems. The need for interoperability may become a problem for volunteer programs that started with home-grown information systems that had been sufficient for their local requirements but that do not meet larger system needs. Further, some interviewees expressed concern about revising their databases, fearing that more uniform data systems may not meet the needs of each individual program. There was also concern over who should own the data. In addition, interviewees from some local health department and MRC volunteer programs expressed reluctance to share their volunteer lists with other organizations and government agencies, for fear that local volunteers would be drawn away for duty elsewhere.

**Verification of VHP professional credentials can be challenging.** Many VHPs are licensed to practice through a state licensing board. State laws govern the licensing regulations, which differ for each occupation. Some health professionals hold other types of credentials that are regulated by other entities. The VHP credentialing process involves determining the area of licensure or type of credential and the credentialing source. Credentials can then be verified with the issuer of the credential, or through a Credential Verification Organization (CVO). Some MRCs and health departments are working to automate the state license verification process so that the volunteer database can be cross-referenced against the state licensing databases.

**Hospitals can serve as a reliable source of credentialing information.** The process of checking credentials is routine for hospitals, given that the Joint Commission for the Accreditation of Health Care Organizations (JCAHO) standards require hospitals to verify all credentials through a primary source prior to granting privileges or

employment to health professionals. Thus, health departments and MRCs are turning to hospitals for assistance in verifying VHPs' credentials for work in non-hospital settings and also for work in other states or for hospitals in which the VHP is not employed nor has any affiliation.

**Electronic real-time credentialing systems may be ideal for use at the state level.** Secure, password-protected commercial websites can be used to allow for real-time primary source verification of credentials for some VHPs. However, while such systems may represent the ideal model for verifying credentials for volunteer health professionals, this may be realistic only at the state level due to funding issues. Local health departments and MRCs are less likely to have the funds to access these commercial resources.

**Online orientation and training are common for volunteers.** The affiliation process often involves some form of training or orientation for the new volunteers. Many programs use an online registration/sign-up system that also includes an orientation course. Online training is a relatively low-cost option for providing potential volunteers with basic knowledge about emergency situations, incident command structure, or to outline expectations for volunteers (i.e., time commitment, job descriptions, length of shifts).

## **Retention and Maintenance**

Maintaining a volunteer corps for public health emergencies can be especially challenging due to the rarity of these events and the need to find ways to keep volunteers committed to serving between events.

**Volunteers require frequent and high-quality contact.** Regularity of contact coupled with a thorough assessment of volunteer needs and constraints was cited by many interviewees as key to keeping volunteers retained and active. The most frequent methods of contact noted were emails, newsletters, and occasional in-person meetings.

**Volunteer recognition is essential to retention.** Official acknowledgment of volunteers when they first sign up is one method of recognition cited by many interviewees. Newly affiliated volunteers are often acknowledged with an item that designates their membership status. Many organizations send an official welcome letter and/or provide volunteers with an ID badge, tee shirt, vest, or other item. Ongoing

recognition of volunteers is also an important component of retention (Brudney, 1999; Hager and Brudney, 2004; Forsyth, 1999; Maryland Governor's Office on Service and Volunteerism, 2006). Recognizing volunteer accomplishments and contributions establishes a sense of community and reminds volunteers that their individual contributions are important to the larger effort.

**Some programs use existing volunteers to recruit new volunteers.** It is important to keep volunteers interested in the organization. Some programs use existing volunteers to attract new recruits at professional meetings. Such efforts have contributed to capacity-building and renewed commitment to volunteering among existing participants.

**Volunteer programs should be flexible when possible.** Because not all volunteers can contribute the same amount of time or effort, some volunteer programs use multiple “membership levels,” each with different obligations or requirements for the volunteer.

**Training incentives can be effective.** Incentives, such as continuing education credit hours or re-certification points, can be used to encourage volunteers to participate in training. Many programs include just-in-time training courses to make sure that new volunteers are prepared to participate during the event. Volunteers might also be encouraged to participate in activities related to routine public health events, such as yearly flu clinics, public education campaigns and community health fairs.

**Updating volunteer information is critical to retention.** Many organizations have a process for ensuring that contact information is correct and to monitor fluctuations in volunteer involvement. Responsiveness data can also be used to revise or enhance plans for volunteer retention.

## **CONCLUSIONS AND RECOMMENDATIONS**

The study resulted in several overarching conclusions for developing a volunteer program for building workforce surge capacity in the event of a public health emergency.

### **Creative Approaches Are Needed to Address Cross-Cutting Challenges**

At each phase of program development, public health officials must confront a series of challenges, including the need to garner sufficient staff and other resources.

While funding a volunteer program can be difficult, we believe that several steps can be taken to minimize and justify the costs. For example, volunteer staff can also be included in public health activities such as conducting immunization clinics and participating in community education about emergency preparedness. Costs can also be minimized by partnering with other community organizations or using volunteers to run the volunteer program.

Local public health departments and MRCs face significant challenges in integrating their efforts to establish and maintain volunteer programs with those of other local volunteer agencies, emergency management organizations, faith-based and community groups, as well as state and federal agencies. A high level of integration is essential to minimize double counting of volunteers, to collect information on volunteers, and to ensure that volunteers know which organizations have priority claims on their services in emergencies. Local and state public health departments may be the most appropriate organizations to take responsibility for convening “volunteer summits” at the state and local levels to begin to work through some of the coordination issues. Despite their central role, public health departments will likely find themselves engaged in partnerships with traditional (health specific) and non-traditional (non-health specific) organizations. These types of interactions have so far proven beneficial to the public health sector broadly, and the lessons learned from development of public health collaboratives to deal with traditional community health issues apply in the case of public health emergencies.

### **Assigning Responsibility to a Single Staff Person Helps Improve Coordination**

Assigning the function of developing and managing a volunteer program to a single staff member – and making that function his or her main or, better still, sole responsibility – can go a long way toward addressing many of the challenges associated with developing an effective volunteer program, especially in a busy public health department. A dedicated staff person can improve the chances of coordinating volunteer programs across agencies and community partners, including areas such as training and data sharing; help resolve issues related to double-counting; identify ways in which volunteers can be used to assist in delivering routine public health services in an effort to

develop their skills, keep up their interest in participating in the program, and help defray program costs.

### **Program Evaluation and Improved Information Dissemination on Promising Practices Will Advance the Field**

The evidence base on the effectiveness of alternative public health preparedness strategies and practices is remarkably thin. This is partly due to the scarcity of metrics to assess public health preparedness outcomes. It is our belief that metrics can and should be developed to assess volunteer programs in public health. Initial measures might focus on recruitment rates and attendance rates for training and drills, volunteer retention, and volunteer satisfaction. In addition, improving the speed and efficiency of verifying credentials, as well as evaluating volunteer response time to call-downs could be useful in determining the expected ratio of volunteers to call-downs should an emergency occur.

There is an abundance of lay and practitioner literature on successful volunteer practices, but we identified only a few rigorous evaluations of volunteer program practices in the academic literature (Brudney, 1999; Hager and Brudney, 2004) and none on volunteer practices in the public health literature. Consequently, we are unable to describe any volunteer program practices in public health that could be considered “best” or even “exemplary.” In the short run, the promising approaches described in this study will have to suffice. However, over the longer term, we emphasize the importance of embarking on a series of program evaluations of these approaches and beginning to develop a set of evidence-based practices.

## **Acknowledgements**

The authors wish to thank the many state and local public health, Medical Reserve Corps and national and local volunteer officials who contributed their time and shared their experiences with developing and managing volunteer programs. We also thank staff from the national ESAR-VHP program and the Medical Reserve Corps for their thoughtful review of the report. And we are especially grateful for the support, feedback, and insights provided by project officer Lara Lamprecht.

# Chapter 1. Introduction

Although the need to prepare for public health emergencies<sup>1</sup> has always been a concern, the events of September 11th, the devastating tsunami in Asia, Hurricane Katrina, and the emergence of avian influenza have all brought the potential for a large-scale disaster to the forefront of public awareness. These and other catastrophic events have drawn attention to the need for a “surge” of additional health care workers and other volunteers to assist public health agencies, emergency management organizations, first responders, and health care facilities with disaster response and recovery efforts. Experience has shown that many volunteers, including health professionals<sup>2</sup>, are typically willing to help in the wake of a natural disaster or other emergency (Hoard and Tosatto, 2005). However, in many cases, large numbers of uncoordinated volunteers, although well intentioned, have hindered an efficient emergency response (Points of Light Foundation & Volunteer Center National Network, 2002; Hodge, et al., 2005; Fernandez, et al., 2006).

For example, after the terrorist attacks of September 11, 2001, over 40,000 people arrived at Ground Zero in New York City to volunteer their assistance (Illinois Terrorism Task Force Committee on Volunteers and Donations, February 2005). However, the volunteer response was unsolicited and there was no mechanism for coordination. In addition, the volunteers who arrived then needed food, sanitation and other accommodations, thus complicating the rescue efforts (HRSA, 2005). Similarly, during Hurricane Katrina, vast numbers of unsolicited volunteers, many who were health professionals, arrived in the disaster areas to help. Although there was an immense need for volunteers, especially for physicians, nurses, and other health professionals, there was no systematic way to assign volunteers to appropriate sites. Moreover, there was no mechanism to verify the identity or qualifications of those volunteers who claimed to be health professionals (Franco, et al., 2006).

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<sup>1</sup> For the purposes of this report, a public health emergency is defined as an event or sequence of events whose scale, timing, or unpredictability threatens to overwhelm the health care delivery system and that requires a large-scale public health response.

<sup>2</sup> Health professionals are individuals licensed or certified by a state licensing authority to provide physical and/or behavioral health care services to the public. Health professionals include but are not limited to physicians, advanced practice nurses, physician assistants, nurses, pharmacists, dentists, social workers, psychologists and others.

These experiences prompted officials from public health, emergency management, and other government and non-government organizations to recognize the need for a coordinated volunteer effort during a public health emergency. Public health agencies increasingly understand the importance of having a program to ensure that volunteers have been identified in advance and are ready to fill their roles when an emergency occurs.

While the need to develop volunteer programs is clear, many public health agencies have never developed such a program before, and are not familiar with the approaches available for recruiting, managing, and retaining volunteers. The purpose of this study is to help fill this gap by providing a framework for developing a volunteer program and by identifying hands-on strategies and approaches that are being used by various organizations (including public health authorities, national disaster relief organizations, local and national volunteer organizations, and faith-based organizations) to establish or expand a volunteer program. This report describes how these organizations are attempting to resolve common challenges in recruiting, affiliating, managing and retaining volunteers, including health professionals.

## **THE NEED FOR VOLUNTEERS IN PUBLIC HEALTH**

A health professional who volunteers to provide health care services to the public during a public health emergency is referred to in this report as a Volunteer Health Professional (VHP). During a public health emergency, both VHPs and non-health professional volunteers can be needed. VHPs may be needed to administer vaccines or medications at point of dispensing (POD) sites, or to provide treatment to the ill and injured at first aid stations, mass care centers, temporary clinics, and other sites where medical care is offered. In some cases, VHPs are needed to supplement hospital staff, or to replace personnel who are unable to do their jobs because they themselves are victims of the emergency event. Large numbers of non-health professional volunteers are also needed to serve in auxiliary roles and to facilitate access to health care services. For example, non-health professional volunteers are typically needed to assist with patient flow, set-up, transport, clean-up and sanitation in a mass prophylaxis clinic. During non-emergency situations, VHPs and non-health professional volunteers can also play important roles in staffing vaccination clinics, providing information about preventive care and emergency preparedness, and assisting with preparedness drills and exercises.

VHPs can also participate in community activities such as health fairs and contribute to outreach and education to promote public health prevention and screening programs (e.g., mammography and cervical cancer screening for women and lead screening for children). Generally, volunteers bring manpower, skills and abilities that can be significant, and valuable to a variety of community organizations (Fernandez et al., 2006; Skoglund, 2006; Volunteer Florida, 2005).

While it is widely recognized that volunteers will be needed during a public health emergency, the precise number of volunteers required can be difficult to estimate. This number will depend on the type of emergency, the duration of the emergency, the numbers of casualties, and the general impact on community infrastructure caused by the emergency, as well as its scope and duration. Even when the number and type of volunteers needed has been accurately estimated in advance, it is not possible to predict the number of volunteers who will actually show up to help during an emergency.

### **Unaffiliated Volunteers Are Likely to Respond**

As noted earlier, an influx of unsolicited volunteers (also referred to as “Spontaneous Unaffiliated Volunteers” or SUVs) at the site of a disaster or during an emergency may hinder response efforts. In most cases, it would be ideal if only volunteers who are officially “affiliated” with a volunteer program respond during an emergency because they generally have the required training to respond effectively and would be part of an organized deployment. However, the reality is that the number of affiliated volunteers may be inadequate, and SUVs will respond if they perceive a need (Fernandez et al., 2006; Volunteer Florida, 2005). Moreover, many affiliated volunteers will not be available when they are needed, whether due to individual circumstances, employment responsibilities, or the nature of the event (e.g., during a contagious disease outbreak, risk of contagion may limit who can respond). Nonetheless, organizations have different policies about whether or not to allow and plan for the arrival of SUVs during an emergency.

## **PARTNERSHIPS, LEGISLATION, PROGRAMS, AND POLICY RELATED TO PUBLIC HEALTH VOLUNTEERS**

A major challenge facing state and local public health agencies is how to effectively partner with other organizations, agencies, and groups to leverage limited resources to fulfill their missions. The need for effective and efficient partnerships spans many domains of public health, but is especially important in public health preparedness.

Given the need for an organized volunteer workforce to respond in public health emergencies, the Federal Government, public health authorities, and nonprofit organizations (NPOs) are developing new programs and bolstering existing programs to recruit and retain volunteers. Establishing partnerships among these organizations can leverage the synergy and resources that many agencies bring to the table and can only improve overall preparedness. We briefly review relevant federal legislation, Federal Government-sponsored programs, and efforts developed by NPOs.

### **Federal Legislation**

Federal legislation has attempted to address some aspects of recruiting and managing volunteers. In 1996, Congress passed legislation ratifying the Emergency Management Assistance Compact (EMAC), a mutual aid agreement and partnership between states that all states have agreed to. The goal of EMAC is to increase the resources and personnel available to states during a disaster. During a state of emergency that is declared by a governor, EMAC offers state-to-state assistance in the form of state personnel and equipment to help disaster relief efforts. EMAC legislation has provisions for resolving liability and reimbursement issues and for allowing credentials to be honored across state lines (EMAC website <http://www.emacweb.org/>). While EMAC is a valuable resource, it is intended for the exchange of state personnel and assets, which are provided only to other State and non-profit entities. However, there are efforts underway in some states to recognize volunteers as state assets, thus allowing them to be deployed as EMAC resources.

In 2002 Congress passed legislation (Public Law 107-188, 2002), the intent of which was to improve the national preparedness response. Congress appropriated funds to build and augment the emergency response capabilities of the public health and health care systems. These funds are distributed to the states by the Department of Health and

Human Services (HHS) through Cooperative Agreements with the Centers for Disease Control and Prevention (CDC) and the Office of the Assistant Secretary for Preparedness and Response (ASPR). CDC's Public Health Emergency Preparedness Program emphasizes public health capabilities, while the ASPR Hospital Preparedness Program<sup>3</sup> focuses on health care capabilities. In recent years, both programs have stressed the importance of having the capacity to expand the workforce in public health departments and hospitals in order to respond to public health emergencies. These programs acknowledge that volunteers – both medical and non-medical – will be needed during a public health emergency, for example, to conduct mass prophylaxis or vaccination clinics, or to augment staff in health care facilities.

In the 2002 legislation Congress recognized the need for organizations to utilize VHPs effectively and voted to authorize the development of the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP). The goal of this program is to establish a state-based national system of emergency volunteer registries that will allow efficient utilization of VHPs in emergencies. When fully implemented, ESAR-VHP will enable states to provide mutual aid in the form of pre-registered and credentialed volunteer health workers. In 2005, Hurricanes Katrina and Rita provided an opportunity to test the program's ability to facilitate deployment of health professionals to areas of need. According to testimony by then HHS Assistant Secretary for Health, John Agwunobi, ESAR-VHP assisted 21 states in deploying a total of over 8,300 pre-credentialed volunteer health professionals to affected areas (HHS, 2006).

