2022 Preparedness Profile Study

Preview Report

NACCHO
National Association of County & City Health Officials

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 preview report provides a highlight of key findings from the 2022 Preparedness Profile on a multitude of important topics in local preparedness. A full report will be released in Summer 2023.

Methods

Study population and sampling

There are approximately 2,800 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.

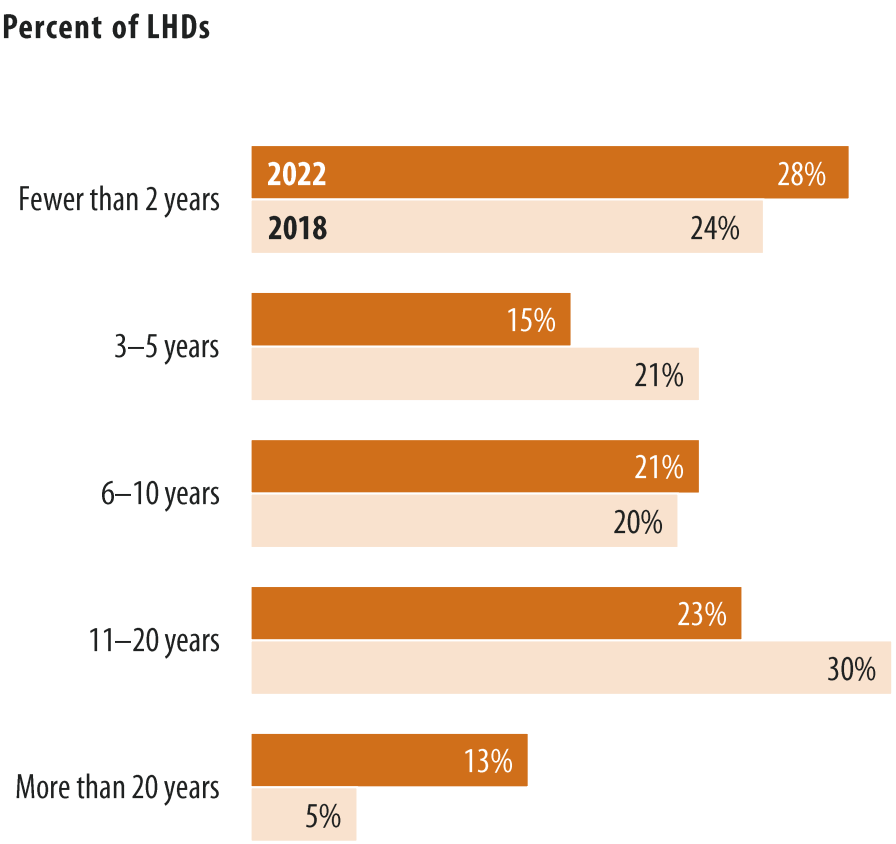
Survey weighting and national estimates

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.

