The Public Health Emergency Preparedness Landscape

FINDINGS FROM THE 2016 PREPAREDNESS PROFILE ASSESSMENT

June 2017

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Background & Methods

Each year, NACCHO conducts the Preparedness Profile assessment to provide a **foundation for future** public health preparedness initiatives. This assessment gathers information about preparedness trends and emerging issues at local health departments (LHDs) to inform priorities at the local, state, and national levels.

In June 2016, a statistically representative sample of 871 preparedness coordinators were asked to complete the Profile assessment. Preparedness coordinators are individuals identified by LHDs as having a significant responsibility for leading or coordinating an LHD's disaster/emergency preparedness planning and response activities. Preparedness coordinators may have various job titles (e.g., preparedness analyst, preparedness director, emergency response planner.)

A total of 458 preparedness coordinators completed the assessment (response rate of 53%).

The assessment included 18 questions and was distributed online via Qualtrics Survey Software™ and stratified by jurisdiction population size.

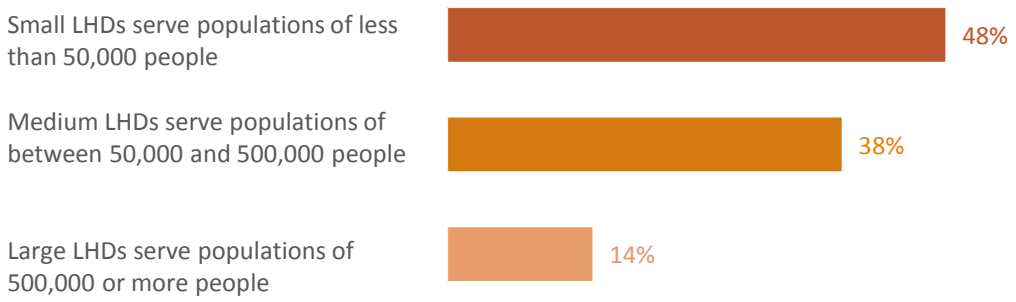
LHDs serving large jurisdictions were oversampled. Results were weighted to adjust for both oversampling and non-response.

All data were self reported; NACCHO did not independently verify the data provided by LHDs.

This document presents the results of the assessment, as well as implications for the future and recommendations.

For the analysis, NACCHO staff took into account the results of this and last year's assessment, as well as qualitative information provided by our membership through workgroups and programmatic activities.

Respondents represent LHDs that serve different size jurisdictions across the United States



Preparedness Workforce

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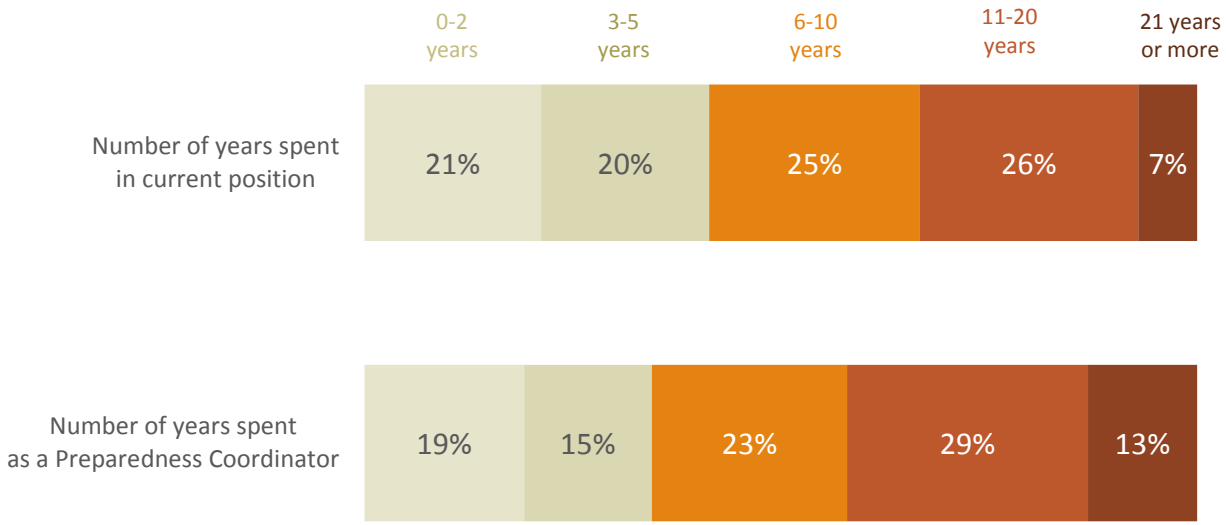
More than half of respondents have worked as preparedness coordinators for more than six years

Regardless of LHD size, approximately 65% of respondents reported working as a preparedness coordinator **for six or more years**. However, about 41% of them have spent **five years or less** in their *current position*.

These findings illustrate the variety of experience and knowledge levels within LHDs in the Preparedness Coordinator position, highlighting the need for training and tools applicable to varying levels of preparedness expertise.



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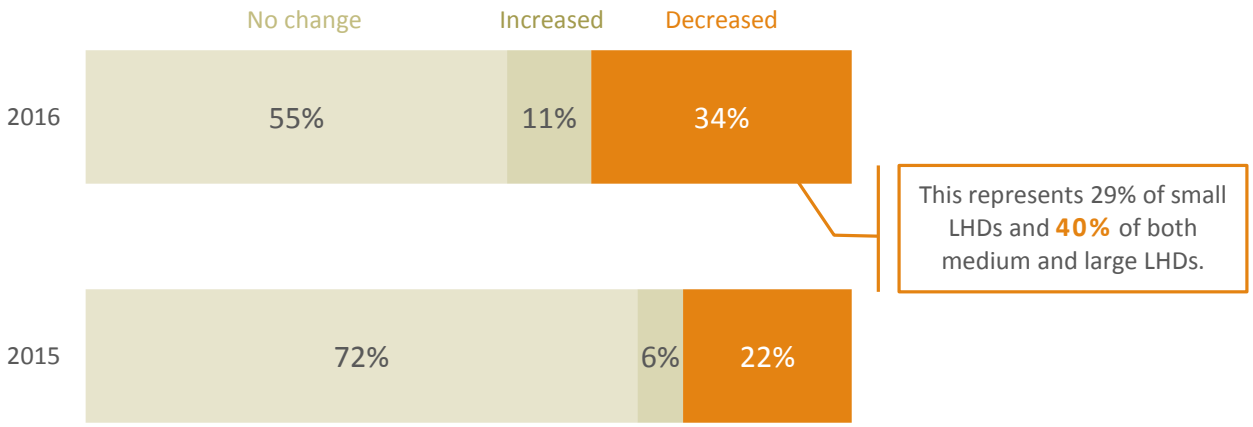
LHDs consistently report decreases in preparedness staff

Overall, 12% more LHDs report decreased preparedness staff than in 2015. **Larger LHDs are more likely to experience decreases**.

In contrast, more than half of LHDs indicate the number of preparedness staff did not change. This reflects the 61% of **small LHDs reporting no change**.



