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Report to Congressional Committees

September 2020

PUBLIC HEALTH PREPAREDNESS

Information on the Use of Medical Reserve Corps Volunteers during Emergencies

Accessible Version

GAO-20-630

GAO Highlights

Highlights of GAO-20-630, a report to congressional committees

September 2020

PUBLIC HEALTH PREPAREDNESS

Information on the Use of Medical Reserve Corps Volunteers during Emergencies

Why GAO Did This Study

The Medical Reserve Corps consists of health care volunteers—medical and public health professionals—who donate their time to help strengthen a response to public health emergencies and build community resilience. These volunteers prepare for and respond to public health emergencies, which may include natural disasters—such as hurricanes and wildfires—as well as disease outbreaks, whether intentional or natural.

The Pandemic and All-Hazards Preparedness and Advancing Innovation Act of 2019 included a provision for GAO to review states' use of health care volunteers during public health emergencies. This report describes (1) the number and type of Medical Reserve Corps volunteers; (2) the types of public health emergencies volunteers have participated in; and (3) how HHS has assisted in developing volunteer capabilities.

To conduct this work, GAO analyzed data reported to HHS as of September 2019; reviewed HHS documentation on four states' use of volunteers, which GAO selected based on population, number of volunteers, and event; and interviewed officials from HHS who oversee the Medical Reserve Corps program.

GAO plans to further examine how states have used health care volunteers to respond to public health emergencies, including COVID-19, and any associated challenges to doing so in a future report.

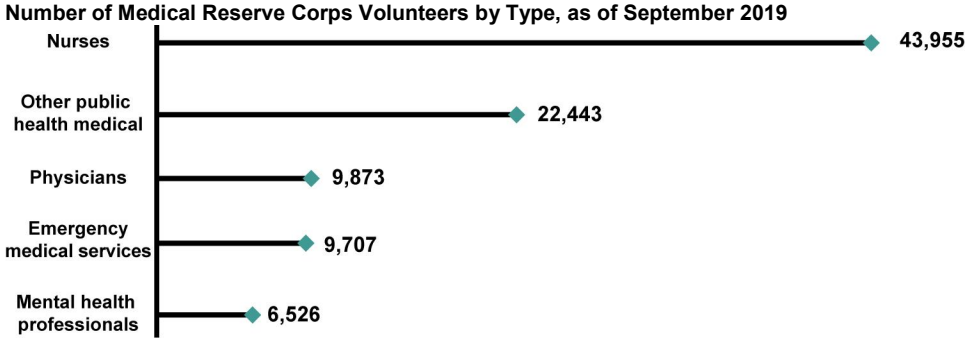
GAO provided a draft of this report to HHS. In response, HHS provided technical comments, which were incorporated as appropriate.

View GAO-20-630. For more information, contact Mary Denigan-Macauley at (202) 512-7114 or deniganmacauleym@gao.gov.

What GAO Found

Almost all states have a network of health care volunteers—the Medical Reserve Corps—who can augment federal, state, and local capabilities in response to public health emergencies, such as those arising from wildfires and hurricanes, and infectious disease outbreaks. Having sufficient, trained personnel, such as these volunteers, is critical to a state's capability to respond and recover from public health emergencies. According to federal data, 48 states and the District of Columbia reported 102,767 health care volunteers in 838 Medical Reserve Corps units as of September 2019, with nurses making up 43 percent.

Number of Medical Reserve Corps Volunteers by Type, as of September 2019



Source: GAO analysis of Office of the Assistant Secretary for Preparedness and Response data. | GAO-20-630

Data table for Number of Medical Reserve Corps Volunteers by Type, as of September 2019

	Number of volunteers
Nurses	43,955
Other public health medical	22,443
Physicians	9,873
Emergency medical services	9,707
Mental health professionals	6,526

Note: These data illustrate 90 percent of total health care volunteers. The remaining five types volunteers each make up less than 5 percent of the total. Other Public Health Medical volunteers may include cardiovascular technicians, sonographers, and phlebotomists.

Medical Reserve Corps volunteers in states included in GAO's review—Alabama, California, North Carolina, and New Mexico—were deployed in response to natural disasters in 2018 and 2019, migrants at the southern border in 2019, and COVID-19 in 2020. Department of Health and Human Services (HHS) documentation shows these volunteers performed a variety of health care activities, such as providing medical services, setting up and providing support at shelters, and distributing medical supplies. Volunteers from these four states and others also participated in the response to COVID-19 by supporting testing sites, collecting specimens, and performing administrative tasks, such as data entry. For example, one unit deployed four volunteers a day for 3 days to work alongside nurses at a drive-through testing site. In addition to responding to

public health emergencies, volunteers participated in preparedness activities, such as an initiative to train the public on how to respond to emergencies.

HHS oversees the Medical Reserve Corps program and has assisted units in developing their volunteer capabilities. For example, HHS

- funded the development of a checklist of activities that should occur during volunteer deployment such as re-verifying medical credentials;
- provided training to new unit leaders on developing, managing, and sustaining Medical Reserve Corps units; and
- issued generally accepted practices, such as periodically re-evaluating volunteer recruitment procedures.

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Abbreviations

ASPR	Office of the Assistant Secretary for Preparedness and Response
ESAR-VHP	Emergency System for Advance Registration of Volunteer Health Professionals
HHS	Department of Health and Human Services

U.S. GOVERNMENT ACCOUNTABILITY OFFICE
441 G St. N.W.
Washington, DC 20548

September 14, 2020

The Honorable Lamar Alexander
Chairman
The Honorable Patty Murray
Ranking Member
Committee on Health, Education, Labor & Pensions
United States Senate

The Honorable Frank Pallone, Jr.
Chairman
The Honorable Greg Walden
Republican Leader
Committee on Energy & Commerce
House of Representatives

Recent major and concurrent natural disasters, such as the 2018-2019 wildfires in California and hurricanes in North Carolina, resulted in massive federal, state, local, and territorial emergency response operations.[1] More recently, in January 2020, the Secretary of Health and Human Services declared a novel coronavirus, Coronavirus Disease 2019 (COVID-19), to be a nationwide public health emergency.[2] The COVID-19 pandemic has affected the entire country and has required support from all of the nation's existing systems and structures, including from the Department of Health and Human Services (HHS), that help

[1]For more information see GAO, *Disaster Assistance*, accessed May 27, 2020, https://www.gao.gov/key_issues/disaster_assistance1/issue_summary.

[2]The Secretary of Health and Human Services may declare a public health emergency if the Secretary determines, in consultation with other public health officials as may be necessary, that (1) a disease or disorder presents a public health emergency; or (2) a public health emergency, including significant outbreaks of infectious disease or bioterrorist attacks, otherwise exists. See 42 U.S.C. § 247d.