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

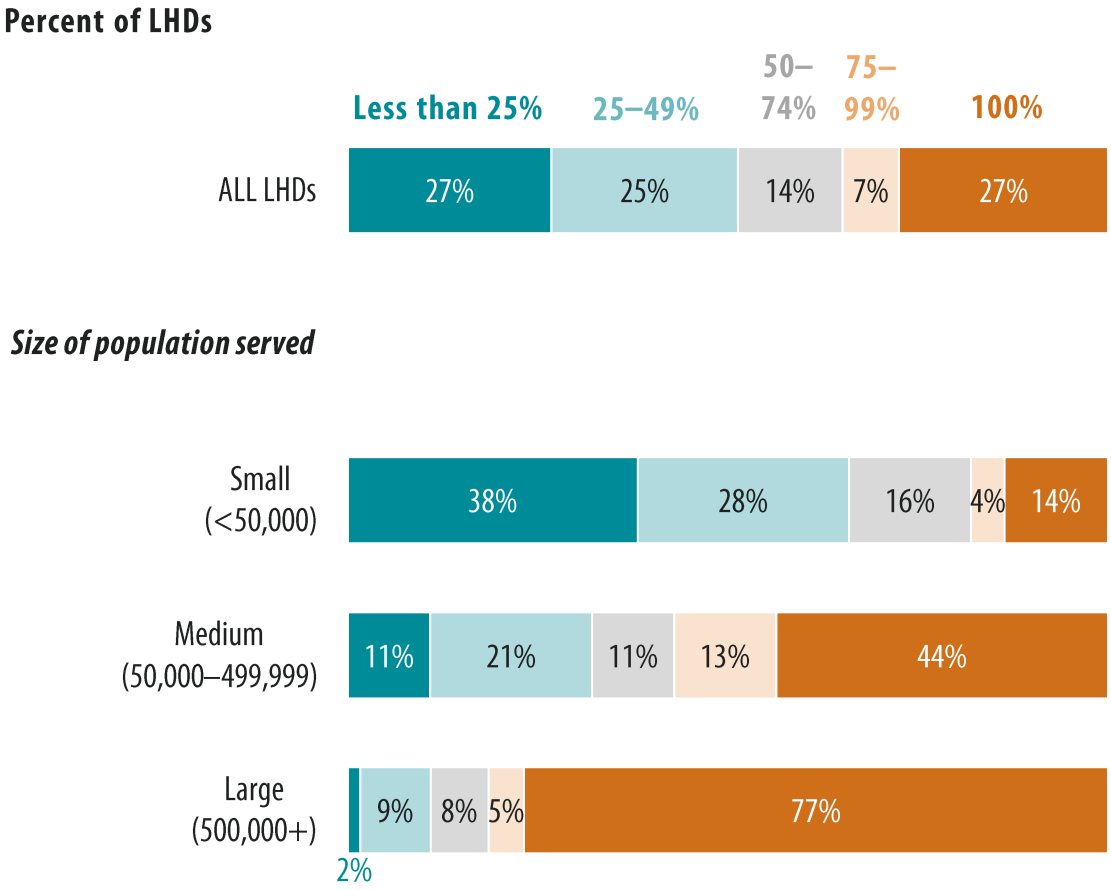


n(2022)=372
n(2018)=387

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



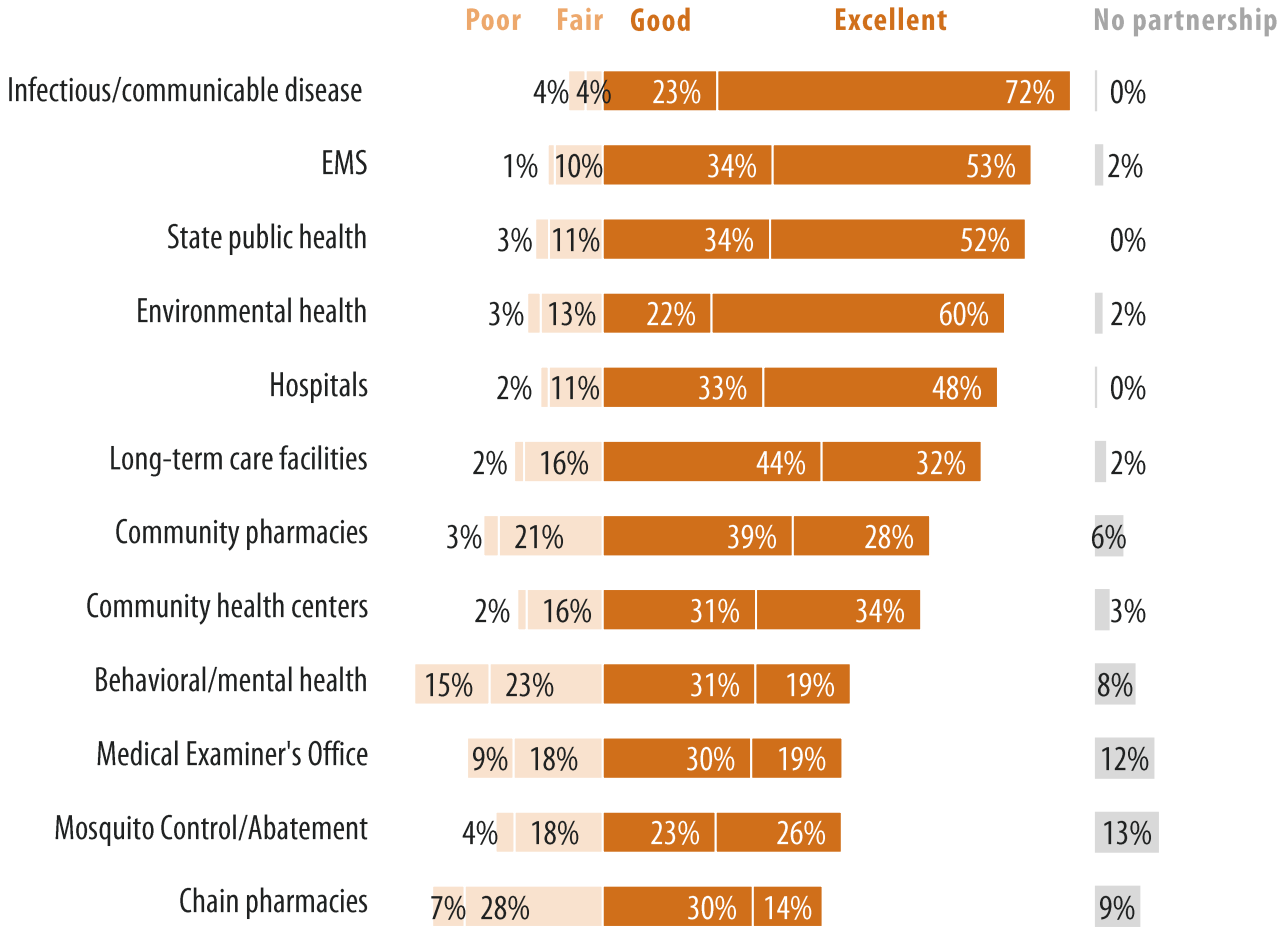
n=372