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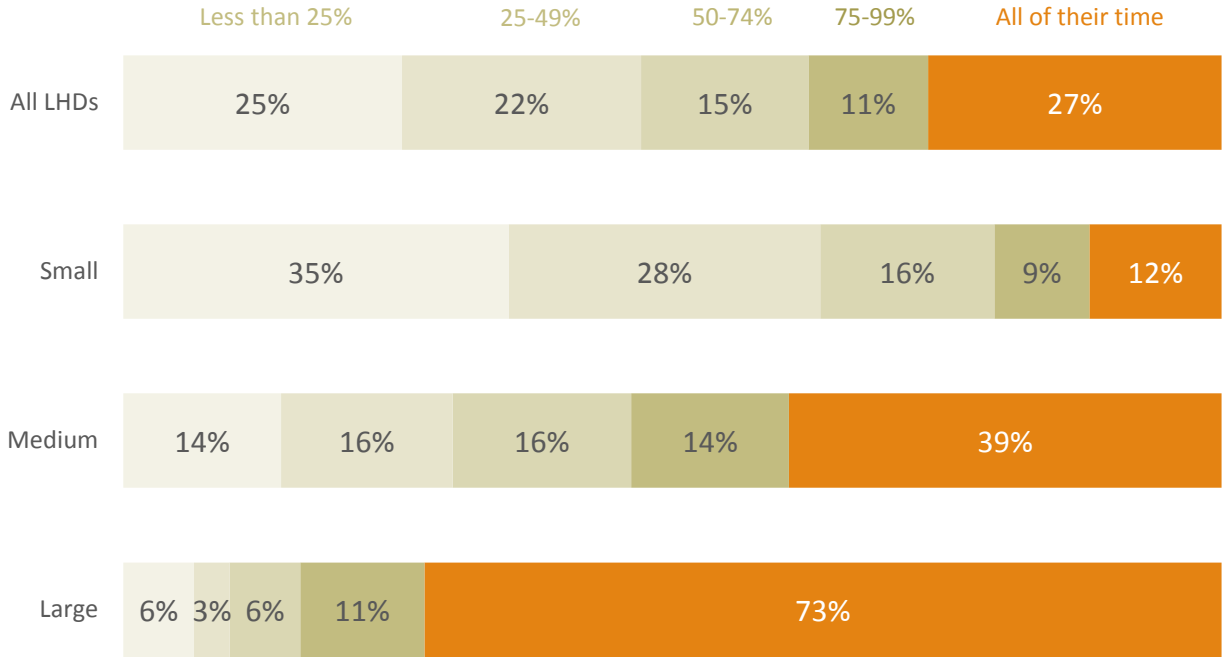
Most preparedness coordinators in large LHDs dedicate all their time to preparedness efforts

Overall, over one-quarter of preparedness coordinators spend **all of their time on preparedness duties**. This is largely driven by preparedness coordinators in **large LHDs** where nearly three quarters report that all of their time is dedicated to preparedness job duties.

In contrast, preparedness coordinators in **smaller LHDs spend their time working in a variety of public health areas**.

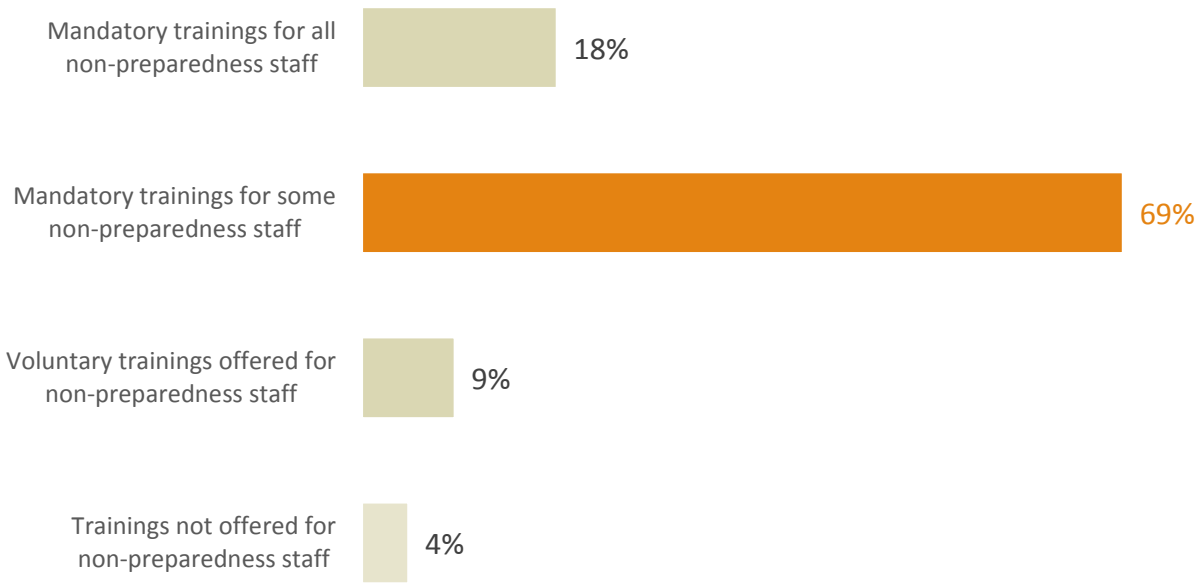


Most LHDs require that at least some non-preparedness staff be trained in preparedness topics

Across all LHDs, non-preparedness staff receive some mandatory training in preparedness topics.

Very few LHDs report not offering any training for non-preparedness staff.

This finding suggests that LHDs recognize that non-preparedness staff are often involved in disaster/emergency response activities.



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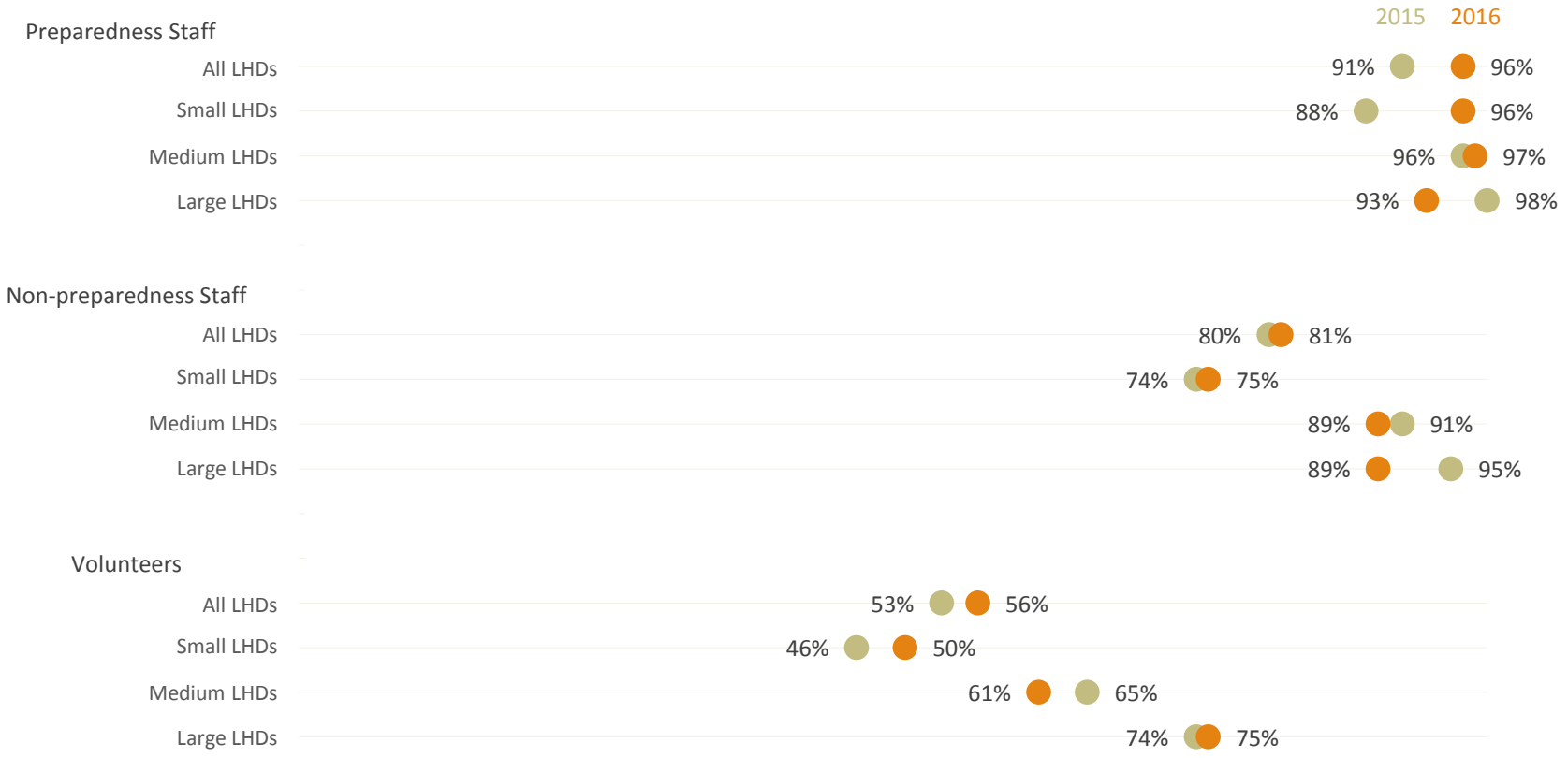
Most LHDs engage preparedness and non-preparedness staff to conduct drills and exercises