Each state ESAR-VHP system is an electronic database of health care personnel who have agreed to volunteer to provide aid in an emergency. States own their data systems, which they build, manage and operate. Systems vary among states, but each ESAR-VHP system must have the capacity to (1) register health volunteers, (2) verify their credentials and qualifications, and (3) assign volunteers to one of four categories based on the credentials and qualifications that the volunteer possesses and has had verified. (HRSA, 2005). ESAR-VHP currently includes credentialing guidelines for 20 health professions with plans to ultimately include 65 health and health related

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<sup>3</sup> Formerly the National Bioterrorism Hospital Preparedness program under the Health Resources and Services Administration (HRSA)

occupations (HRSA, 2005). States may also choose to include other health profession occupations, as well as non-health professional occupations, in their databases.

Integrating local public health volunteer programs and Medical Reserve Corps units with the state ESAR-VHP system is an important goal of the program. This would ensure a pool of VHPs that are locally based and available to respond to emergencies in their communities, and that are also available to be deployed to other jurisdictions if needed. However, it should be noted that volunteers are considered a local resource. They are not deployed to other jurisdictions unless they have indicated a desire to do so and there is an incident requiring a regional, state, or national response.

Although states are in various stages of developing their ESAR-VHP programs, the recent Pandemic and All-Hazards Preparedness Act (Public Law 109-417, 2006) requires that all states receiving Hospital Preparedness Program and Public Health Emergency Preparedness Program cooperative agreement funds must participate in the ESAR-VHP program by 2009. Additional information regarding the ESAR-VHP program will be discussed later in this report.

### **Federal Volunteer Programs**

There have been other national efforts to develop volunteer programs to respond to large-scale public health emergencies. For example, in 2002, President Bush created USA Freedom Corps (USAFC) as a coordinating council at the White House charged with promoting volunteerism and service throughout the country. Citizen Corps is a National service program within USAFC which promotes opportunities for Americans to participate in community activities to promote safety and preparedness (USAFC website: <http://www.usafreedomcorps.gov>; Citizen Corps website: [www.citizencorps.gov](http://www.citizencorps.gov)).

The Medical Reserve Corps (MRC) is a partner program with Citizen Corps and administered within the Department of Health and Human Services' Office of the Surgeon General. It is a network of community-based groups of volunteers, including VHPs and non-health professionals, who donate their time and expertise to promote the health and safety of their communities. MRC members are identified, credentialed, trained and organized in advance of an emergency, and can be utilized throughout the year to improve the public health system. MRCs are designed primarily to organize and utilize volunteers to supplement existing local emergency response and public health resources (MRC

website: <http://www.medicalreservecorps.gov>). As of September 2007, there were over 700 MRC units across the country, the majority of which are associated with a local public health department, though some are sponsored in emergency management agencies, hospitals, universities, or community volunteer organizations. Recent legislation calls for a strengthening of the Medical Reserve Corps across the country (Public Law 109-417, 2006).

The Community Emergency Response Team (CERT) is another Citizen Corps volunteer program that was developed to prepare citizens to help meet a community's immediate needs following a major emergency event. The CERT concept was developed and implemented by the Los Angeles City Fire Department in 1985. CERT is a training program that helps citizens understand their responsibilities in preparing for an emergency and increases their ability to safely help themselves, their families, and their neighbors. As part of this program, civilian volunteers can be recruited and trained as teams that, in essence, will be auxiliary responders after a disaster. These groups can provide immediate assistance to victims in their area, organize spontaneous volunteers who have not had training, and assist professional responders. In many communities, CERT teams and MRCs work closely together. In 1993, CERT training became available through the Federal Emergency Management Agency (FEMA) (CERT website: <http://www.citizencorps.gov/cert/>)

### **Non-Profit Volunteer Programs**

Many community non-profit volunteer organizations, including faith-based groups, are also supplementing the workforce available to respond to a public health emergency. These organizations recruit primarily non-health professional volunteers and often work collaboratively with public health departments and MRCs. In many cases, these volunteer organizations are also experienced in managing spontaneous unaffiliated volunteers and perform that role in the event of an emergency.

Other non-profit organizations active in disaster response collaborate with local, state and national emergency response officials to provide food, shelter, and basic first aid to affected populations during emergencies. By Congressional Charter, the American Red

Cross (ARC) is the lead non-profit disaster relief organization<sup>4</sup> in the nation (American Red Cross website: <http://www.redcross.org>). Many disaster relief organizations are members of the National Voluntary Organizations Active in Disaster (NVOAD), an organization that provides a coordinating function for its member organizations as they prepare for and respond to emergencies. Members of NVOAD include national disaster relief organizations such as ARC and the Salvation Army. NVOAD is not itself a service delivery organization, but it provides assistance to help other community organizations work in cooperation to provide service delivery for disaster relief and recovery. NVOAD convenes and facilitates coordination prior to an event to encourage organizations to participate in advance training and to gain familiarity with the other member organizations.

Most states also have a VOAD, consisting of state and regional voluntary organizations active in disaster relief. These members convene regularly to strategize and coordinate efforts in the event of a disaster. At the national, state, and local levels, VOAD provides communication, cooperation, and coordination among its members, as well as education, training, and leader development.

Today, the VOAD role in disaster relief and recovery has been formalized through the development of many emergency planning policy documents. State emergency management officers often look to VOAD to facilitate communication, coordination, and cooperation among voluntary agencies in the state. At the national level, NVOAD works closely in a joint process with ARC, FEMA and other emergency response organizations to convene meetings of voluntary agencies following major disasters, with the goal of improving coordination of response and recovery (NVOAD website: <http://www.nvoad.org/>).

## **GOALS AND FRAMEWORK FOR THIS STUDY**

This report aims to provide hands-on strategies and approaches that can be used by public health agencies and other organizations to establish or expand a volunteer program for building workforce surge capacity in the event of a public health emergency. Because

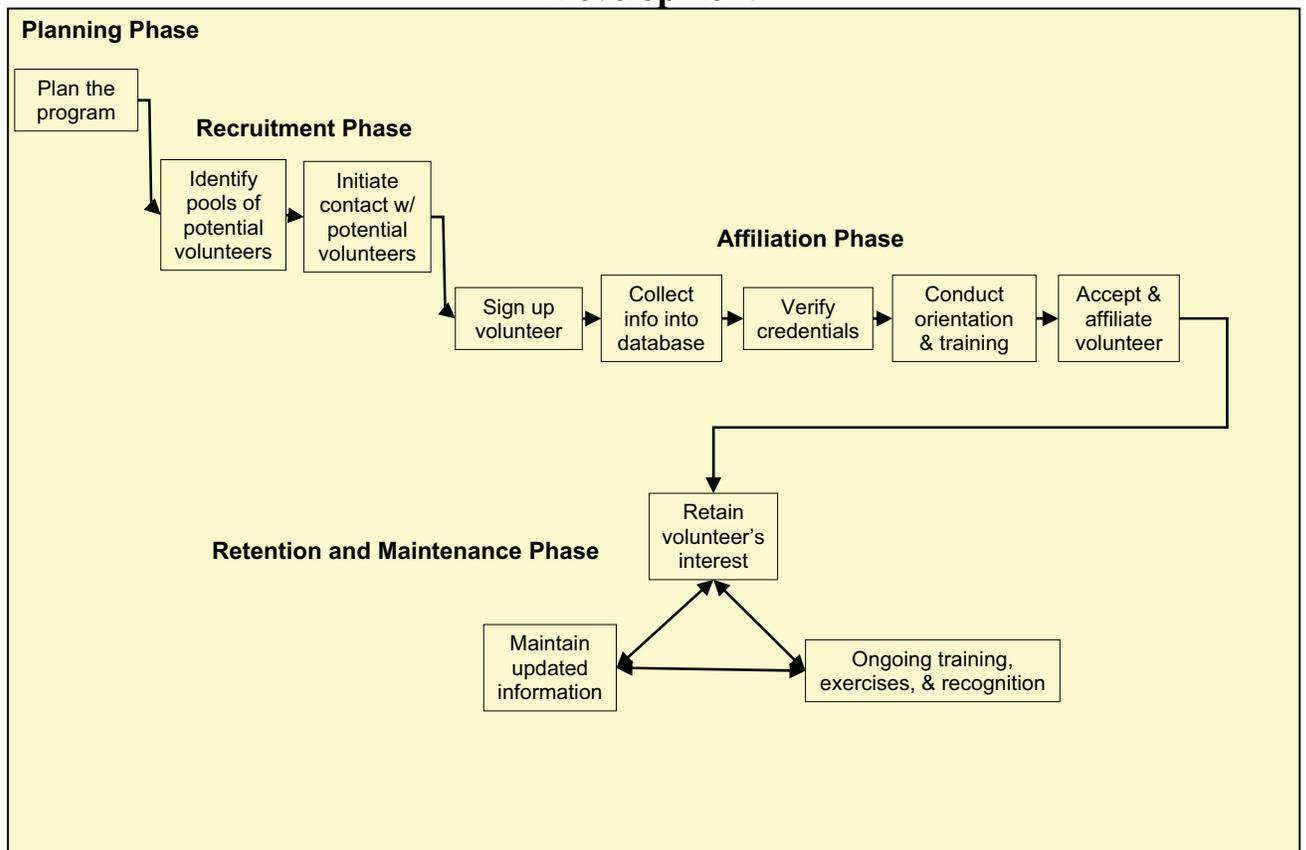
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<sup>4</sup> A disaster relief organization is an entity that provides disaster relief services or assistance in response to an emergency declaration (National Conference of Commissioners on Uniform State Laws, 2006).

the evidence base in public health emergency preparedness is still being developed, we do not attempt to rate the approaches or to identify “best” practices. However, we do describe certain approaches that are “promising” and that appear to be successful in certain situations. We also describe specific factors that are likely to facilitate the successful implementation of these approaches. In addition, we discuss continued challenges for public health in developing a strong volunteer workforce and identify needs for future research and program/policy development.

Note that the focus of this study is on the steps involved in developing a volunteer program and that it does not address the mobilization of volunteers once an event occurs. The authors recognize that developing a volunteer program and successfully registering volunteers does not ensure a systematic and organized deployment. Public health and other organizations that deploy volunteers during emergencies would likely benefit from a study that closely examines the process of mobilization and deployment.

**Figure 1-1 Process Diagram for Volunteer Program Development**



## **METHODS**

We first conducted a targeted review of the lay, academic, and public health literature on volunteer recruitment, management, and retention. Based on this review, we developed a process map to illustrate the major steps involved in recruiting, managing, and retaining volunteers for public health emergencies (Figure 1.1). A process map diagrams the flow or sequence of steps necessary to complete an activity. The process map was developed by laying out the steps involved in developing a volunteer program and then grouping the steps into phases. We paid particular attention to which steps are prerequisites to others, and sequenced the steps accordingly. We considered a step to be distinct if it involved a set of approaches, skills, or resources that differed from those required for another step. We then refined the process map based on input received during a series of interviews with key stakeholders, described below.

For purposes of organization, we show the diagram as a series of sequential phases, each consisting of several steps. The process map contains four phases: planning, recruitment, affiliation, and retention/maintenance. Each phase will be discussed in detail in later chapters. Note that the focus of this study is on the steps involved in developing a volunteer program and does not address the mobilization and deployment of volunteers once an event occurs.

The process for building a volunteer program for public health emergencies varies depending on each agency's particular needs and the design of its program. Consequently, this diagram will not be an exact match to every organization's volunteer program; rather it will represent the key processes involved. It should also be recognized that volunteer programs will likely be engaged in several of the steps concurrently. For example, new pools of volunteers will be periodically identified, even as recruitment from existing pools occurs and current volunteers are trained and exercised.

We then conducted telephone interviews with key program staff in health departments, MRCs, and other volunteer organizations (see Table 1.1) to explore current volunteer recruitment and retention practices. Each interview was facilitated by two project team members and lasted approximately one hour. Questions in our interview protocol (see Appendix A) were organized around the draft process map, which was

modified based on our interview findings. Interviewees and the sites they represented were assured confidentiality and thus are not identified in this report. Views expressed in this report are those of interviewees. Readers are cautioned that these views may not reflect factual data about a given program.

### **Selection of Interview Sites**

In selecting candidate interview sites, we drew upon a number of sources, including:

- Internet search using a select combination of terms such as volunteer, emergency, health professional, public health, community, etc.
- Search of the social sciences peer-reviewed literature
- Search of the public health peer-reviewed literature
- Referrals from the National Association of County and City Health Officials (NACCHO), CDC Division of Strategic National Stockpile (DSNS), Advisory Board member, student volunteer recruiter
- State and local health departments cited in the CDC webcast, *Mass Antibiotic Dispensing-Managing Volunteer Staffing* (CDC Public Health Training Network, 2004)
- Contacts made at the Association for Research on Nonprofit Organizations and Voluntary Action Annual Conference
- Past RAND work on public health emergency preparedness
- ESAR-VHP Guidelines (HRSA, 2005)
- Interviewee referrals
- Association of State and Territorial Health Organizations (ASTHO) Report, *State Mobilization of Health Personnel During the 2005 Hurricanes* (ASTHO, 2006)
- Referrals from The Points of Light Foundation

All of the city/county and regional/district health departments<sup>5</sup> interviewed were associated with the Medical Reserve Corps. This was not intentional and there may be local health departments that have a volunteer program that is not associated with the MRC. To the extent possible, we also attempted to balance our selection of health

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<sup>5</sup> In this paper we use “local health departments” to refer to the combined total of city/county and regional/district health departments.

departments with regard to geographic region and rural/urban nature of the area served to be as broad as possible. In most cases, we included the state health department for every city/county or regional/district health department interviewed.

We also interviewed a small sample of local and national non-profit volunteer organizations that have some involvement with recruiting and managing volunteers in preparation for disasters. The local non-profit volunteer organizations interviewed have extensive experience recruiting community volunteers for a variety of roles. Each of these organizations is also involved with assisting a public health department and/or MRC with some element of volunteer program development – recruiting non-health professionals, managing spontaneous unaffiliated volunteers, or general volunteer recruitment and management practices.

**Table 1.1 Organizations Interviewed**

<b>Organization Type</b>	<b>Number of Interviews Conducted</b>
State health department	14
City/County health department with a Medical Reserve Corps unit	11
Regional/District health department with a Medical Reserve Corps unit	1
Medical Reserve Corps unit not directly associated with a health department	2
National nonprofit disaster relief organization	2
National nonprofit volunteer organization	1
Local nonprofit volunteer organization	3
Faith-based volunteer organization	1

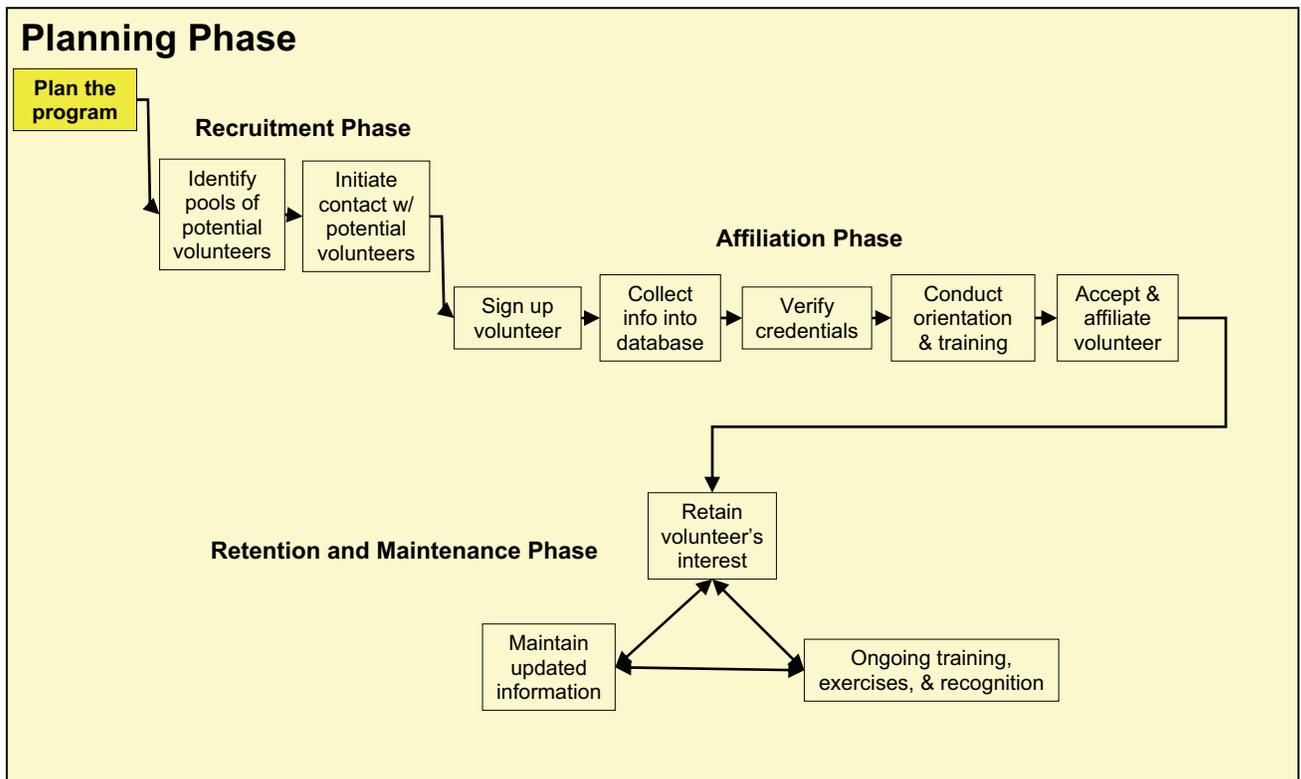
## **ORGANIZATION OF THIS REPORT**

The remainder of this report is divided into five chapters. In chapter 2, we focus on issues to consider when planning a volunteer program in public health. Chapters 3-5 address, respectively, recruitment, affiliation, and retention/maintenance of volunteers, and include tables listing practices that emerged from our interviews. Chapter 6 summarizes our conclusions and recommendations for future research and program/policy development.