In March 2020, the World Health Organization characterized COVID-19 a pandemic, and the President declared COVID-19 a national emergency pursuant to the National Emergencies Act and an emergency under the Robert T. Stafford Disaster Relief and Emergency Assistance Act (Stafford Act). The President has also declared major disasters in all 50 states, the District of Columbia, and five territories pursuant to the Stafford Act.

manage public health emergencies across multiple federal departments, as well as state agencies.[3]

Additionally, Medical Reserve Corps volunteers can deploy in response to a federal, state, local, or tribal public health emergency.[4] The Medical Reserve Corps consists of health care volunteers—medical and public health professionals—as well as others who donate their time to help strengthen a response to public health emergencies, such as the COVID-19 pandemic, by augmenting federal, state, and local capabilities and building community resilience.[5] Medical Reserve Corps volunteers can help communities prepare for, respond to, and recover from a variety of public health emergencies, which may include emergencies related to natural disasters—such as wildfires, hurricanes, tornadoes, blizzards, and floods—as well as other emergencies that affect public health, such as infectious disease outbreaks, and chemical spills and attacks, whether intentional or natural. For example, Medical Reserve Corps volunteers can participate in vaccination clinics, provide health education, and supply first aid at large gatherings, among other things.

HHS's Office of the Assistant Secretary for Preparedness and Response (ASPR) leads the nation's medical and public health preparedness and response to public health emergencies. ASPR is responsible for the planning and coordination of federal public health, health care delivery, and emergency response systems to minimize or prevent health emergencies from occurring, among other things. As part of its role,

[3]GAO, *COVID-19: Opportunities to Improve Federal Response and Recovery Efforts*, GAO-20-625 (Washington, D.C.: June 25, 2020).

[4]Willing members of the Medical Reserve Corps may be deployed to areas of need during a public health emergency, whether or not the Secretary of Health and Human Services has declared a public health emergency under section 319 of the Public Health Service Act. See 42 U.S.C. § 300hh-15(e). A public health emergency may arise from, or be related to, other types of emergencies and disasters, including (1) a national emergency declared by the President under the National Emergencies Act, and (2) an emergency or major disaster declared by the President under the Stafford Act.

[5]According to HHS, community health resilience is the ability of a community to use its assets to strengthen public health and health care systems and to improve the community's physical, behavioral, and social health to withstand, adapt to, and recover from adversity.

The capability to respond and recover from public health emergencies consists of the resources—personnel, training, equipment, and systems—and the mechanisms to effectively and efficiently direct those resources toward a specific effort in the response or recovery.

ASPR oversees the Medical Reserve Corps program and supports the units by providing communication, grants and contract oversight, and information for communities to establish, implement, and maintain Medical Reserve Corps units, among other things.

The Pandemic and All-Hazards Preparedness and Advancing Innovation Act of 2019 included a provision for GAO to review states' use of health care volunteers in the event of a public health emergency.[6] This report describes

1. the number and type of health care Medical Reserve Corps volunteers by state who may respond to public health emergencies;
2. the types of public health emergencies that volunteers have participated in; and
3. how HHS has assisted in the development of Medical Reserve Corps capabilities.

To describe the number and type of health care Medical Reserve Corps volunteers by state who may respond to public health emergencies, we analyzed data provided by ASPR from its Medical Reserve Corps database on units by state, as well as the District of Columbia, as of September 2019, which is when ASPR extracted the data based on our request.[7] According to ASPR officials, data on the number and type of Medical Reserve Corps volunteers were self-reported by the units in each state and not independently confirmed by ASPR. To ensure that the data are accurate, complete, and reliable, ASPR relies on Medical Reserve Corps unit leaders' adherence to guidance regarding profile updates and conducts routine data reviews. ASPR's data do not include sub-specialties of provider types, or the status of providers' credentials or licenses. To learn more about the number and types of volunteers, we also reviewed Medical Reserve Corps unit names from ASPR's data to identify special capabilities, such as the ability to respond to radiological emergencies. We obtained additional details on these capabilities from the Medical Reserve Corps website, as needed. We also reviewed

[6]Pub. L. No. 116-22, § 208(b), 133 Stat. 905, 929 (2019). We also plan to examine how states have used health care volunteers to respond to public health emergencies, including COVID-19, and any associated challenges to doing so in a future report.

[7]We excluded Medical Reserve Corps units and volunteers in U.S. territories. We also focused on health care volunteers for humans, and therefore excluded veterinarians and non-public health non-medical volunteers from our analysis. Medical Reserve Corps units consisting of only veterinarian volunteers were not included in the total count of Medical Reserve Corps units.

Medical Reserve Corps program guidance that provides information on Medical Reserve Corps reporting requirements, interviewed agency officials, and obtained information from them on how ASPR reviews these data. We concluded the data were sufficiently reliable for our purposes.

To describe the types of public health emergencies that volunteers have participated in, we reviewed ASPR documentation for four selected states on the activities Medical Reserve Corps volunteers in each state conducted during selected public health emergencies. This documentation included information reported by the Medical Reserve Corps units on their responses to public health emergencies, such as the number of volunteers deployed, the activities performed by the Medical Reserve Corps volunteers, and the number of hours Medical Reserve Corps volunteers were deployed.

We chose the four states in our review to provide a variety of examples of volunteer capabilities in various settings. State selection was based on population size, the number of Medical Reserve Corps volunteers in the state, and the types of public health emergencies that occurred in the state in 2018 and 2019.[8] To the extent possible, we chose states that experienced the same type of event in 2018 and 2019, such as wildfires and hurricanes, among others. We also chose states to ensure we included at least one of each of the following types of declarations: (1) a public health emergency declared by the Secretary of Health and Human Services, (2) a major disaster declared by the President under the Stafford Act, (3) an emergency declared by the President under the Stafford Act, and (4) a national emergency declared by the President under the National Emergencies Act. Based on these criteria, we selected Alabama (tornadoes, Stafford Act major disaster declarations), California (wildfires, Stafford Act major disaster and emergency declarations, and public health emergency declaration), New Mexico (border security, National Emergencies Act declaration), and North Carolina (hurricanes,

[8]States were divided into large, medium, and small categories based on the size of the state's population using U.S. Census Bureau data. The number of Medical Reserve Corps volunteers in a state was divided into high, medium, and low categories using data provided by ASPR.

Stafford Act major disaster and emergency declarations, and public health emergency declaration).[9]

For the selected declarations, we reviewed 2018-2019 data reported by Medical Reserve Corps units in these states to ASPR's web-based activity system. ASPR has provided Medical Reserve Corps units guidance and instructions on how to submit activity information, which is periodically reviewed by ASPR to determine that units are providing updated data. We reviewed ASPR's guidance and instructions, and interviewed ASPR officials, and determined these data were reliable for our purposes. Additionally, during the course of our review, states began responding to the COVID-19 pandemic. As a result, we included Medical Reserve Corps volunteer participation for the four states in our review and additional states that responded to the COVID-19 pandemic by deploying Medical Reserve Corps volunteers. To do so, we reviewed two ASPR internal reports on Medical Reserve Corps response to COVID-19 by state, reviewed ASPR data on the number of Medical Reserve Corps units that have responded, and interviewed ASPR officials to determine how states have used Medical Reserve Corps volunteers to respond to COVID-19 in 2020. We judgmentally chose examples of Medical Reserve Corps volunteers' activities to give a breadth of activities conducted by volunteers during the response to COVID-19. The information we obtained on activities Medical Reserve Corps volunteers conducted cannot be generalized to all such activities.