Across all LHDs, a majority of staff with regular and non-routine preparedness responsibilities have participated in trainings and drills over the last two years. However, **non-preparedness staff at small LHDs are less likely to be engaged in drills and exercises**.

While **large LHDs are more likely to engage volunteers** in drills and exercises, more than half of all LHDs do so. Overall, results from the 2015 and 2016 assessments were similar.

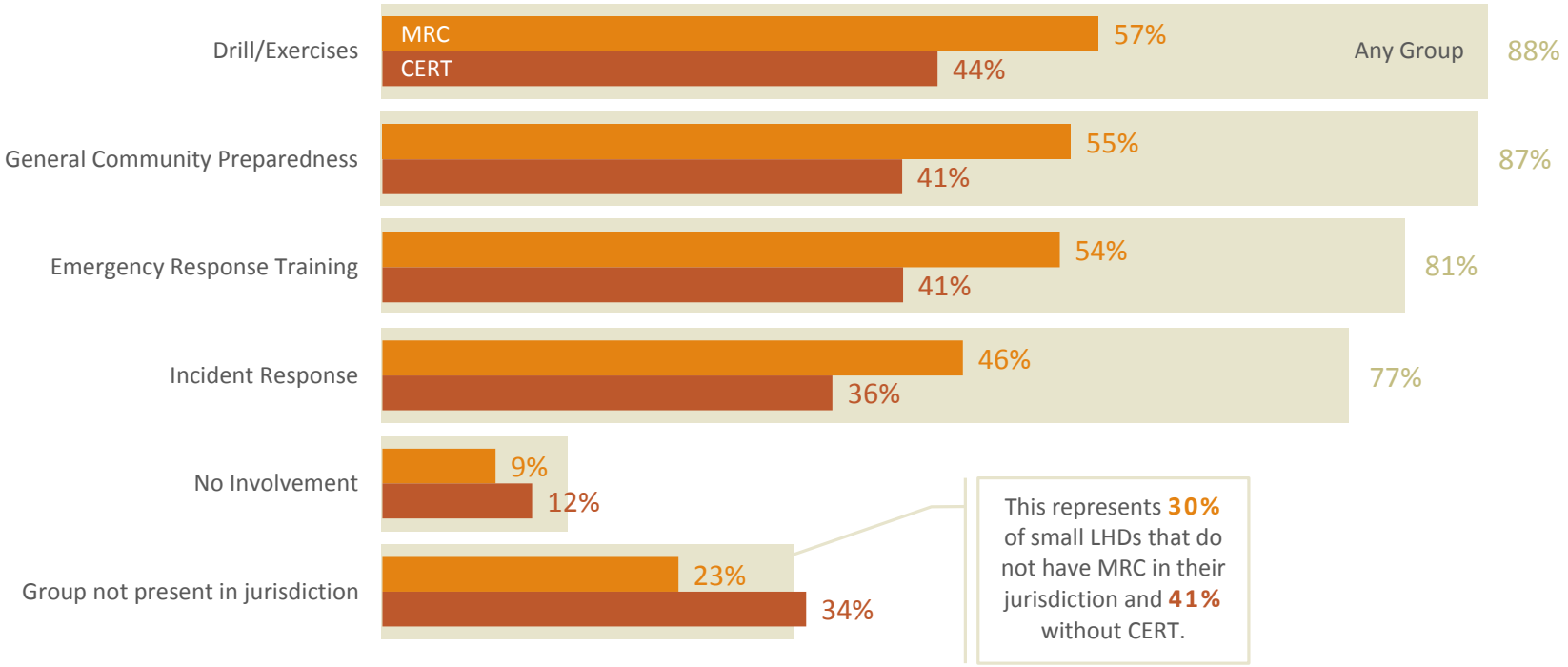


Most LHDs engage their volunteer groups in preparedness activities

More than half of all LHDs engage volunteers in preparedness activities such as community preparedness, emergency response training, drills/exercises, and incident response.

Overall, **drills and exercises** are the most common activities in which at least one volunteer group is involved.

Small LHDs are least likely to have Medical Reserve Corps (MRC) and Community Emergency Response Team (CERT) groups present in their jurisdictions.



Preparedness Planning & Capacity

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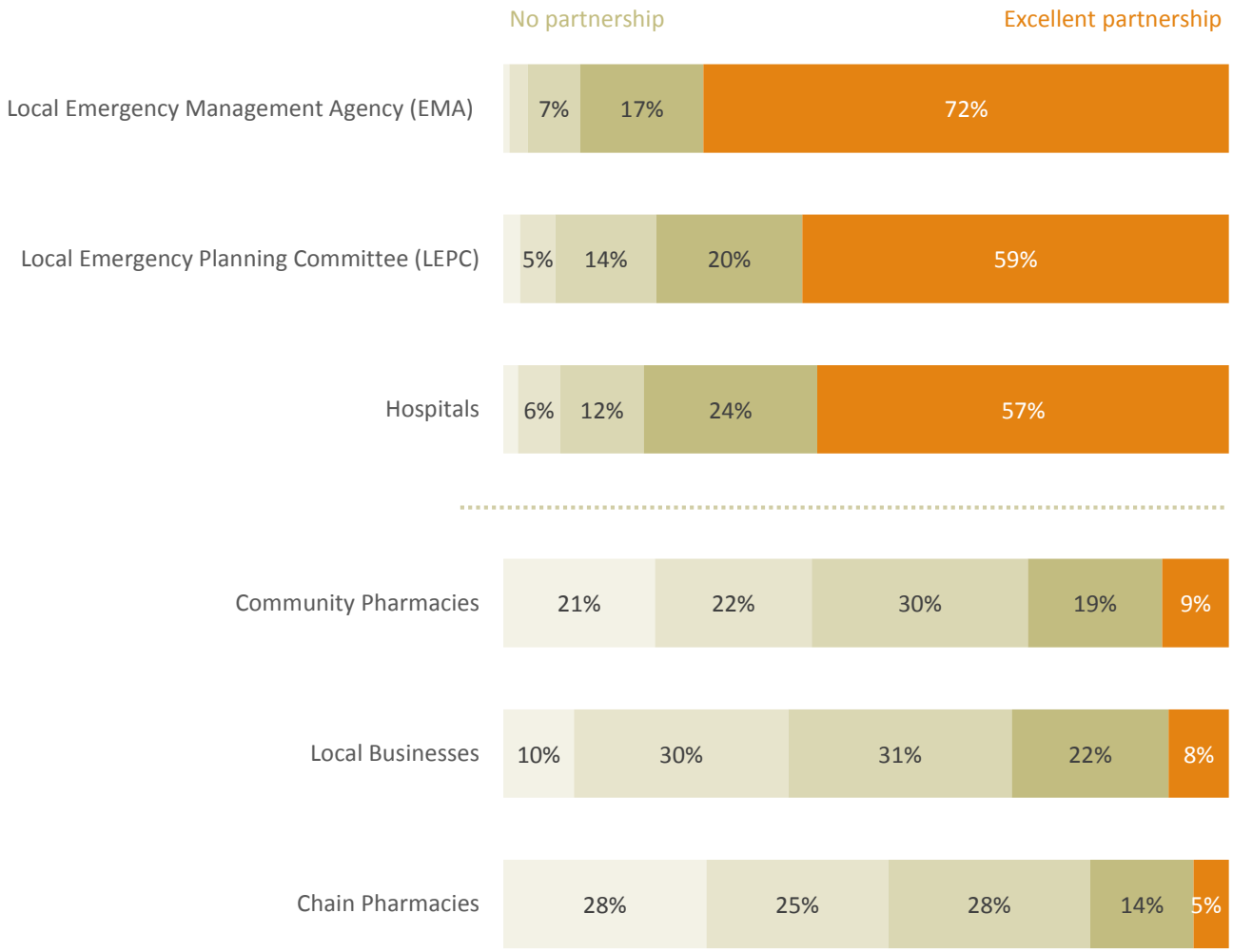
Most LHDs report strong partnerships with traditional partners