## Chapter 2. The Program Planning Phase

Careful planning, the step highlighted in Figure 2.1, is critical to the success of any volunteer program (Forsyth, 1999; McCurley and Lynch, 2006; Maryland Governor's Office on Service and Volunteerism, 2006). In public health, a volunteer program to expand the workforce in the event of an emergency requires that program goals are aligned with the broader public health emergency planning goals. For example, the emergency plan might describe scenarios (e.g., mass prophylaxis for anthrax) for which volunteers would be needed and for what tasks. Elements of the public health emergency plan should also accurately reflect what the volunteer program can (and cannot) provide. For instance, if an organization does not have an electronic volunteer database, then the emergency plan cannot include an electronic volunteer call-down system. The goals and objectives of a volunteer plan may shift as the volunteer program develops, but should remain aligned with the broader emergency plan.

Figure 2-1 Program Planning



## **KEY ISSUES TO CONSIDER IN PLANNING A VOLUNTEER PROGRAM**

Based upon our review of the literature and our key stakeholder interviews, we identified a number of key questions and issues that arise when planning each phase of a volunteer program; many of these questions and issues are also reviewed on a regular basis. Some of the questions to be answered in planning a volunteer program include:

- What will the roles of volunteers be?
- How many volunteers are required for each role?
- What plans are needed to prepare for an influx of spontaneous unaffiliated volunteers (SUVs)?
- What legal issues must be considered?
- What resources (i.e., funding, staffing) are needed to administer the program?
- How will the program be evaluated?

We will discuss approaches for addressing each of these issues in this chapter. However, this is by no means a complete list. In planning a volunteer program, many more decisions will need to be addressed such as determining:

- who will be responsible for command, control and communication of the volunteer registry
- which occupations and credentials will be collected and verified
- which specific information will be collected from the volunteer
- how the system will be activated and by whom
- what relationships need to be established to ensure the ability to use the volunteers (e.g., local and state emergency management agencies)

## **APPROACHES FOR PLANNING**

### **Determining the Roles of Volunteers Is an Important Planning Step**

It is generally accepted that determining why volunteers are needed and establishing the specific jobs they will be asked to perform is a critical element of a successful volunteer program (American Red Cross, 2006; Brudney, 1999; McCurley and Lynch, 2006; Murk and Stephan, 1991; Maryland Governor's Office on Service and

Volunteerism, 2006). In fact, Brudney (1999) states that creating job descriptions for volunteer positions is a “highly recommended best practice.” Public health departments will want to establish the roles of volunteers and determine whether they will be called upon only in emergency situations or also to assist with routine public health functions.

Our interviews revealed that some public health departments and MRCs recruit volunteers only for emergency response. Common roles for public health volunteers during an emergency event might include:

- Assisting at Points of Dispensing (PODs) for mass antibiotic dispensing or mass vaccination
- Assisting at first aid or triage centers
- Operating alternate clinical care sites or field hospitals
- Providing medical services at emergency shelters
- Supplementing or relieving hospital staff
- Assisting emergency management officials with patient transport

Other public health departments and MRCs we interviewed reported recruiting volunteers for both routine public health functions and other community activities as well as for emergency response. Potential non-emergency volunteer roles might include:

- Assisting with flu immunization clinics
- Participating in community health fairs
- Contributing to the development and dissemination of public education campaigns on preparedness, smoking, hypertension, obesity etc.
- Assisting with management of the volunteer program
- Providing clinical services and support in public health clinics

Clearly, in the planning phase, the health department or MRC should establish whether volunteers will be called upon only in emergency situations, or whether they will also be asked to assist with routine public health functions. In either case, job descriptions or “job action sheets” can help a volunteer organization to further refine the role of its volunteers. In addition, creating a clear scope of participation will help potential volunteers to better understand their roles in the organization.

Establishing roles for volunteers will also help to determine the types of volunteers that will be needed. Many of the health departments and MRCs we interviewed are

focusing their initial planning efforts solely on the recruitment of volunteer health professionals, particularly doctors and nurses. However, it is widely accepted that large numbers of volunteers who are not health professionals will also be needed during a public health emergency (e.g., to operate a point of dispensing, first aid center or alternate clinical care site). Some health departments and MRCs that are focusing only on VHPs are partnering with local volunteer organizations for the recruitment of non-health professional volunteers. Others are planning to recruit non-health professionals as the next step in the development of their program. For many, the decision to recruit non-health professional volunteers is a function of resources and personnel.

### **Estimating the Number of Volunteers Needed During an Event Is Challenging**

There is no straightforward method for determining how many volunteers an organization will need in an emergency. Thus, few of the volunteer programs in our study have a particular targeted recruiting number. Instead, many programs seek to recruit as many volunteers as they can. Given that a public health emergency could encompass a broad range of events and scenarios, it is especially challenging to estimate the number of volunteers that might be needed or the number that might be willing to respond to a particular event. Consequently, there are no current guidelines except for those developed for PODs. In a scenario requiring mass prophylaxis, there are staffing guidelines under development that depend upon the number of planned PODs and the expected throughput of each POD.

Estimating the number of volunteers that will be needed during an emergency event is further complicated by the fact that some affiliated volunteers will be unavailable, unwilling, or unable to serve when the need arises. Some volunteers may become unavailable because they themselves have been affected by the event (e.g., persons who become ill during an outbreak or those who need to care for their own homes and families, as seen during Hurricane Katrina). Another factor affecting the number of volunteers needed is the duration of an event. Additional volunteers may be needed to relieve regular workers and other volunteers if the event spans many days. Consequently, recruiting more

volunteers than the estimated number needed is prudent. Hence, as one interviewee stated, “If you think you need 20 [volunteers], you need to have 40-50 recruited.”

### **Double-Counting Volunteers Is Problematic.**

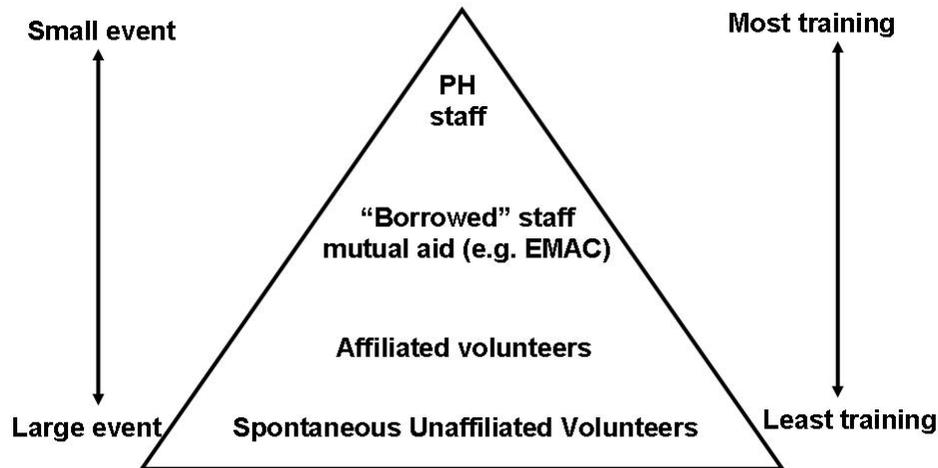
An important issue that emerged from our interviews is the problem of “double-counting” volunteers, which may result in an overestimation of the number of volunteers who would be available to respond when needed. Double-counting can occur when an organization enlists some volunteers who are also affiliated with other volunteer emergency response organizations, such as the American Red Cross or CERT. Moreover, volunteers might also be counted more than once if they are expected both to be at their regular workplace and at a volunteer location during a public health emergency.

One of the main factors contributing to the problem of double counting is the fact that there is little integration and sharing of databases across different emergency volunteer organizations. Many local health departments and MRCs operate their own databases and do not share their data electronically. Some states however, operate a common volunteer database for the various local programs; volunteers sign up online and a local program coordinator is responsible for follow-up activities. This process helps eliminate duplication of efforts and can mitigate the double-counting problem, since the common database includes not only local health departments and MRCs, but in some cases Citizen Corps and CERT program volunteers as well. Although sharing volunteer data is desirable from the perspective of coordination, concerns about privacy of the data were raised by some local and state public health and MRC officials.

### **Managing Spontaneous Unaffiliated Volunteers is Challenging**

In some scenarios, the scale of the emergency event will drive the need for volunteers. As depicted in Figure 2.2, catastrophic events are likely to require large numbers of volunteers, many of whom may be SUVs, and smaller events can be handled by fewer numbers of more highly trained individuals.

**Figure 2-2 Types and Relative Numbers of Volunteers in Relation to Scale of Event and Training Required**



Although there is agreement that SUVs can be problematic in an emergency, their relevance should be noted. Many health department and MRC officials we interviewed acknowledged, as does much of the literature, that unsolicited SUVs *will* arrive wanting to help (Volunteer Florida, 2005, no date; Fernandez et. al., 2006; California Office of Emergency Services, 2001; Marshall, 1995; California Service Corps, 2004). Further, their services could be critical, especially if an event extends for many days. In addition, SUVs, especially VHPs, may bring skills that are lacking or provide essential skills at an economic savings (Fernandez et. al., 2006). Although the use of SUVs can be controversial, some health department officials argued that there should be a system in place to manage SUVs rather than discourage their use, especially in a large scale event. There is also literature on managing volunteers during emergencies that supports this view as well (Fernandez, et. al., 2006; Points of Light Foundation and The Allstate Foundation, 1999; California Office of Emergency Services, 2001; Illinois Terrorism Task Force Committee on Volunteers and Donations, 2005; California Service Corps, 2004; Points of Light Foundation & Volunteer Center National Network, no date).

Our interviews revealed however, that managing SUVs can be a labor-intensive task that health departments may not be prepared to do, especially during a public health

emergency. Some health department and MRC officials reported that their programs will not accept SUVs at the time of an emergency event. Others do not have a plan for managing SUVs but are open to the idea, and some are actively planning strategies for managing SUVs and using them effectively. For example, one site is developing “just-in-time training” focused specifically on SUVs. In other sites the public health department or MRC has partnered with the American Red Cross or another local volunteer organization to assist with SUV intake and staging logistics. Others plan to partner SUVs with trained, affiliated volunteers. In addition, some plan to establish a Volunteer Reception Center (VRC), where large numbers of volunteers can be quickly processed and deployed to wherever needed (Points of Light Foundation & Volunteer Center National Network, no date; California Office of Emergency Services, 2001; Fernandez, et., al., 2006; Illinois Terrorism Task Force Committee on Volunteers and Donations, 2005; California Service Corps, 2004).

As noted earlier, SUVs can hinder response efforts due to their lack of training and their need for potentially scarce resources such as food, water, and housing. Screening SUVs with a series of questions may help to prevent well-meaning volunteers from becoming victims during an emergency event. One site reported that they give all of their volunteers a self-screening form that is sensitive to the individual’s desire to volunteer but that asks questions about the person’s suitability for deployment. Questions include, “Do you like to camp?” “Can you work in an environment without air conditioning?” “Do you have chronic medical conditions or take medications that need refrigeration?” “Are you willing to sleep in shared quarters?” These questions could be used to identify SUVs as well as affiliated volunteers who might not be reliable, who might not be appropriate for certain missions, or who themselves might need assistance during an emergency.

Clearly, managing SUVs is challenging. However, there are strategies that can mitigate the negative impact of SUVs and capitalize on the skills and abilities they can bring (Fernandez, et. al., 2006).

### **Emergency Declarations May Affect State Laws**

Key legal issues may influence the development and implementation of a volunteer program for responding to public health emergencies. Each state has statutory or administrative authority related to liability, workers’ compensation, and licensure,

credentialing, and privileging. State laws give government officials the power to declare an emergency for varied disasters and public health emergencies. The declaration of an emergency usually results in the granting of additional powers and duties to the governor as well as to emergency management, public health, or public safety authorities (HRSA, 2006). In order to increase the capacity of the health care system, an emergency declaration may result in the suspension of certain health care-related statutes and regulations. For example, under normal circumstances, most licensed health professionals cannot legally practice in a state in which they are not licensed. However, during a declared emergency, this regulation may be waived, allowing health professionals licensed in another state to practice in the state where the emergency event has occurred. For example, during Hurricane Katrina, the state of Louisiana waved this regulation, thus allowing health professionals from other states to fill many of the health care manpower gaps. Given that public health departments and MRCs recruit licensed health professionals, it would be wise for these organizations to assess their state's existing laws and understand how an emergency declaration may affect these laws.

### **Liability Issues Are of Special Concern to VHPs**

The risk of liability should a disaster victim become ill, injured, or killed as a result of a volunteer's actions is a critically important issue with which all program planners should be familiar with. However, liability issues are complex and thus, an in-depth discussion is out of the scope of this report<sup>6</sup>.

Although liability is an issue for all volunteers, VHPs and physicians in particular are especially concerned about liability. As noted in the ESAR-VHP Legal and Regulatory Issues Report, "VHPs may face civil liability for negligently providing health services, care, and treatment during an emergency" (HRSA, 2006, p.12). In all states, Good Samaritan Laws protect volunteers from liability to some degree; however, many feel this protection is not broad enough to adequately protect VHPs. Many states have thus recognized the need for broader protections for volunteers in general, but especially for VHPs who hold a professional license to practice. Some states, such as California,

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<sup>6</sup> For a complete review of the issues, readers are referred to The Center for Law and the Public's Health at Georgetown and Johns Hopkins Universities (<http://www.publichealthlaw.net/>) and the ESAR-VHP Legal and Regulatory Issues Report online at [ftp://ftp.hrsa.gov/bioterror/May\\_06\\_Legal\\_Report.pdf](ftp://ftp.hrsa.gov/bioterror/May_06_Legal_Report.pdf).

have passed legislation that would recognize volunteers as agents or employees of the state when they are mobilized by a state agency or emergency management agency. This action would offer the same immunity protection to volunteers as that available to state employees.

### **Workers' Compensation Protection Is Limited**

Workers' compensation protection refers to monetary coverage for injuries sustained while on the job. As with liability there are many complex issues surrounding worker's compensation and how it applies to volunteers during a declared emergency<sup>7</sup>. According to Hodge, et al., (2006), workers' compensation laws generally do not cover volunteer workers since they are not considered "employees." However, in some states, coverage is available under certain conditions. For example, in California, a volunteer is eligible for workers' compensation coverage through the state if there is a declared emergency and if the volunteer is officially associated with a disaster relief organization such as the American Red Cross (Marshall, 1995). Interviewees told us repeatedly that workers' compensation coverage for volunteers is limited or does not exist in their state. At a minimum, volunteer programs should be prepared to explain what, if any, workers' compensation benefits are available to those who volunteer during a public health emergency.

