2022 Preparedness Profile Study

NACCHO℠
National Association of County & City Health Officials

Table of Contents

Introduction

This chapter includes:

- Background and purpose for the 2022 Preparedness Profile Study
- Sampling, weighting, and other survey methods

Background

National health security is a state in which the nation and its people are prepared for, protected from, and resilient in the face of incidents with health consequences. Local health departments (LHDs) play a key role in achieving national health security by preparing their communities for public health emergencies, responding when they occur, and lending support through the recovery process.

The importance of public health preparedness in ensuring that LHDs can quickly respond to emerging threats and adequately protect the health and safety of their communities was underscored during the COVID-19 pandemic. LHDs are at the forefront of mobilizing public health actions to prevent the spread of the virus and ensure the health and safety of their communities while keeping essential public health services in place.

Since 2016, the National Association of County and City Health Officials (NACCHO) has conducted the Preparedness Profile study every few years to provide a foundation for future public health preparedness initiatives.

This nationally representative survey gathers information about preparedness trends and emerging issues at LHDs to inform priorities at the local, state, and national levels.

This report provides findings from the 2022 Preparedness Profile on a multitude of important topics in local preparedness, including administrative preparedness, training for staff, partnerships with local entities and communities, and at-risk and vulnerable populations served in preparedness planning.

Methods

Study population and sampling
There are approximately 2,500 agencies or units that meet the definition of an LHD, for purposes of surveying. Some states have a public health system structure that includes both regional and local offices of the state health agency. In those states, the state health agency chooses to respond to the survey at either the regional or local level, but not at both levels.

NACCHO used a database of LHDs based on the 2020 Forces of Change survey to identify LHDs for inclusion in the study population. For the 2022 Preparedness Profile, a nationally representative sample of 985 LHDs were included in the study. Rhode Island was excluded from the study because the state has no sub-state public health units.

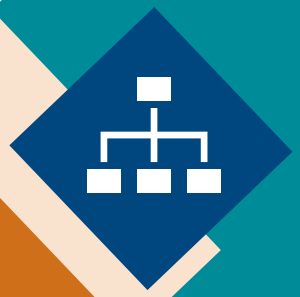
The 2022 Preparedness Profile survey sample was stratified by the size of population served. LHDs serving larger jurisdictions were oversampled to ensure representation. For this report, small LHDs serve populations of less than 50,000 people. Medium LHDs serve populations of 50,000 to 499,999 people. Large LHDs serve populations of 500,000 people or more.

Survey distribution
The assessment was distributed online via Qualtrics Survey Software™ to individuals identified by LHDs as having a significant responsibility for preparedness planning and response activities. Respondents included preparedness coordinators and top executive staff. Responses were collected between April and May 2022.

Survey weighting and national estimates
There were 375 responses included for analysis (38% response rate). Statistics were computed using post-stratification weighting to adjust for oversampling and non-responses. Therefore, results can be interpreted as nationally representative estimates. Some detail may be lost in the figures within this report due to rounding.

Limitations
All data are self-reported by LHD staff and are not independently verified. LHDs may have provided incomplete, imperfect, or inconsistent information for various reasons. In addition, non-response bias could impact the results presented in this report, and any comparisons presented are not tested for statistical significance.

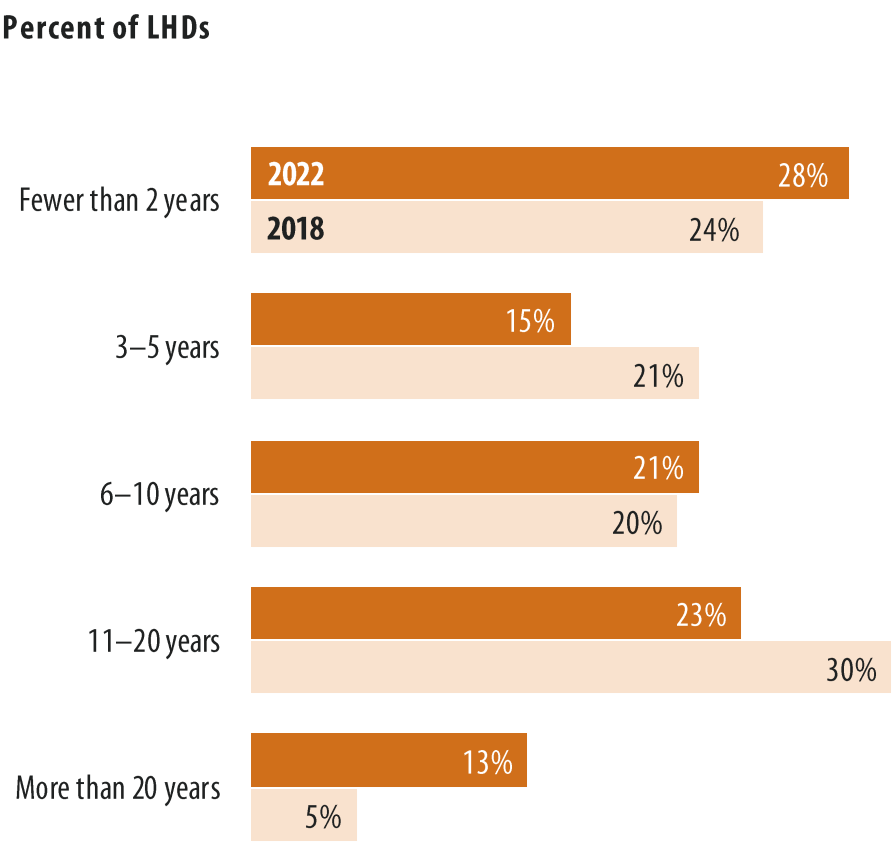
Preparedness Workforce



This chapter includes:

- Years of preparedness experience of lead LHD staff
- Amount of lead LHD staff's job dedicated to preparedness
- Lead preparedness staff's training needs
- LHD volunteer capacity to support public health emergencies
- LHD sponsorship of Medical Reserve Corps

Years of experience as a preparedness coordinator or equivalent, over time

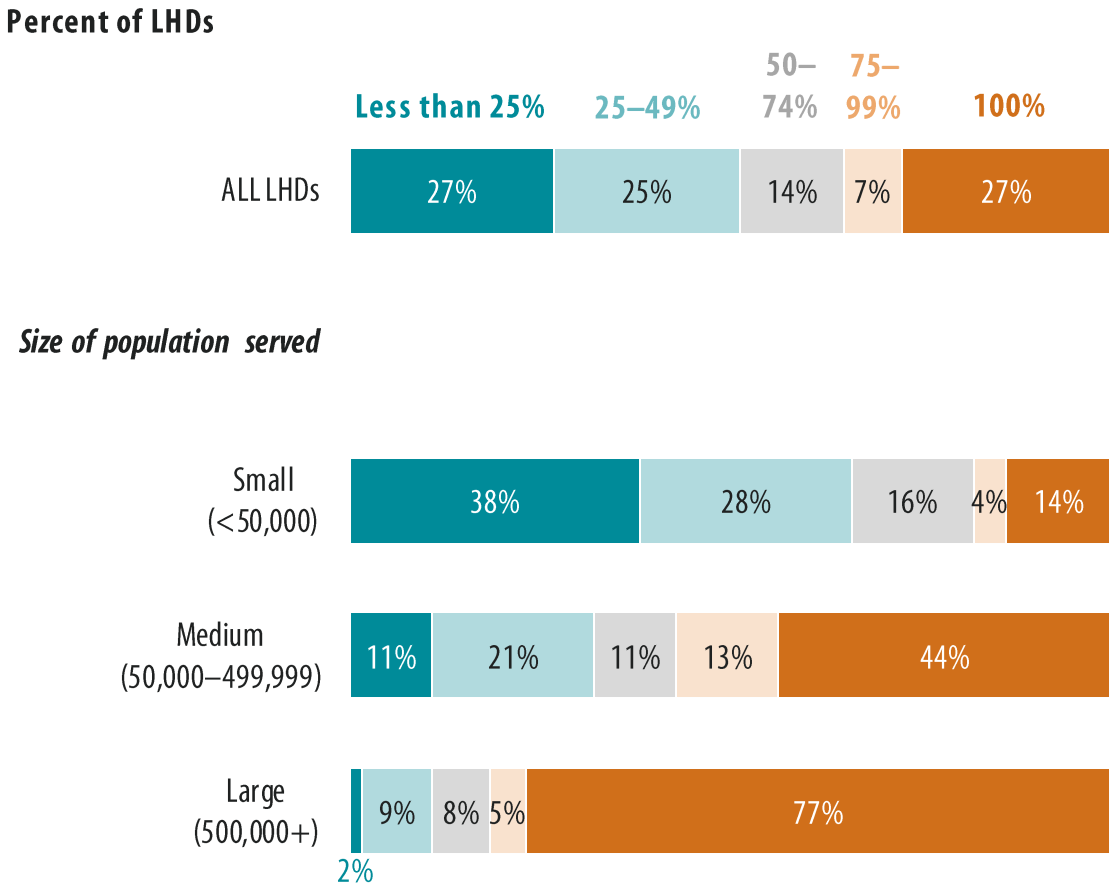


n(2022)=372
n(2018)=387

More than half of LHDs reported having a preparedness coordinator or equivalent staff member with at least six years of experience. The percentage of LHDs with this staff member having either fewer than 2 years or more than 20 years of experience was higher in 2022 than in 2018. This may suggest the preparedness workforce is aging, and training specifically for individuals new to the preparedness field could be timelier now more than ever.

Although not shown in the figure, individuals in large LHDs reported more preparedness experience compared to those in medium and small LHDs. In 2022, those in large LHDs averaged 11–20 years of preparedness experience, while those in medium and small LHDs averaged 6–10 years.

Percentage of coordinator/equivalent's time on the job dedicated to preparedness duties, by population size served

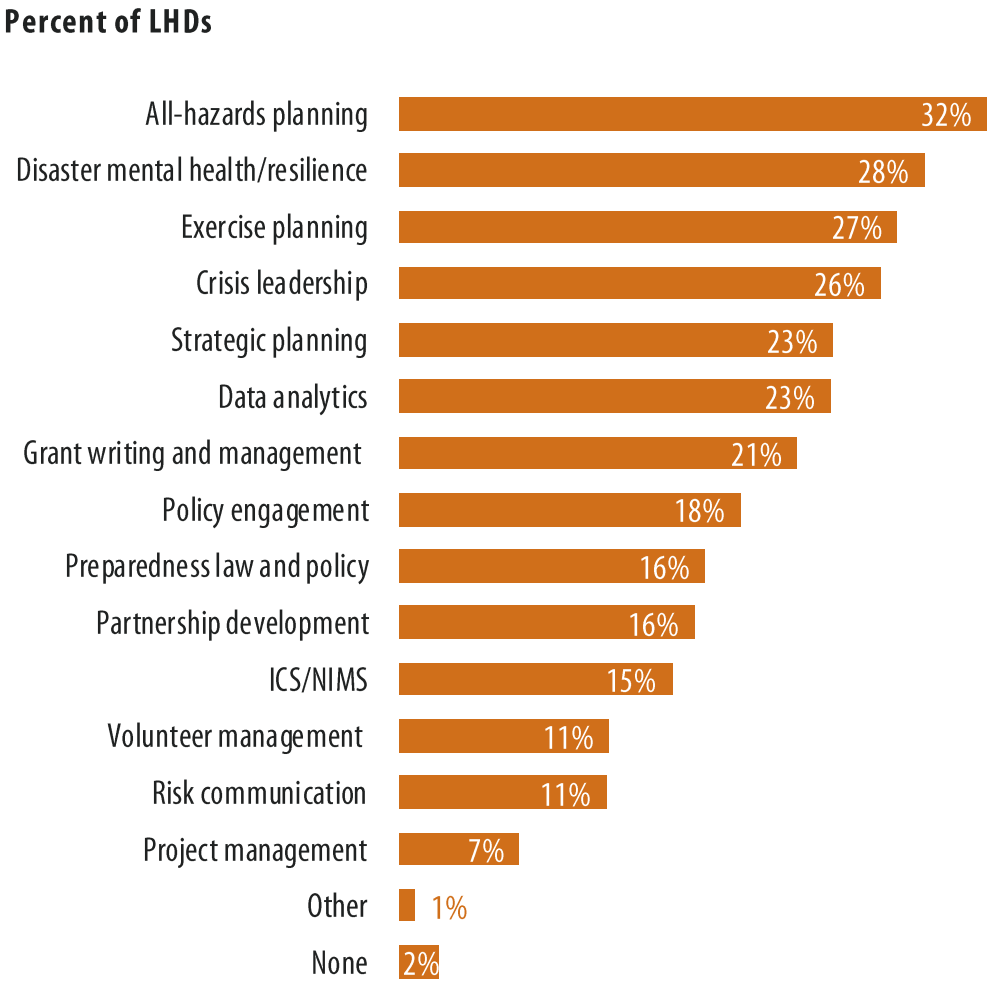


n=372

Approximately half of LHDs have a preparedness coordinator or equivalent that spends more than half of their job duties on preparedness. One in four LHDs have this staff member spending all of their time on preparedness-related duties—which appears to be driven by large LHDs, with 77% of these agencies reporting this.