Most LHDs reported **excellent partnerships with local agencies** including emergency management, emergency planning committees, and hospitals.

In contrast, LHDs were **least likely to report excellent partnerships** with non-traditional partners like pharmacies and local businesses.

LHDs were moderately likely to report excellent partnerships with organizations including K-12 schools, mental and behavioral health providers, and faith-based organizations.

More than one-quarter of LHDs reported that they were **unable to partner** with federally qualified health centers and colleges because those organizations do not exist in their jurisdictions.



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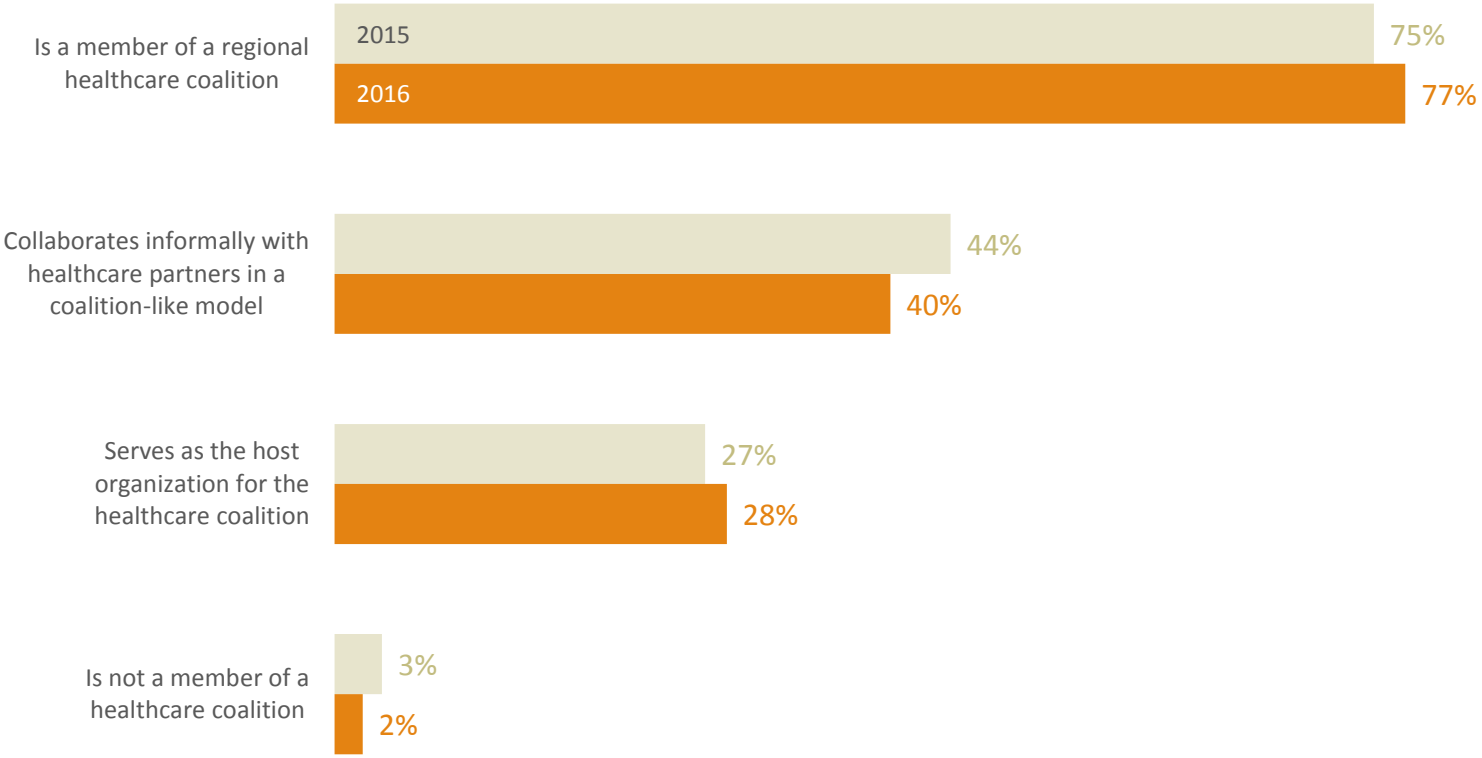
Most LHDs are members of a regional healthcare coalition

Overall, LHDs' participation in healthcare coalitions was similar in 2015 and 2016. In both years, LHDs were **most likely to be members of a regional healthcare coalition** (as opposed to a state or privately-run coalition) to plan and implement preparedness activities.

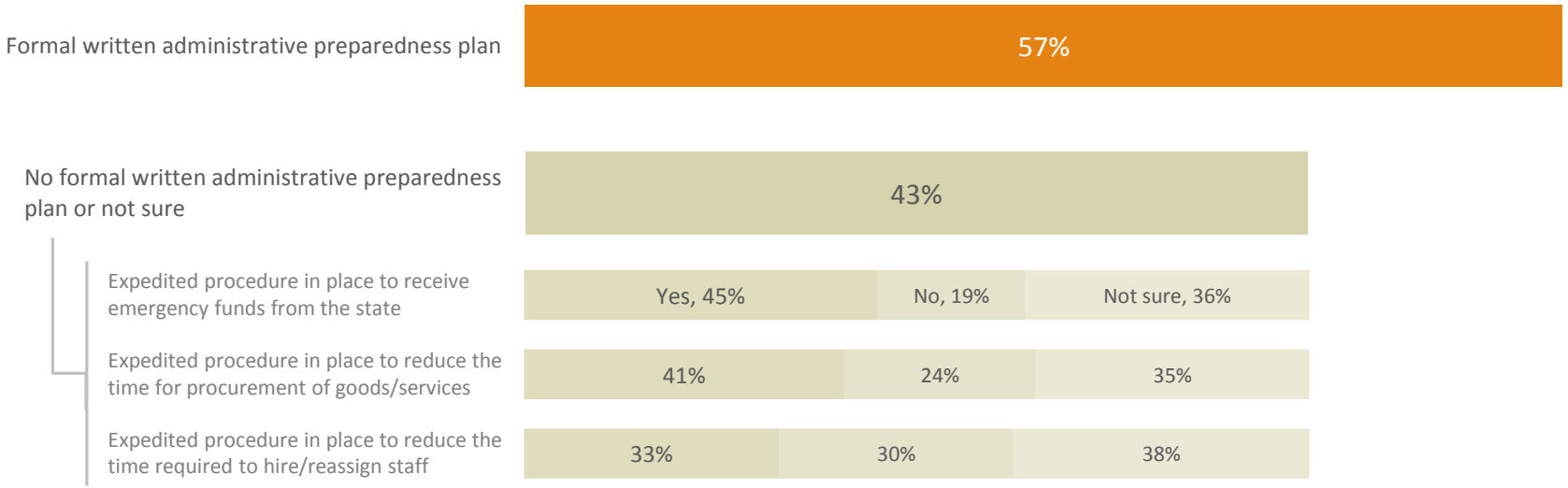
Both years also saw very few LHDs that reported not being a member of any healthcare coalition.