To describe how HHS has assisted in the development of Medical Reserve Corps capabilities, we reviewed ASPR guidance and documentation it provided to Medical Reserve Corps units, such as a guide for deployment of volunteers funded by ASPR and generally accepted practices for success of the Medical Reserve Corps units. We also interviewed officials from ASPR and the National Association of County and City Health Officials involved in overseeing Medical Reserve Corps units.[10] The National Association of County and City Health

[9]The majority of California's wildfire events were Fire Management Assistance declarations. The Federal Emergency Management Agency can approve declarations for fire management assistance when the Administrator determines that a fire or fire complex on public or private forest land or grassland threatens such destruction as would constitute a major disaster. See 44 C.F.R. § 204.21 (2019). We interpreted "event" broadly to include California's wildfires that were Fire Management Assistance declarations, as well as those declared major disasters or emergencies, because Medical Reserve Corps units deployed volunteers to respond to these events.

[10]The National Association of County and City Health Officials is an association of local health departments across the United States.

Officials has a cooperative agreement with ASPR for work related to the Medical Reserve Corps, such as to award funding to Medical Reserve Corps units.

We conducted this performance audit from October 2019 to September 2020 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

ASPR, on behalf of the Secretary of Health and Human Services, leads the public health and medical services response for the National Response Framework during a disaster, emergency, or incident that may lead to a public health emergency.[11] Per this framework, ASPR's responsibility is to coordinate the assistance and associated capabilities provided in response to an actual or potential public health and medical disaster or incident, including medical surge support. While local, state, tribal, and territorial area officials retain primary responsibility for meeting public health and medical needs, ASPR is responsible for coordinating with states to integrate federal assets with state plans and assets. This can include civilian volunteers deployed from local, state, and other authorities, including those deployed through the Medical Reserve Corps.

Medical Reserve Corps Units Reported More Than 100,000 Volunteers, with Nurses Comprising the Highest Percentage

According to ASPR data, as of September 2019, Medical Reserve Corps units in 48 states and the District of Columbia reported 102,767 health

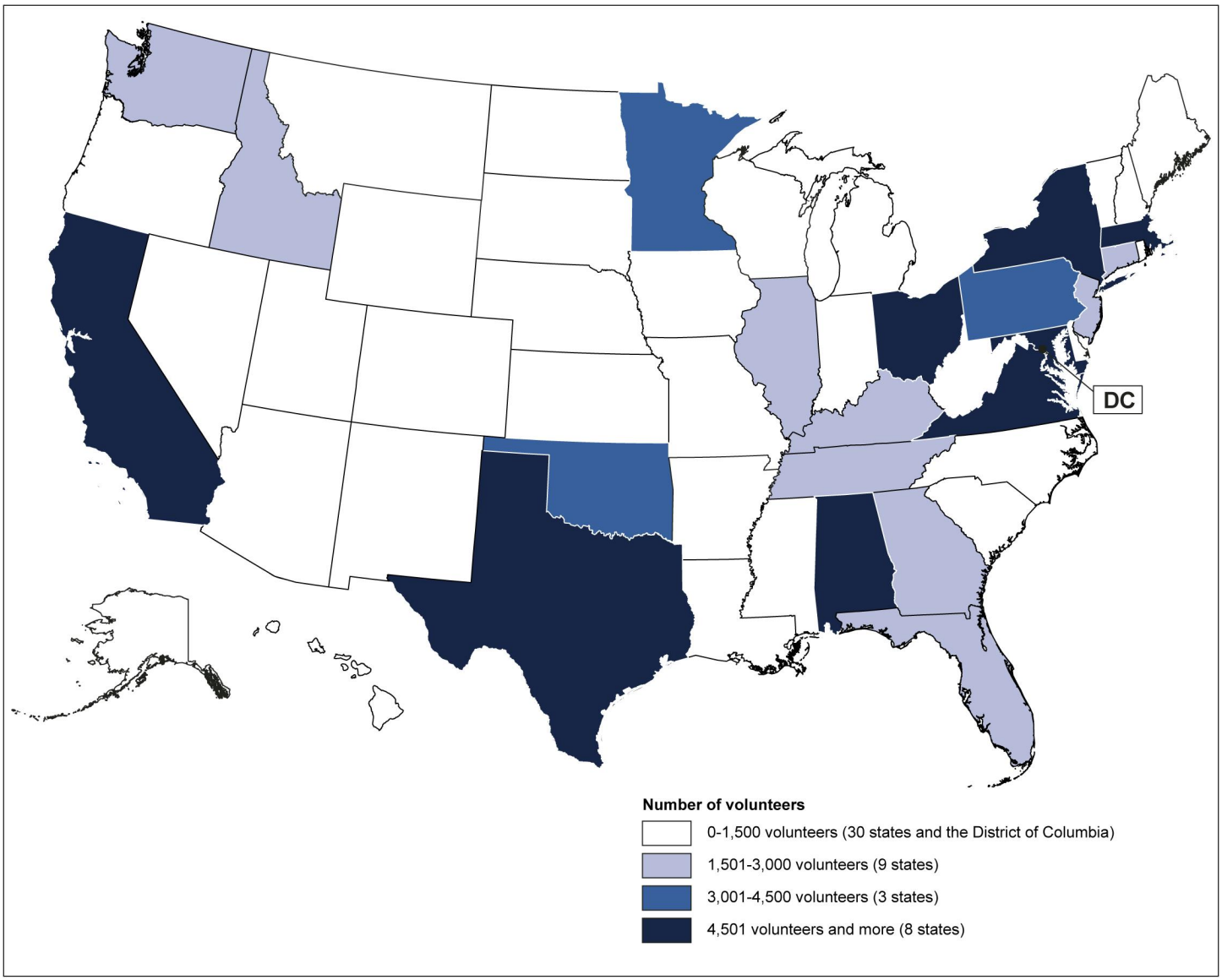
[11]The National Response Framework is an all-hazards response structure to coordinate federal resources during emergencies and disasters. It divides the federal response into 15 emergency support functional areas that are most frequently needed during a national response. See Department of Homeland Security, *National Response Framework, Fourth Edition* (Washington, D.C.: Oct. 28, 2019), and *Emergency Support Function #8 – Public Health and Medical Services Annex* (Washington, D.C.: June 2016).

care volunteers in 838 units across the United States.[12] The number of registered health care volunteers per state ranged from 12,014 in New York to 17 in Montana.[13] Units in eight states reported more than 4,500 registered Medical Reserve Corps health care volunteers, while units in 30 states and the District of Columbia reported fewer than 1,500. The number of Medical Reserve Corps units also varied by state, ranging from one unit each in Montana, North Dakota, and Rhode Island, to 75 units in Ohio. See figure 1 and appendix I for more information on the number of Medical Reserve Corps volunteers and units.