Conversely, 27% of LHDs reported that less than a quarter of their coordinator/equivalent's job duties are dedicated to preparedness. Small LHDs were more likely to report this than medium or large LHDs. Often, staff in smaller agencies work across a variety of public health areas rather than in specialized positions.

Areas of training to most help preparedness coordinators address current gaps or needs in their jobs



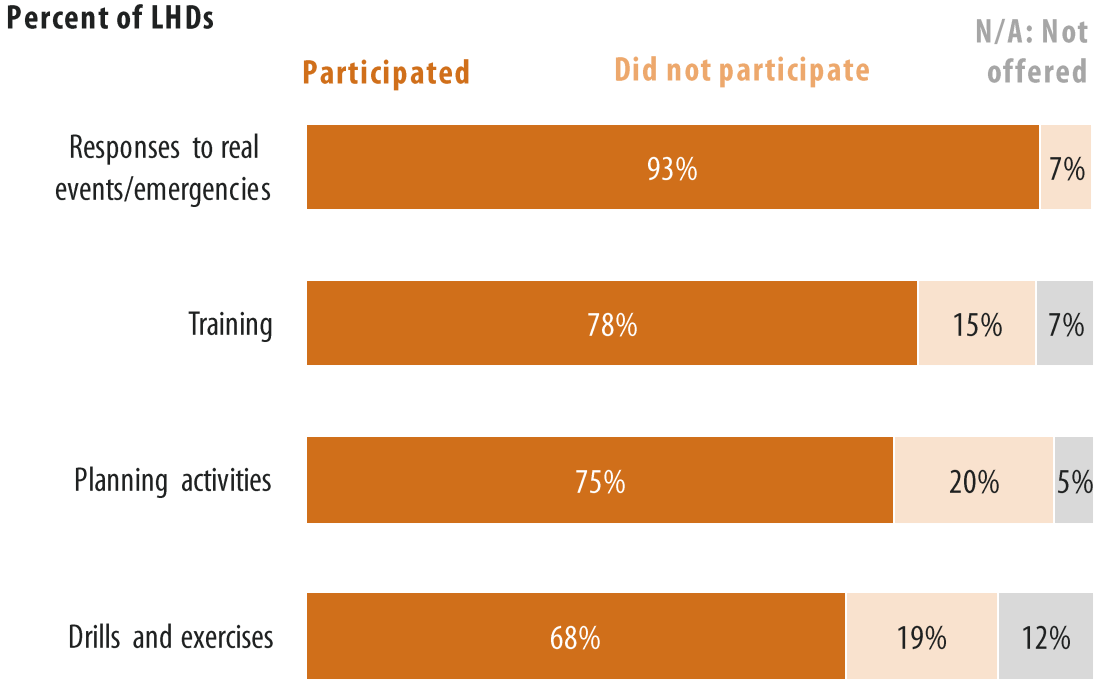
n=373

Overall, the most common areas of training needs were all-hazards planning and disaster mental health/resilience.

These areas presenting within the top three needs did not vary when stratified by population size served. Exercise planning was also among the top three for small LHDs, while policy engagement and crisis leadership were key needs for large and medium LHDs, respectively.

For LHDs that selected preparedness law and policy, they were most interested in emergency powers/authorities and constitutional foundations of public health law. In addition, small LHDs were interested in training about emergency powers and authorities.

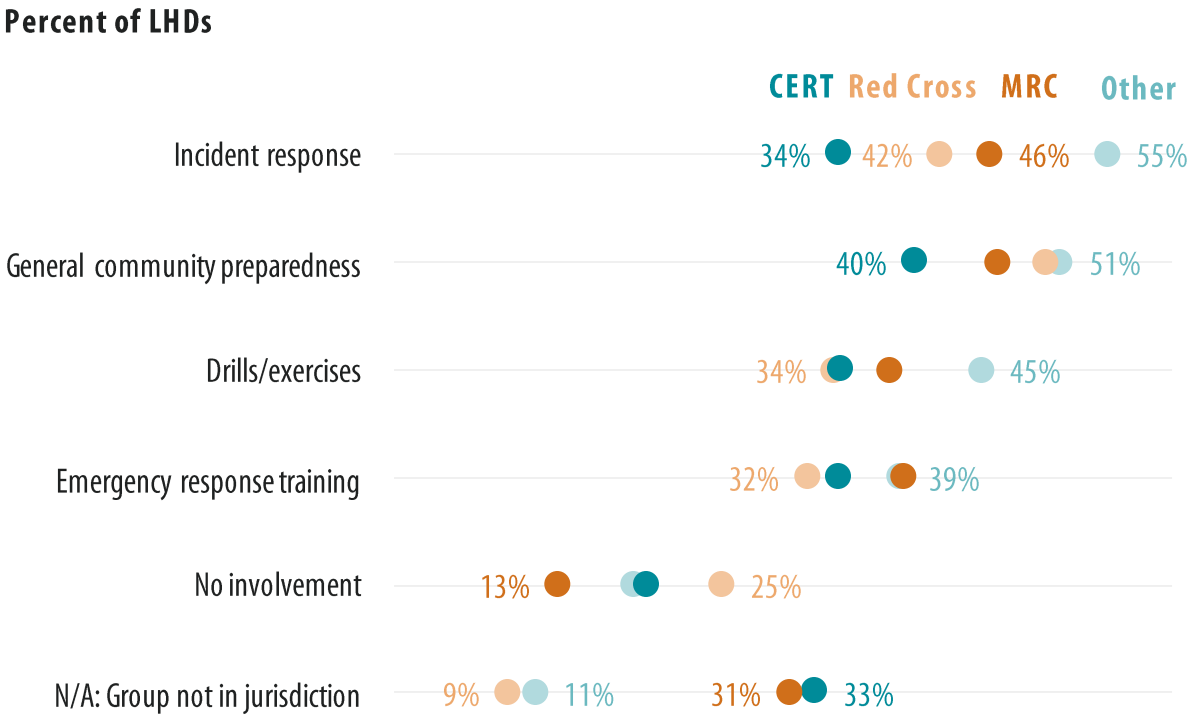
Preparedness activities in which non-preparedness LHD staff participated in the past year



Nearly all LHDs reported that non-preparedness staff participated in response to real events/emergencies. In addition, more than two in three LHDs reported these staff participated in drills and exercises. Although not shown in the figure, results did not vary when stratified by the population size served.

n=372–374

Preparedness activities in which LHDs work with volunteer groups

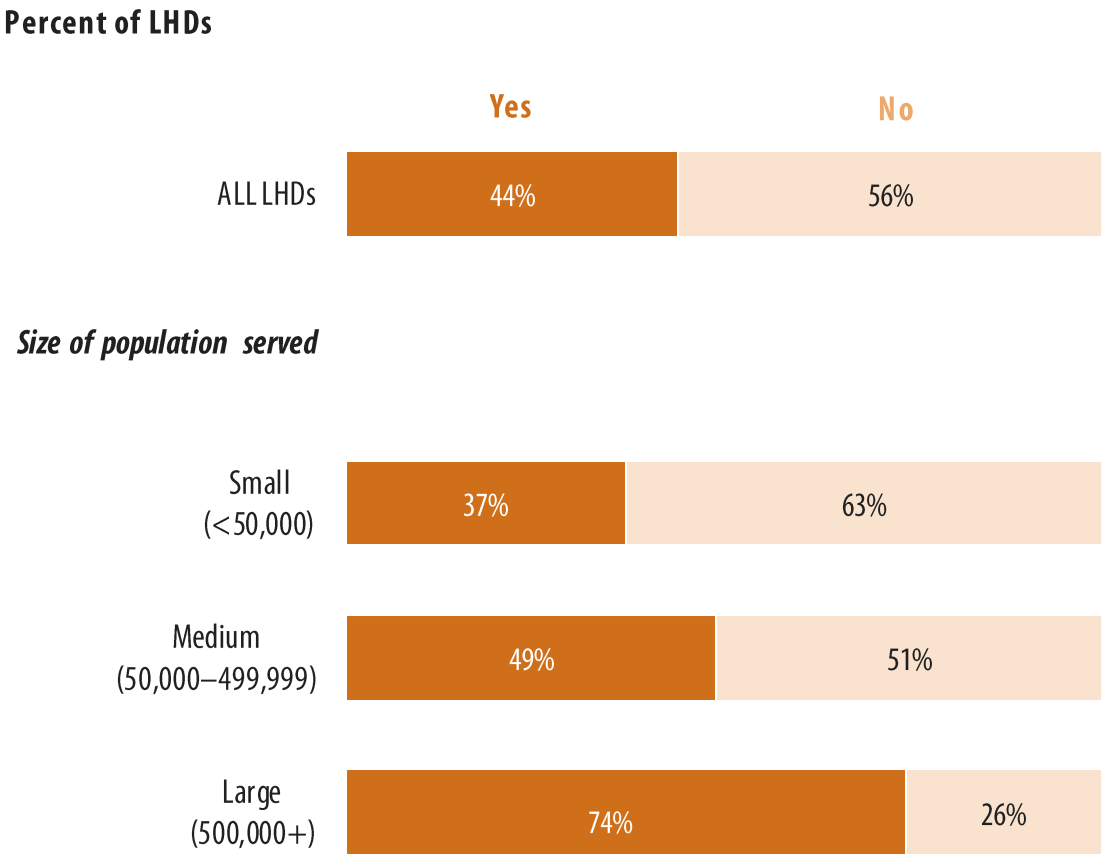


n=254–309

LHDs most commonly work with volunteer groups to conduct general community preparedness and incident response. Overall, Medical Reserve Corps (MRC) was the formal volunteer group most likely to be engaged in these activities, while Community Emergency Response Team (CERT) was least likely to be engaged.

Although not shown in the figure, large LHDs were likely to report working with volunteer groups across multiple preparedness activities.

LHD sponsorship of a Medical Reserve Corps (MRC) unit, by population size served



n=372

Many LHDs reported engaging MRC in preparedness activities, but less than 50% reported sponsoring a unit to support preparedness and response plans and workforce surge needs. Almost three in four large LHDs reported a sponsorship, compared to less than half of small and medium LHDs.

Of LHDs that did not sponsor a MRC unit, one in four indicated that they would.

The most common challenges to MRC sponsorship were limited staff capacity and limited resources for management. Small and medium LHDs also reported limited availability of volunteers.