Most LHDs have processes in place for administrative preparedness

Administrative preparedness is the process of ensuring that the fiscal, legal, and administrative authorities and practices that govern funding, procurement, contracting, and hiring can be accelerated, modified, streamlined, and accountably managed at all levels of government during a state or federally declared emergency.

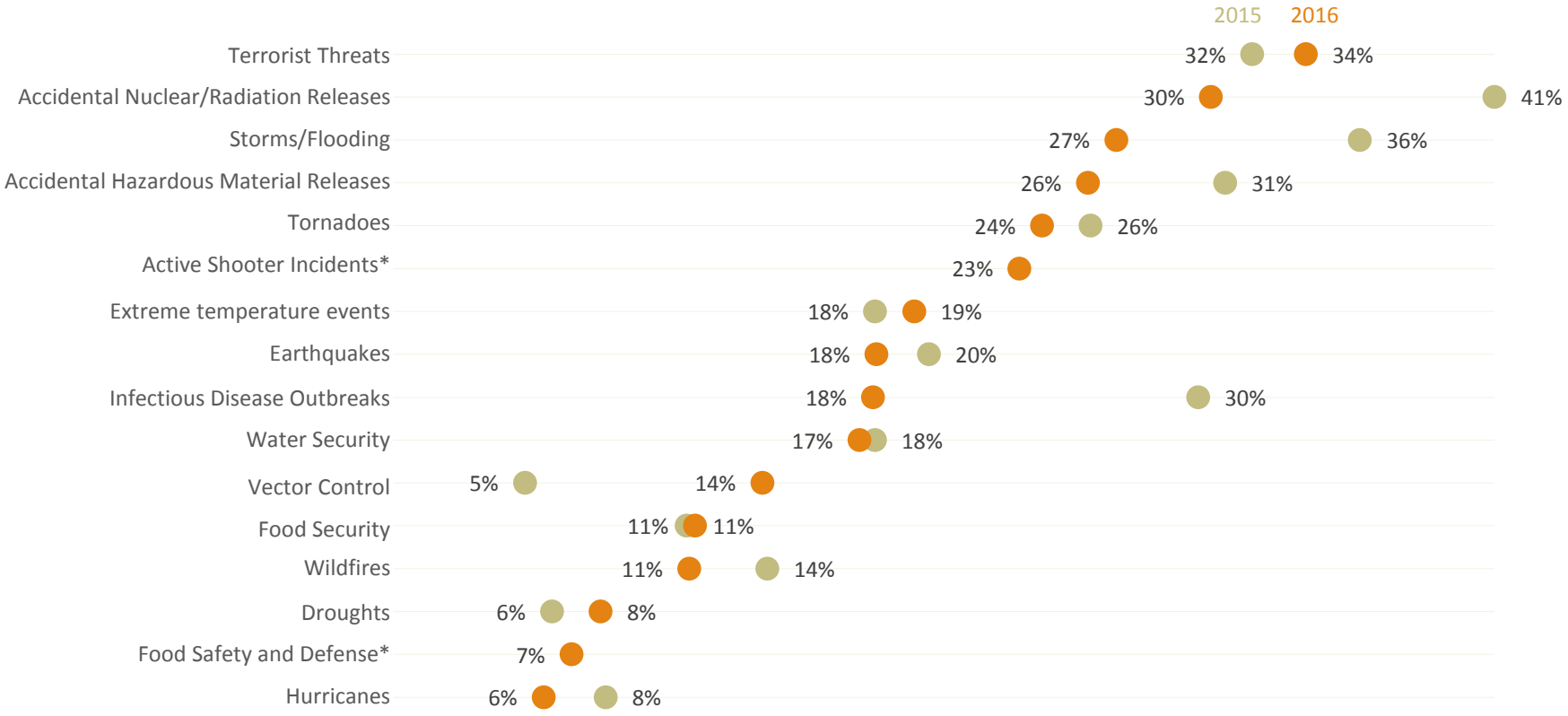
Although the majority of LHDs have a **formal written administrative preparedness plan**, nearly half do not have, or are not sure whether they have, a formal written plan. Of those that do not have a plan or are unsure, many respondents indicated they do have at least one expedited procedure in place to address administrative needs during an emergency.



LHDs feel least prepared to address man-made threats and flooding

LHDs most frequently selected terrorist threats as one of the top three *current community* threats that they feel **least prepared to address** in 2016. Large LHDs most frequently selected accidental nuclear/radiation releases.

Since 2015, **fewer LHDs** have felt least prepared to address accidental nuclear/radiation releases, storms/flooding, and infectious disease outbreaks. However, **more LHDs** have felt least prepared to address vector control issues. Some of these findings may be a result of LHDs' recent activities in Ebola and Zika response, but future assessments will help to determine if these are notable trends or random changes.

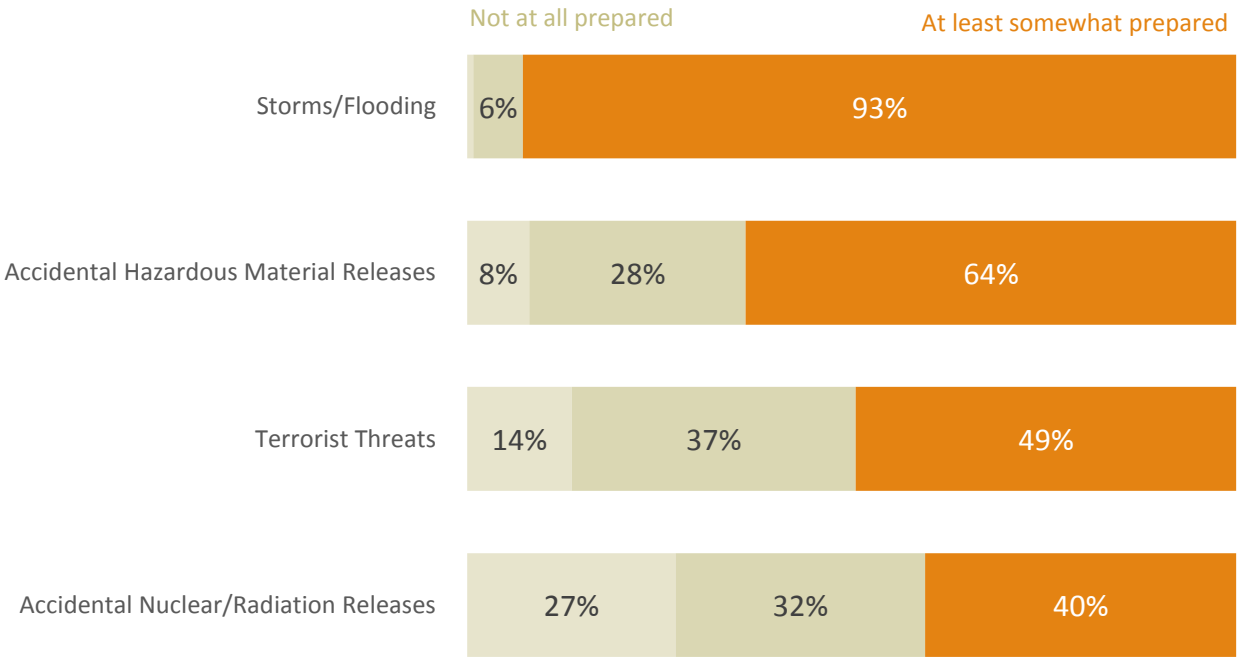


* Indicates a new response option for 2016

LHDs feel at least somewhat prepared to address many diverse threats

When looking at the top four current threats that LHDs felt least prepared to address, LHDs reported that they were still **at least somewhat prepared** to address them. This indicates that LHDs are receiving resources helping them to address a diverse array of hazards and threats.