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.

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

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



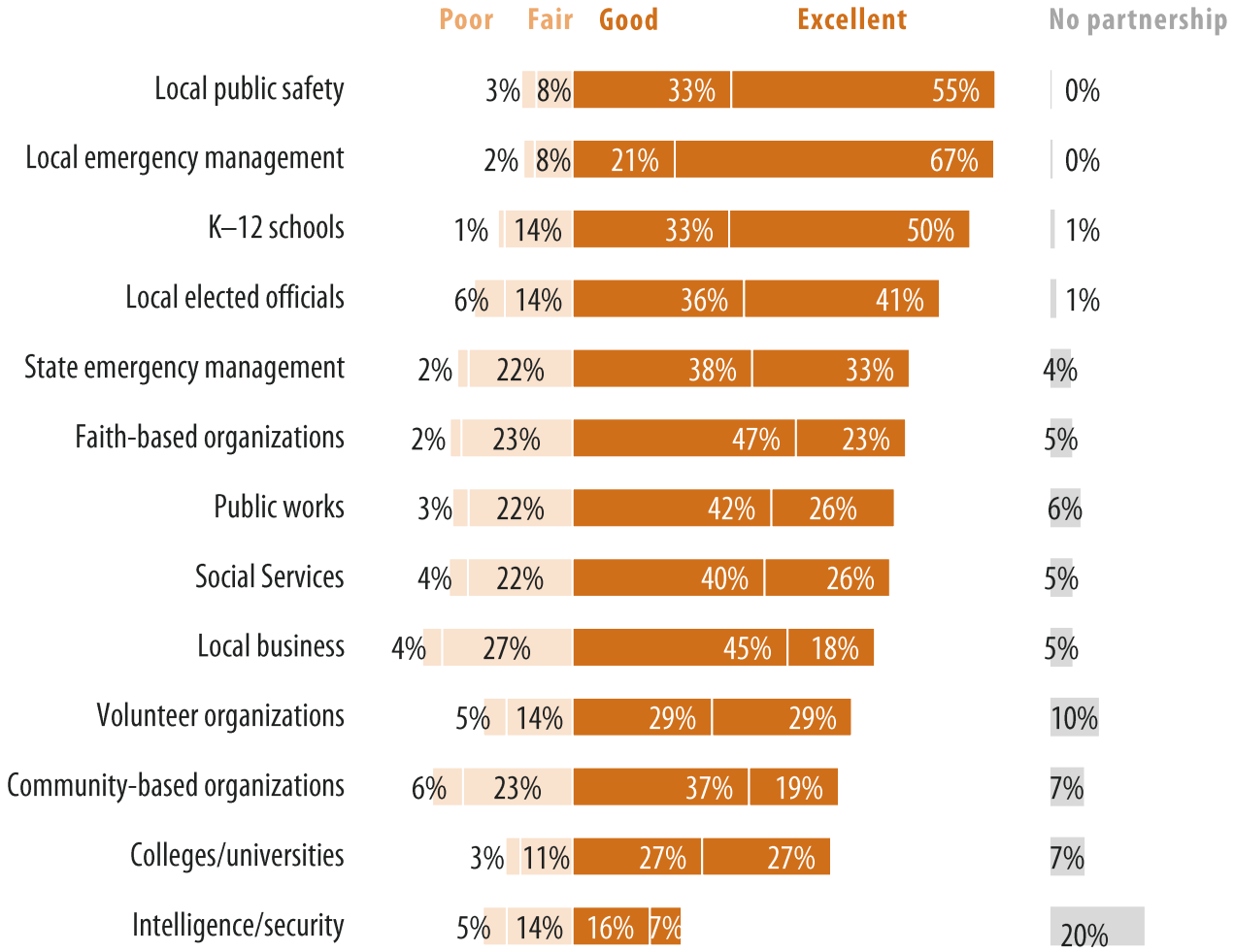
Most LHDs reported partnering with nearly all the listed public health and healthcare organizations. More than 80% noted strong relationships (i.e., "good" or "excellent") with infectious/communicable disease, EMS, state public health, environmental health, or hospitals.