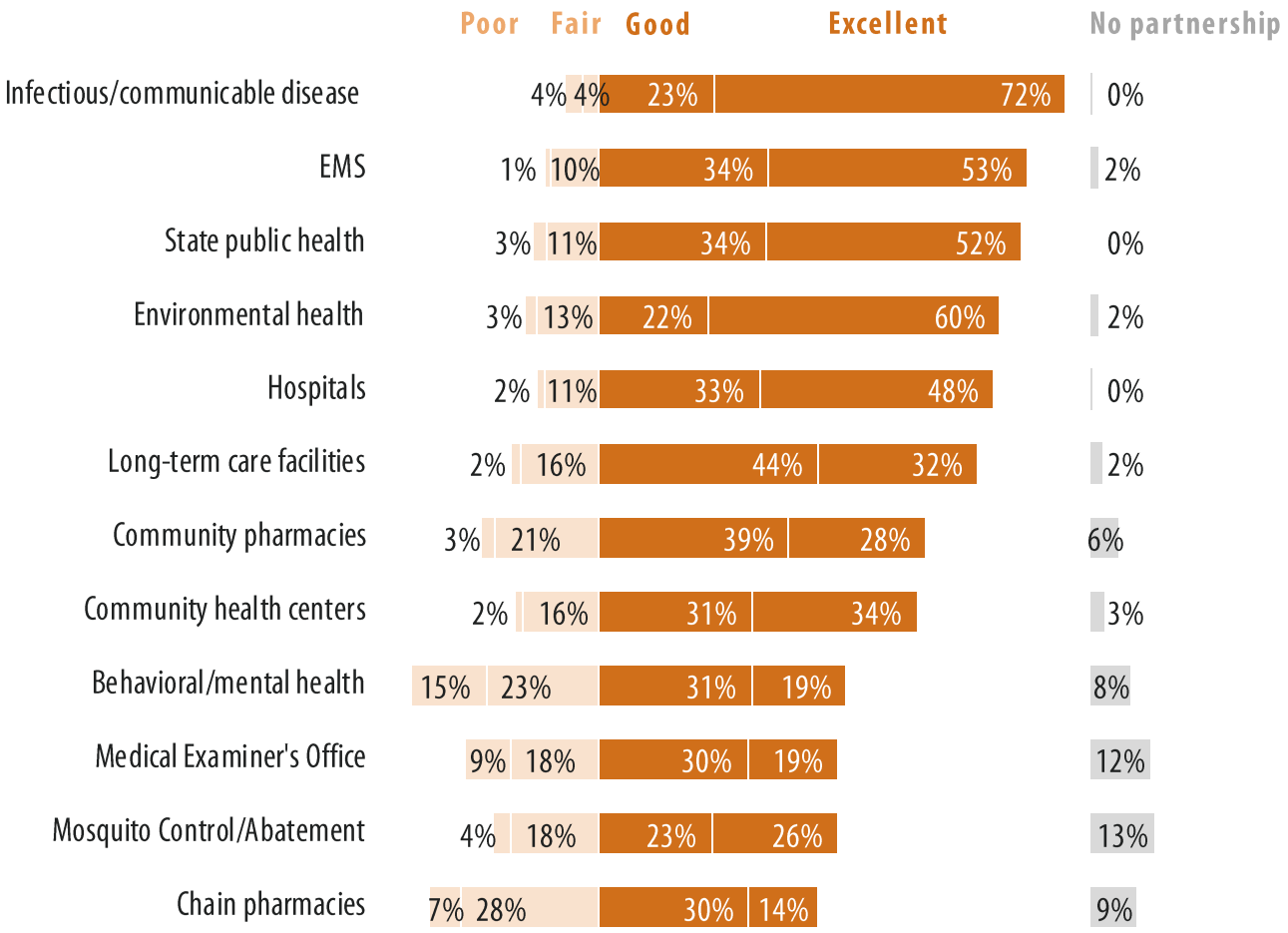
Partnerships & Collaboration

This chapter includes the following:

- Strength of LHD partnership with organizations
- Groups represented in LHD-engaged healthcare coalitions

Strength of LHD partnership with public health and healthcare organizations for emergency preparedness planning activities

Percent of LHDs *(N/A not displayed)*



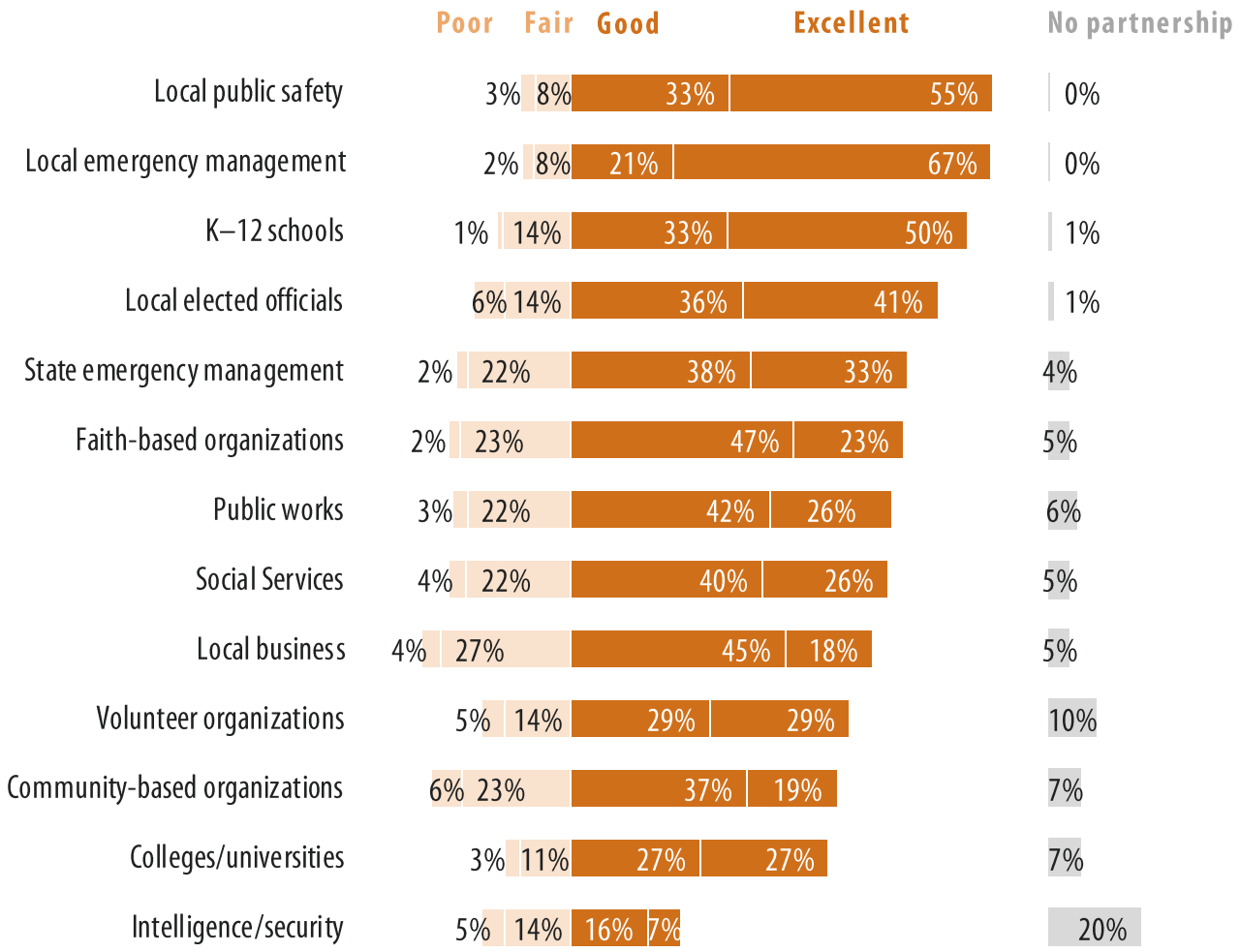
Most LHDs reported partnering with nearly all the listed public health and healthcare organizations. More than 80% noted strong relationships (i.e., "good" or "excellent") with infectious/communicable disease, EMS, state public health, environmental health, or hospitals.

Although not shown in the figure, more than 15% of LHDs indicated that mosquito control/abatement organizations did not exist in their jurisdiction.

n=362–365

Strength of LHD partnership with community and government organizations for emergency preparedness planning activities

Percent of LHDs *(N/A not displayed)*



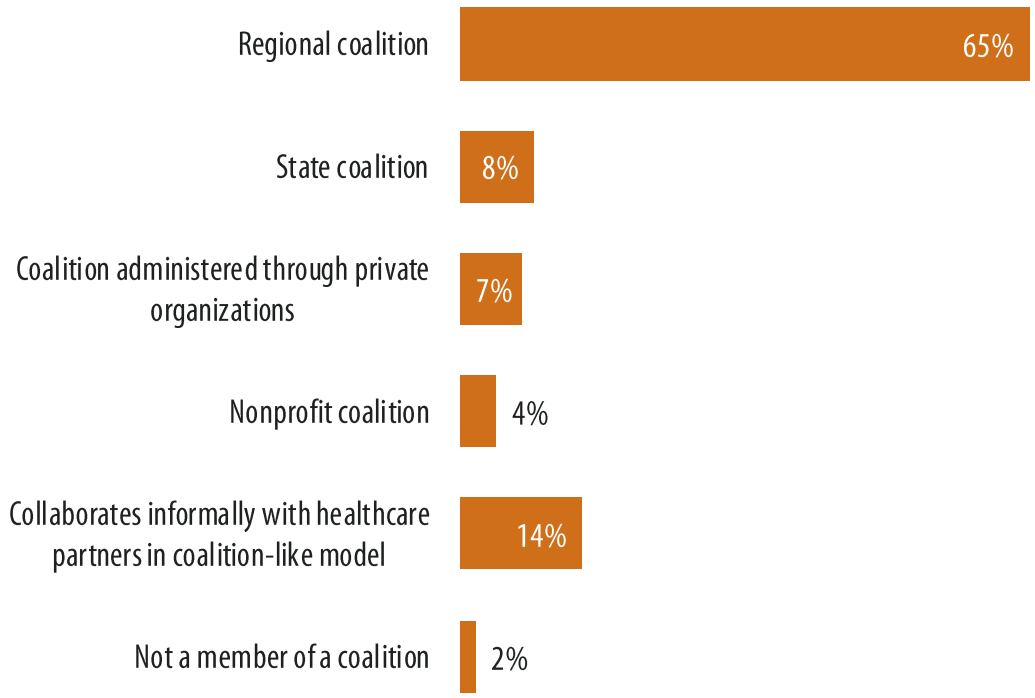
n=362–365

Local public safety, local emergency management, and K-12 schools were the most common community and government organizations with which LHDs had strong relationships. The least common organizations were colleges and intelligence/security agencies.

However, these were also the most common to not exist in the LHD's jurisdiction—with more than 15% of LHDs indicating this (not shown in the figure).

LHD engagement in healthcare coalitions

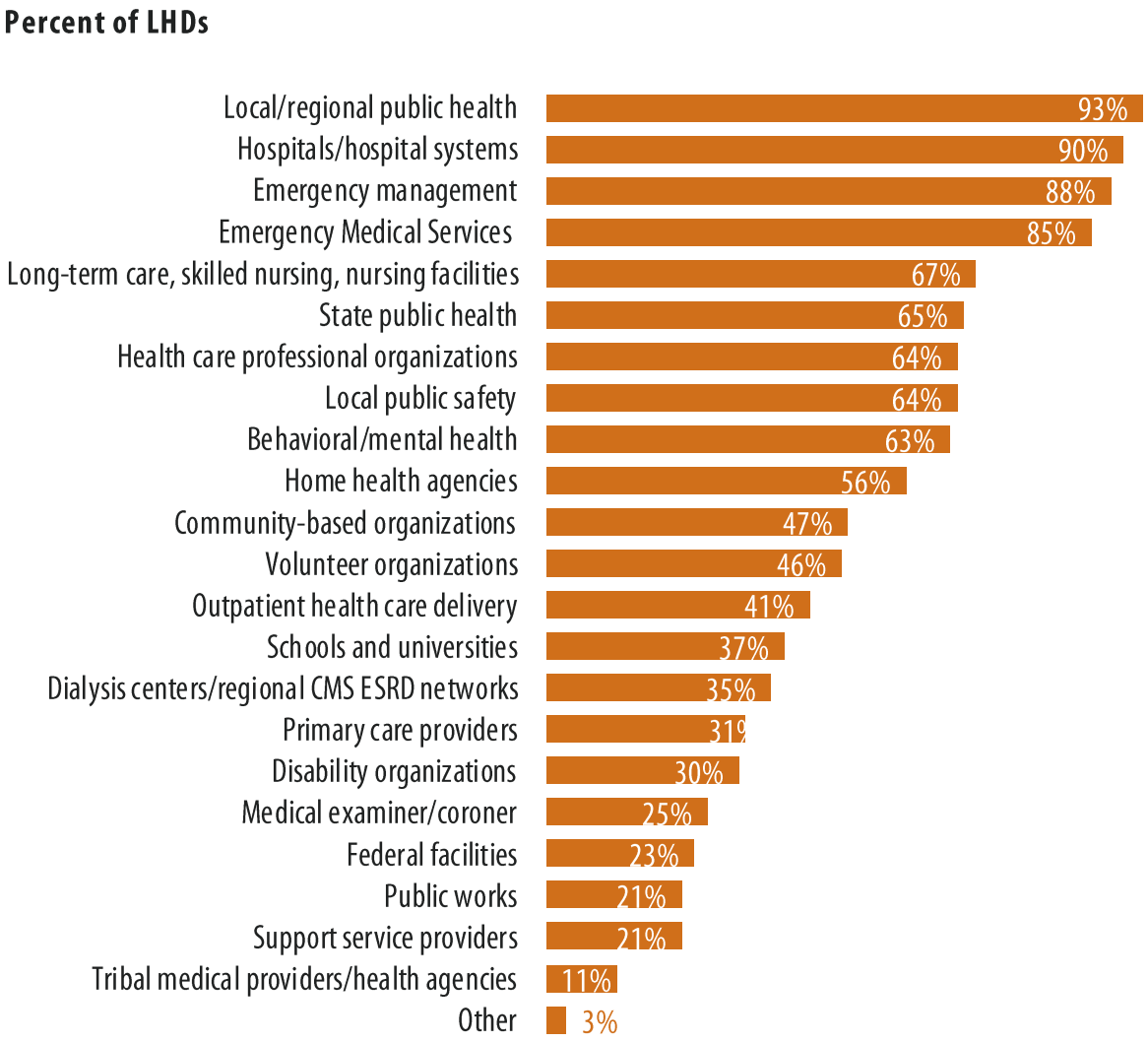
Percent of LHDs



Most LHDs were engaged in regional healthcare coalitions to plan and implement preparedness activities. Less than 20% participated in either a state, nonprofit, or private coalition, while 14% collaborated informally with healthcare partners in a coalition-like model. Only 2% were not members of any healthcare coalition.

n=344

Groups represented in LHD-engaged healthcare coalitions



n=332

The most commonly represented groups in LHD-engaged healthcare coalitions were hospitals, public health, emergency management, and Emergency Medical Services (EMS). Tribal medical providers, support service providers (e.g., clinical laboratories, pharmacies), and public works agencies were not commonly engaged.