However, more than one-quarter of LHDs feel **not at all prepared** to address issues related to accidental nuclear/radiation releases.



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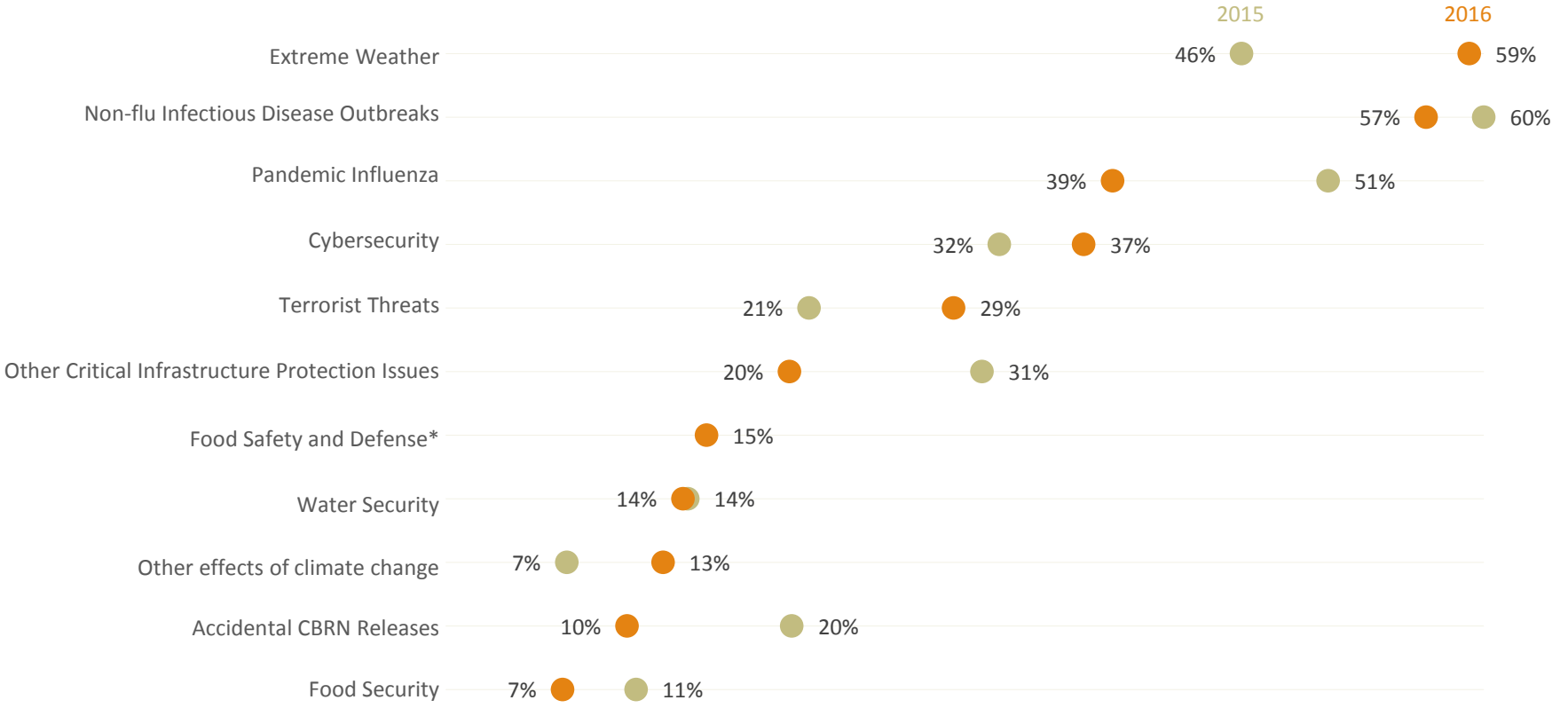
LHDs ranked extreme weather and infectious diseases as top global or emerging threats

In 2016, LHDs most frequently selected extreme weather as one of the top three *global or emerging* threats about which they are **most concerned will affect their community in the future**. Large LHDs most frequently selected non-flu infectious disease outbreaks.

Notably, **more LHDs** are concerned about extreme weather and terrorist threats than in 2015. On the other hand, **fewer LHDs** are concerned about pandemic influenza and other critical infrastructure protection issues. Additional longitudinal quantitative data and qualitative research is needed to understand the context of these changes.



* Indicates a new response option for 2016

Preparedness Activities

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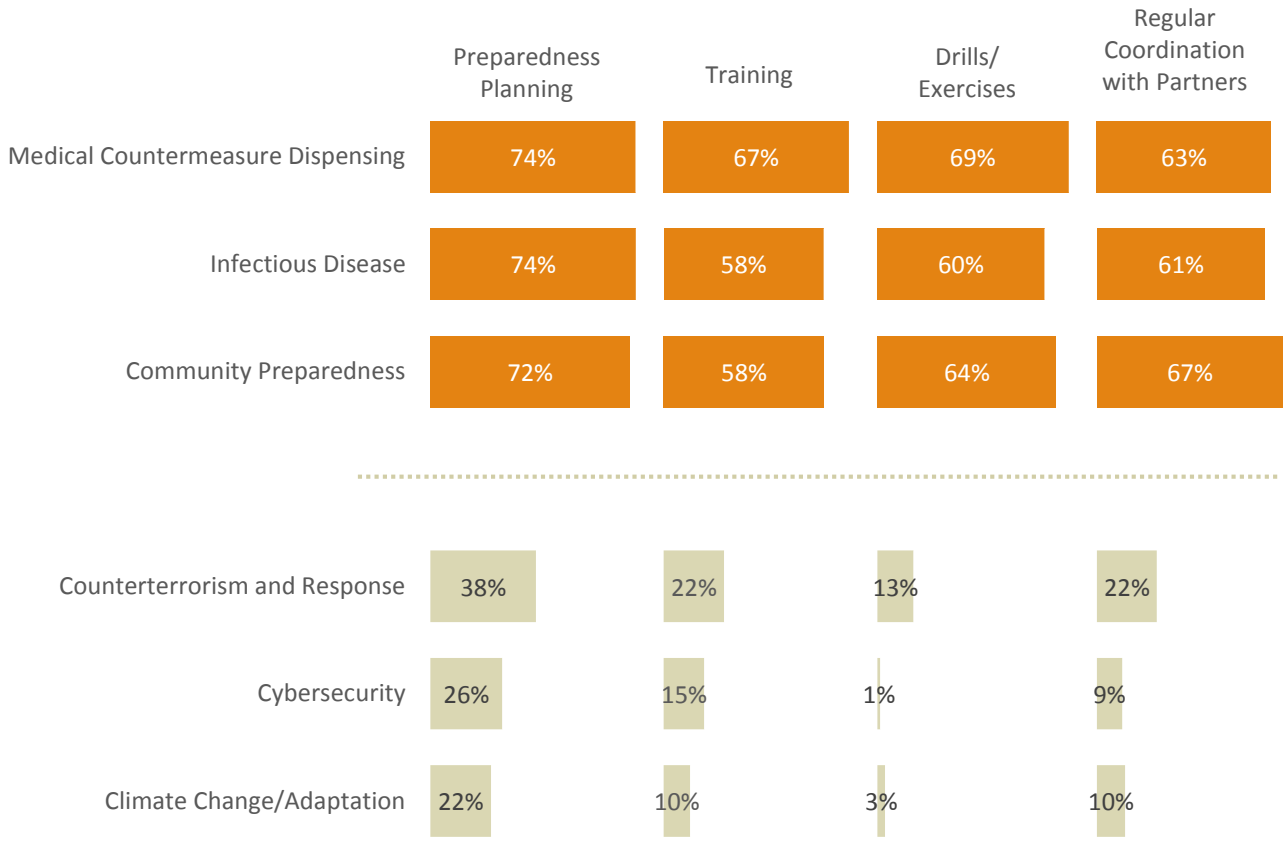
Most LHDs conduct medical countermeasures and community preparedness activities

Overall, the **broadest range of activities conducted** by LHDs in the past year were focused on medical countermeasure, community preparedness, and infectious disease topics. These activities range from planning to training and drills, as well as regularly coordinating with partners.