### **Programs Need to Address Potential Funding Limitations**

In our interviews we repeatedly heard that developing a volunteer program and then managing and maintaining the program is very costly. Information technology (IT) systems – including hardware, software and personnel to support and maintain the system – are a significant cost. Consequently, many we spoke with, especially at the local level, are simply using an Excel spreadsheet for recording volunteer information. Simple spreadsheets might be adequate for local programs, but they do not allow for efficient data sharing with other emergency response programs at the local, state, and federal levels.

In addition to IT systems and other data management expenses, there are other significant costs that must be considered when planning a volunteer program. These

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<sup>7</sup> Readers are again referred to The Center for Law and the Public's Health at Georgetown and Johns Hopkins Universities (<http://www.publichealthlaw.net/>) and the ESAR-VHP Legal and Regulatory Issues Report online at [ftp://ftp.hrsa.gov/bioterror/May\\_06\\_Legal\\_Report.pdf](ftp://ftp.hrsa.gov/bioterror/May_06_Legal_Report.pdf) for a complete review.

include the cost of materials such as recruitment literature, ID badges, newsletters, equipment, supplies etc. Also, for automated systems, there may be costs for electronically verifying credentials using a Credential Verification Organization (CVO).

One of the greatest cost concerns that emerged from our interviews was that of staffing a volunteer program. All but the most automated systems require personnel to collect and enter data, update and maintain the database, verify credentials and conduct training. Moreover, all programs require personnel to design and conduct training exercises, interact with potential and established volunteers and activate the system in an emergency event. Ideally, staff would be dedicated to developing, implementing and maintaining the volunteer program. However, most health departments and MRCs do not have the resources to dedicate staff to this activity. Consequently, it is more common that health departments embed program activities in staffs' overall tasks.

There is also limited funding available for purchasing and maintaining IT systems for volunteer programs in public health. Initially, state public health departments received \$200,000 to establish ESAR-VHP programs. Interviewees consistently asserted that the cost of a commercial system that is compatible with ESAR-VHP is considerably greater than \$200,000. Some sites are using "home grown" systems that have been developed within the health department. However, many have found that these systems are also costly and are less likely to be compatible with ESAR-VHP and with other emergency response systems such as the Health Alert Network (HAN). Consequently communication and coordination of volunteer efforts could be hampered during an emergency response.

### **Program Evaluation Is Another Consideration**

Another issue to consider when planning a volunteer program is how the program will be evaluated. We found very few examples of programs that incorporate an evaluation component into their programs. Only a few track statistics measuring recruitment, training completion, and response to drills and exercises. One example from our interviews came from a local public health department/MRC. They conducted an exercise that entailed sending an email survey describing a specific scenario to the volunteers in their database. The survey asked volunteers about their availability, how quickly they could respond, and if they would be expected to respond to another agency or to report to work. The site reported that the response rate gave them a good indication of

how many active volunteers are in their program. In addition, the exercise provided valuable data on volunteer availability, time to respond and the prevalence of double counting. As with many areas of public health preparedness, there is no evidence base for setting standards for evaluating volunteer programs. However, setting goals for recruitment and call-down drills and measuring progress toward achieving those goals is a reasonable starting point.

## **CONTINUING CHALLENGES**

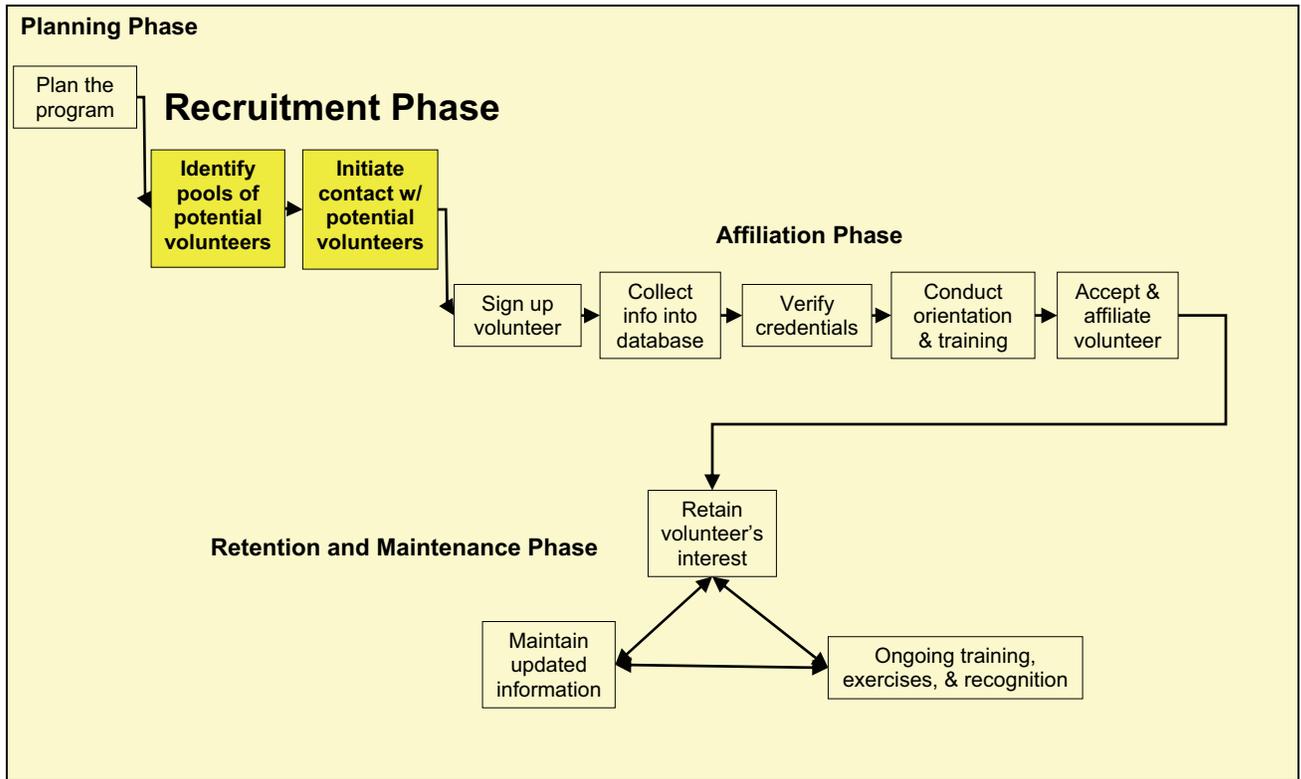
Clearly, important issues must be considered when planning a volunteer program in public health. However, many of these issues such as liability, worker's compensation, funding and staffing will remain as ongoing challenges throughout the program's development and maintenance.

## **Chapter 3. The Recruitment Phase**

After the initial planning for volunteer recruitment is completed, the next stage in the recruitment process is to identify and initiate contact with potential groups of volunteers. This stage is critical in building a volunteer program since organizations must be able to find and connect with potential volunteers in order to establish a program in the first place.

While all organizations face challenges in finding and connecting with potential volunteers, two special types of challenges are especially relevant to the recruitment of volunteers for public health emergencies. Public health emergencies often require volunteers with specific skill sets, educational backgrounds, and/or credentials and thus require recruitment approaches targeted to specific populations. In addition, because public health emergencies are, thankfully, rare, it can be difficult to engage volunteers for an event that might or might not happen. As a result, special attention is needed to motivate potential volunteers to join such programs and to remain involved.

**Figure 3-1 Steps in the Recruitment Phase**



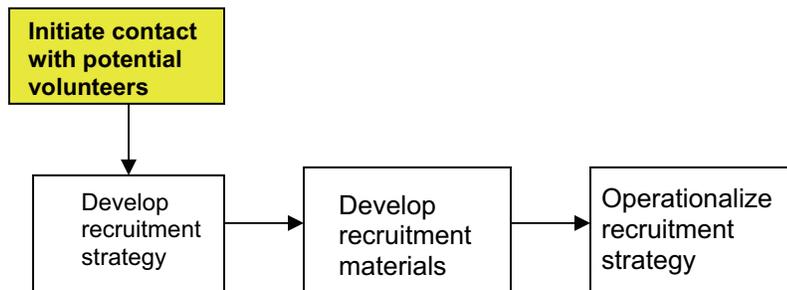
## STEPS IN THE RECRUITMENT PHASE

Although planning will go on continuously as a volunteer program develops, the recruitment phase generally begins once the initial planning phase is completed. As shown in Figure 3.1, there are two main steps in the recruitment phase:

- identify target audiences to be recruited
- initiate contact with potential volunteers

Because a variety of health professional and non-health professional volunteers may be needed for a public health emergency, identification of the potential pools of volunteers may require several approaches, as will be discussed in more detail later in this chapter. Once pools of potential volunteers have been identified, initial contact with them must be made, whether through direct mailing, face-to-face meetings, or other means. Initiating contact involves three sub-steps as shown in Figure 3.2.

**Figure 3-2 Sub-steps in Initiating Contact with Potential Volunteers**



## **APPROACHES FOR IDENTIFYING AND RECRUITING VOLUNTEERS**

We identified three general strategies for recruiting volunteers. These include “warm body,” “word of mouth,” and targeted recruitment (McCauley, 1995). *Warm body* recruitment, as its name suggests, is useful for jobs that just about anyone can fill, regardless of skill level. According to McCurley and Lynch (2006), this strategy is particularly useful for recruiting large numbers of volunteers for a short-term assignment. Warm body recruitment typically involves spreading the message about positions broadly through public service announcements (PSAs) and other media sources as well as focusing on community groups such as churches and colleges. However, this method does not provide much control of the quantity of volunteers recruited or the caliber of those recruited. *Word of mouth recruitment* is based on the idea that those that are already connected to the recruiting organization are the best targets for a recruitment campaign (e.g., incumbents asking incumbents, former clients, or current volunteers to suggest additional volunteers).

A third approach is *targeted recruitment*. This approach is based on the premise that there are jobs the recruiting organization wishes to fill that are not suitable for most people, thus requiring specific skills and special commitment. Questions to address when utilizing targeted recruitment include:

- What skills/attitudes are needed to do this job?
- Where can we find these people?
- What motivations can we appeal to in our recruitment effort?

Targeted recruitment is the most appropriate method for the recruitment of most volunteers for public health emergencies since the goal of these recruitment efforts is to

fill volunteer spots with people who have the skill sets and levels of experience that will be needed to respond to a public health emergencies (i.e. doctors, RNs, etc.) (Watts & Edwards 1983).

### **Multiple Pools of Volunteers Will Likely Be Needed**

Once an organization has determined “who” is needed for “what,” the next step is to identify pools of potential volunteers who might take on specific roles. In most cases, it will be necessary to identify multiple pools of possible volunteers, both to ensure that a sufficient number of volunteers are available and to have access to health professionals with target specialties. It is especially important to understand the skill sets and levels of experience that will be needed by volunteers responding to a public health emergency, since the organization will likely require special strategies to recruit individuals with special expertise.

Table 3.1 shows potential sources of volunteers identified by our interviewees. These groups are organized according to whether the need is for health professionals or non-health professionals. For instance, if the planning phase determines that registered nurses (RNs) will be needed to administer vaccines at a POD, then professional conferences and organizations that involve RNs would likely be a good place to find potential volunteers. On the other hand, if there is a need for non-medical volunteers to perform services such as handing out forms or managing the flow of people in and out of the POD, then community groups, churches or synagogues, universities, and other broad-based organizations would be useful places to focus recruiting efforts. In some cases, non-health professional volunteers may require special skills and thus will need a targeted recruitment effort as well. For example, volunteers capable of providing security for a POD are likely to be found in groups composed of law enforcement and security personnel. In addition, volunteers who are fluent in a specific foreign language may be found in community groups that serve the population that speaks that particular language.

**Table 3.1 Potential Pools of Volunteers**

Health Professional Volunteers	Non-Health Professional Volunteers
<ul style="list-style-type: none"> <li>▪ Professional conferences</li> <li>▪ Professional organizations (e.g., medical or nursing societies)</li> <li>▪ Licensing boards</li> <li>▪ Hospitals</li> <li>▪ Doctor’s offices/community clinics</li> <li>▪ Schools for health professionals</li> </ul>	<ul style="list-style-type: none"> <li>▪ Community groups (e.g., Kiwanis)</li> <li>▪ Faith-based organizations</li> <li>▪ Ethnic community groups</li> <li>▪ Community events (e.g., health fairs)</li> <li>▪ Colleges/universities</li> <li>▪ Staff at elementary or secondary schools</li> <li>▪ Civil/state employee groups</li> <li>▪ Worksite groups</li> <li>▪ Community volunteer organizations</li> </ul>

**Initiating Contact with Potential Volunteers Requires a Variety of Approaches**

The next step in targeted recruitment is to determine how to communicate with groups identified as potential pools of volunteers (McCurley and Lynch, 2006). Although data on effectiveness are lacking, McCurley and Lynch (2006) suggest that contact methods facilitating two-way communication, such as speaking to small groups are more effective than one-way communication methods such as posters or public service announcements. However, two-way communication methods are much more labor intensive.

Interviewees shared many approaches for contacting groups of potential volunteers using both communication methods. Many have put up exhibits or given presentations at professional conferences and community events. Others have held meetings or given presentations about the need for volunteers to local businesses, hospitals, doctor’s offices and clinics, schools, colleges and universities and various community groups. A number of sites also use advertisements in the form of public service announcements on local radio and TV, and articles in the local newspaper. In one large city, public health officials implemented an aggressive advertising campaign with ads for volunteers in subways, buses, and transit stations.

Networking is another approach for accessing potential pools of volunteers. It is important for an organization to review its current relationships with other community organizations and determine the extent to which they will need to expand existing networks to find volunteers. For example, building and strengthening relationships with

local volunteer organizations is critical. Although these organizations are unlikely to have experience with VHPs, they are very likely to have the infrastructure and procedures in place for effectively recruiting, managing and maintaining non-health professional volunteers. Many of the local public health departments and MRCs in our study are partnering with local volunteer organizations to assist with recruitment efforts.

At the state level, public health departments have contacted health professionals by advertising in or submitting articles to professional association newsletters. In addition, many states are collaborating with their state licensing boards to include volunteer recruitment literature in professional license renewal mailings.

Although sophisticated marketing efforts are expensive and not commonly used by health departments, several organizations reported that they had hired consulting firms to help them develop a sustainable marketing plan for recruitment of volunteers. Most of these efforts were funded by grants or operational budgets specifically set aside for this purpose. One state HD hired a marketing firm to do a substantial amount of research on the recruitment process. The firm surveyed medical professionals, pharmaceutical companies, and medical suppliers about their preferences for volunteering and recruitment. The state now plans to take these findings and translate them into a viable marketing campaign.

Interviewees offered a number of specific approaches for initiating contact with potential volunteers. Table 3.2 lists those approaches, some of which are unique and deserve further explanation. For example, in one large city, the public health department partners with medical and nursing schools as well as with other allied health professional schools within local colleges and universities. Students are recruited as volunteers and are also encouraged to recruit other students. In one graduate nursing program, the instructor developed a course on service learning that involved recruiting for the MRC. Students successfully recruited other students, faculty and alumni.

Another example is a rural health department that taps into its other volunteer programs to make contact with potential volunteers. In other words, the public health department will contact volunteers who work in programs other than preparedness (e.g., a volunteer program to help the homeless) and encourage them to sign up as volunteers for their preparedness program. Many health departments have found this approach

successful and report that it requires minimal effort since the volunteers are already affiliated with the public health department. This effort has also been successful as a means to retain volunteers, keeping them actively involved in work that the public health department is doing, both during non-emergency and emergency situations.

A third example is the more common practice of making contact with volunteers at events that the public health department already sponsors. For instance, many public health departments hold health fairs that draw in the community as a means to educate and inform on a variety of health topics, and frequently include volunteer programs in these fairs by having them set up booths and sign-up opportunities. The presence of MRCs or other volunteer programs has been a successful way to approach outreach and contact potential volunteers.