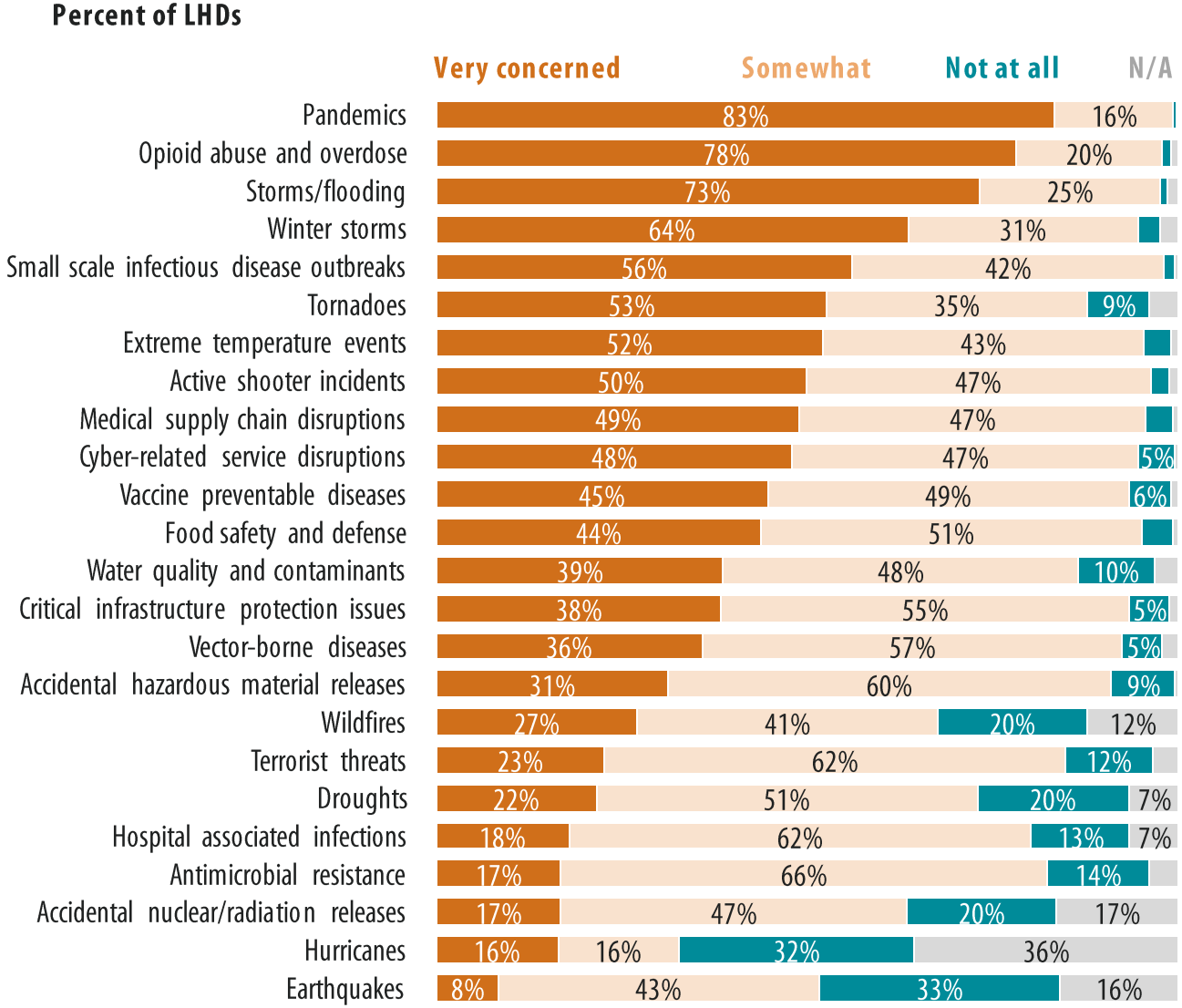
Coalitions in larger jurisdictions had a broader range of groups represented than those in smaller jurisdictions.

Preparedness Planning Capacity

This chapter includes the following:

- Level of concern and preparedness about public health threats and hazards
- Populations addressed in preparedness planning activities
- Administrative preparedness mechanisms in place
- Barriers to administrative preparedness
- Existence of local stockpiles
- Awareness of the National Health Security Strategy (NHSS)
- Supplemental funds received by LHDs for COVID-19 response

Level of concern about the impact of threats or hazards in community

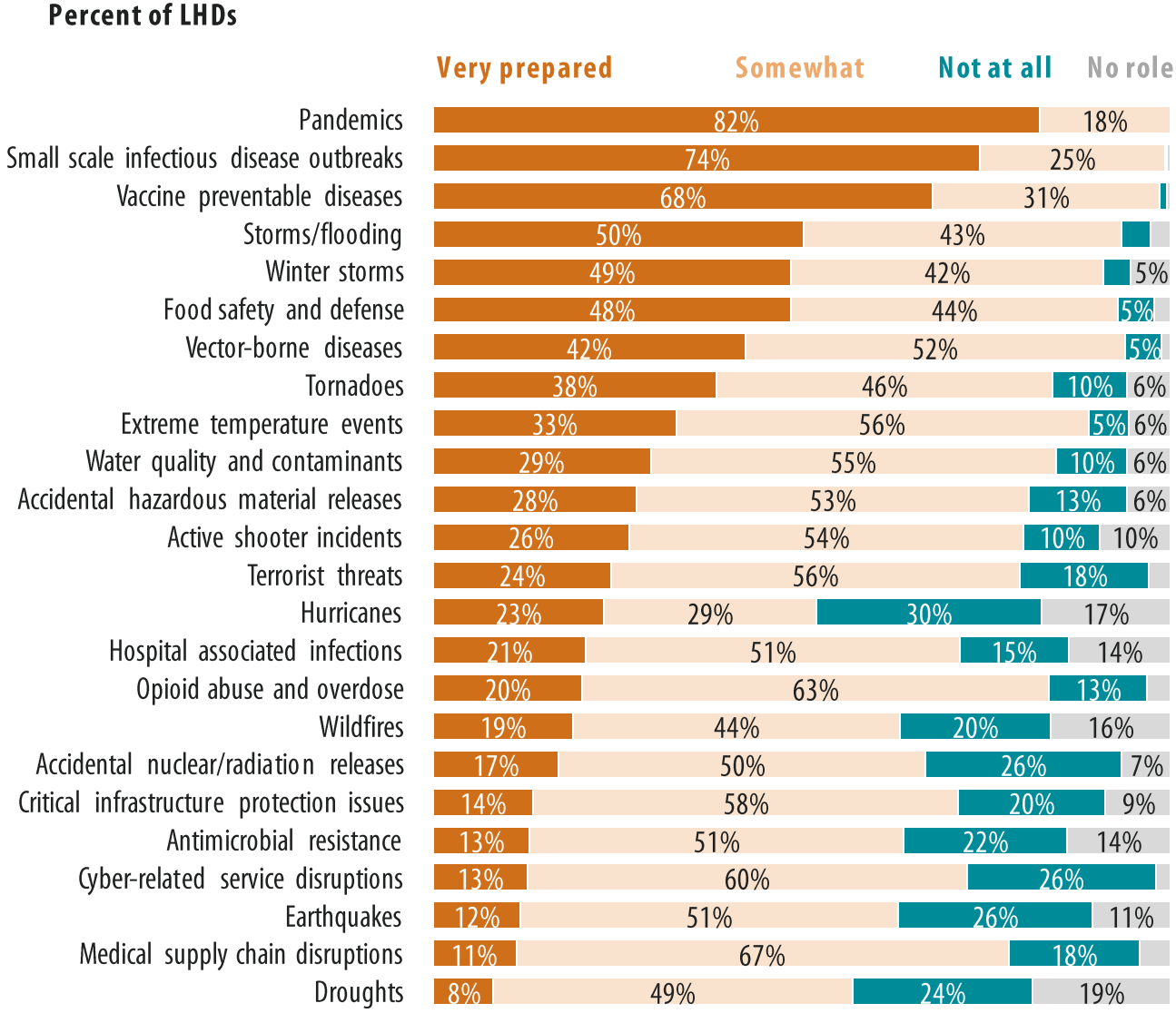


n=360–364

More than 60% of LHDs reported being very concerned about pandemics, opioid abuse and overdose, storms/flooding, and winter storms.

Approximately one in three LHDs indicated being not at all concerned about earthquakes and hurricanes.

Level of preparedness to respond to threats or hazards identified as facing community



n=236–362

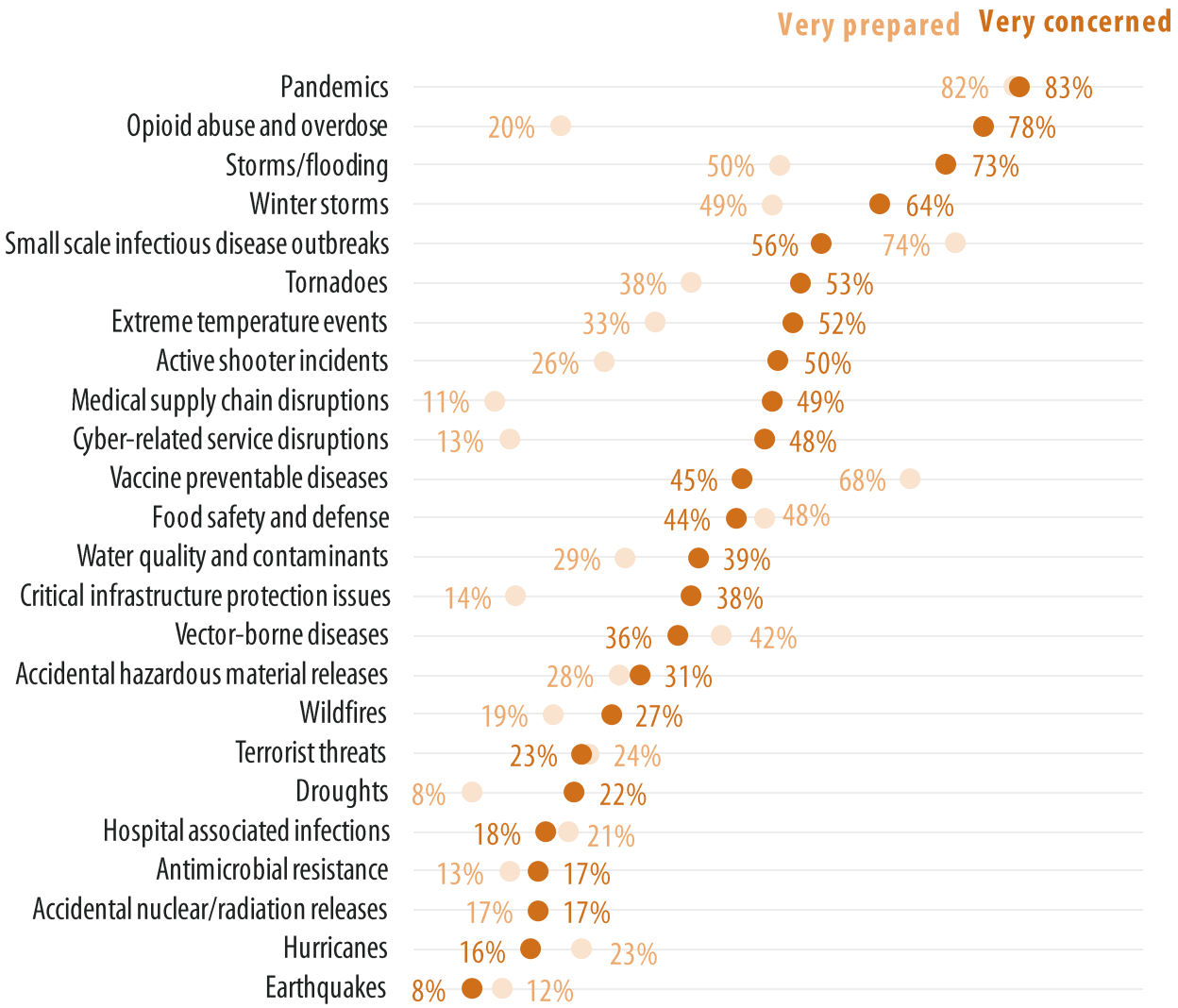
LHDs are prepared to address most threats or hazards identified as facing their community. In particular, more than half of LHDs are very prepared to respond to pandemics, small scale infectious diseases, and vaccine preventable diseases.