LHDs most often report **not conducting any activities** in climate change/adaptation, cybersecurity, and counterterrorism. These findings are consistent with the 2015 Preparedness Profile assessment.

Other topic areas in which LHDs report not conducting many activities include CBRN events, critical infrastructure protection, and long term recovery.



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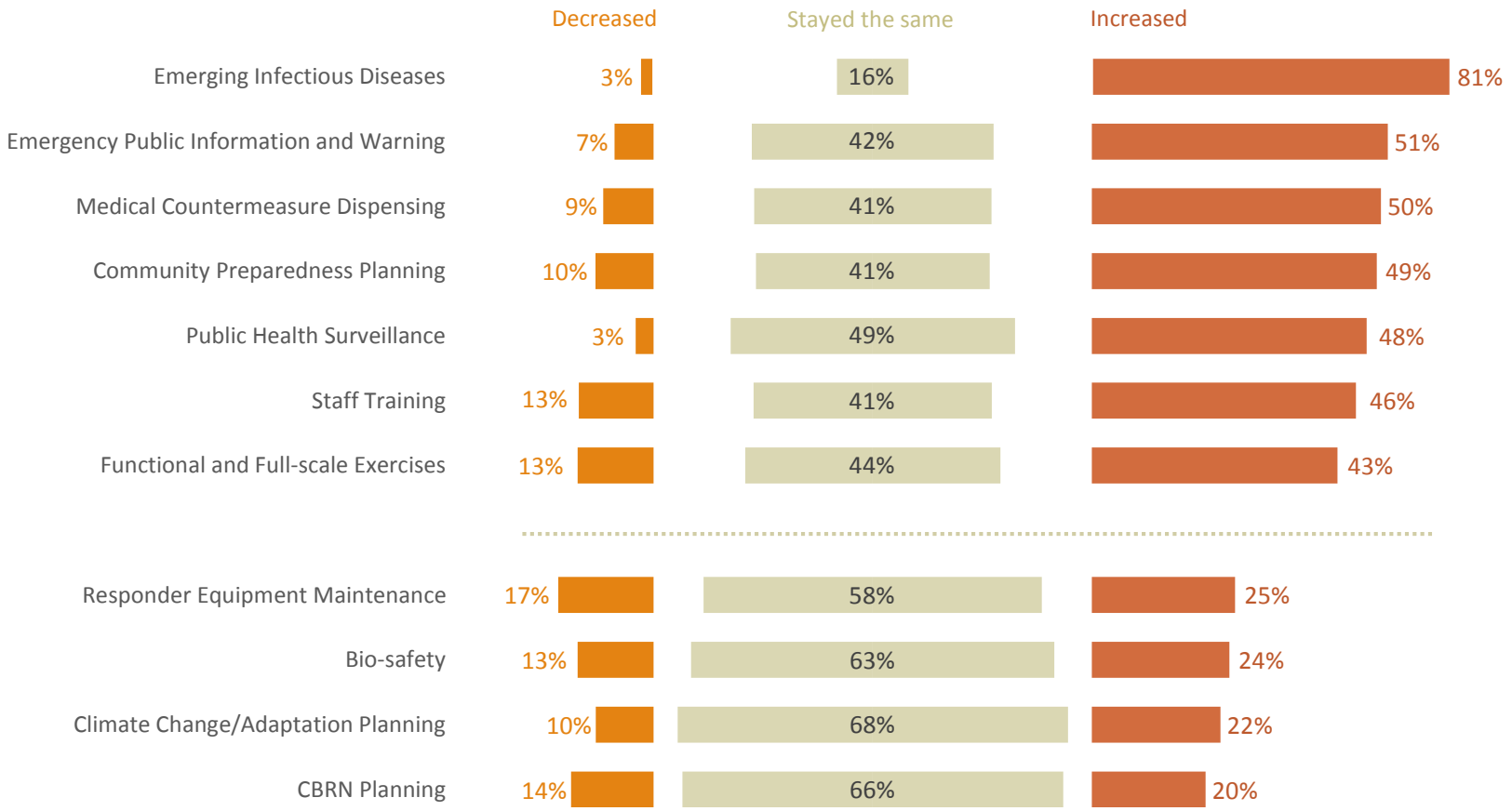
LHDs report modest increases or stability in their preparedness activities

Overall, most LHDs reported their CDC PHEP activities **increased or stayed the same since 2013**. The largest increase in activities was associated with emerging infectious disease—possibly as a result of recent Ebola and Zika responses. In contrast, LHDs reported the overall largest decrease in non-PHEP activities including responder equipment maintenance, CBRN planning, and staff training.



National Health Security Strategy

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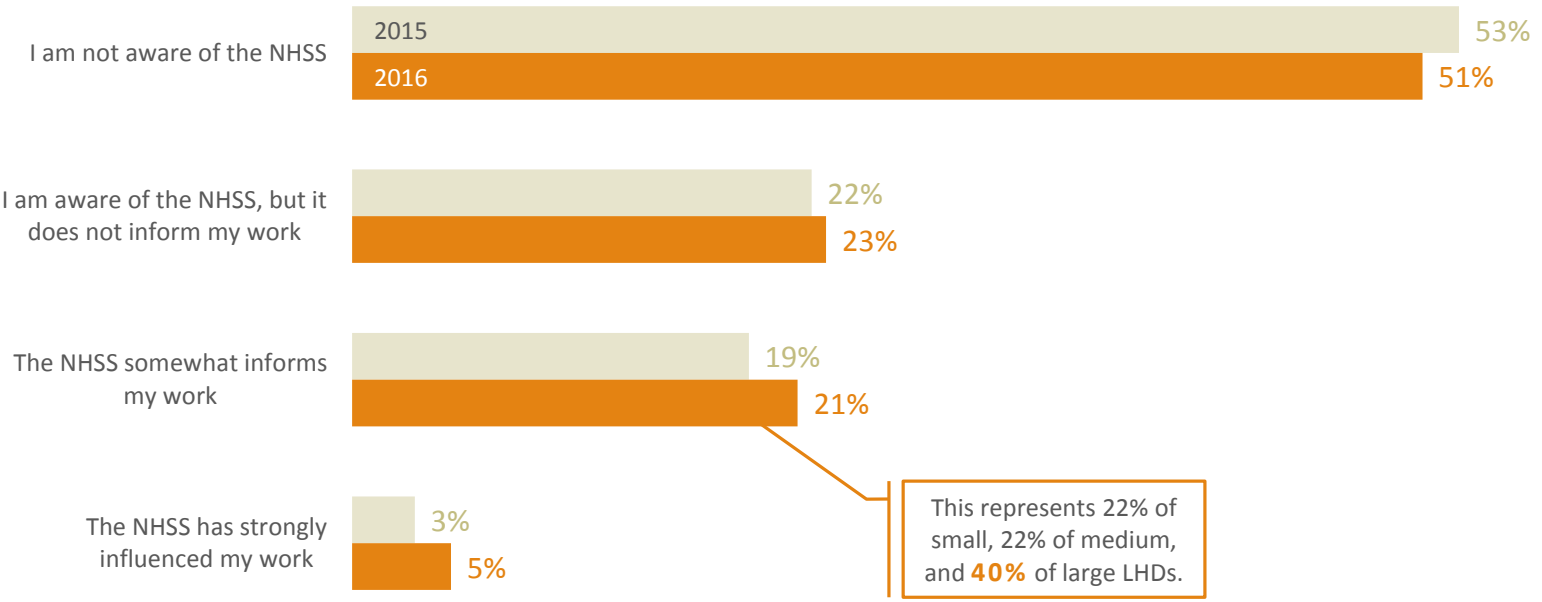
Most LHDs are not aware of the National Health Security Strategy approach

The National Health Security Strategy (NHSS) is a comprehensive strategic approach to coordinating the nation's health security system. Developed by the Office of the Assistant Secretary for Preparedness and Response (ASPR) in collaboration with a broad range of stakeholders, the goal of the NHSS is to strengthen and sustain communities' abilities to prevent, protect against, mitigate the effects of, respond to, and recover from disasters and emergencies.