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)*



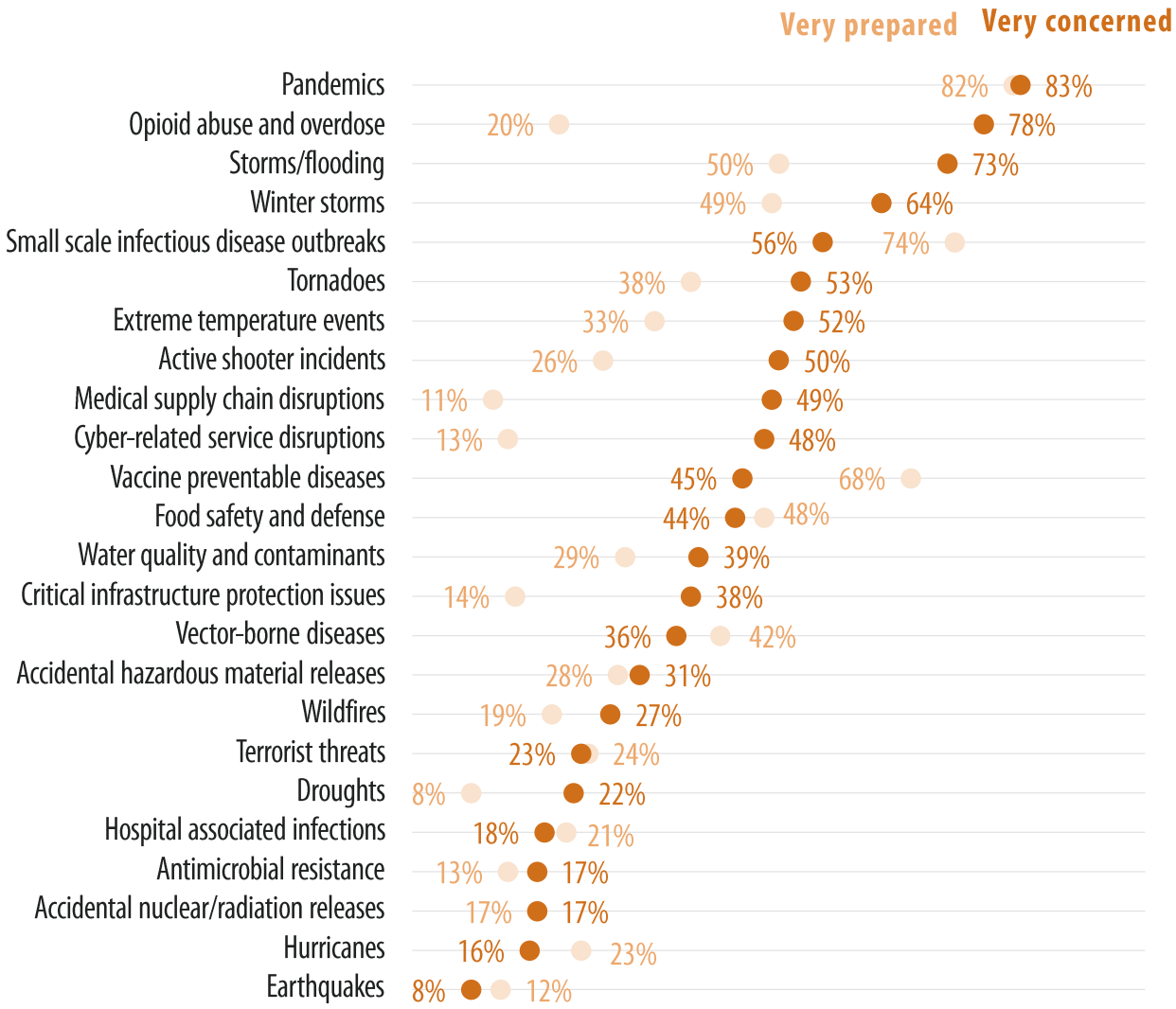
n=362–365

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).

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

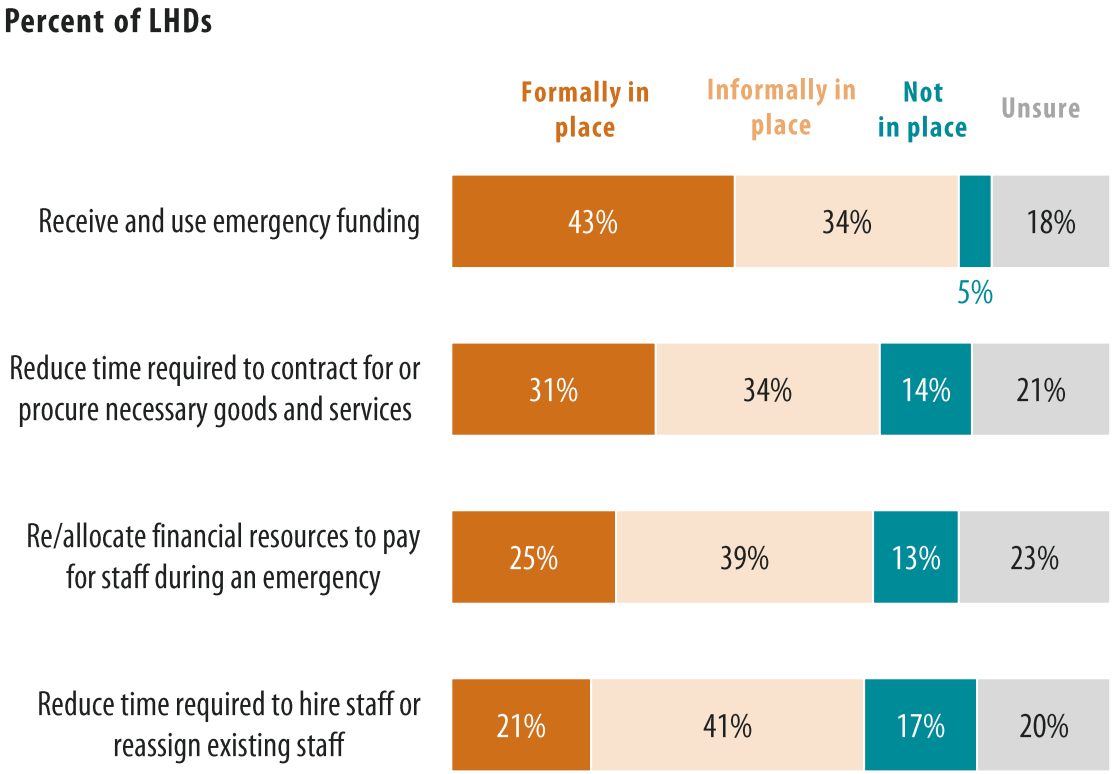


n=236–364

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.