**Table 3.2 Approaches for Recruiting Volunteers**

<b>Approach</b>	<b>Setting Cited</b>	<b>What is potentially useful?</b>	<b>Circumstances/situations/considerations for putting into practice</b>	<b>What is likely to enhance success?</b>
Use volunteers to recruit other volunteers	Local HD volunteer organization	Take burden away from public health staff to “find” the volunteers	Works well when volunteers are actively engaged and vested in seeing the program grow	Making it a program “norm” to “bring a friend” into the program
Use respected colleagues to solicit volunteers (e.g., a state health commissioner sent a recruitment letter to registered health professionals)	Local HD	Can defer costs when leaders are involved in recruitment and increase buy-in from the targeted professional community	Requires good relationships with leaders; sound infrastructure to ensure leaders that they are vouching for a good program	An “advisory board” that is vested in the program and wants to participate in increasing numbers of volunteers.
Recruit through hospital relationships	Local HD	Reaches out to people within hospital (existing network)	Requires stable hospital infrastructure to facilitate communication	Buy-in from hospital leadership to push program
Use other volunteer opportunities to recruit volunteers for health positions (e.g., a HD recruits volunteers that participate in a volunteer project to provide health education to the homeless)	Local HD	Efficient use of limited resources	Requires connection to existing volunteer opportunities	Coordination between the volunteer program managers
Invite volunteers from other organizations to join recruiting organization	State HD	Taps into an empathetic population	Programs should not “compete” for the same volunteers	Cooperation from other program managers
Partner with colleges and universities to include volunteer recruitment as part of the nursing (or other health) curriculum requirement	Local HD	Uses a peer population that has health knowledge & credibility with other students.	Good relationship is needed with local colleges/universities	Willingness on the part of college or university to offer credit to students who recruit others

**Recruitment Materials Typically Focus on Key Motivations for Volunteering**

Organizations engaged in volunteer recruiting efforts will need to spend time developing an appropriate message or series of messages for potential volunteers. A clear understanding of volunteer activities and responsibilities will also help in developing appropriate messages and outreach strategies for potential volunteers. Messages will be most effective if they focus on the particular volunteer groups being sought, and address

the specific need of the organization for their skills, in other words, how they as volunteers can alleviate this need, and the potential benefits to the volunteer (Maryland, 2006). These kinds of messages can build upon the goals specified in the planning phase and focus on motivating individuals to sign up. For example, two local health departments developed mottos that they feel resonate best within the medical community: “Be a Local Hero.” Different messages may be needed if an organization is attempting to recruit a wide range of volunteers. Often included in a good message is information about exactly what the volunteer will be doing and why that is important. This will alleviate concerns that could cause barriers to signing up by clarifying what will be expected of a volunteer. These messages will differ depending on whether the purpose is to recruit a medical versus non-medical volunteer. However, regardless of the work the person might be doing, the common theme in recruitment literature is often based on altruistic and/or patriotic messages that send the message that everyone can be a “hero” by participating in a volunteer program.

Key messages might also focus on how one signs up as a volunteer. For example, one State HD reported that it found that medical volunteers prefer to sign up with programs that allow them to become affiliated prior to an event, have simple and streamlined places to look for information and sign up, and make them feel safe and protected while engaging in medical practice during an event. In addition to the personal safety of the volunteer, the safety of the volunteer’s family may also be a concern in certain types of emergency situations. Not surprisingly, our interviews revealed that volunteers are more likely to be willing to serve if they are assured that their families are safe from the disaster, or in the case of an infectious disease outbreak, that they will be given priority status for receiving immunizations.

Key messages can be disseminated through recruitment materials that inform potential groups about volunteer opportunities. Most programs distribute brochures and/or posters that provide details of the program and urge people to sign up. Many programs also have websites that are hyperlinked to many other sites. Some of the better-funded programs use public service announcements, billboards, and commercials to send a message. In addition to making the request for volunteers, recruitment materials typically

include instructions about how to sign up, who to contact, and how to get more information.

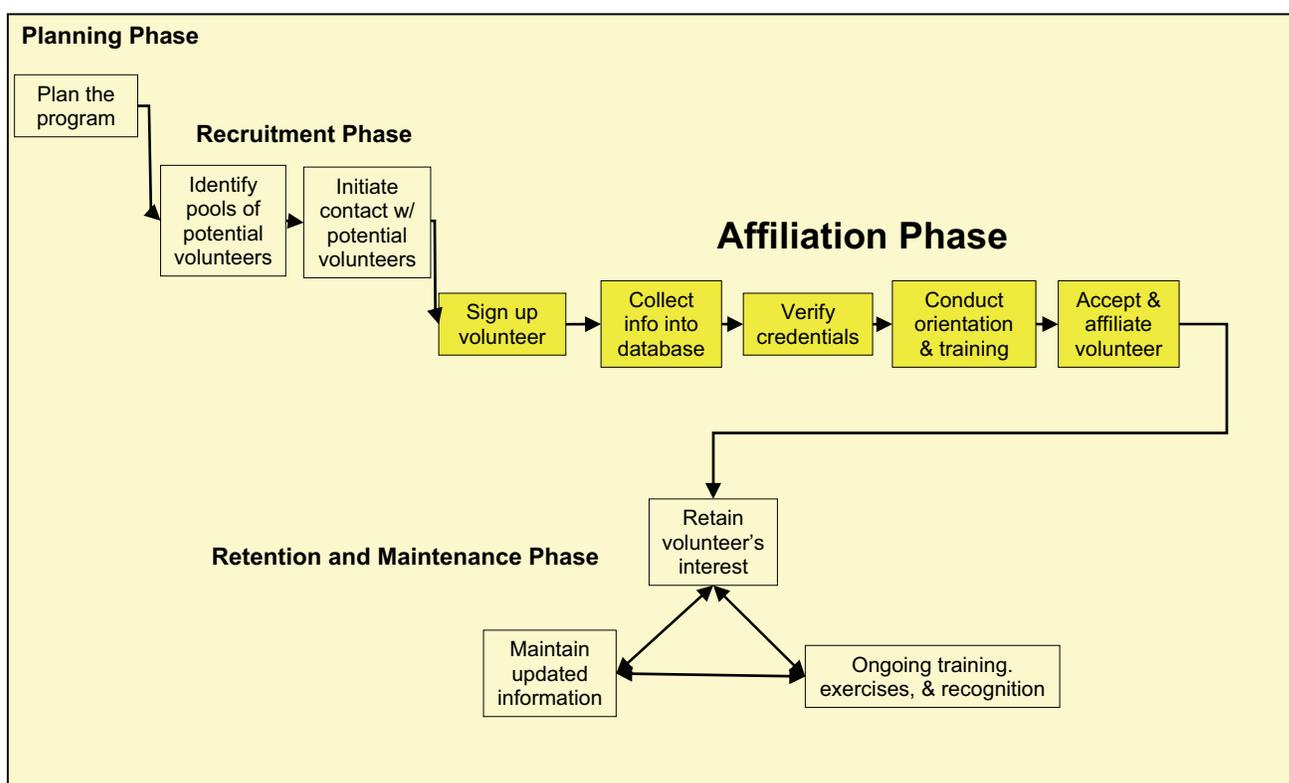
## **CONTINUING CHALLENGES**

Although there are a number of challenges to recruiting volunteers for public health emergencies, by far the greatest challenge is finding the financial and personnel resources to carry out the recruitment efforts. If resources are limited, health departments and MRCs may consider partnering with a volunteer management organization or enlisting current volunteers to assist with recruitment. Ultimately, devoting sufficient resources to volunteer recruitment within the organization may be the key to a successful program.

## Chapter 4. The Affiliation Phase

The affiliation phase, highlighted in Figure 4.1, is the process by which a person makes the transition from being a recruit to being an official volunteer who is “affiliated” with the volunteer program, and who is known to, and has been approved by, the agency or organization. This is in contrast to those who are “spontaneous unaffiliated volunteers” (SUVs), i.e., people who show up to help in an emergency but are otherwise unknown to authorities. In the affiliation phase, the individual makes him- or herself available to the volunteer organization, and the volunteer organization in turn accepts the individual as part of its program.

**Figure 4-1 Steps in the Affiliation Phase**



Some of the challenges that public health volunteer organizations face in the affiliation phase are common with most other volunteer organizations. Like other volunteer organizations, public health volunteer organizations must keep track of their volunteers. Consequently, the technology issues are similar – purchasing software and

developing and managing a database of volunteers can be costly, time-consuming, and labor-intensive, especially for those organizations that do not use a web-based system. Databases for public health volunteer organizations have an added requirement, however, that the membership list be readily accessible in an emergency.

A much larger challenge that is specific to affiliating volunteers for public health emergencies is the more stringent acceptance process. There is the need to identify and verify relevant credentials for VHPs. Further, these credentials must be kept current and ideally should be re-verified before a volunteer health professional can be deployed during an emergency.

## **STEPS IN THE AFFILIATION PHASE**

As shown in Figure 4.1, the process of affiliating volunteers typically includes several steps:

- **Sign up the volunteer:** The new recruit makes the decision to sign up as a volunteer, informs the volunteer organization, and begins the process of submitting personal information. The organization, in turn, responds to the new recruit in order to maintain his or her interest and to collect additional information.
- **Collect information:** Information provided by the new volunteer is collected. At a minimum, programs collect contact information about the individual, including basic demographics. However, most programs also collect additional information such as education, skills, credentials, and availability. To ensure that information provided is correct, permission is usually obtained to verify information about the volunteer.
- **Verify credentials:** Volunteers who declare themselves to be licensed health professionals must provide proof of their professional qualifications. At a minimum, the volunteer program must verify each VHP's license to practice his or her profession. Information on other professional credentials, current employment, and past experience may also be collected. Some programs also perform criminal background checks on all volunteers.
- **Conduct orientation and training:** Some programs require volunteers to undertake some training or go through an orientation process. Although Figure 4.1

shows orientation and training as taking place prior to official affiliation, many volunteer organizations offer training *after* a volunteer has been officially accepted and some do not require any training.

- **Officially accept and affiliate the volunteer:** Once these steps are complete, the applicant is formally accepted as a member of the volunteer program. In many cases, programs will issue items (e.g., a membership card) that designate membership status and that serve during an emergency to identify the individual as an “affiliated,” as opposed to an SUV.

## **APPROACHES FOR VOLUNTEER AFFILIATION**

### **Prompt Response to Sign-up, Helps Establish Initial Volunteer Interest**

Signing up a volunteer refers to the process of responding to a potential recruit once the individual has expressed interest. Some programs invite volunteers to sign up on a web-based computer application, while others use traditional pen-and-paper means and input the information into a database later. Some use a two-step process whereby the volunteer initially indicates interest in a simple manner, such as via a tear-off postcard, a phone call, or a short online form. The organization then follows up with the individual with a more detailed application and information collection process.

Following up by responding promptly to a potential volunteer’s interest is critical, and not doing so may result in losing a potential candidate. A mechanism for initial contact with a volunteer can help to keep interest levels high. Some interviewees emphasized the importance of having a personal contact at this early stage. Even if a volunteer signs up online through a centralized state-run computer database, the information about that volunteer is usually sent back to a local program coordinator who follows up with the new volunteer. However, as noted in the chapter on recruitment, most interviewees reported having little funding for staffing this and other tasks necessary for a successful volunteer program in public health.

### **Organizations Collect Information To Ensure Their Ability To Contact Volunteers In An Emergency Via Multiple Means**

When a prospective volunteer signs up, the health department or volunteer program begins collecting information about that person. At a minimum, contact

information is needed to ensure that the volunteer can be notified and activated for duty in the event of an emergency. A variety of contact means are typically included, such as phone numbers (work, home, mobile), pager numbers, and email addresses. Some systems can transfer this information into an automated call or email system, so that large numbers of volunteers can be quickly called during an emergency. These contact systems may include “reverse-911” and similar systems that can automatically dial a set of phone numbers and play a pre-recorded message, “blast email” systems that send electronic mail to a list of individuals, and the Health Alert Network and other automated information systems that push information out to recipients. More sophisticated contact systems will also allow recipients to send back an acknowledgement of receipt to the system.

### **Volunteer Roles Affect the Skill and Credential Information Collected**

The way in which volunteers will be used in an emergency will drive the type of information that needs to be collected and the way in which it should be managed. For example, programs that plan to use volunteer physicians in medical roles will need to collect information necessary to verify each physician’s qualifications to legally practice medicine. ESAR-VHP takes an alternative approach; rather than using roles to determine the type of information collected, the information collected is used to define what roles the volunteer can play. This enables ESAR-VHP to make assignments for volunteers who may not be willing to provide all of their credentialing information.

Volunteer programs typically collect information on the prospective volunteer’s professional credentials, licenses, and privileges<sup>8</sup> at health care institutions, depending on program capability and local and state requirements. Some programs may need to track different levels of credential information depending on where the volunteers will work. In a mass dispensing setting, it may be sufficient to know that a VHP holds a valid license to practice. However, if augmentation of hospitals is envisioned, specific data regarding privileges, specialties, and certifications could be needed.

In addition, the federal government has also outlined required credential information for volunteers included in the ESAR-VHP program. Consequently, state

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<sup>8</sup> Privileges or the process of privileging refers to the authorization given by a health care organization to a qualified health professional allowing that health professional to provide patient care, treatment, and services in that organization.

public health departments and many local health departments and MRCs are currently striving to collect the credentialing data required by ESAR-VHP. While participation in their state ESAR-VHP program will likely facilitate volunteer credential verification by health departments and MRCs, some interviewees expressed concern that the ESAR-VHP program will usurp control from local health departments and MRCs. While we did not find examples of this occurring, the belief may dampen enthusiasm and efforts to cooperate with the ESAR-VHP program.

Programs may track other information about volunteers in their databases. Some programs ask their volunteers about other commitments that might interfere with emergency volunteering duties, such as family obligations, or other volunteer or emergency response commitments. Typically programs will also ask volunteers about other skills they may have, such as language ability. One university-based MRC noted that medical and nursing students possess different levels of skills depending on their progression in their academic program; these are not categories often captured by traditional credentialing categories. Programs may also track the participation record of the volunteer, including completion of training sessions. Programs may categorize volunteers depending on the training level received, or the type of roles the volunteers are expected to play.

### **Need to Share Information Among Databases and Automated Systems Affects Technology Requirements**

Most of the health departments and volunteer organizations reported that they use some type of electronic database for collecting and managing volunteer information, although at least one still uses a paper-based file. Database complexity varies dramatically, ranging from simple Excel spreadsheets to sophisticated commercial systems. The technical requirements of complying with ESAR-VHP data exchange standards have prompted many programs to revamp their databases. In some cases, the software is developed in-house; in other cases software is purchased, or the entire service of maintaining the software and hosting a website is outsourced to a contractor.

Some agencies use databases that can be accessed via the Internet. Such systems have the advantage of allowing prospective volunteers to input information themselves and can also be accessed by the health department official or the volunteer out in the field.

This enables previously registered volunteers to be checked-in during an exercise or an operation, and may allow SUVs to be added to the system. One MRC couples a field-accessible system with mobile scanners that are used to scan the ID badges of volunteers. This system allows MRC officials to check-in and track volunteers in the field, either during an exercise or an actual event. Some programs also include volunteer photographs in the database; this facilitates the verification of identity and issuance of ID cards/badges.

As mentioned earlier, some agencies use automated systems for contacting members of their volunteer organization in an emergency or to verify the credentials of VHPs. This capability requires volunteer databases to be compatible with such automated systems.

### **Data Sharing Facilitates Coordination but Raises Concerns About Costs and Control**

Sharing volunteer data among local volunteer organizations, between local and state health departments, and between state health departments and the federal ESAR-VHP program can minimize the “double-counting” of volunteers and also facilitate deployment of pre-registered health care volunteers within and across jurisdictions during a public health emergency. However, efficient data-sharing requires interoperability of data systems.

While many local health departments and MRCs run their own databases, some states run a common database for the various local programs, and sometimes other volunteer programs as well; volunteers sign up online and the local program coordinator is responsible for the follow-up activities. This process helps eliminate duplication of efforts and can mitigate the double-counting problem, since the common database includes not only local health departments and MRCs, but in some cases Citizen Corps and CERT program volunteers as well.

The need for sharing volunteer information is often a problem for programs that started with home-grown information systems that had been sufficient for their local

requirements but that do not meet larger system needs.<sup>9</sup> Upgrading these systems might not be feasible and replacing them with a commercial system is costly.

Conversely, these larger systems may not collect the data required to meet the needs of the local community. Some interviewees expressed concern about revising their databases, fearing that more uniform data systems may not meet the needs of each individual program. In addition, interviewees from some local health department and MRC volunteer programs expressed reluctance to share their volunteer lists with other organizations and with government agencies, for fear that local volunteers would be drawn away for duty elsewhere, potentially harming the local health department or MRC's ability to serve its intended purpose as a local resource.