Approximately half of LHDs were **not aware of the NHSS**, but this has decreased slightly from 2015.

Only 26% of LHDs reported that their work is influenced by the NHSS, with large LHDs being more likely to use the NHSS to inform their preparedness planning and activities.



Recommendations

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NACCHO Recommendations and Priority Areas

The information collected as part of this assessment represents a significant contribution by preparedness coordinators to the knowledge base of preparedness at the local level, and should help inform preparedness activities and priorities for the future. NACCHO will continue to educate, advocate, and promote the work of LHDs towards ensuring the health, safety, and resilience of their communities.

Findings from the 2016 Preparedness Profile illustrate the strengths, gaps, and opportunities in local public health preparedness, informing the following recommendations and national priority areas.

Preparedness Workforce:

Assessment results indicate that approximately 34% of LHDs have experienced a decrease in preparedness staff.

This represents an increase of 12% more LHDs reporting staffing decreases than in 2015, indicating a potential trend in decreasing preparedness capacity.

For many LHDs, impacts of staffing decreases result in the elimination of programs and the inability to coordinate with partners, leave communities vulnerable in the event of an emergency.

Reductions in staff may be due to decreased funding. As LHDs experience decreases, policymakers need to be educated about the harmful impacts of these cuts to the safety of communities across the nation.

Preparedness Coordinators reported a range of experience levels and time in their current role.

The range of experience levels and time in the Preparedness Coordinator role suggests the potential need for training and professional development opportunities tailored towards varying levels of preparedness expertise.

NACCHO recommends additional assessments be done to identify existing training opportunities and potential gaps.

Most LHDs report offering some training to non-preparedness staff.

Only 4% of LHDs indicated that preparedness trainings are not offered to non-preparedness staff.

Non-preparedness staff are often involved in local emergency and disaster response, so additional research is needed to determine the resources and tools LHDs need to support training their non-preparedness staff in preparedness topics.

NACCHO Priority Areas and Recommendations (continued)

Partnerships and Coalitions:

LHDs were least likely to report excellent partnerships with pharmacies, local businesses, and faith-based organizations.

Many LHDs still have significant progress to make in building partnerships with non-traditional partners in preparedness and response. However, with decreased staffing and resources dedicated to emergency preparedness, LHDs may not have the capacity to strengthen engagement with these partners.

Efforts to address this gap in LHD community preparedness capacity should include steady preparedness funding, promoting promising practices, and developing tools and resources tailored to these partnerships between public health and non-traditional partners.

NACCHO supports the development and strengthening of partnerships by providing tools and programs to foster collaboration. NACCHO's Project Public Health Ready, a criteria-based training and recognition program, is one program that can encourage LHDs to work closely with state and local partners to develop and enhance their preparedness plans.

Less that half of LHDs report collaborating informally with healthcare partners, and only 28% of LHDs report serving as the host for their coalition.

LHDs may have a unique role to play in supporting healthcare partners' engagement in healthcare coalitions and preparedness planning, training, and exercising. Given the emergency preparedness requirements recently finalized for providers who participate in Medicare and Medicaid for participants in Centers for Medicaid and Medicare (CMS), local health departments and healthcare coalitions can play a key roll in community outreach and support for providers (e.g., long term care facilities, clinics, behavioral health providers) who have been less likely to engage in coalitions thus far.

NACCHO supports the strengthening of existing coalitions and the development of new partnerships at local, regional, and state levels in order to form a collaborative preparedness planning group within the emergency response community.

Preparedness Planning:

Nearly half of LHDs report that they do not have, or are unsure whether or not they have, a formal written administrative preparedness plan.

Administrative preparedness removes barriers that can prevent the timely occurrence of response activities and is routinely identified as an area needing improvement by LHDs following responses such as Ebola and Zika.

If LHDs do not have mechanisms in place to expedite, modify, streamline, and manage administrative procedures, delays can occur in the acquisition of goods and services, the hiring or assignment of response personnel, the disposition of emergency funds, and legal determinations needed to implement protective measures during an emergency.

NACCHO can encourage the development and evaluation of administrative preparedness plans by raising awareness among LHDs; identifying barriers to efficient expedited administration of the receipt of emergency funding, procurement for goods and services, and hiring or reassigning staff during public health emergencies; and sharing resources that support LHDs' engagement with their local and state partners in developing and exercising administrative preparedness plans.

NACCHO Priority Areas and Recommendations (continued)

LHDs feel least prepared to address terrorism-related events and accidental nuclear/radiation releases.

When asked to identify the top threats facing their community LHDs reported that they feel least prepared to address man-made threats, including terrorism-related events, CBRN, hazardous materials releases, and cybersecurity.

NACCHO should continue to engage with LHDs, such as through the preparedness workgroups, to define the role of LHDs and their community partners in preventing and responding to these threats. Additional assessment is needed to identify what support LHDs need in planning, training, and exercising with partners around these areas.

LHDs are most concerned about extreme weather and infectious disease outbreaks as the top global or emerging threats that will affect their community *in the future*.

NACCHO should continue to engage with national partners and LHDs to inform and identify research, policy, and practices that support LHDs' preparation for these emerging hazards.

Preparedness Activities:

LHDs most often report not conducting any activities in climate change/adaptation, cybersecurity, and counterterrorism and response.

Assessment results show that the majority of activities conducted by LHDs in the past year focused on medical countermeasures, community preparedness, and infectious disease topics.

Further research is needed to better understand and clarify the role of LHDs and their federal and state counterparts in conducting activities in climate change/adaptation, cybersecurity, and counterterrorism; the barriers to effective implementation; and the resources LHDs need to bolster local capabilities in comprehensive preparedness planning and response.

Efforts to support LHD activity in these areas should include promoting promising practices, providing technical assistance, supporting continued learning, and developing tools and resources to strengthen diverse preparedness capacities.

National Health Security:

Assessment findings indicate that 51% of LHDs are not aware of the National Health Security Strategy (NHSS).

While this represents mostly small and medium LHDs, increased awareness of the NHSS amongst all LHDs is crucial for effective coordination of the nation's health security system.

Efforts to align the NHSS with other national preparedness guidance may increase awareness and adoption of the NHSS. NACCHO should continue to engage LHDs in a dialogue around the use of NHSS as a guide to plan preparedness activities and build upon projects focused on communicating its core concepts.

THANK YOU

Acknowledgements

This document was supported in part by the Centers for Disease Control and Prevention (Cooperative Agreement #5NU38OT000172-04-00).

Its contents are solely the responsibility of NACCHO and do not necessarily represent the official views of the sponsors.

For more information, please contact NACCHO's Preparedness Team at preparedness@naccho.org.

The mission of the National Association of County and City Health Officials (NACCHO) is to be a leader, partner, catalyst, and voice with local health departments.

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