[12]Alaska and South Dakota did not report any Medical Reserve Corps health care volunteers as of September 2019. Additionally, there were 75,421 Non-Public Health Non-Medical volunteers registered in Medical Reserve Corps units. Some Medical Reserve Corps units may include these volunteers who can provide education, logistics, communication, coordination, and other support. We did not include these volunteers in our analysis.

[13]Medical Reserve Corps volunteers are registered in an electronic system for states that can be used to verify volunteer credentials.

Figure 1: Medical Reserve Corps Health Care Volunteers by State, as of September 2019



Sources: GAO analysis of data from the Assistant Secretary for Preparedness and Response, (data); Map Resources, (map). | GAO-20-630

Data table for Figure 1: Medical Reserve Corps Health Care Volunteers by State, as of September 2019

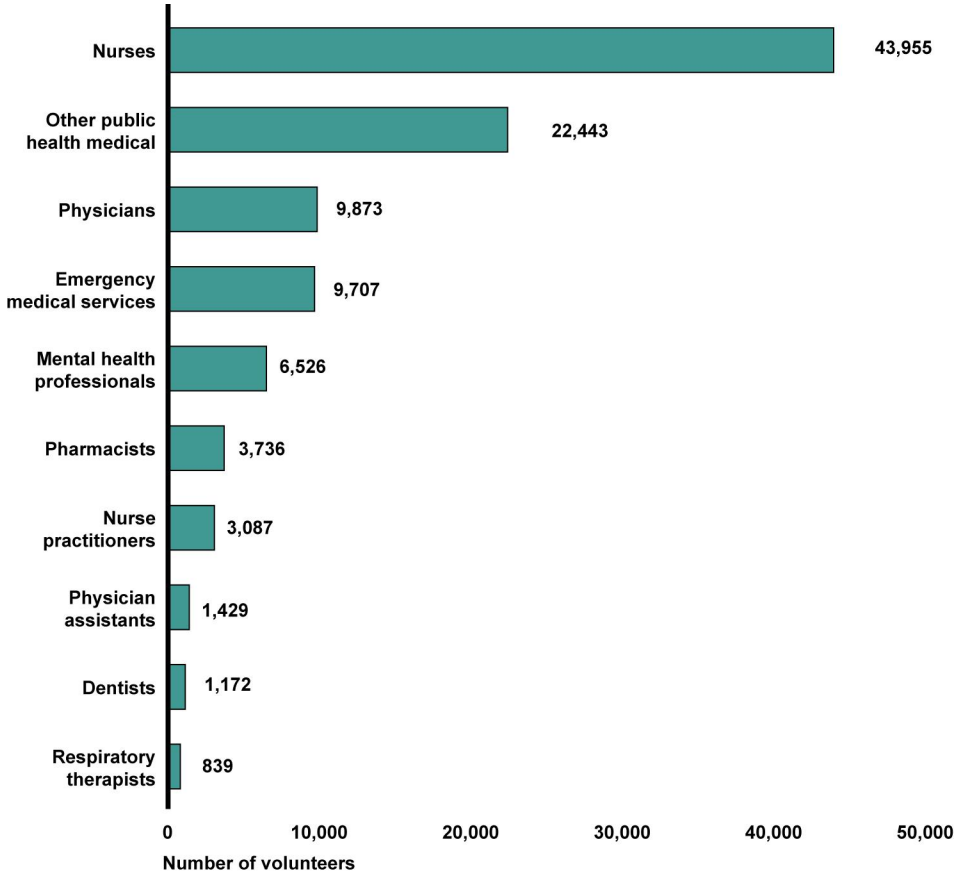
	Number of volunteers
30 states and District of Columbia	0-1,500
9 states	1,501-3,000
3 states	3,001-4,500
8 states	4,501 and more

Note: Alaska and South Dakota did not report any Medical Reserve Corps health care volunteers as of September 2019. Additionally, we excluded veterinarians and Non-Public Health Non-Medical volunteers from our review. States had a total of 2,619 veterinarians and 75,421 Non-Public Health Non-Medical volunteers registered in Medical Reserve Corps units as of September 2019. Because we excluded veterinarians from our review, four Medical Reserve Corps units focused exclusively on veterinarian services were not included in our analysis.

Our analysis of ASPR data shows that as of September 2019, nurses comprised 43 percent of the total number of Medical Reserve Corps health care volunteers, while 10 percent of the Medical Reserve Corps health care volunteers were physicians. Over 22,000 Other Public Health Medical volunteers supported these medical providers, including an unspecified number of cardiovascular technicians, sonographers, and phlebotomists, among others. See figure 2 for a breakdown of Medical Reserve Corps health care volunteers by provider type.[14]

[14]ASPR's data on Medical Reserve Corps as reported by units in each state does not distinguish among sub-specialties of provider types, such as whether registered mental health professionals are psychologists or psychiatrists, so we are unable to provide a further breakdown of volunteers by sub-specialty.

Figure 2: Medical Reserve Corps Health Care Volunteers by Type, as of September 2019



Source: GAO analysis of Office of the Assistant Secretary for Preparedness and Response data. | GAO-20-630

Data table for Figure 2: Medical Reserve Corps Health Care Volunteers by Type, as of September 2019

Type	Number of volunteers
Nurses	43,955
Other public health medical	22,443
Physicians	9,873
Emergency medical services	9,707
Mental health professionals	6,526
Pharmacists	3,736
Nurse practitioners	3,087
Physician assistants	1,429
Dentists	1,172
Respiratory therapists	839

Notes: Other Public Health Medical volunteers may include cardiovascular technicians, sonographers, and phlebotomists.

We excluded veterinarians and Non-Public Health Non-Medical volunteers from our review. States had a total of 2,619 veterinarians and 75,421 Non-Public Health Non-Medical volunteers registered in Medical Reserve Corps units as of September 2019.

Descriptions of some Medical Reserve Corps units on ASPR's website indicate that some units provide specialized care such as behavioral health, radiological, or mortuary services.[15] For example, a Medical Reserve Corps unit in Arizona is described as being comprised of specialized behavioral health volunteers skilled in working with survivors of trauma. Additionally, the Durham Medical Reserve Corps unit in North Carolina, in partnership with Duke University's State Medical Assistance Team, is described as being able to provide decontamination services for chemical, biological, radiological, nuclear, and explosive events; mass prophylaxis; mass fatalities management; and care to populations with special medical needs.[16] ASPR's website describes other Medical Reserve Corps units with the ability to provide pediatric, mortuary, acupuncture, or pharmacological services. Furthermore, in some communities, the Medical Reserve Corps units were affiliated with educational institutions including high schools, technical training programs, and universities, according to ASPR's website. Also, some Medical Reserve Corps units serve specific communities, such as the

[15]Office of the Assistant Secretary for Preparedness and Response, *Medical Reserve Corps* website, unit descriptions accessed from May 4 through May 21, 2020, https://mrc.hhs.gov/HomePage.