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.

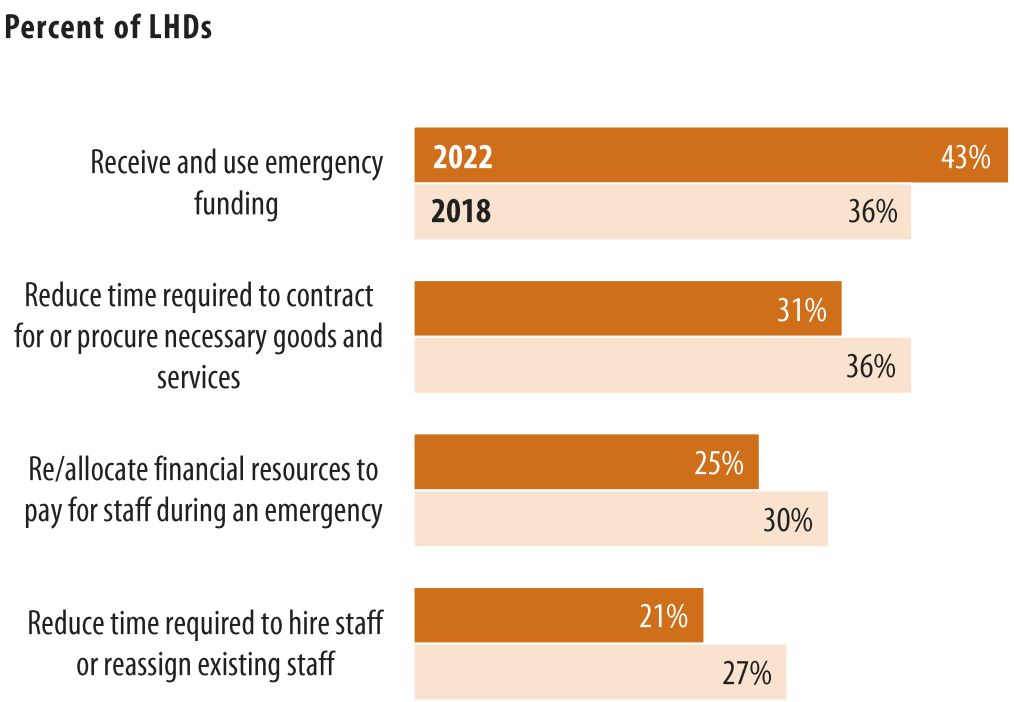
Almost 20% of LHDs were unsure about whether there were expedited mechanisms in place.