There was also concern over who should own the data. Even when local organizations were willing to allow their data to be read by a state database, they wanted to keep local control and ownership of the database out of a concern that a central, uniform database would not be able to meet the particular needs of each individual program. In addition, there were concerns about privacy and the potential for identity theft if databases were breached. This is especially of concern if personal health information is collected on volunteers, which then raises issues concerning HIPAA<sup>10</sup> regulations.

Interviewees offered a number of specific approaches for collecting volunteer data. Table 4.1 lists those approaches that emerged from our interviews.

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<sup>9</sup> We did not interview any coordinating agencies such as law enforcement and our questions to public health departments focused on coordination within public health and volunteer groups they are associated with. All mention of collaboration is specifically related to volunteer management.

<sup>10</sup> Health Insurance Portability and Accountability Act of 1996 that addresses the use and disclosure of individuals' health information and seeks to ensure that individuals' health information is properly protected. For further information, see <http://www.hhs.gov/ocr/privacysummary.pdf>

**Table 4.1 Approaches for Collecting Volunteer Data**

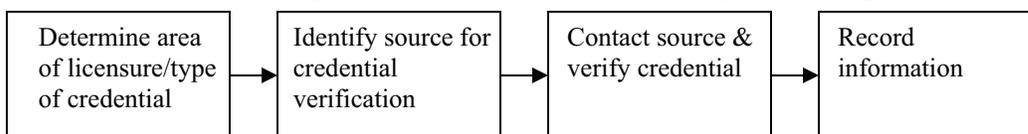
<b>Approach/ Practice</b>	<b>Setting Cited</b>	<b>What is potentially useful?</b>	<b>Circumstances/situations/ considerations for putting into practice</b>	<b>What is likely to enhance success?</b>
Comply with ESAR-VHP	State HD Local HD	Facilitates mutual aid. Condition for Hospital Preparedness and Public Health Emergency Preparedness Cooperative Agreement funding.	Systems selected or developed must be flexible enough to additionally accommodate agency-specific requirements that go beyond those of ESAR-VHP	Early identification of this need during system development process
Track additional training, job assignments, and skills in database	State HD Local HD MRC	Facilitates identification of volunteers for leadership roles. Can facilitate active training program and follow-up with volunteers.	Systems selected or developed must be flexible enough to accommodate new categories of information	Early identification of this need during system development process. Coordination with training program to ensure tracking.
Use automated contact system	State HD Local HD	Facilitates emergency call-downs	Requires development/purchase of system	Automated contact system may be under the control of emergency agencies outside of health department; coordination is needed
Check for potential availability conflicts	State HD Local HD	Gives more accurate picture of volunteer availability	Volunteers must self-identify conflicts. Systems must track this information.	Centralized database or data exchange may assist, if privacy issues can be worked out.
Link to centralized database: state and local; MRC and other volunteers	State HD	Prevents duplication of effort and duplication of volunteer records	Requires willingness to share information	Some volunteer programs prefer maintaining local control. Locals need to be reassured of their control over their members and information.
Use Internet accessible database	State HD Local HD MRC Vol. Org.	Allows volunteers to sign up online and allows agencies to access database in the field	Requires web-based database and Internet connectivity	Public campaign to encourage prospective volunteers to sign up online
Conduct in-the-field scanning of ID to track personnel	MRC	Tracks volunteers for check-in at exercises, training events, and deployments	Requires web-based database and Internet connectivity	Operations in the field should be aware of this capability and have a plan for making use of it.
Develop ability to manage spontaneous unaffiliated volunteers (SUV) in database	State HD	Allows some tracking of volunteers who have not pre-registered	Requires system to be accessible in the field	Departments need to decide their policy on use of SUVs: some programs don't want to use them, while others consider them inevitable, and ultimately needed, even if not ideal

## Credentialing Licensed Volunteer Health Professionals Requires Sub-steps

Once data have been collected from a potential volunteer, the next step in the affiliation phase is usually to verify that individual's qualifications, or professional credentials if the volunteer is a health professional. Licensed VHPs include people in many different occupations such as physicians, nurses, pharmacists, social workers, psychologists and many others. State laws govern the licensing regulations for most health professionals and these regulations differ for each occupation.

The process of credentialing involves four steps, as shown in Figure 4.2.

**Figure 4-2 Key Credentialing Sub-steps**



First, the area of licensure or type of credential must be determined. Although this may seem to be a simple step, there are many different health professions and it may not be obvious what type of credentials are required to practice in a particular state. The next step is to identify the source for verifying the credentials. In the case of licensure, the source will be state-specific, but for other credentials the sources are varied. The credentialing source must then be contacted. This is most often done manually either by phone, by mail or by checking an online database. This type of direct verification of a credential by the entity that originally issued the credential is referred to as primary source verification. Other accepted organizations that can provide primary source verification include Credential Verification Organization (CVO) or an organization that the Joint Commission for the Accreditation of Health Care Organizations (JCAHO) has deemed a Designated Equivalent Source<sup>11</sup>. And finally, verification of the credential must be recorded on paper or entered into a database either manually or electronically.

The final two sub-steps, verifying credentials and recording the information, are important recurring steps. Volunteer organizations must pay particular attention to regularly re-verifying the personal information and credentials of VHPs. The October 31, 2006 ESAR-VHP Draft Compliance Requirements state, "Each State is required to re-

<sup>11</sup> Selected agencies that have been determined to maintain a specific item or items of credential information that is identical to the information at the primary source (HRSA, June 2005).

collect personal information and re-verify credential information for each volunteer every 6 months” (HRSA October 2006, p.4). These requirements are slated to be in effect in February 2008 for some states and February 2009 for others. Re-verification of VHP credentials is also important in limiting the volunteer organization’s risk of liability.

### **Verifying Credentials Can Be Challenging**

Some programs are working to automate the credentialing process so that the volunteer database can be cross-referenced against the state licensing databases. This is an important capability since credentials must be verified during the initial sign-up and then re-verified periodically as well as in an emergency event.

However, some licensed health professionals hold more than just a state-issued license to practice. Physicians and physician extenders (physician assistants (PAs) and advanced practice nurses (APNs) hold other credentials including privileges that, if not verified, may limit their ability to practice, especially in hospitals and other acute care settings. Verifying physician and physician extender credentials and privileges can be daunting and many programs are in the early stages of development and do not yet have the capability to verify credentials other than the state license to practice. In our sample of local and state health departments and MRCs, we found that four state health departments and two free-standing MRCs currently verify other credentials.

**Table 4.2 Common Credentials and Primary Source for Verification**

<b>Credential</b>	<b>Description</b>	<b>Primary Source</b>
Practitioner license	A state-granted designation that allows an individual to practice his/her profession in that state	State licensing board
Board certification	A formal certification indicating that an MD has completed training in a particular specialty and passed a certifying exam	American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA)
Hospital privileges	Privileges granted by a hospital for an MD, PA or NP to work in that hospital	Hospital in which practitioner works
DEA License	A number assigned to a practitioner allowing him or her to write prescriptions for controlled substances	Drug Enforcement Administration
Status with the Office of the Inspector General (OIG) and General Services Administration (GSA)	Presence or absence of sanctions in the Healthcare Integrity and Protection Data Bank (HIPDB) which was developed to combat fraud and abuse in health insurance and health care delivery <a href="http://www.npdb-hipdb.hrsa.gov/hipdb.html">http://www.npdb-hipdb.hrsa.gov/hipdb.html</a>	Office of the Inspector General, Department of Health and Human Services
American Medical Association (AMA)	Flags a physician’s profile if disciplinary action reports are received from the state medical boards	State Medical Boards
National Practitioner Data Bank (NPDB) Status	Presence or absence of “flags” in the NPDB; this is a clearinghouse for information related to professional competence and conduct of physicians <a href="http://www.npdb-hipdb.hrsa.gov/pubs/Data_Banks_at_a_Glance.pdf">http://www.npdb-hipdb.hrsa.gov/pubs/Data_Banks_at_a_Glance.pdf</a>	National Practitioner Data Bank (NPDB)

**Hospitals Are a Reliable Source of Credentialing Information**

The process of checking credentials other than state licensure requires information to be collected from multiple sources, some of which are not easily accessible. However, this is a routine process for hospitals given that JCAHO standards require hospitals to verify all credentials through a primary source prior to granting privileges or employment to health professionals. In the event of an emergency, health care workers credentialed in a JCAHO accredited hospital would likely be accepted as “credentialed” in another hospital with the same accreditation requirements. Thus, health departments and MRCs

are turning to hospitals for assistance in verifying credentials for potential volunteer health professionals.

The six interview sites that reported verifying credentials other than state licensure do so in coordination with hospitals. In two states and one MRC, volunteer programs verify employment and credentials with the hospital that the volunteer lists as his or her place of employment. In the other free-standing MRC, there is a “credentialing cooperative” between the local hospitals, which was in existence before the MRC was developed. This agreement between hospitals means that a health professional who works in one hospital in the collaborative could work in another member hospital in an emergency situation. A form authorizing the cooperative to release credentialing information is included with the MRC recruitment literature. If the release is signed, the new volunteer gains emergency privileges at any of the 10 participating hospitals in the region.

Two of the four state health departments that verify credentials do so electronically. One state has an online system for volunteer registration, which is also used to enter license and other credential information. The system includes 32 hospitals across the state. Each hospital is required to gather and verify credentialing elements for all of the VHPs that the participating hospital includes in the database. When a VHP enters credentials into the online system, the record is flagged for the employing hospital, which then verifies the volunteer’s credentials. Hospitals are also required to re-verify credentials quarterly.

### **Electronic Real-Time Credentialing May Be the Ideal at the State Level**

In the course of our interviews, we discovered many unique volunteer and ESAR-VHP programs and promising practices across the nation. For example, electronic credentialing systems, such as that used in the State of Wisconsin,<sup>12</sup> can facilitate the process of verifying VHPs’ credentials. The Wisconsin Disaster Credentialing (WDC) system forms the credentialing and privileging component of the Wisconsin Division of

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<sup>12</sup> We promised anonymity to our interviewees and the sites they represent, thus limiting our description of particular programs. We received written permission to identify and describe the Wisconsin Disaster Credentialing System in this paper.

Health's ESAR-VHP system. WDC is a secure, password-protected commercial website that allows hospitals, public health departments and MRCs to perform real-time primary source verification of the credentials of physicians and other licensed health professionals in the State of Wisconsin. The system also determines the current quality and competency of physicians on staff at Wisconsin hospitals for the purpose of privileging by the deploying organization. The goal of the WDC is to provide the necessary information about a health professional's qualifications and competencies so that hospitals, health departments, and MRCs can rapidly credential, privilege, and deploy them. WDC is owned and managed by hospitals in the state of Wisconsin.

Through a commercial vendor, WDC allows for real-time primary source verification of the following credentials:

- State Licensure
- DEA License (Drug Enforcement Agency)
- OIG (Office of Inspector General)
- GSA (Government Services Administration)
- NPDB (National Practitioner Data Bank)
- ABMS (American Board of Medical Specialties)
- AMA (American Medical Association: Master Profile)
- Criminal Background Check

Verification can be completed in as little as 10 seconds. Consequently, as long as there is an Internet connection during an emergency, credentials for volunteer health professionals can be immediately verified. In addition, all hospitals have satellite telephone capability to access the Internet if the landline-based Internet service is inoperable.

The quality and competency of providers can be verified through the Provider Affiliation database, into which participating hospitals can voluntarily enter information for their medical staff. The database includes only physicians who are not under investigation or who have not been suspended, thus assuring hospitals of a physician's immediate status for deployment. For those hospitals that choose not to participate in the Provider Affiliation database, a paper form, "Application to Serve as a Volunteer," is used so that the physician can attest to his/her current quality and competency. Information from the database and the form can be used by hospitals in granting disaster privileges to

health professionals. WDC does not itself privilege health professionals, but it provides the critical information that a hospital needs to privilege a volunteer health professional.

Once a volunteer health professional's credentials and competency have been verified by WDC, hospitals, public health departments and MRCs can be assured that the volunteer meets all the necessary requirements to be affiliated or granted privileges. In addition, the State Expert Panel on Human Resources has provided template policies that can be used by the deploying organization to quickly move volunteers through the necessary Human Resource process to comply with all applicable rules and regulations for performing services as a volunteer.

Online, real-time credentialing systems such as WDC may represent the ideal model for verifying credentials for volunteer health professionals. However, due to funding constraints it may only be realistic to implement these systems at the state level.

### **Criminal Background Checks Are Costly and May Involve Law Enforcement**

Some volunteer programs conduct criminal background checks on all potential volunteers to ensure that none have a history of criminal behavior. Generally, in situations where volunteers will work with children, background checks are often required. Although many individuals we spoke with recognize the value of conducting background checks on all of their volunteers, few organizations actually conduct such checks. Most who do not conduct background checks cite cost as the major barrier. In one case, the cost was quoted as \$7.00 per background check, which for this particular program was cost-prohibitive. Also, the process of conducting background checks varies by location, but in many sites it is the responsibility of law enforcement. Requiring action by another agency adds another layer of complexity to the process and thus an additional barrier. As with all of the credentialing information, data on criminal background checks must be recorded in the volunteer database and should be re-verified on a regular basis.

Approaches for verifying volunteer credentials are summarized in Table 4.3.

**Table 4.3 Approaches for Verification of Volunteer Credentials**

<b>Approach</b>	<b>Setting Cited</b>	<b>Purpose / Why is it potentially useful?</b>	<b>Circumstances/situations/ considerations for putting into practice</b>	<b>What is likely to enhance success?</b>	<b>What are the drawbacks?</b>
Verify only professional license manually through primary source	State HD Local HD MRCs Volunteer organization	Ensures minimal legal requirement for delivering treatment and services to patients	Requires accessing state licensing board data online, by phone or by mail; then requires manual entry of information into database	Adequate staff; adequate time in advance of event	Time-consuming; labor-intensive
Verify other practitioner credentials manually	State HD Local HD MRC	Provides additional information on practitioner background, skills, qualifications	Requires accessing various national databases online, by phone or by mail; then requires manual entry of information into database	Adequate staff; adequate time in advance of event	Time-consuming; labor-intensive; limited access to certain databases
Verify other practitioner credentials through CVO	State HD	Provides real-time additional information on practitioner skills, qualifications; streamlines credentialing process	Typically requires a fee to be paid and/or specific hardware/software	Appropriate IT system and funding	Cost; requires online capability
Verify practitioner privileges manually	State HD MRC	Defines the scope and content of practitioner privileges	Requires contacting authorizing entity (usually a hospital) for privileging information	Adequate staff; adequate time in advance of event	Time-consuming; labor-intensive; limited access to information
Verify practitioner privileges through a hospital consortium	State HD MRC	Defines the scope and content of practitioner privileges; Streamlines privileging process	Requires agreement among hospitals	Electronic system	Requires agreement among multiple hospitals
Conduct criminal background checks on all volunteers	State HD Local HD MRC	Ensure that volunteer has no history of criminal behavior	Process differs by locale	Access to an electronic system	Time-consuming; labor-intensive; cost; usually requires involvement of a law enforcement agency

### **Online Orientation/Training Is Common**

As noted earlier, some programs will require orientation and training before a volunteer is formally accepted and affiliated. One public health department MRC in our study requires potential volunteers to pass a follow-up test before acceptance into the MRC. In addition, at the national level, core competencies have been established for MRC members. Core competencies represent the baseline level of knowledge and skills that MRC volunteers should have, regardless of their roles within the MRC unit (MRC website: <http://www.medicalreservecorps.gov/TRAINResources>).

Many of the programs that require orientation use an online registration/sign-up system and have incorporated their online orientation course at the end of the registration process. Other organizations guide individuals to an online training course directly after completing registration, but do not require the volunteer to complete the training in order

to become affiliated. Still other volunteer organizations make recommendations on their websites regarding online training, but do not require the training or connect the training courses to the end of the registration process. Some organizations simply notify volunteers about available training.

While online training lacks face-to-face contact with the organization and with other volunteers, it is a relatively low-cost opportunity to provide potential volunteers with basic knowledge about emergency situations. Introductory online training can also be used to outline expectations for volunteers unfamiliar with the working conditions associated with providing disaster relief (i.e., time commitment, job descriptions, length of shifts, living conditions). Many interviewees noted the large amount of time required to organize face-to-face trainings and ensure the participation of volunteers. Online orientation and training can be an effective way to engage volunteers without spending precious time and money needed to organize in-person training sessions. If an organization already has an IT system capable of receiving online registrations, it may be beneficial to guide potential volunteers to an online training directly after completion of volunteer registration.