More than 25% of LHDs reported not being prepared at all to respond to hurricanes, accidental nuclear/radiation releases, cyber-related service disruptions, or earthquakes.

Although not shown in the figure, larger LHDs tended to report being very prepared to many threats at higher percentages than smaller LHDs.

High level of concern about the impact of threats/hazards compared to a high level of preparedness to address those threats/hazards

Percent of LHDs

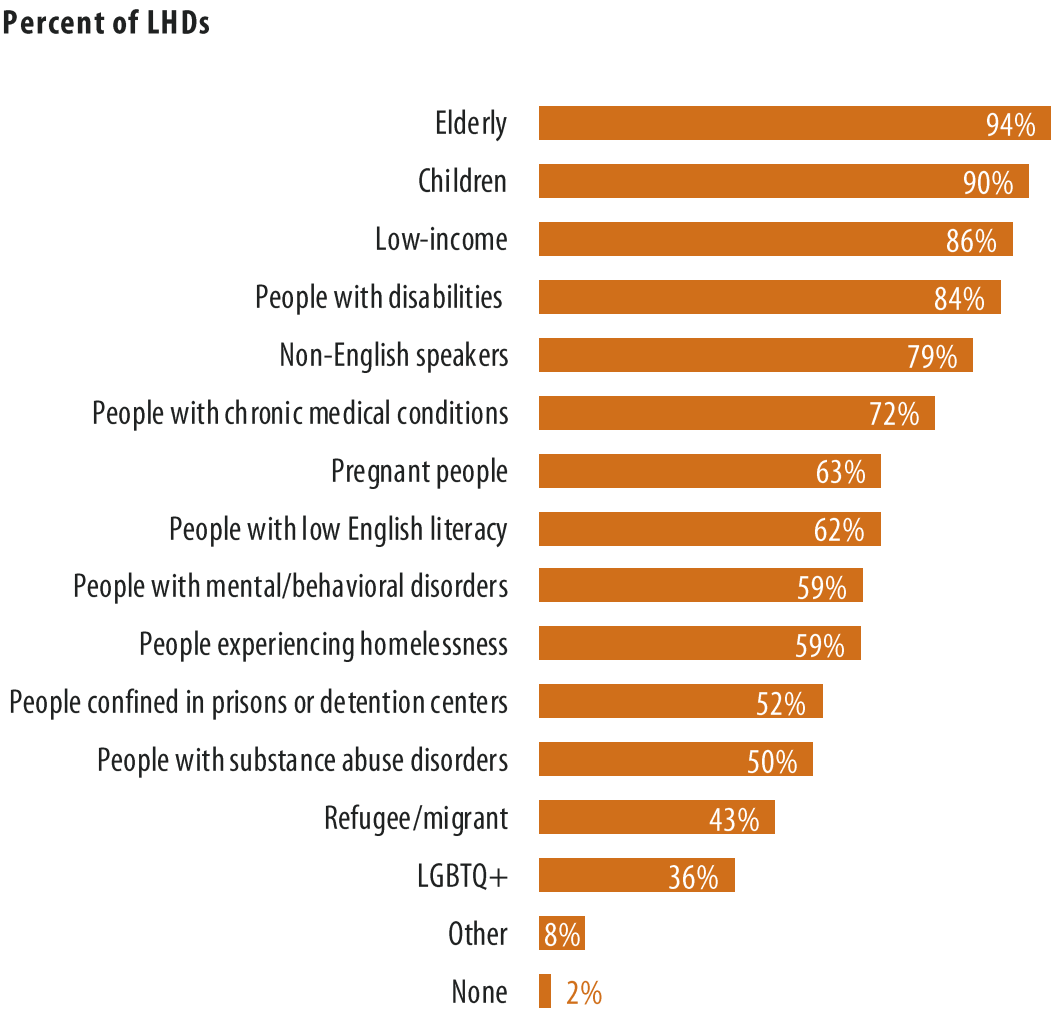


n=236–364

LHDs reported being both very concerned and very prepared to address pandemics. In comparison, they indicated feeling much more concerned than prepared to respond to several threats, including opioid abuse, medical supply chain disruptions, and cyber-related service disruptions.

LHDs felt more prepared than concerned about small-scale infectious diseases and vaccine preventable diseases.

At-risk/vulnerable populations addressed in preparedness planning efforts



n=344

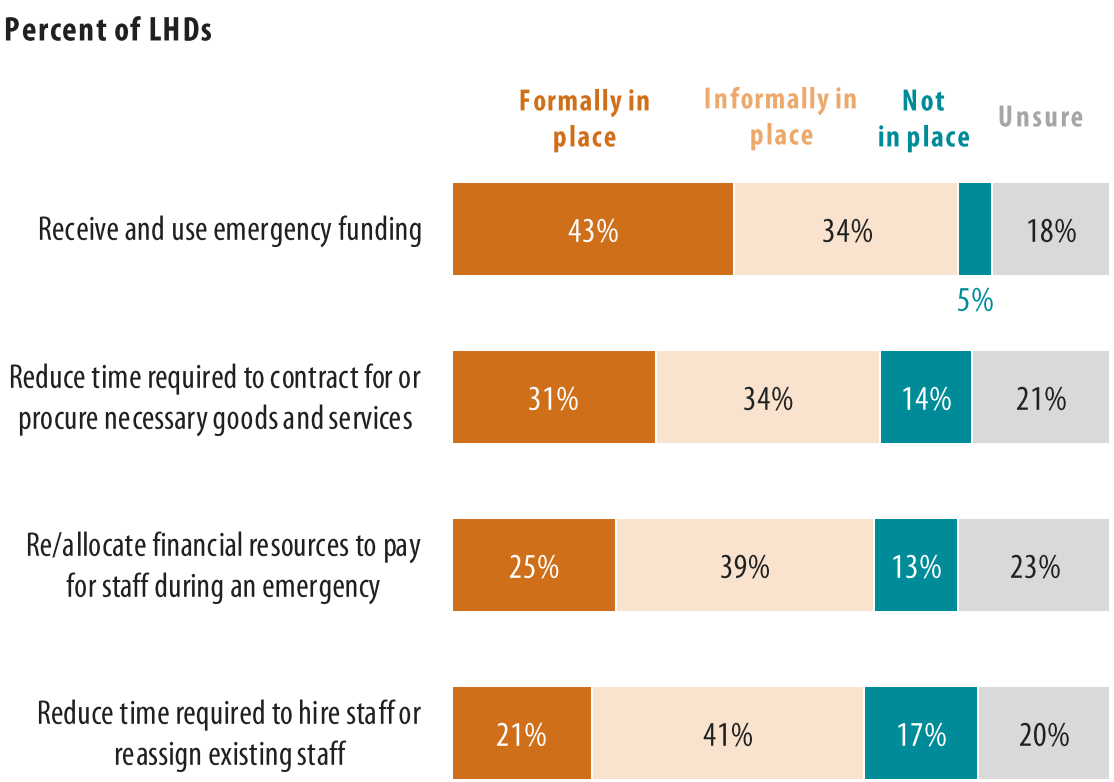
More than 75% of LHDs reported addressing a variety of at-risk/vulnerable populations in their preparedness planning efforts, including children, the elderly, low-income, non-English speakers, and people with disabilities.

However, less than half of LHDs indicated considering LGBTQ+ and refugee/migrant populations in their preparedness planning efforts.

Although not shown in the figure, larger LHDs were generally more likely to address many of these at-risk/vulnerable populations compared to smaller LHDs.

In addition, approximately half of LHDs (47%) offer specific training for working with at-risk and vulnerable people during public health emergencies.

Expedited mechanisms in place to address administrative preparedness activities during a local, state, or federally declared emergency



LHDs were most likely to have informal mechanisms in place to address administrative preparedness needs during a public health emergency. Formal mechanisms were generally less common than informal mechanisms, except in the case of receiving and using emergency funding.

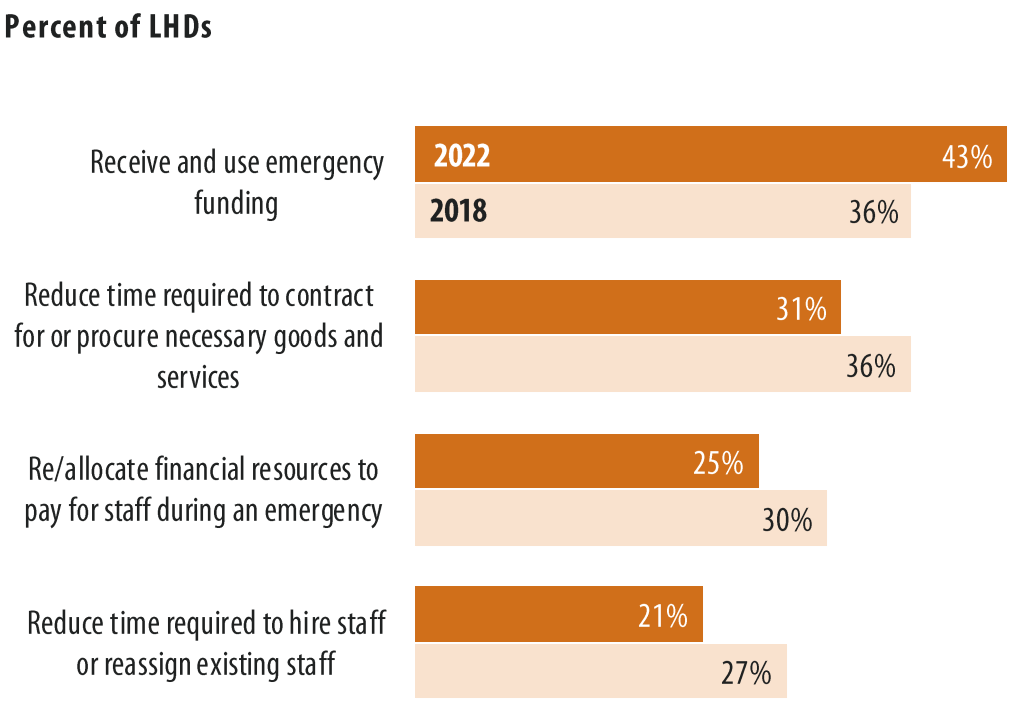
Almost 20% of LHDs were unsure about whether there were expedited mechanisms in place.

Although not shown in the figure, large LHDs were more likely to report having formal mechanisms in place, compared to within small and medium LHDs.

n=338–339

Formal mechanisms are defined as written agreements or plans established prior to an emergency. Informal mechanisms are cases in which a plan is agreed to verbally but not formally written; a process developed in an ad-hoc manner during an emergency.

Formal mechanisms in place to address administrative preparedness activities during a declared emergency, over time

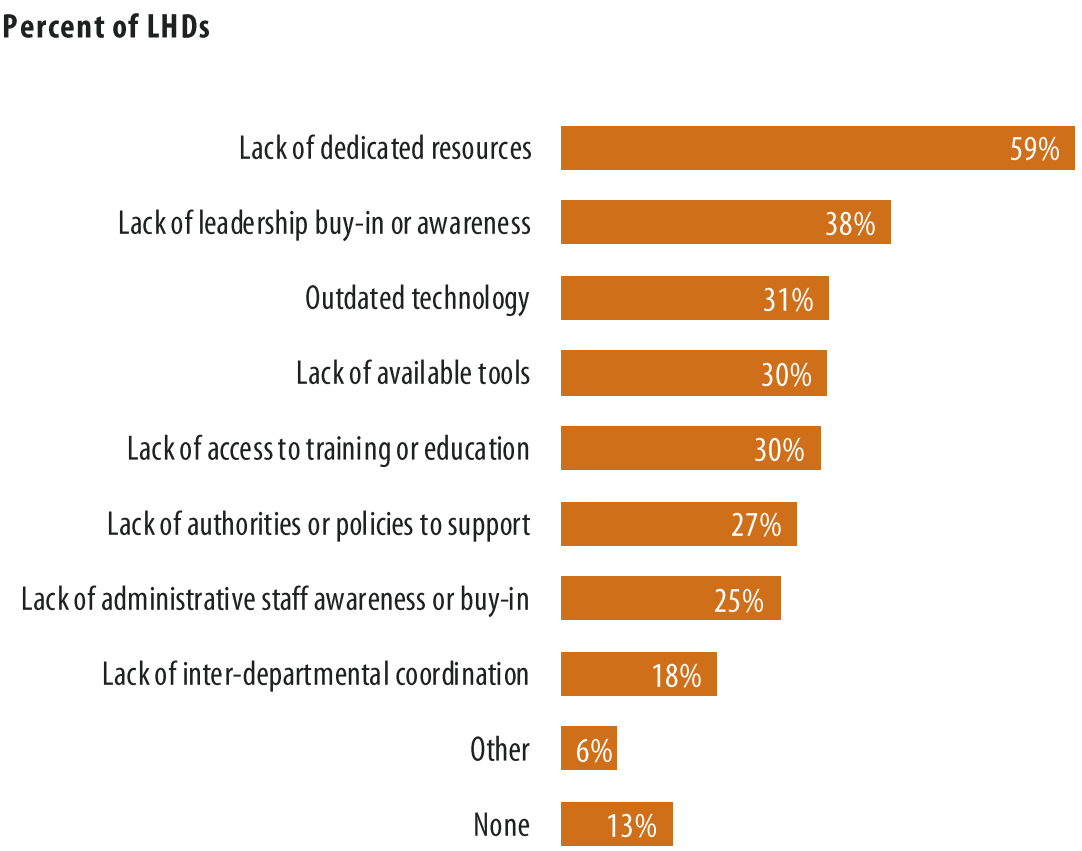


In 2022, fewer LHDs reported having formal mechanisms in place to address administrative preparedness activities than in 2018—except in the case of receiving and using emergency funding.