[16]Duke University Trauma Center, *NC 400 State Medical Assistance Team*, accessed May 21, 2020, https://trauma.duhs.duke.edu/disaster-response/nc400-smat.

Colorado Muslim Society, Chicago's Familia Latina Unida, and units serving different tribal populations.

Medical Reserve Corps Volunteers in Selected States Deployed in Response to Natural Disasters, Migrant Border Crossings, and COVID-19

Our review of ASPR documentation shows that Medical Reserve Corps units in selected states deployed volunteers in response to a range of different events.[17] Specifically, Medical Reserve Corps volunteers in three of the four states in our review—Alabama, California, and North Carolina—deployed to respond to natural disasters in 2018 and 2019. Volunteers in the fourth state, New Mexico, deployed to respond to the migrant border crossings in 2019. Additionally, Medical Reserve Corps volunteers in Alabama, California, New Mexico, and North Carolina deployed to respond to the COVID-19 pandemic in 2020. According to ASPR data we reviewed, Medical Reserve Corps volunteers from an additional 38 states and the District of Columbia deployed in response to the COVID-19 pandemic. The following are examples of activities Medical Reserve Corps volunteers performed in 2018, 2019, and in response to COVID-19. (See sidebar for information on Medical Reserve Corps preparedness activities.)

Natural Disasters

Alabama tornadoes. ASPR documentation shows that in March 2018, 90 volunteers from one Medical Reserve Corps unit provided over 345 hours of service while deployed in response to a tornado in Jacksonville, Alabama. These Medical Reserve Corps volunteers operated first aid stations at local volunteer fire departments and other locations. They also stocked and inventoried supplies. Volunteers also provided non-health care services, such as debris cleanup.

In March 2019, a Medical Reserve Corps unit deployed in response to a tornado in Alabama's Lee County, ASPR documentation shows. Seventy-six Medical Reserve Corps volunteers spent 1,150 hours providing a

[17]According to ASPR officials, volunteers may have been counted more than once if they were deployed for multiple activities for the same event.

variety of medical services, including triage, first aid, and medication verification and replacement. For example, volunteers provided first aid for citizens, first responders, and workers. The unit also utilized a mobile unit to deliver services.

Examples of Medical Reserve Corps Preparedness Activities

The Medical Reserve Corps is a network of health care volunteers who can augment federal, state, and local capabilities when events, such as wildfires and hurricanes, lead to public health emergencies. Medical Reserve Corps units have conducted activities to prepare for such emergencies. For example, according to Office of the Assistant Secretary for Preparedness and Response (ASPR) documentation, units participated in a variety of events in fiscal year 2019, including training and educating the public about how to respond to emergencies.

According to ASPR documentation, during National Stop the Bleed Month in May 2019, more than 50 Medical Reserve Corps units participated in or led Stop the Bleed training events in their communities. Stop the Bleed is a national initiative that encourages the general public to become trained and empowered to help reduce deaths from bleeding in emergencies before professional help arrives. Units also conducted similar personal preparedness trainings–such as first aid, naloxone administration for opioid overdoses, and active shooter training–for community audiences throughout the year.

Source: National Association of County and City Health Officials. | GAO-20-630

California wildfires. California experienced several wildfires in 2018 and 2019.[18] ASPR documentation showed that Medical Reserve Corps volunteers contributed over 15,000 service hours by providing services such as medical support at shelters and distributing protective masks in 2018. For example, 11 Medical Reserve Corps units deployed 81 volunteers who provided medical and general shelter support to evacuees of the Camp Fire wildfire in Butte County in November 2018—the most destructive wildfire in California history according to the California Department of Forestry and Fire Protection.[19] One unit also worked with the Sacramento County Coroner's Office to process human remains.

In fiscal year 2019, Medical Reserve Corps units supported wildfire response efforts by assisting with sheltering operations and providing medical care, ASPR documentation shows. For example, during the October Kincade wildfire in Sonoma County, at least 10 Medical Reserve Corps volunteers provided 120 hours of service in at least five different evacuation shelters.

North Carolina hurricanes. ASPR documentation also shows that 135 volunteers from nine North Carolina Medical Reserve Corps units deployed in response to Hurricane Florence in 2018. These volunteers set up and provided support at shelters and treatment centers, acute care treatment centers, and mobile disaster hospitals. In at least one shelter, the Medical Reserve Corps volunteers received assistance from federal responders.

In response to Hurricane Dorian in 2019, 48 North Carolina Medical Reserve Corps volunteers from four separate units deployed to different

[18]Some of these wildfires were Fire Management Assistance declarations, which the Federal Emergency Management Agency can approve when the Administrator determines that a fire or fire complex on public or private forest land or grassland threatens such destruction as would constitute a major disaster. See 44 C.F.R. § 204.21 (2019). If a wildfire increases in size and intensity in a manner that overwhelms the ability of state, tribal, territorial, or local governments to respond effectively, a state or tribal government can request, and the President can approve, a major disaster declaration under the Stafford Act. See 42 U.S.C. § 5170. The declarations can be found on the Federal Emergency Management Agency's website. Federal Emergency Management Agency, *Disasters,* accessed January 17, 2020, https://www.fema.gov/disasters.

[19]Two additional Medical Reserve Corps units deployed volunteers that were outside the scope of our review. One of these units deployed veterinarian volunteers who participated in the search and rescue, fairground sheltering, and wellness checks on the animals affected in the Butte County wildfires, among other activities.

sites around the state, ASPR documentation shows. For example, volunteers from one unit set up and provided medical care at shelters, including a shelter established for displaced nursing home and home health individuals. Volunteers from another Medical Reserve Corps unit deployed to disaster relief stations and provided first aid.

New Mexico Migrant Border Crossing

To assist with the national emergency declared in 2019 concerning the security of the southern border of the United States, 60 Medical Reserve Corps volunteers deployed in New Mexico to provide medical assistance, translation, and operational support at shelters and medical clinics, ASPR documentation shows.[20] These shelters and medical clinics were set up by state and local entities to assess the health of migrants who were apprehended in the United States during the spring 2019 by the Department of Homeland Security. The Medical Reserve Corps volunteers provided medical triage, distributed medications, distributed food, and set up cots for sleep, among other activities, for at least 290 individuals.

COVID-19 Pandemic

According ASPR officials, Medical Reserve Corps units have deployed volunteers in 42 states and the District of Columbia in response to the COVID-19 pandemic, as of May 26, 2020. According to ASPR documentation, Medical Reserve Corps volunteers have been conducting a variety of activities, such as supporting a local health department epidemiology team with contact tracing for positive COVID-19 cases.[21] Medical Reserve Corps volunteers are also supporting testing sites, including drive-through testing, by collecting specimens and performing administrative tasks, such as data entry and screening calls to manage

[20]The President issued Proclamation 9844 on February 15, 2019, which stated that the situation at the southern border presented a border security and humanitarian crisis that threatened core national security interests and constituted a national emergency under the National Emergencies Act. See 84 Fed. Reg. 4,949 (Feb. 20, 2019).