An online learning management system can also be used to manage volunteer training. For example, the National MRC uses TRAIN<sup>13</sup>, or the Training Finder Real-Time Affiliate Integrated Network. TRAIN is a free resource for all MRC volunteers. Using TRAIN, volunteers can locate training in 42 content areas, register for online trainings available locally and nationally, build skills, meet licensure requirements, and maintain personal transcripts to track their learning. Although states incur a cost to use TRAIN or other online learning management systems, many states have found that these systems ultimately save money. Such systems enable states and local jurisdictions to coordinate state-level training exercises, generate reports on competencies and readiness, and send course and email announcements to MRC groups easily.

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<sup>13</sup> TRAIN is a project of the Public Health Foundation with a grant from The Robert Wood Johnson Foundation and funding from participating states and the Centers for Disease Control and Prevention. Readers are referred to ([www.train.org](http://www.train.org)) for further information on TRAIN.

## **Official Acknowledgment of Volunteers Can Be Useful**

Affiliating volunteers is an important component of volunteer management because it provides recognition to volunteers for their “membership” in the volunteer program. Often, volunteer organizations will acknowledge newly affiliated volunteers with an item that designates this membership status and that also serves during an emergency to identify the individual as an affiliated volunteer. Many organizations we spoke with send an official welcome letter and/or provide volunteers with an ID badge, tee shirt, vest, or in one case, backpacks that could be filled with supplies necessary during an emergency deployment. Some HDs do not have such formal means for affiliating their volunteers, particularly in a resource-scarce environment. However, we found that the most successful programs find some tangible way to identify their volunteers as affiliated with their organization.

## **CONTINUING CHALLENGES**

The challenges of affiliating volunteers are primarily centered on funding for technology and for staffing. Hardware and software systems as well as personnel are required to establish and maintain an accurate, up-to-date database of volunteers. For example, the technology and capability for real-time credential verification exists but is costly. Rather, in most cases the extent of automation consists of a worker searching for each individual license record online. While several volunteer programs report that they are working on automating the process, only a few programs currently have a working automated credential checking system. Another example is the need for an automated call down process so that volunteers can be easily mustered in the event of an emergency. Both of these challenges are technical issues that could be solved; however the challenge is primarily related to finding funding to develop the systems and personnel to maintain them.

Data-sharing remains another major challenge. Agencies or organizations with volunteer programs are reluctant to share their volunteer lists with other jurisdictions and government entities. Local health departments and MRCs have reported unease over sharing their volunteers with state agencies, and further concern has been raised due to the prospect that ESAR-VHP may allow a local program’s volunteers to be called up for state

service without the consultation of the local program. Even if ESAR-VHP succeeds in providing standards for interoperable state databases, the ultimate success of the effort depends on the ability to actually recruit volunteers willing to have their names entered into the databases.

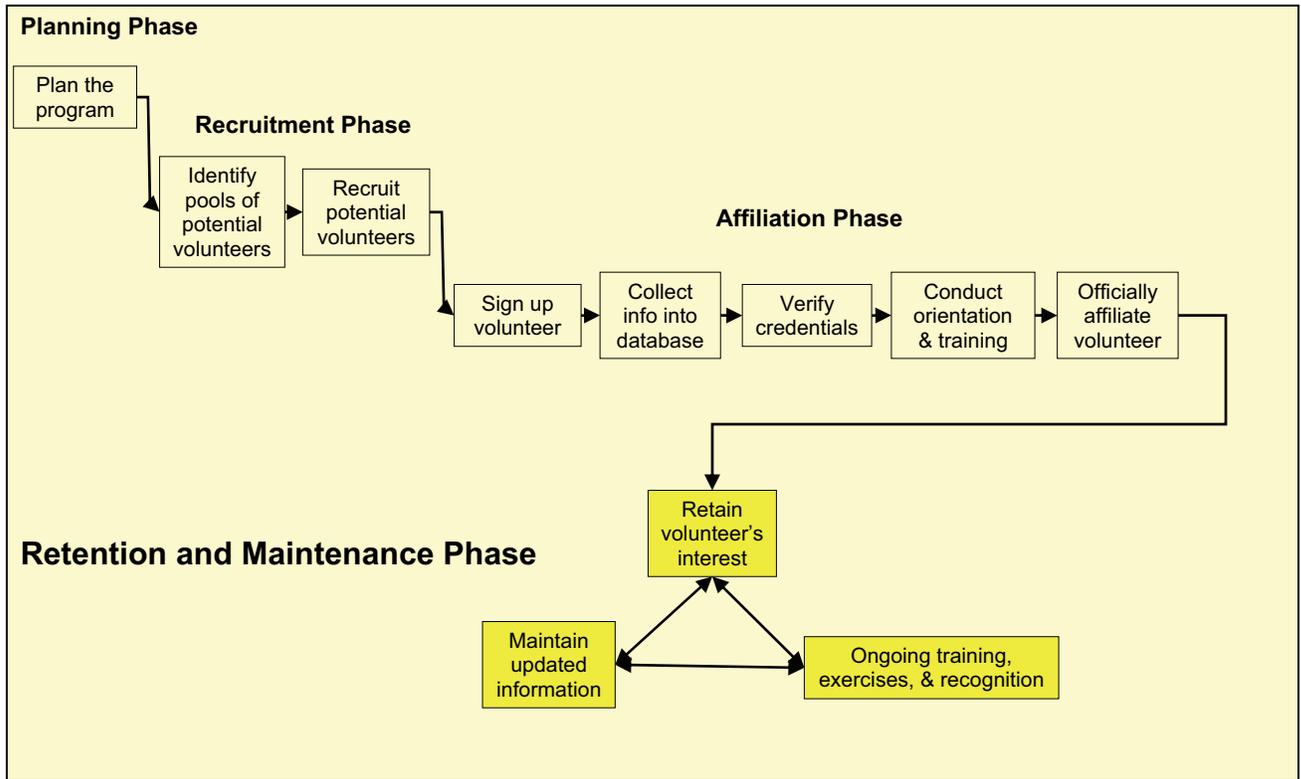
The problem of double-counting volunteers is related to the issue of whether volunteer information will be shared between programs. Although the question of whether volunteers will have other obligations in an emergency is not purely or even primarily a technical problem, information systems can play a role in at least raising awareness and perhaps even mitigating that issue. The question is whether lists held by medical volunteer programs may be cross-referenced with lists held by other volunteer programs or with staff lists of hospitals and emergency response organizations. The challenge here is not only one of funding, but a matter of whether privacy regulations would allow such information sharing.

Regardless of the challenges, affiliation is a critical phase in the development of a volunteer program in public health. The goal of affiliation is to create a cadre of volunteers who are invested in the organization. It is then critical to retain the affiliated volunteers and maintain a current and accurate database.

## **Chapter 5. The Retention and Maintenance Phase**

Many volunteer programs confront the challenges of retaining volunteers, the step highlighted in Figure 5.1, and the field of public health is currently facing this issue as it develops a sustainable volunteer workforce. The development of a corps of public health volunteers presents many of the same obstacles to retention as experienced by other volunteer efforts, including maintaining regular contact with volunteers and verifying whether there are enough volunteers for an event. However, the issue of retention is further complicated by two realities specific to public health. First, as we noted in discussing volunteer recruitment, given the rarity of public health emergency events, it can be especially challenging to find opportunities to keep volunteers involved between events. Second, the gravity of public health emergencies when they do occur makes it critical to have a viable volunteer base to activate at any point in time. Without ongoing, consistent contact with volunteers, retention can be particularly difficult. Thus, public health volunteer programs have to employ a variety of techniques to keep members retained in case of an emergency.

**Figure 5-1 Steps in the Retention and Maintenance Phase**

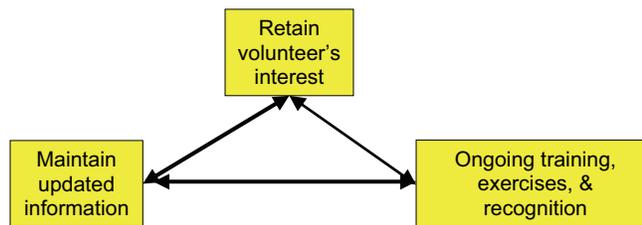


Research examining the motivations of volunteers has indicated that most volunteers initially register out of a sense of altruism and for self-enhancement benefits (Murk and Stephan, 1991). However, altruism does not typically sustain long-term engagement and retention (Smith, 1981). Rather, volunteer programs require some type of incentive structure. Incentives can take many forms, given that volunteering addresses diverse needs and functions for those who commit their time. Clary (1996) finds that volunteering satisfies many needs including the needs to act on prosocial values, to increase knowledge or practicing skills, to gain experience to enhance careers, to develop self-esteem, to engage a social group, and to build a forum to cope with anxieties. Many volunteer programs purposefully advertise how their programs will address some of these needs, often focusing on humanitarian aspects and skills development. In public health, volunteers are frequently motivated by one of two broad types of incentives: the opportunity to enhance skills and develop their careers, or the opportunity to contribute to disaster relief efforts related to events like Hurricane Katrina. Regardless of the motivation to volunteer, recognizing volunteer efforts is a key factor in retention

(McCurley and Lynch, 2006; Murk and Stephan, 1991; Forsyth, 1999; Brudney, 1999; Maryland Governor's Office on Service and Volunteerism, 2006). Recognition can take many forms and often includes certificates, awards, and notices of volunteer involvement in different media. Of special note is the President's Volunteer Service Award program, which recognizes individual volunteers, families and groups for their service (<http://www.presidentialserviceawards.gov/>).

## STEPS IN THE RETENTION AND MAINTENANCE PHASE

**Figure 5-2 Steps in Retention and Maintenance Phase**



There are three steps in retaining and maintaining a corps of public health volunteers. Unlike the steps in the other phases described so far, the steps in the Retention and Maintenance Phase do not proceed in a linear manner. Rather they are interrelated steps that form a cycle of activities. For example, ongoing training and exercises may help to retain volunteer interest, and interested volunteers may be more likely to attend training and exercises. Similarly, initiating contact with a volunteer for the purpose of updating their personal information may help to retain volunteer interest, and interested volunteers are more likely to maintain updated personal information. Unlike steps in the earlier phases which may only be performed once per volunteer, the steps in this cycle are repeated throughout the time the volunteer stays active in the organization.

The first step is to retain a volunteer's interest; this is itself a goal. This requires that the volunteer program contact volunteers regularly and verify that the program is meeting the needs and interests of the volunteers. The second step involves ongoing training and exercising. This is essential because these activities allow a volunteer program to make sure that volunteers are engaged as well as appropriately prepared for a

public health emergency event. While these first two steps focus on reaching out to volunteers and keeping them connected to the organization, the third step is focused on the recruiting organization and its need to maintain an updated database on volunteers. Given that volunteer contact numbers and licensure status can change, it is important for volunteer programs to review their volunteer databases routinely in order to confirm that they have the most up-to-date and complete information on volunteers. This is critical not only to maintain contact with volunteers, but also to ensure that the program can access volunteers when an emergency occurs.

## **APPROACHES FOR RETAINING AND MAINTAINING VOLUNTEERS**

### **Volunteers Require Frequent and High-Quality Contact**

Regularity of contact coupled with a thorough assessment of volunteer needs and constraints is critical to keeping volunteers retained and active. Most interviewees cited three key components to successful volunteer retention: emails, newsletters, and occasional in-person meetings.

For example, programs have used weekly emails supplemented with quarterly or monthly in-person meetings to ensure that they are connecting with volunteers and taking the time to gauge whether volunteers continue to be committed to the program. The use of a newsletter (either paper or e-digest form) helps to diversify contact with volunteers to ensure that at least one form of contact reaches volunteers.

### **Tailor Volunteer Opportunities and Offer Flexibility**

Several volunteer program organizers shared concerns that potential volunteers may be dissuaded from joining the program due to other work or life responsibilities. One idea that has been successful for a few volunteer programs is to use multiple “membership levels,” each with different obligations or requirements for the volunteer. This approach allows programs to tailor volunteer opportunities to individuals by offering two to three levels of commitment for participation. For example, some volunteers may sign up only for emergency events and opt for monthly emails, while others may choose to be involved

in community health events and receive weekly communication. It can be time-consuming to maintain multiple tiers within a volunteer program; however, this approach can be cost-effective by limiting the staff effort expended to engage volunteers who have minimal time.

Our interviews revealed that offering flexible training opportunities is also important for both persuading those with little time to volunteer, and for retaining volunteer interest over time. Since conducting the same training course multiple times may not be feasible, offering different levels of training for different membership levels is one alternative approach. Another approach is to offer online training that can be completed at the volunteer's convenience.

### **Volunteer Recognition Is Important for Retention**

The process of retaining volunteers includes ongoing acknowledgment of their contributions. This step of recognizing volunteer accomplishments and contributions establishes a sense of community and reminds volunteers that their individual contributions are important to the larger effort. Activities may include award ceremonies, celebratory meals, and highlights in a volunteer newsletter or on a health department or MRC website. In addition, programs might consider disseminating information about volunteer activities through the local newspaper or other media outlets to provide community recognition and an opportunity for community appreciation events. Empowering and recognizing existing volunteers for the recruitment of others can also serve as a reward because it builds capacity and increases a sense of ownership and commitment to the program.

### **Existing Volunteers Can Be Used to Recruit Others**

While it is important for volunteer programs to continuously find opportunities and venues to recruit *new* volunteers, it is also critical to tend to the volunteers who are active by keeping them interested. Some programs have used existing volunteers to attract new recruits at professional meetings. Such efforts have contributed to capacity-building and renewed commitment to volunteering among existing participants.

Table 5.1 provides a summary list of approaches for engaging public health volunteers and retaining their interest, as informed by our interviews. The table outlines

features of particular approaches that will enhance success and, where applicable, the potential challenges to implementing the practice.

**Table 5.1 Approaches for Retaining Volunteers**

<b>Approach</b>	<b>Setting Cited</b>	<b>Why is it potentially useful?</b>	<b>Circumstances/situations/ considerations for putting into practice</b>	<b>What is likely to enhance success?</b>	<b>What are drawbacks or challenges?</b>
Use email to send volunteer updates	Almost all volunteer programs	Quick point of contact, also helps to verify contact information	Increases the frequency of email contact	Short emails; use for call down exercises; emails coupled with face-to-face contact	Some volunteers may prefer to communicate by means other than email
Disseminate newsletters	Local HD MRC	Increases interest in local events, activities of HD or MRC	Works when the organization has a volunteer program staff member who can develop these newsletters at least four times a year	Visual appeal, with information relevant to specific pool of volunteers (e.g., calendar of training activities, professional information)	It is important not to overload volunteers with documents
Use membership levels for volunteers	Local HD	Allows volunteers to select amount of participation-increasing potential numbers of volunteers	Works when organization is sufficiently large and/or diversified to offers options for participation (e.g., volunteers can choose how much correspondence they receive, how many activities they are called for)	Tiers that work for organization's volunteer pool	Labor-intensive to maintain contact with different types of volunteers
Engage retired professionals	State HD Local HD MRC	Utilizes individuals who have more time	Works when organization has local chapters or groups of retired health professionals who can be targeted with promotional materials		Challenging to correspond with this population (many do not use email)
Use strategies to formally affiliate or identify volunteers	Local HD	Provides identification cards so that volunteers feel part of a team	Works when organization has a large enough pool of volunteers and sufficient resources in which affiliation makes a difference		
Continue marketing program through other volunteers	Local HD MRC	Can attract volunteers through peers; also engages existing volunteers in leadership opportunities which will enhance retention	Works when organization has existing networks that can disseminate information on program	Initiative on the part of current volunteers in developing marketing plan, targeting prospects, etc.	

### **Training Incentives Can Be Effective**

Ideally, all volunteers would be trained extensively before entering a disaster situation, but, due to financial challenges and volunteers' time constraints, organizations must frequently ration the type and frequency of training offered. During the interviews, several program leaders described how they creatively engage volunteers in training and exercises through a few key approaches.

Interviewees reported that volunteer programs, and particularly those run through health departments, were successful in using incentives to encourage participation in training. Incentives may include credit hours or re-certification points. Several program leaders stated that the most useful process for engaging volunteers in training is to contact the faculty of local health-related programs (e.g., nursing, medical) to determine what types of continuing education would be most useful to their students. Several volunteer program leaders noted that they had developed a training plan in collaboration with school leaders.