In particular, 25% or fewer LHDs reported having formal administrative preparedness mechanisms in place to re/allocate financial resources to pay for staff during an emergency or reduce the time required to hire staff or reassign existing staff.

n(2022)=338–339
n(2018)=372–374

Barriers to administrative preparedness



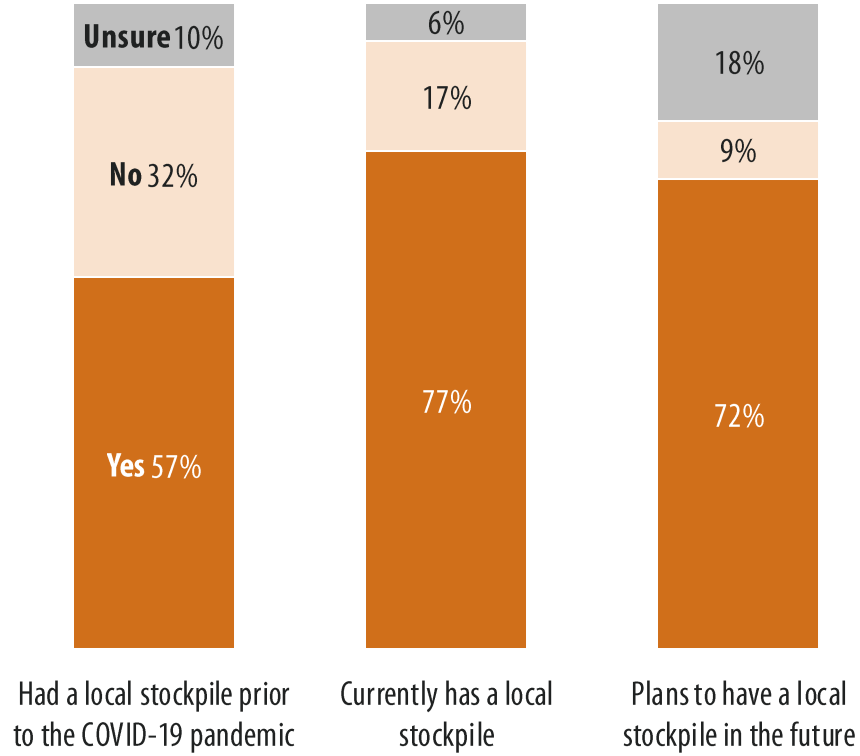
n=328

Most LHDs indicated at least one barrier to administrative preparedness. The most common was the lack of dedicated resources, and this was reported as a major challenge across LHDs serving different population sizes.

Other barriers were more relevant to LHDs of different sizes. In particular, the lack of leadership buy-in or awareness was a common barrier for small LHDs, while outdated technology was a barrier for medium LHDs. Lack of authorities or policies to support particularly affected large LHDs.

Existence of stockpiles within local jurisdictions before, during, and after the COVID-19 pandemic

Percent of LHDs



n=341–342

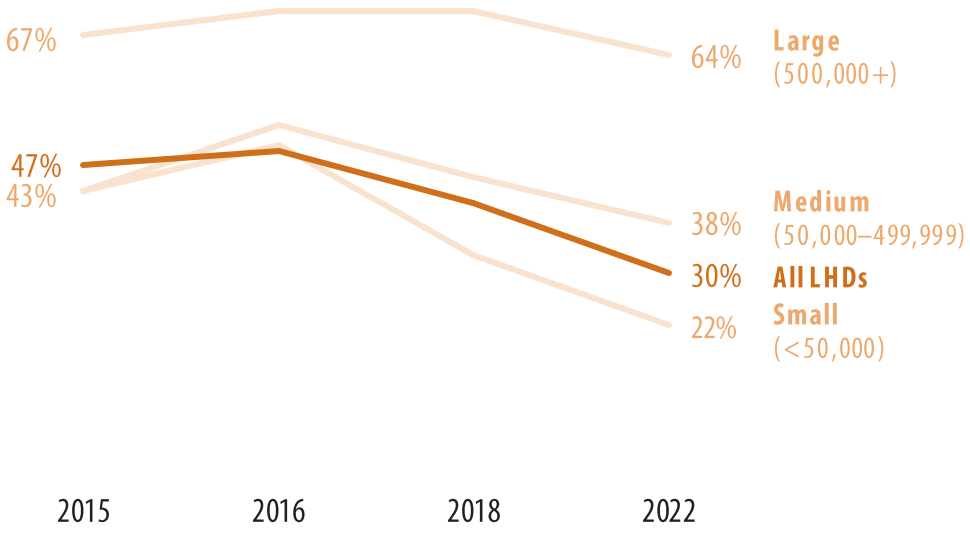
More than half of LHDs indicated having had a stockpile prior to the COVID-19 pandemic, while almost three in four LHDs indicated currently having a stockpile or having plans to have a stockpile in the future. Although not shown in the figure, the existence of a local stockpile was more common in larger jurisdictions.

The top barriers to having a local stockpile were maintenance and limited funds.

Within local stockpiles, LHDs indicated that the most common items were personal protective equipment (e.g., gloves, masks, and gowns). Other common items were medical supplies and medications/vaccines.

Awareness among LHDs of the National Health Security Strategy (NHSS), by population size served and over time

Percent of LHDs reporting awareness



n(2022)=336, n(2018)=365
n(2016)=430, n(2015)=330

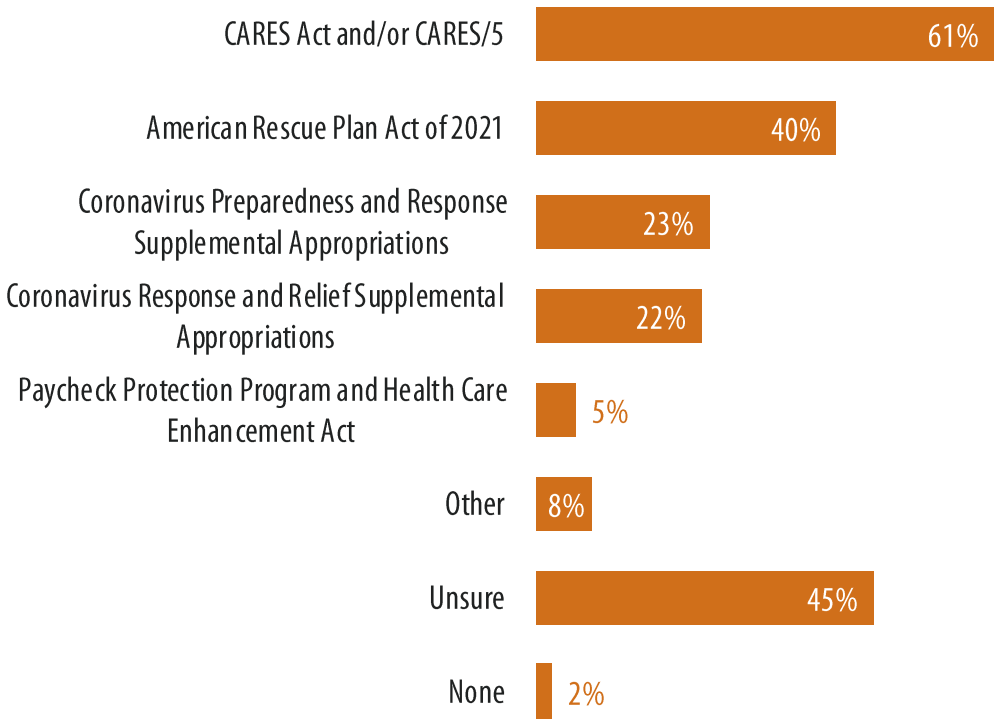
In 2022, only one in three LHDs were aware of the National Health Security Strategy (NHSS)—a comprehensive strategic approach to coordinating the nation's health security system. The proportion of LHDs aware of this approach has been declining since 2016.

However, this finding varies by jurisdiction size, with a majority of large LHDs indicating they were aware each year.

Among LHDs that were aware of NHSS in 2022, 57% indicate that the strategy somewhat or strongly informs their preparedness work. Across population size served, 49% of small, 66% of medium, and 87% of large LHDs reported this.

Supplemental funds received by LHD jurisdiction since the start of the pandemic to support the COVID-19 response

Percent of LHDs



n=323

More than half of LHDs reported receiving CARES ACT and/or CARES/5 funds to support their COVID-19 response. However, many LHDs reported being unsure about which supplemental funds they received, if any.

Although not shown in the figure, large LHDs were more likely to report receiving supplemental funds than smaller LHDs. In particular, 62% of large LHDs received funds from American Rescue Plan Act of 2021, while this was the case for only 34% of small LHDs.

Preparedness & Response Activities

This chapter includes the following:

- Activities conducted during the past year
- Changes in LHD participation in activities in the past three years
- COVID-19 response activities strengthened by Public Health Emergency Preparedness (PHEP) funding and guidance

Preparedness and response activities conducted by LHDs during the past year to address the topics

Percent of LHDs

	Planning	Training	Drills/ exercises	Regular coordination	Outreach	Real-event responses	No activities
Infectious disease	51%	36%	22%	52%	39%	79%	3%
Non-pharmaceutical interventions	47%	29%	16%	50%	41%	81%	5%
Medical countermeasure dispensing	53%	35%	28%	51%	37%	73%	6%
Community preparedness	48%	29%	24%	45%	43%	62%	6%
Emergency risk communications	42%	29%	25%	42%	33%	65%	6%
Healthcare preparedness	55%	30%	25%	50%	30%	55%	10%
Other at-risk populations	40%	17%	13%	47%	48%	58%	12%
Weather-related events	52%	23%	24%	33%	22%	37%	17%
Environmental health	46%	27%	11%	36%	25%	40%	18%
Volunteer management	36%	26%	17%	35%	33%	57%	19%
Bio-surveillance	35%	19%	10%	37%	26%	56%	19%
Disaster behavioral/mental health	38%	26%	10%	33%	32%	29%	26%
Long-term recovery	37%	11%	7%	23%	17%	39%	29%
Disaster sheltering	44%	20%	16%	23%	28%	16%	30%
Mass fatality	45%	22%	18%	23%	8%	14%	34%
People experiencing homelessness	22%	4%	3%	28%	36%	36%	36%
Cybersecurity	36%	29%	9%	16%	4%	11%	37%
CBRN events	38%	20%	14%	16%	6%	3%	48%
Critical infrastructure protection	31%	10%	8%	18%	11%	9%	51%
Terrorist threats	33%	18%	11%	2%	11%	6%	55%
Climate change/adaptation	23%	8%	4%	12%	10%	7%	65%