[21]According to the Centers for Disease Control and Prevention, contact tracing, a core disease control measure employed by state and local health department personnel, is a key strategy for preventing further spread of COVID-19. In contact tracing, public health staff work with a patient to help them recall everyone with whom they have had close contact during the time frame while they may have been infectious. Public health staff are then to warn these exposed individuals (contacts) of their potential exposure as rapidly and sensitively as possible.

testing appointments. For example, a Medical Reserve Corps unit in Georgia deployed four volunteers a day to work alongside district public health nurses at a drive-through testing site for 3 days in March 2020. These Medical Reserve Corps volunteers also assisted with the logistics and coordination of setting up a state mobile surge unit at a hospital. Additionally, Medical Reserve Corps volunteers made reusable face masks; coordinated the logistics, storage, and delivery of personal protective equipment and supplies; and screened the population by performing temperature and symptom checks for visitors at hospitals, municipal buildings such as a courthouse and jail, and homeless shelters, among other tasks.

ASPR documentation shows that Medical Reserve Corps units have registered additional volunteers in response to COVID-19. For example, after a call for volunteers from the Mayor of the District of Columbia in March 2020, over 3,000 registrations were received for that unit as of April 2020. As of May 5, 2020, the District of Columbia had more than 4,800 registered volunteers. Another Medical Reserve Corps unit in Allegheny County, Pennsylvania, had 425 registered volunteers as of September 2019, ASPR data show. ASPR's documentation showed the same unit received more than 300 new volunteer registrations by the end of March 2020—an almost 71 percent increase.

ASPR Has Assisted Medical Reserve Corps Units in Developing Volunteer Capabilities

ASPR has provided resources to assist Medical Reserve Corps units in developing their volunteer capabilities by issuing a guide and other information to assist with the recruitment, retention, and deployment of volunteers. Specifically, ASPR has provided the following resources to Medical Reserve Corps units:

- **Deployment readiness guide.** ASPR provided funding for the National Association of County and City Health Officials to develop and publish a 2019 Deployment Readiness Guide that created a national recommended standard for volunteer deployment readiness for Medical Reserve Corps units. While allowing for modification to fit the unique missions of each unit, the guide contains a common set of tools for Medical Reserve Corps unit leaders to use to develop the capabilities of their Medical Reserve Corps volunteers to support medical and public health emergency responses. For example, the guide includes a checklist of activities that should occur during the

phases of a deployment—pre-deployment, deployment, and post-deployment—such as re-verifying volunteers' medical credentials and ensuring that necessary equipment and resources are available. The guide also includes sample Mission Sets, which the Medical Reserve Corps unit leaders can use to demonstrate their units' capabilities.[22] For example, a Mission Set for medical surge—that is, volunteers who could provide both clinical and non-clinical support to hospitals and clinics after a public health emergency—contains information such as whether volunteers are required to be licensed or certified; the type of volunteer that should be part of the response, such as a physician or nurse; and training required, such as an annual exercise on triage procedures within the facility. According to officials from the National Association of County and City Health Officials, the Mission Set is a way to standardize information on unit capabilities and can be used by ASPR to determine the number of units that have developed a particular capability.

- **Training resources.** ASPR also provided webinars and other training resources to assist local Medical Reserve Corps units with recruiting and retaining volunteers to build unit capabilities. According to ASPR officials, ASPR Regional Liaisons have facilitated new leader orientation that provides an overview of the program, the duties and responsibilities of unit leaders, and resources available to help unit leaders develop, manage, and sustain their Medical Reserve Corps units; coordinated calls with state Medical Reserve Corps coordinators; and conducted workgroups on Medical Reserve Corps priority areas, such as the use of the Emergency Management Assistance Compact.[23] See appendix II for more information on the Emergency Management Assistance Compact.
- **Generally accepted practices.** In February 2017, ASPR issued generally accepted practices associated with volunteer or non-profit

[22]According to officials from the National Association of County and City Health Officials, the Mission Set was introduced in August 2019. Officials do not know the number of Medical Reserve Corps units that have completed a Mission Set, but said they have heard that some Medical Reserve Corps units are using the tool. Officials had planned to conduct a workshop on the 2019 Deployment Readiness Guide, including the Mission Set, but have had to reschedule because of the COVID-19 pandemic.

[23]The Emergency Management Assistance Compact is a congressionally ratified interstate mutual aid mechanism that is supported through legislation enacted by all 50 states, the District of Columbia, Puerto Rico, Guam, the U.S. Virgin Islands, and the Commonwealth of the Northern Mariana Islands. See Pub. L. No. 104-321, 110 Stat. 3877 (1996). The Emergency Management Assistance Compact established a structure for participating states to request and deploy assistance, reimburse states that provide assistance, and confer liability and workers' compensation protections.

organizations. According to ASPR documentation, these practices can, among other things, help Medical Reserve Corps units enhance their capacity to assist their communities, including when preparing for and responding to public health emergencies. For example, these practices include the expectation that Medical Reserve Corps units will develop a volunteer retention and recognition program and the unit will periodically re-evaluate its volunteer recruitment procedures in accordance with changes in community needs or Medical Reserve Corps unit capabilities.

- **Technical assistance.** ASPR Regional Liaisons have provided technical assistance to Medical Reserve Corps units, such as conducting assessments of Medical Reserve Corps unit capabilities, according to ASPR officials. Additionally, according to ASPR officials, Regional Liaisons may help Medical Reserve Corps units identify potential partners the units may want to work with, such as universities and schools of nursing.

ASPR has also provided states guidelines to develop and maintain their volunteer registration systems, called the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP). ESAR-VHP can be used by a state to register and verify credentials of potential health professional responders, including the credentials of Medical Reserve Corps volunteers and other volunteers who can be called upon in case of a public health emergency.[24] See appendix III for information on ESAR-VHP requirements.

Agency Comments

We provided a draft of this report to HHS for review and comment. HHS provided technical comments, which we incorporated as appropriate.

We are sending copies of this report to the appropriate congressional committees and the Secretary of Health and Human Services. In addition, the report is available at no charge on the GAO website at https://www.gao.gov.

[24]See 42 U.S.C. § 247d-7b.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or DeniganMacauleyM@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix IV.

Mary Denigan-Macauley
Director, Health Care

Appendix I: Medical Reserve Corps Unit Health Care Volunteers, by State, as of September 2019

The Medical Reserve Corps is a national network of local health care and other volunteers who can strengthen public health, reduce vulnerability, build resilience, and improve preparedness, response, and recovery capabilities. Medical Reserve Corps units support community public health missions, participate in local and regional exercises across the nation, and respond during federal, state, local, and tribal public health emergencies. In addition to responding to public health emergencies, Medical Reserve Corps health care volunteers assist with activities to improve public health in their communities, such as increasing health literacy, supporting prevention efforts, and eliminating health disparities. Medical Reserve Corps health care volunteers can assist with activities including health screenings, vaccination clinics, disaster medical support, and first aid during large public gatherings.