Given the rarity of public health emergency events, it is important to keep volunteers active by involving them in activities other than drills and exercises. These might include activities related to routine public health events, such as yearly flu clinics. Participation in routine activities allows volunteers to engage their skills more often than do annual drills or an actual emergency event alone.

### **Just-in-Time Training Can Minimize Time Burden on Volunteers**

Many volunteer program staff also pointed out that it is impossible to recruit all volunteers in advance of a public health emergency. Therefore, many programs include just-in-time training courses to make sure that new volunteers have sufficient training to allow them to participate during the event. For example, sites have developed short training modules and job action sheets that can be distributed on-site with volunteers who register at the time of the event.

Table 5.2 outlines a list of approaches for training and exercising with volunteers and highlights ways in which these approaches can facilitate or pose challenges to implementation.

**Table 5.2 Approaches for Training and Exercising with Volunteers**

<b>Approach</b>	<b>Setting Cited</b>	<b>What is potentially useful?</b>	<b>Circumstances/situations/considerations for putting into practice</b>	<b>What is likely to enhance success?</b>	<b>What are drawbacks or challenges?</b>
Attach online training courses to volunteer registration	State HD Local HD MRC Volunteer organization	Provides volunteers with an introduction to volunteering while placing minimal strain on staffing resources	Requires IT infrastructure	Brief initial training to ensure registration process is completed	
Provide incentives attached to training	Local HD MRC	Encourages volunteers to continue training despite competing obligations	Requires resources to provide material incentives or connections to schools and accreditation organizations to provide credit hours	Connecting the right volunteer population with the right incentives (e.g., school credit, material goods, early access to prophylaxis)	
Provide short training associated with drills or exercises	State HD Local HD MRC	Provides an optimal time to prepare and engage volunteers		Collaboration among health departments and volunteer organizations	
Engage volunteers in non-public health emergency activities	State HD Local HD	Keeps volunteers active more often than infrequent drills	Works when the HD has community health activities in which to involve volunteers, including health clinic service, health fairs, etc.	Survey of volunteers on the types of activities that are of most interest	Labor-intensive to organize
Provide skills training opportunities	Local HD MRC	Engages volunteers who are motivated by professional development	Works when there are enough volunteers seeking continuing education opportunities	Links to professional organizations that can offer training (e.g., first aid)	Labor-intensive to organize
Offer just-in-time training	State HD Local HD MRC	Provides volunteers with expectations, effective communication tools, and skills to serve the population	Works if the need for volunteers exceeds the number of trained and registered volunteers available at the time of the crisis	A simple, common message and defined expectations for volunteers	

## **Updating Volunteer Information Contributes to Retention**

As described earlier, it is important to track volunteer retention by also maintaining updated volunteer information. Organizations should ensure that contact information is correct and should monitor fluctuations in volunteer involvement. One approach for gauging responsiveness is to track the number of replies to an email query. This approach can also be used to identify those volunteers who need other forms of follow-up or whose contact information and credentials need to be confirmed and re-verified. Responsiveness data can also be used to revise or enhance plans for volunteer retention.

## **CONTINUING CHALLENGES**

As described in this chapter, there are several challenges to retaining a pool of public health volunteers even when these approaches are implemented. These barriers are described below.

Most jurisdictions have limited staff (e.g., very few health departments have even one full-time staff member) and minimal administrative support to devote to running a volunteer program. In order to successfully retain volunteers, it may be critical to have the time of one full-time staff member to contact volunteers regularly both via email and in-person, develop or identify activities to engage volunteers, and update the database to keep information on active volunteers as current as possible. Ideally, public health departments would have a dedicated staff member to handle volunteer recruitment. However, given funding constraints, this may not be a realistic option for most. Thus, departments must find other ways to staff volunteer recruitment programs, including exploring creative partnering of two or more staff members who can devote partial time to the volunteer program.

Communities are already hard-pressed to recruit enough volunteers, which presents organizations with a potential trade-off between obtaining more volunteers with little to no training and discouraging potential volunteers because of the time commitment associated with joining the cadre. Furthermore, the time needed to coordinate training sessions and engage existing volunteers can be significant. Some public health professionals argue that intermittent training sessions may not be the most efficient use of

funds if volunteers forget what they have learned between the time of the training and the emergency event.

It can also be challenging to accommodate the varying schedules of potential volunteers. This issue can be addressed through levels of volunteer commitment, but it can be labor-intensive to maintain multiple tiers.

Limited funding can make it difficult to engage volunteers in activities that are interesting and useful. It is essential to continuously market and promote the program in order to maintain a high level of interest, but this may necessitate more time and/or funding. Thus, it is important to weigh costs against potential benefits in numbers of volunteers. For example, programs should consider which activities will likely interest the most volunteers and put resources into those endeavors.

Retention and maintenance clearly pose a critical challenge for most volunteer programs, yet establish the cornerstone for a viable public health workforce. Health departments, MRCs, and other programs that indicate the most success in maintaining an active pool of volunteers are those that have a full-time staff person, engage volunteers in varied and non-emergency health activities, allow flexibility in the amount of participation, and partner with traditional volunteer centers who can alleviate some of the resource burden in running a program. In addition, sites that are able to evaluate retention by tracking their volunteers to know how many are truly active have used this information to survey volunteers and develop strategies for additional recruitment.

## **Chapter 6. Conclusions and Recommendations**

State and local public health departments and medical reserve corps face myriad challenges in determining how they can best enhance their ability to prepare for, and respond to, a range of public health threats at a time when resources seem especially scarce. Public health officials at all levels of government must constantly juggle the demands placed on them in meeting their day-to-day obligations with the longer term and more uncertain demands associated with preparing for a public health emergency. It is therefore easy to understand why the development of an adequate and well-trained volunteer workforce may not receive the attention that we believe it deserves.

In this report, we have described the steps required for states and local public health departments to develop and maintain a volunteer workforce. We have also tried to highlight that doing so requires a significant and sustained effort on the part of health department or MRC staff. The process map we have provided details the individual steps that a state or locale must go through to plan for, develop, and maintain a volunteer program. In describing the map, we have discussed some of the approaches that public health departments have taken in addressing the planning, recruitment, affiliation, and retention and maintenance phases. It is important to stress that while some of the approaches taken appear to be promising – based on logic, expert opinion, and/or self-reports from states and locales that have adopted them – none have been formally evaluated. Thus, we cannot assert that any of them represent what might be considered “best” or even “exemplary” practices in any strict sense of these terms.

In addition, we recognize that an additional limitation of our report stems from the necessary use of a convenience sample of interview sites; thus we cannot assert that the approaches we present are a comprehensive representation. However, we believe that we have succeeded in presenting a reasonable cross-section of promising approaches to developing, managing, and maintaining a volunteer program designed to expand the workforce in the event of a public health emergency.

## **CREATIVE APPROACHES ARE NEEDED TO ADDRESS CROSS-CUTTING CHALLENGES**

At each phase, public health officials must confront a series of challenges. Although the particulars of these challenges vary from phase to phase, a number of cross-cutting issues emerged during the course of the project. Perhaps the most significant and persistent challenge is the need to garner sufficient staff and other resources is. Ideally, a typical local health department or MRC would have a full-time staff person dedicated to developing and running its volunteer program. Large county or city health departments may require more than one full-time equivalent (FTE); smaller, rural health departments would have to get by with a part-time person.

While finding the resources necessary to fund dedicated staff to manage a volunteer program may be easier said than done, we believe that several steps can be taken to minimize and justify the costs. For example, as indicated previously, using volunteer staff to conduct routine public health functions is a promising way to train volunteers, maintain their interest in the health department's work, and keep their skills fresh. At the same time, volunteer time and effort may obviate the need for paid health department staff to conduct some routine functions such as administering immunizations. This, in turn, may offset any costs associated with running the volunteer program. Opportunities to realize savings of this type may simply not exist for some health departments, especially smaller ones. In those instances, health department directors may attempt to partner with another community organization interested in establishing a volunteer program. In some cases, the health department may even consider recruiting a volunteer to run the volunteer program.

## **PARTNERSHIPS ARE ESSENTIAL TO LEVERAGING RESOURCES**

In addition to the challenges posed by staffing and funding, a major challenge facing state and local public health agencies is how to effectively partner with other organizations, agencies, and groups to leverage limited resources to fulfill their missions. Effective and efficient partnerships among government agencies, faith-based

organizations, and other community groups are critical as public health departments and MRCs work to establish and maintain volunteer programs. A high level of integration is essential to minimize double counting of volunteers, to collect information on volunteers (including, but not limited to, their contact information, professional credentials, and skill sets), to ensure that volunteers know which organizations have priority claims on their services in emergencies, to make maximum use of local resources, and so on. Because local and state public health departments play a central, if not the central, role in local and state public health systems, they may be the most appropriate organizations to take responsibility for convening “volunteer summits” at the state and local levels to begin to work through some of the coordination issues. State-level, and even cross-state, summits could also be used to begin to tackle issues related to liability, workers compensation, and credentialing.

## **ASSIGNING RESPONSIBILITY TO A SINGLE STAFF PERSON HELPS IMPROVE COORDINATION**

We believe that assigning the function of developing and managing a volunteer program to a single health department staff member – and making that function his or her main or, better still, sole responsibility – will go a long way toward addressing many of the challenges associated with developing an effective volunteer program. That is, having an FTE who dedicates the vast majority of his or her time to the program will improve the chances of coordinating volunteer programs across agencies and community partners, including areas such as training and data sharing; help resolve issues related to double-counting; identify ways in which volunteers can be used to assist in delivering routine public health services in an effort to develop their skills, keep up their interest in participating in the program, and, as noted above, help defray program costs.

## **PROGRAM EVALUATION AND IMPROVED INFORMATION DISSEMINATION ON PROMISING PRACTICES WILL ADVANCE THE FIELD**

The evidence base on the effectiveness of alternative public health preparedness strategies and practices is remarkably thin. This is partly due to the scarcity of metrics to assess public health preparedness outcomes. However, it is our belief that various metrics could be developed to assess volunteer programs in public health. For example, recruitment rates and attendance rates for training and drills could be easily measured. Additionally, regular surveys (possibly by email) to determine the number of volunteers who are currently “active,” could be an effective way to measure retention. Measures of volunteer satisfaction could also be established through online surveys. These activities are also likely to maintain the interest of volunteers who, thankfully, will be called upon infrequently. Further, measures of speed and efficiency of verifying credentials, and evaluating volunteer response time to call-down exercises could be useful in determining the expected ratio of volunteers to call-downs should an emergency occur.

There is an abundance of lay and practitioner literature on successful volunteer practices, but we identified only a few rigorous evaluations of volunteer program practices in the academic literature (Brudney, 1999; Hager and Brudney, 2004). Perhaps not surprisingly, we have been unable to identify any rigorous evaluations of volunteer practices for public health emergency preparedness. Consequently, as noted above, we are unable to describe any practices that could reasonably be considered “best” or even “exemplary” in this report. However through the social sciences, lay, and practitioner literature, as well as our interviews with officials from health departments, MRCs, and other volunteer organizations, we were able to identify promising approaches for each of the components of a volunteer program.

In the short run, these promising approaches will have to suffice. However, over the longer term, we cannot overstate the importance of embarking on a series of program evaluations of these approaches and beginning to develop a set of evidence-based practices. At the same time, federal, state, and local policymakers should think creatively about how promising, and ultimately evidence-based, practices can be more effectively disseminated to public health departments and their community partners.

This report is a step in that direction, but a sustained effort is required. Volunteers have played, and will continue to play, a key role in mitigating the effects of a public health emergency. The larger the emergency, the more we will have to rely on

them. We now have a chance to step back and learn the lessons from Hurricane Katrina and other recent disasters and emergencies. We must correct the problems and address the workforce surge issue by assessing how volunteers can be used more effectively before the next public health emergency strikes. We simply can not afford to miss this opportunity.

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## APPENDIX A: Protocol for Health Department Interviews

RAND is working with the US Department of Health and Human Services (HHS), Office of the Assistant Secretary for Preparedness and Response (ASPR) to develop resources and to prepare analyses to describe and enhance key aspects of state and local public health emergency preparedness. The project is composed of several tasks. One of these tasks is to identify the processes involved in establishing a volunteer workforce in public health, and then to identify exemplary practices within each of these processes. We will also be looking at how other organizations build a volunteer workforce and what their challenges and successes have been.

***Required (Consent Procedures):*** Thank you for agreeing to talk with us about developing a volunteer workforce in public health. Before we begin, let me assure you that your responses to these questions will be held in strict confidence, except as required by law. Summary information from these interviews, together with material taken from public documents, will be presented at the state level; however, no specific individual or agency will be identified by name or affiliation in any reports or publications. If we would like to associate your health department with a particular exemplary practice, we will explicitly request your consent prior to releasing the information. Findings from the study will be shared with all participants.

Your participation in this discussion is completely voluntary. We would like to have your responses to all of the questions; however, if you are uncomfortable with any question we can skip it. We estimate that the interview will take about 1 hour.

Do you have any questions about our confidentiality procedures before we begin? (If yes, respond to all questions. If no, proceed with discussion).

The goal of these interviews is to obtain more information on current volunteer recruitment, training and retention practices employed by health departments and to identify those practices that have been particularly successful. General topic areas include questions such as those below.

**Opening question:**

What were the reasons/motivations for your HD to embark on developing a volunteer program? Was it part of a mandate or to meet grant requirements?

**Program Description**

1. Describe the volunteer program you have in place (or are working to create). Ask about each component of the process map

**a. Identify**

- What is your process for volunteer identification? How do these steps differ based on need, composition, in advance vs. just in time, etc (if at all)?
  - How do you assess needs for volunteer staffing? [Probe: number of volunteers to implement strategic response]
  - How do you reach out to medical volunteers?
  - How do you reach out to non-medical volunteers?
- What factors went into determining this process? Did you model your process on other HDs, other fields?
- Is the process/system linked to other agencies and if so, which ones? When did these partnerships start and why?
- What are the challenges and/or facilitators of identifying volunteers?
- How is your health department addressing the issues of double counting medical staff from hospitals or volunteers signing up with multiple volunteer efforts?

**b. Contact**

- How do you make initial contact with potential volunteers who did not self-identify?
- How do self-identified volunteers contact you?

**c. Collect information**

- What information do you collect on your volunteers?
- What kind of IT infrastructure do you have to maintain your program - database, computers, IT support
- Is your health department involved with the HRSA ESAR-VHP program?
  - If so, describe; if not, are there plans to integrate with the system

**d. Verify credentials**

- What are your processes for credentialing? What are key steps?
- How are issues of liability addressed?
- What are challenges/facilitators to this process?

**e. Conduct training**

- What are key steps in the training of volunteers? What issues should be considered?
- What are the key components of training? How did you/would you develop this protocol for your volunteer training?
- How would/does training differ for in advance vs. just in time training?
- What are the criteria for developing a short or “good” list of volunteers? How would you assess (in advance, in real-time)?

**f. Maintain updated information**

- How do you maintain/update your volunteer data?

**g. Conduct drills**

- How do you “call down” your volunteers
- Have you exercised the “call down;” if so, how successful was it?
- Have you used your volunteers in real drills or exercises (esp. mass prophylaxis)? If so, explain.

**h. Retain volunteers**

- How do you keep your volunteers interested and involved?
- Do you track the number of volunteers recruited who complete training?
- Do you look at retention rates? If so, how do you determine those rates, i.e., how do you determine that a volunteer is active?
- How do you evaluate the success of your volunteer program?

2. Do you have dedicated staff working on your volunteer program?
3. Does your program include both health professional and non-health professional volunteers?
  - a. If yes, describe how the programs are similar/different.
4. Who do you partner with (other organizations) as part of your volunteer program?  
[Probe: these might be other HD, nonprofits, government agencies, other volunteer recruitment programs that you may have developed relationships with. Other examples might include volunteer fairs, recognition activities, training programs etc...]

**Just-In-Time Volunteer Coordination**

1. Will your department accept unsolicited volunteers during a crisis?
2. What is your plan for credentialing, training, and processing unsolicited volunteers (both medical and non-medical) during a surge?

**General thoughts on volunteer recruitment and training**

1. What are the challenges/facilitators of implementing a volunteer program?
2. Why is it important to have a program in place now, rather than as a crisis situation unfolds?

**Are there materials you are willing to share?**

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- What are the key points from this interview?
- What practices are potentially “exemplary” and why?
- Are there other factors (internal or external to the health department) that contribute to the success of this program or to a specific practice?