n=347–356

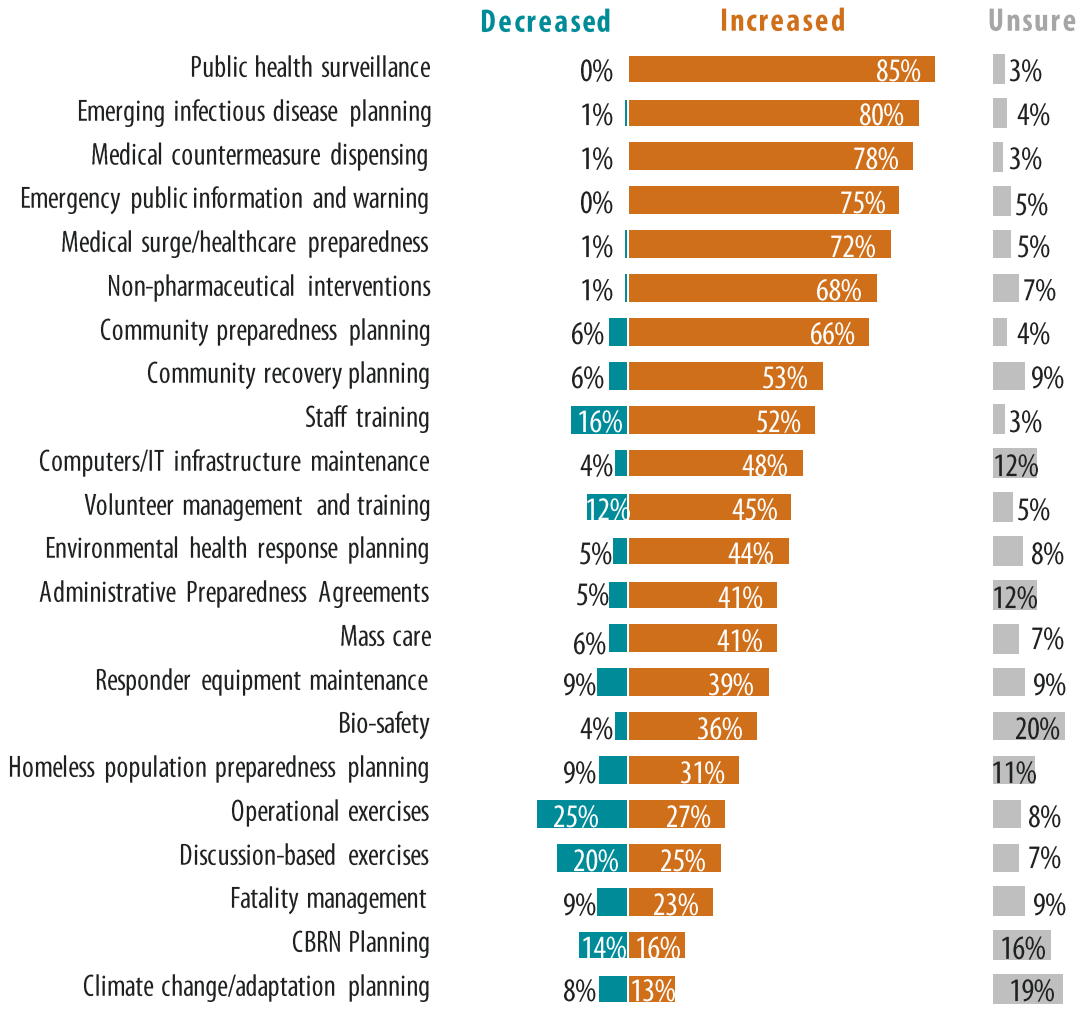
LHDs indicated conducting the most activities to address infectious disease, non-pharmaceutical interventions, and medical countermeasures.

They were least likely to report conducting drills/exercises for each of the topics listed, compared to other activities.

More than half of LHDs reported no activities related to climate change/adaption, critical infrastructure protection, and terrorist threats. Although not shown in the table, smaller LHDs were more likely to report no activities than larger LHDs.

Changes in LHD participation in public health preparedness activities in the past three years, among LHDs that engage in the activity

Percent of LHDs *(No change not displayed)*



n=277–344

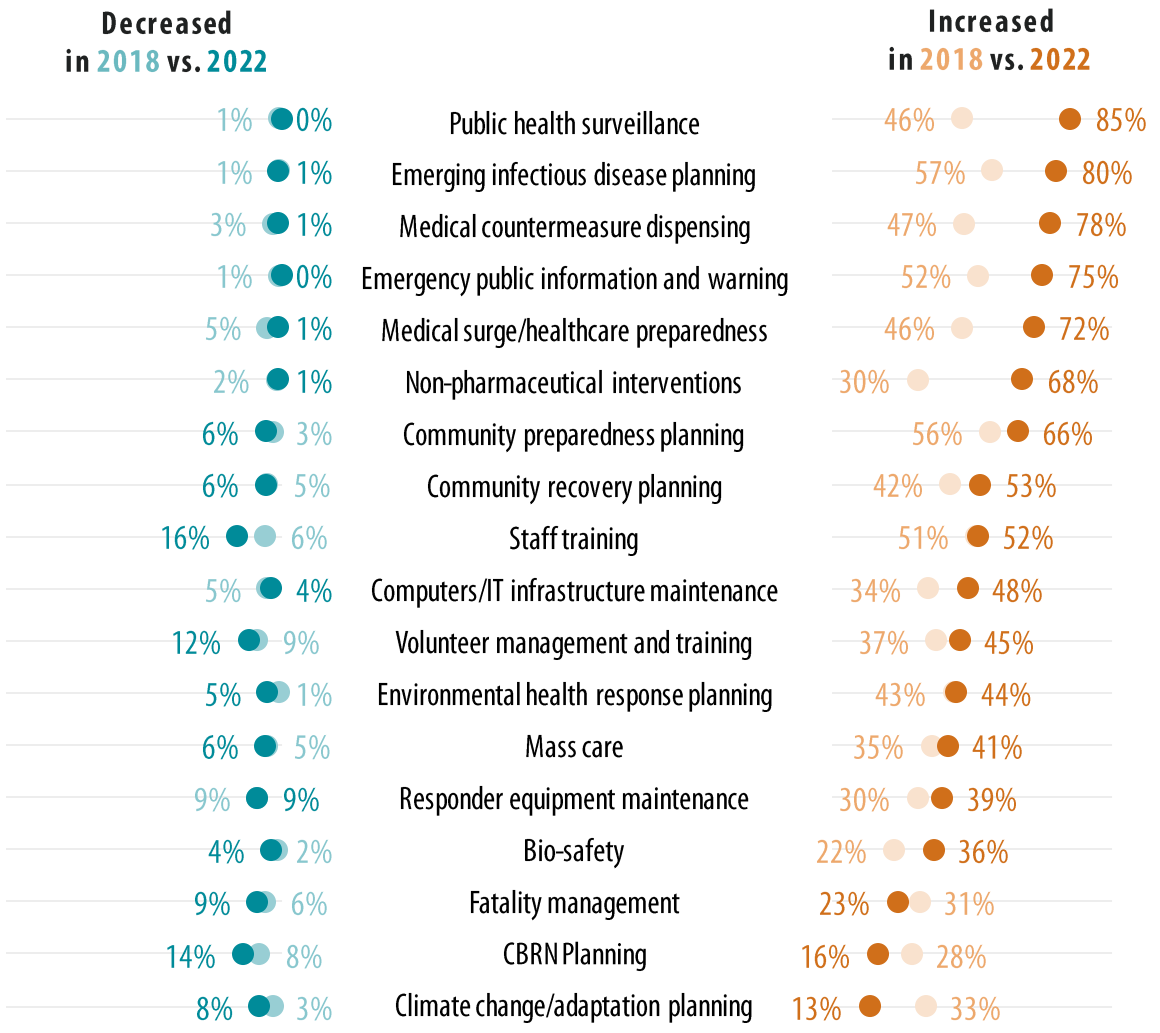
A large majority of LHDs indicated that their participation increased in public health surveillance/epidemiological investigation, emerging infectious disease planning, or medical countermeasure dispensing/ medical materiel distribution.

A similar proportion of LHDs increased and decreased their participation in discussion-based exercises and operational exercises.

Approximately one in five LHDs were unsure about how their participation in bio-safety and climate change/adaption planning changed in the past three years.

Changes in LHD participation in public health preparedness activities in the past three years, over time, among LHDs that engage in the activity

Percent of LHDs *(No change and N/A not displayed)*



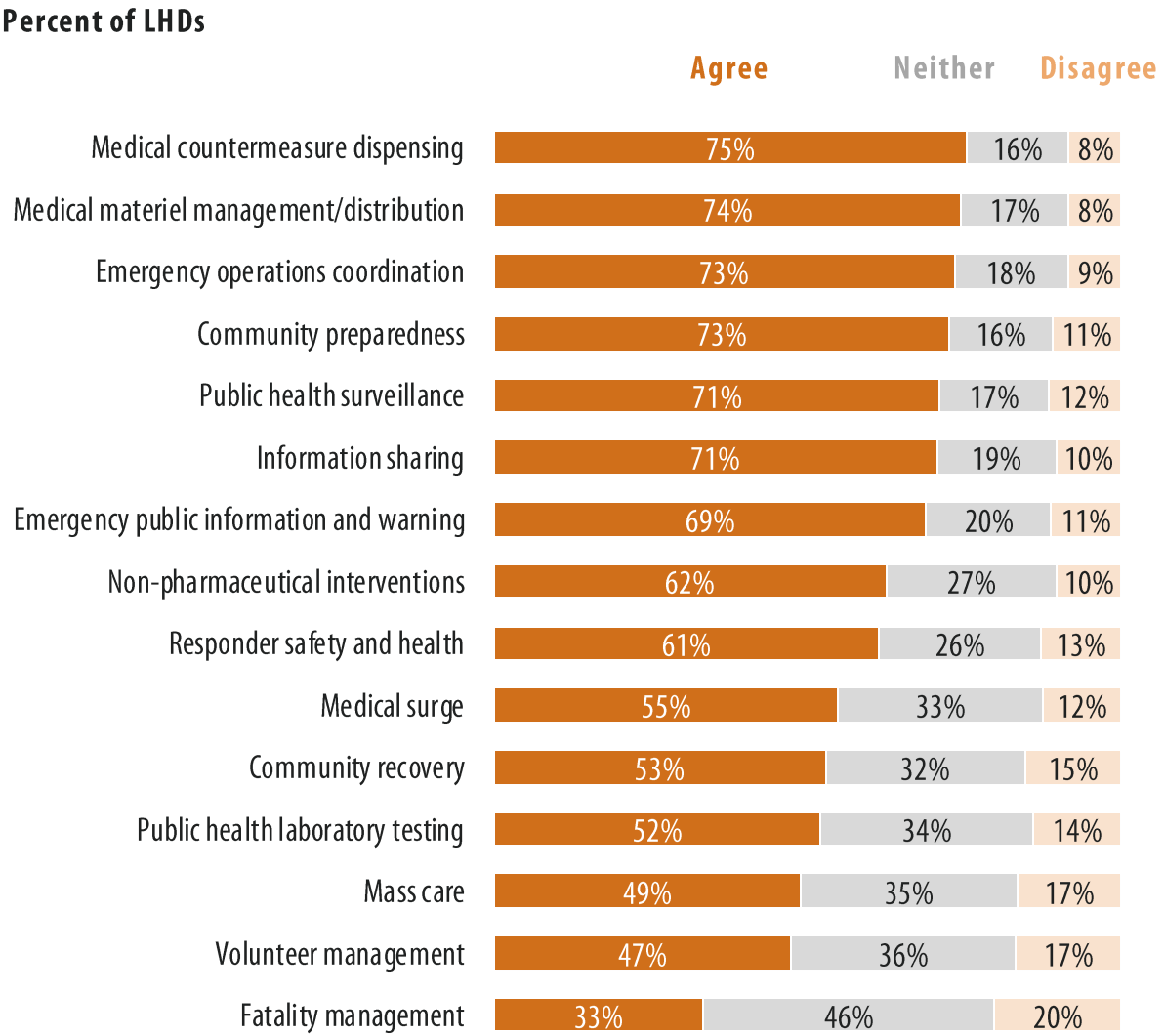
n=277–344

In 2022, LHDs were much more likely to have increased their participation in several preparedness activities than in 2018. In particular, the proportion of LHDs reporting public health surveillance, medical countermeasure dispensing, or non-pharmaceutical interventions increased by at least 30 percentage points.

In contrast, LHDs were more likely to have increased participation in fatality management; chemical, biological, radiological, and nuclear (CBRN) planning; and climate change planning in 2018 than in 2022.

Notably, the proportion of LHDs increasing engagement in staff training remained the same between 2018 and 2022. However, more LHDs decreased their engagement in this activity in 2022 than in 2018.

Degree to which Public Health Emergency Preparedness (PHEP) funding and guidance strengthened LHD's ability to respond to the COVID-19 pandemic



n=321–324

Most LHDs somewhat or strongly agreed that Public Health Emergency Preparedness (PHEP) funding and guidance strengthened their ability to conduct medical countermeasure dispensing/administration during the COVID-19 pandemic. In contrast, LHDs were least likely to agree that PHEP bolstered their fatality management capabilities.