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

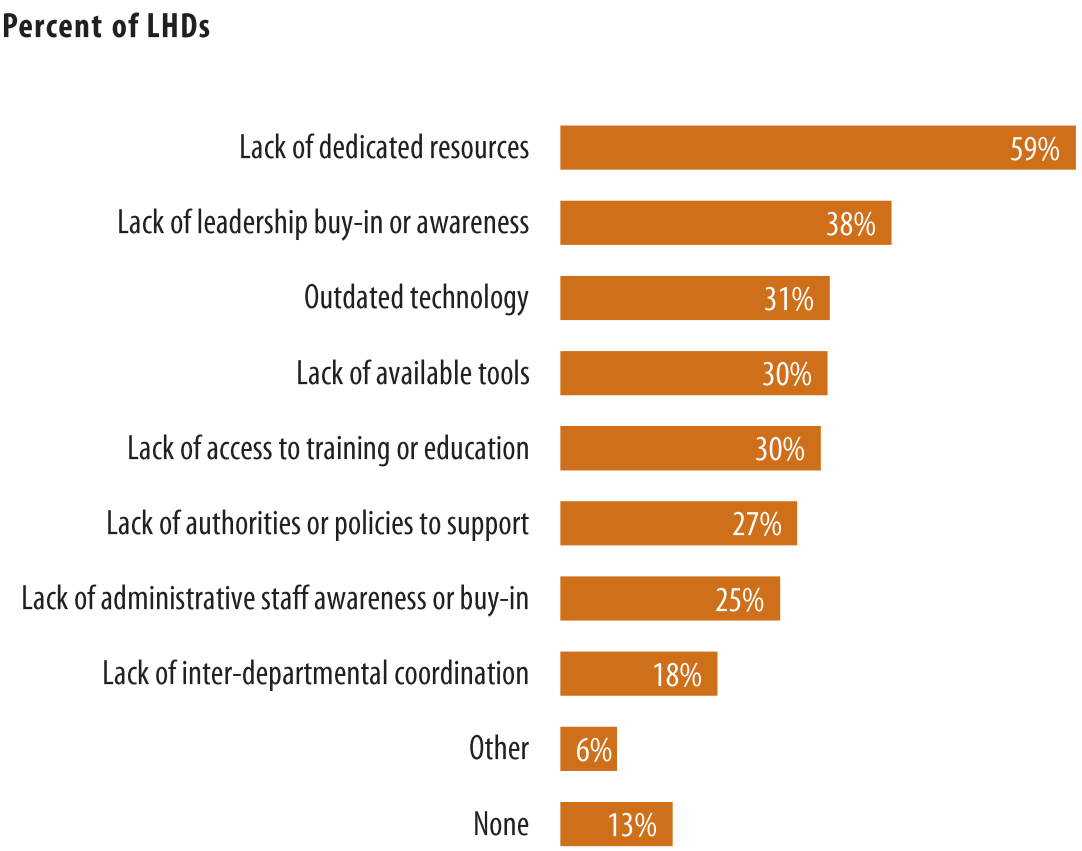


In 2022, fewer LHDs reported having formal mechanisms in place to address administrative preparedness activities than in 2018—except in the case of receiving and using emergency funding.

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



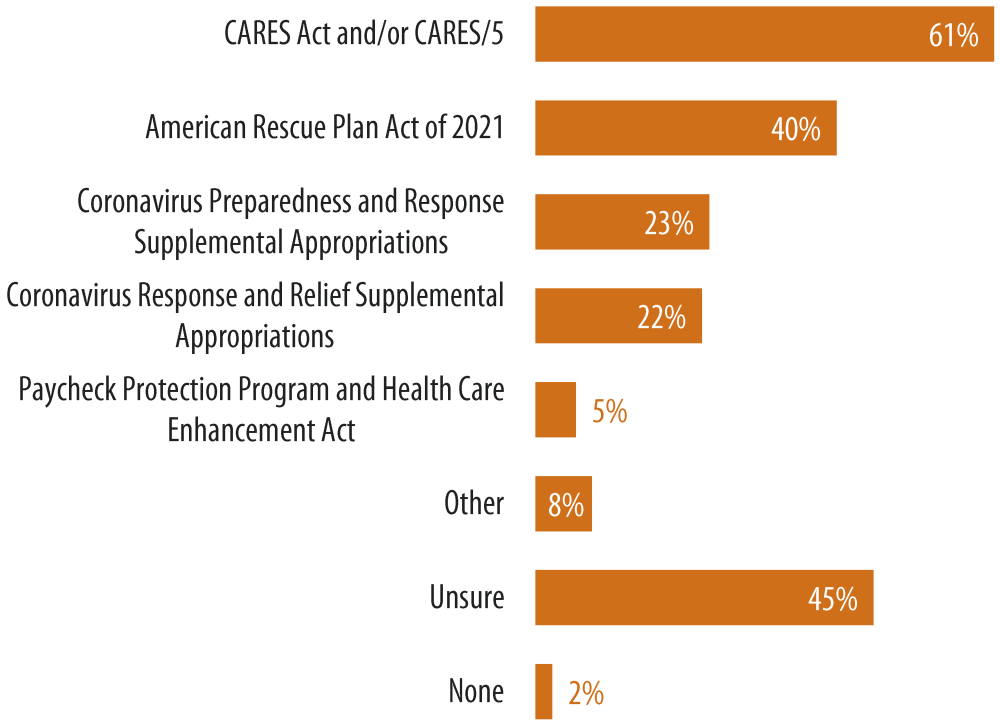
n=328

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.

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 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.

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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.

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