The Office of the Assistant Secretary for Preparedness and Response (ASPR) in the Department of Health and Human Services collects information on units by state, as well as the District of Columbia, in its Medical Reserve Corps database. According to agency officials, information on health care volunteers is self-reported by units in each state and not independently confirmed by ASPR. See table 1 for ASPR's information on the number of Medical Reserve Corps health care volunteers by provider type and state as of September 2019, which is when ASPR extracted the data based on our request.

Table 1: Medical Reserve Corps Unit Health Care Volunteers, by State, as of September 2019

	Provider type										
State	Dentist	EMS	Mental health	NP	Nurse	PA	Pharmacist	Physician	Respiratory therapist	Other public health medical[a]	Total
Alabama	96	206	116	61	1,205	25	87	545	83	2,079	**4,503**
Alaska	0	0	0	0	0	0	0	0	0	0	**0**
Arizona	5	85	179	65	279	11	44	84	5	116	**873**
Arkansas	3	17	6	4	51	6	13	17	2	50	**169**
California	53	872	240	186	3,206	189	303	718	101	2,143	**8,011**
Colorado	3	77	67	17	206	15	7	58	1	196	**647**
Connecticut	47	134	50	61	818	19	29	156	2	370	**1,686**
Delaware	4	29	35	16	431	1	26	28	4	347	**921**
District of Columbia	0	137	0	3	83	21	15	83	1	175	**518**
Florida	19	244	143	163	1,068	48	96	306	47	588	**2,722**
Georgia	9	125	76	67	756	38	58	140	28	429	**1,726**
Hawaii	8	7	7	15	208	5	98	26	5	156	**535**
Idaho	7	160	131	33	655	20	35	27	21	733	**1,822**
Illinois	47	232	154	92	1,669	21	68	213	20	335	**2,851**
Indiana	21	74	27	36	693	1	35	46	5	227	**1,165**
Iowa	1	54	55	11	161	1	10	3	2	48	**346**
Kansas	0	18	15	5	124	2	5	2	2	50	**223**
Kentucky	22	207	30	74	917	27	52	62	8	196	**1,595**
Louisiana	16	138	32	14	381	10	23	154	13	360	**1,141**
Maine	0	16	10	4	63	1	3	10	0	31	**138**
Maryland	68	279	452	153	2,420	73	671	639	64	735	**5,554**
Massachusetts	36	611	255	162	2,694	37	120	316	29	2,145	**6,405**
Michigan	4	152	41	14	310	11	18	25	8	114	**697**
Minnesota	17	278	339	35	1,557	9	101	153	15	1,352	**3,856**
Mississippi	0	57	17	23	229	1	15	17	4	74	**437**
Missouri	9	221	39	38	713	7	52	65	25	171	**1,340**
Montana	0	3	0	0	12	0	0	1	0	1	**17**
Nebraska	1	109	16	6	198	4	6	14	0	20	**374**
Nevada	1	46	17	10	171	8	12	20	7	48	**340**
New Hampshire	4	69	24	15	176	7	15	10	3	62	**385**
New Jersey	47	306	101	102	1,670	17	109	265	22	317	**2,956**

Appendix I: Medical Reserve Corps Unit Health Care Volunteers, by State, as of September 2019

	Provider type										
State	**Dentist**	**EMS**	**Mental health**	**NP**	**Nurse**	**PA**	**Pharmacist**	**Physician**	**Respiratory therapist**	**Other public health medical[a]**	**Total**
New Mexico	5	119	49	13	108	20	11	48	4	82	**459**
New York	338	799	1,938	549	3,999	328	423	2,349	81	1,210	**12,014**
North Carolina	2	430	25	19	514	36	35	122	20	219	**1,422**
North Dakota	11	286	93	35	590	9	12	27	13	83	**1,159**
Ohio	40	433	262	107	2,937	38	224	236	39	2,006	**6,322**
Oklahoma	10	348	415	167	2,736	37	62	110	23	502	**4,410**
Oregon	6	153	49	59	659	17	44	212	11	158	**1,368**
Pennsylvania	27	309	135	69	975	83	141	363	13	1,231	**3,346**
Rhode Island	5	527	54	30	450	18	67	80	7	170	**1,408**
South Carolina	5	48	68	26	299	3	15	33	18	40	**555**
South Dakota	0	0	0	0	0	0	0	0	0	0	**0**
Tennessee	38	190	54	83	1,257	22	103	196	11	319	**2,273**
Texas	33	298	262	107	1,740	91	82	1,407	24	971	**5,015**
Utah	12	273	43	33	354	10	51	73	5	160	**1,014**
Vermont	0	49	10	15	131	3	2	20	2	55	**287**
Virginia	58	228	264	182	2,437	37	232	180	29	1,056	**4,703**
Washington	22	130	97	85	1,059	27	51	161	5	368	**2,005**
West Virginia	12	78	18	23	515	10	48	48	7	108	**867**
Wisconsin	0	35	4	0	61	5	5	4	0	34	**148**
Wyoming	0	11	12	0	10	0	2	1	0	3	**39**
Total	**1,172**	**9,707**	**6,526**	**3,087**	**43,955**	**1,429**	**3,736**	**9,873**	**839**	**22,443**	**102,767**

Legend:

EMS = emergency medical services

NP = nurse practitioner

PA = physician assistant

Source: GAO analysis of Office of the Assistant Secretary for Preparedness and Response data. | GAO-20-630

Note: We excluded veterinarians and Non-Public Health Non-Medical volunteers from our review. States had a total of 2,619 veterinarians and 75,421 Non-Public Health Non-Medical volunteers registered in Medical Reserve Corps units as of September 2019. Additionally, Medical Reserve Corps units and volunteers in U.S. territories are not included in this analysis.

[a]Other Public Health Medical volunteers may include cardiovascular technicians, sonographers, and phlebotomists.

See table 2 for the number of Medical Reserve Corps units by state as of September 2019.

Table 2: Number of Medical Reserve Corps Units by State, as of September 2019

State	Medical Reserve Corps units
Alabama	8
Alaska	0
Arizona	13
Arkansas	9
California	38
Colorado	18
Connecticut	23
Delaware	4
District of Columbia	5
Florida	24
Georgia	18
Hawaii	4
Idaho	7
Illinois	71
Indiana	26
Iowa	15
Kansas	8
Kentucky	37
Louisiana	6
Maine	8
Maryland	7
Massachusetts	38
Michigan	16
Minnesota	23
Mississippi	5
Missouri	29
Montana	1
Nebraska	6
Nevada	4
New Hampshire	13
New Jersey	24
New Mexico	9
New York	29
North Carolina	16
North Dakota	1

Appendix I: Medical Reserve Corps Unit Health Care Volunteers, by State, as of September 2019

State	Medical Reserve Corps units
Ohio	75
Oklahoma	32
Oregon	14
Pennsylvania	10
Rhode Island	1
South Carolina	5
South Dakota	0
Tennessee	13
Texas	32
Utah	14
Vermont	8
Virginia	24
Washington	23
West Virginia	12
Wisconsin	8
Wyoming	4
Total	**838**

Source: GAO analysis of Office of the Assistant Secretary for Preparedness and Response data. | GAO-20-630

Note: Four Medical Reserve Corps units focused exclusively on veterinarian services. We excluded veterinarians from our review; therefore, these Medical Reserve Corps units are not included in the table.