Although not shown in the figure, small LHDs were more likely to agree that community preparedness was strengthened, compared to medium and large LHDs. Meanwhile, large LHDs were more likely to agree that emergency operations coordination was strengthened.

Two in three LHDs provided consensus, concurrence, or approval on the overall strategies and priorities described in the most recent PHEP work plan.

Recommendations

This chapter includes NACCHO's recommendations on the following:

- Preparedness workforce
- Volunteer management
- Partnership and coalitions
- Preparedness planning
- Administrative preparedness
- Preparedness activities

Summary of Recommendations

NACCHO recommends that national partners (e.g., federal agencies, and national organizations), states, and local public health organizations continue working together to strengthen preparedness and response at the local level, as local health departments are the boots on the ground when a public health emergency occurs.

Preparedness workforce
NACCHO recommends a systematic reinvestment in workforce development and training for LHDs. Opportunities should be targeted to different skill levels, including dedicated resources for disaster mental health.

Volunteer management
NACCHO encourages engaging and mobilizing volunteer response groups (such as MRC, CERT, Red Cross) in all preparedness activities at the local level, not only during incident responses, but also during planning, training, drills, and exercises.

Partnership and coalitions
NACCHO recommends continued strengthening of partnerships between public health and other sectors that play a key role in preparedness, response, and recovery at the local, state, and national levels, particularly capacity building among different departments within LHDs and local governments.

Preparedness planning
NACCHO recommends that LHDs involve non-preparedness staff and leadership from all departments (e.g., Health Services, Environmental Health, Behavioral Health, Infectious Diseases, Nutrition) in preparedness planning, training, and exercises to increase knowledge sharing and connect resources to enhance preparedness responses.

Administrative preparedness
NACCHO re-commits to working with federal partners to increase awareness of administrative preparedness through training and resource sharing, promoting the establishment of formal administrative procedures at the local level.

Preparedness activities
NACCHO recommends that national, state, and local organizations work together to address national health security threats, particularly those outlined in the National Health Security Strategy, including climate adaptation, supply chain, and cybersecurity.

Preparedness Workforce

NACCHO recommends a systematic reinvestment in workforce development and training for LHDs. Opportunities should be targeted to different skill levels, including dedicated resources for disaster mental health.

The 2022 Preparedness Profile showed a range of experiences within local public health preparedness. Compared to the previous assessment conducted in 2018, a higher percentage of LHDs reported having a preparedness coordinator or equivalent staff member with fewer than two years or more than 20 years of experience. Given the timing of this assessment, these results may portray the influx of new preparedness staff due to the COVID-19 response and the aging of the public health workforce. Retention of these individuals should be a priority and will require investment in professional development.

Rebuilding and investing in targeted training that speaks to a professional's years of experience on the job can strengthen the preparedness workforce across all local health departments. More than half of LHDs reported staff spending 49% or less on job duties dedicated to preparedness. This was more frequent among small LHDs, where staff often work across a variety of public health areas rather than in specialized positions. These findings demonstrate the need to target training and resources to jurisdictional size and organizational capacity. NACCHO suggests reassessing how training needs are identified at the local level and reinvesting in workforce development through dedicated resources and/or allotted time for LHD staff to spend on training and professional development.

One quarter of LHDs, including nearly 40% of small LHDs, spend less than a quarter of staff time on preparedness activity. This can lead to disparities across different communities. Additional investments are needed to ensure all LHDs can have a full-time preparedness coordinator. Resources, like the federal Public Health Emergency Preparedness program at the Centers for Disease Control and Prevention, need robust funding to help support LHDs' ability to hire and retain preparedness professionals for all communities.

NACCHO recommends refinement of our existing repository of resources, NACCHO's toolbox, to make it more readily accessible and up-to-date for LHDs. NACCHO's toolbox should include a repository of resources (i.e., guidelines, guides, templates) with skill-building and just-in-time training for specific roles and types of responses. A large number of LHDs indicated the need for all-hazards planning and disaster mental health trainings, likely due to the COVID-19 pandemic. Based on the results of this assessment and continued interest from preparedness coordinators, investments should be made to restore and revamp NACCHO's Roadmap to Ready program to provide training and professional development opportunities for those with less than two years and more than six years of preparedness experience.

Volunteer Management

NACCHO encourages engaging and mobilizing volunteer response groups in all preparedness activities at the local level, not only during incident responses, but also during planning, training, drills, and exercises.

Volunteer groups are crucial to general community preparedness and incident response, with the Medical Reserve Corps as the volunteer group most likely to be engaged at the local level. NACCHO encourages strengthening partnerships with volunteer groups like the MRC, CERT, Red Cross, and other groups, especially in emergency plans, training, drills, and exercises. Based on the results of the Preparedness Profile, less than 50% of LHDs are engaging volunteer response groups at any level of the preparedness cycle; NACCHO considers collaboration with volunteer groups to be critical to better prepare LHD staff and communities to respond to our most concerning threats and hazards like pandemics, opioid abuse and overdose, storms/flooding, and winter storms.

Increasing investment and collaborations with volunteer groups, like the MRC, through incident response, general community preparedness, drills and exercises, and emergency response training will help support surge capacity for the future. The most common challenges to MRC sponsorship were limited staff capacity and limited resources for management, however, one in four LHDs that did not sponsor an MRC unit indicated they would. Involving volunteer groups in disaster behavior/mental health planning and training can also increase the mental health and behavioral health workforce capacity. In addition, many MRC units have begun to create stress response teams and provide psychological first aid training to support disaster behavior/mental health for both their volunteers and communities.

NACCHO's MRC Operational Readiness Awards, administered under a cooperative agreement with ASPR, provide MRC units with funding to support the immediate needs of the MRC network, increase capacity to address response efforts, and ensure units are resourced for future mission requirements.

Partnership and Coalitions

NACCHO recommends continued strengthening of partnerships between public health and other sectors that play a key role in preparedness, response, and recovery at the local, state, and national levels.

LHDs indicated strong collaboration across a range of public health and healthcare partners (i.e., infectious/communicable disease, EMS, state public health, environmental health, and hospitals). However, fair and poor partnerships are still being reported with key sectors, including behavior/mental health, pharmacies, and intelligence/security agencies. The recent COVID-19 pandemic emphasized the importance of mobilizing partnerships among different departments within LHDs and local government, such as maternal and child health, environmental health, epidemiology, and others. However, developing and maintaining these partnerships can be challenging due to time, staff capacity and turnover, and/or lack of interest from partners to engage in preparedness planning efforts.

NACCHO encourages the continued strengthening of partnerships between public health and other sectors that play a key role in preparedness, response, and recovery at the local, state, and national levels. Recognizing that formal and routine partnerships with some organizations, like chain pharmacies and intelligence/security agencies, must be supported at the state and national levels, it is still critical that LHDs are part of these partnerships to inform strategy and action with their unique perspective. NACCHO recommends that national partners (e.g., federal government, national organizations) explore additional avenues for enhancing engagement between public health and these sectors. NACCHO also recommends capacity building and engagement among different departments within LHDs and local governments, as well as healthcare organizations and coalitions at all stages of the preparedness cycle.

Preparedness Planning

NACCHO recommends that LHDs involve non-preparedness staff and leadership from all departments in preparedness planning, training, and exercises to increase knowledge sharing and enhance responses.

While more than 80% of LHDs reported being very concerned about pandemics, the majority also felt that they were very prepared to respond to such threats. Similarly, many LHDs felt very prepared to address vaccine-preventable diseases and small-scale infectious disease outbreaks. The COVID-19 response likely played a key role in improving preparedness planning for similar threats for LHDs. Best practices identified in LHDs' COVID-19 response highlighted the importance of having non-preparedness staff and leadership from all departments involved in all steps of preparedness planning to establish harmony in preparedness responses.

As a result of the pandemic, emphasis has been placed on recovery planning as well as a need to take a One Health approach to preparedness planning overall that encompasses human, animal, and environmental health. As we move to the recovery stage of the COVID-19 response, it is important to continue to address lessons learned and implement best practices throughout the preparedness cycle. Among these lessons learned is to increase training for those working with at-risk and vulnerable populations to ensure that they are accounted for in preparedness planning.

Results from the current and previous Preparedness Profiles, as well as qualitative research conducted by NACCHO in 2020, have shown that LHDs remain concerned about commonly recurring natural disasters such as flooding, winter storms, and extreme temperature events, due to their increased frequency and magnitude. However, new threats, such as opioid abuse and overdose, and active shooter incidents, are also a growing concern as LHDs reported a lack of adequate funding to respond to complex and often simultaneous public health crises. NACCHO encourages sustainable and continuous funding and investments to build capacity and capability in preparedness at the local level. Similarly, NACCHO recommends increased inclusion of LHDs in state and federal preparedness planning to ensure that plans at those levels include the expertise of local public health and are workable at the ground level.

NACCHO has resources, including Mobilizing for Action through Planning and Partnerships (MAPP) training, Adaptive Leadership Training programs, and Strategic Planning Guides for LHDs to use as they go through their strategic planning processes in their preparedness planning efforts. NACCHO's Project Public Heath Ready (PPHR), a criteria-based recognition and training program for LHDs, provides a framework and encourages LHDs to work closely with non-preparedness staff and leadership to develop and enhance preparedness plans.

Administrative Preparedness

NACCHO re-commits to working with federal partners to increase awareness of administrative preparedness through training and resource sharing, promoting the establishment of formal procedures at the local level.

NACCHO recognizes that formal administrative procedures are vital to ensuring a strong administrative preparedness response. Data from the current and previous Preparedness Profiles indicate that the formalization of administrative procedures is a work in progress. Since 2018, fewer LHDs have reported having formal mechanisms in place to address administrative preparedness activities. However, results indicate that the size of the LHD plays an integral role in the presence of formal administrative procedures. Across most of the administrative activities surveyed, large LHDs were more likely to report having formal mechanisms in place compared to small and medium LHDs. Results from previous qualitative research conducted by NACCHO have shown the complexity of this topic since few LHDs reported having an understanding of funding streams from federal to state and local levels. However, strong administrative preparedness can ensure timely and equitable resource sharing to support local public health efforts.

Consequently, it is important that further research investigate the impact of state policies and procedures, jurisdiction size, the impact of unions, and other factors that may affect the formalization of administrative procedures at the local level. Understanding this dynamic can help national organizations and federal partners assist smaller LHDs in addressing variables that impact the formalization of administrative procedures.

In addition to the role of LHD size, there are other barriers to administrative preparedness procedures reported by LHDs, including lack of dedicated resources, lack of leadership buy-in and awareness, and lack of access to training and tools. To address these barriers, NACCHO recommends LHDs increase interdepartmental partnerships (e.g., human resources, quality improvement) to streamline administrative procedures. Additionally, NACCHO commits to working with federal partners to develop and distribute training and available resources (e.g., guidelines, templates) to support the establishment of formal administrative procedures at the local level.

Preparedness Activities

NACCHO recommends that national, state, and local organizations work together to address national health security threats, particularly those outlined in the National Health Security Strategy.

In comparison with the previous Preparedness Profile, in 2022, LHDs reported increased participation in several preparedness activities in the past year, including public health surveillance, medical countermeasure dispensing, and non-pharmaceutical interventions. While these results illustrate the public health scenario LHDs were facing due to the COVID-19 pandemic, they also highlight core and timely public health activities that have decreased in the past year, such as fatality management, CBRN planning, and climate change/adaptation planning.

To strengthen core public health systems to prepare for and respond to concurrent health emergencies, it is important to understand the complex needs and different capacities of small vs. large, urban vs. rural communities, to support planning for public health threats facing LHDs across the country. As outlined in the National Health Security Strategy, national, state, and local organizations; the healthcare industry; public health professionals; pharmaceutical manufacturers; communities; and other stakeholders need to work together to address the nation's health security threats that have the potential to significantly disrupt and strain health care and public health services, including climate change, cybersecurity, CBRN events, and supply chain.

NACCHO will continue to raise awareness and engage and support LHDs in developing and strengthening preparedness planning, training, and exercising around these areas.

Funding for this project was provided by the Centers for Disease Control and Prevention, under cooperative agreement 5 NU38OT000306-04-00. Contents of this document are solely the responsibility of NACCHO and do not necessarily represent the official views of our sponsors.

Report authors: Kellie Hall, MSOD; Krishna Patel, DrPH, MPH; Deise Galan, DrPH, MPH; Ashley Vigil; Evelyn Zavala, MPH; Laura Biesiadecki, MSPH.

The mission of the National Association of County and City Health Officials (NACCHO) is to improve the health of communities by strengthening and advocating for local health departments.

1201 I Street, NW • Fourth Floor • Washington, DC • 20005

Phone: 202.783.5550 • Fax: 202.783.1583

www.naccho.org