Appendix II: Mechanisms for Licensure Coverage between States

States have responded to public health emergencies in recent years—such as those arising from natural disasters, infectious diseases, and other events—through deployment of health care volunteers within their state and across state lines when needed. The federal government can waive state licensing requirements for the purposes of federal programs—Medicare, Medicaid, and the Children's Health Insurance Program—if the Secretary of Health and Human Services has declared a public health emergency and the President has declared an emergency or major disaster under the Robert T. Stafford Disaster Relief and Emergency Assistance Act or a national emergency under the National Emergencies Act.[1] Outside of these federal programs, deployment of health care volunteers across state lines has raised issues related to licensure coverage.

For health care professionals deployed across state lines, there are mechanisms that allow for the recognition of out-of-state licenses. The Emergency Management Assistance Compact is a congressionally ratified interstate mutual aid mechanism that is supported through legislation enacted by all 50 states, the District of Columbia, Puerto Rico, Guam, the U.S. Virgin Islands, and the Commonwealth of the Northern Mariana Islands.[2] The compact established a structure for states to request and deploy assistance, reimburse states that provide assistance, and recognize out-of-state licenses and permits, among other things. The compact only applies to the sharing of state resources and personnel, such as health care professionals employed by the state, and does not apply to private sector health care volunteers. Therefore, coverage for professional licensure under the compact does not apply to these private sector volunteers. States must take action, either through legislation, executive order, or another mechanism, to extend licensure coverage to

[1]See 42 U.S.C. § 1320b-5(b)(2). This codifies section 1135 of the Public Health Service Act; waivers under this section are commonly referred to as "section 1135 waivers."

[2]See Pub. L. No. 104-321, 110 Stat. 3877 (1996).

private sector public health and medical volunteers deployed to another state. According to National Emergency Management Association officials, some states are unable to deploy private sector volunteers across state lines because the states do not have enabling legislation allowing them to do so.[3] However, they can send state officials, such as state-employed health care professionals, according to Department of Health and Human Services documentation. Mechanisms that may allow for the deployment of materials and volunteers across state lines include a memorandum of understanding, memorandum of agreement, governor executive order, intergovernmental agreement, contract, and legislation. National Emergency Management Association officials said legislation is the preferred enabling mechanism because it helps to establish procedure and protocol for how to respond during a public health emergency. According to the National Emergency Management Association, as of April 2020, 12 states and the District of Columbia do not have sufficient authority to deploy volunteer resources across state lines. Of the states with such authority, 29 have legislation as the enabling mechanism, two use policy, 13 have a memorandum of agreement, and eight have a governor executive order, according to the National Emergency Management Association.[4]

In March 2020, the Secretary of Health and Human Services sent a letter to states recommending that they use mechanisms for the Coronavirus Disease 2019 (COVID-19) response that allow licensed health care professionals to provide aid in another state without being licensed in that state. According to the National Conference of State Legislatures, as of April 16, 2020, 44 states have taken action related to licensure for the COVID-19 response.

[3]The National Emergency Management Association is a professional association of emergency management directors from all 50 states, eight U.S. territories, and the District of Columbia. The association works on the implementation of the Emergency Management Assistance Compact and integration of non-state resources into the Emergency Management Assistance Compact process, among other things.

[4]The categories of enabling mechanisms are not mutually exclusive and will not add to 38 as some states use multiple mechanisms, according to the National Emergency Management Association. For example, Colorado uses legislation, memorandum of agreement, and a governor executive order.

Appendix III: The Emergency System for Advance Registration of Volunteer Health Professionals

The Public Health Security and Bioterrorism Preparedness and Response Act of 2002 created a state-based system—the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP)—to collect and verify information on the identity, licensure status, privileges, and credentials of medical volunteers, including those from Medical Reserve Corps units.[1] The ESAR-VHP program was created to support states and territories in establishing standardized volunteer registration programs for public health emergencies. According to the Department of Health and Human Services' Office of the Assistant Secretary for Preparedness and Response (ASPR), which manages the ESAR-VHP program at the federal level, volunteers' identities, licenses, credentials, accreditations, and hospital privileges are all verified in advance of an emergency by registering through ESAR-VHP.

ASPR has provided guidelines on the data elements that are required in each state's ESAR-VHP system. ASPR guidelines require that the volunteer's name, address, contact information, and occupation specific credentials and the data needed to verify them—such as the name on a license, license number, and the date of expiration—be included in the state's ESAR-VHP system. ASPR guidelines also require that a state's ESAR-VHP system be able to record all volunteer health professional and emergency preparedness affiliations of an individual, including local, state, and federal entities.[2]

According to ASPR guidelines, to make the most effective use of health care volunteers who may have varying levels of clinical competency, the ESAR-VHP program has developed a uniform process for classifying and

[1]Pub. L. No. 107-188, § 107, 116 Stat. 594, 608 (2002) (codified, as amended, at 42 U.S.C. § 247d-7b).

[2]The purpose of this requirement is to avoid the potential confusion that may arise from having a volunteer appear in multiple registration systems, such as Medical Reserve Corps units and the National Disaster Medical System. Public health and medical responders registered through the National Disaster Medical System include doctors, nurses, and paramedics.

assigning volunteers into one of four credential levels, based on the credentials provided and verified:

- Level 1: Identifies volunteers who are clinically active in a hospital, either as an employee or by having hospital privileges.
- Level 2: Identifies volunteers who are clinically active in a wide variety of settings, such as clinics, nursing homes, and shelters.
- Level 3: Identifies volunteers who meet the basic qualifications necessary to practice in the state in which they are registered.
- Level 4: Identifies volunteers who have health care experience or education that would be useful for assisting clinicians and providing basic health care not controlled by the scope of practice laws (may include health profession students or retired health professionals who no longer hold a license).

According to ASPR officials, ESAR-VHP systems are not connected between states, and are not able to communicate across systems. However, ESAR-VHP program guidelines standardize the data elements for licensing and credentialing nationally, and because the systems all use the same data definitions, ASPR considers ESAR-VHP to be interoperable.

Appendix IV: GAO Contact and Staff Acknowledgments

GAO Contact

Mary Denigan-Macauley, (202) 512-7114 or DeniganMacauleyM@gao.gov.

Staff Acknowledgments

In addition to the contact named above, Kelly DeMots (Assistant Director), Sarah Resavy (Analyst-in-Charge), Anne Hopewell, and William Horowitz made key contributions to this report. Also contributing were Sam Amrhein, Kaitlin Farquharson, Rich Lipinski, Diona Martyn, and Vikki Porter.

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