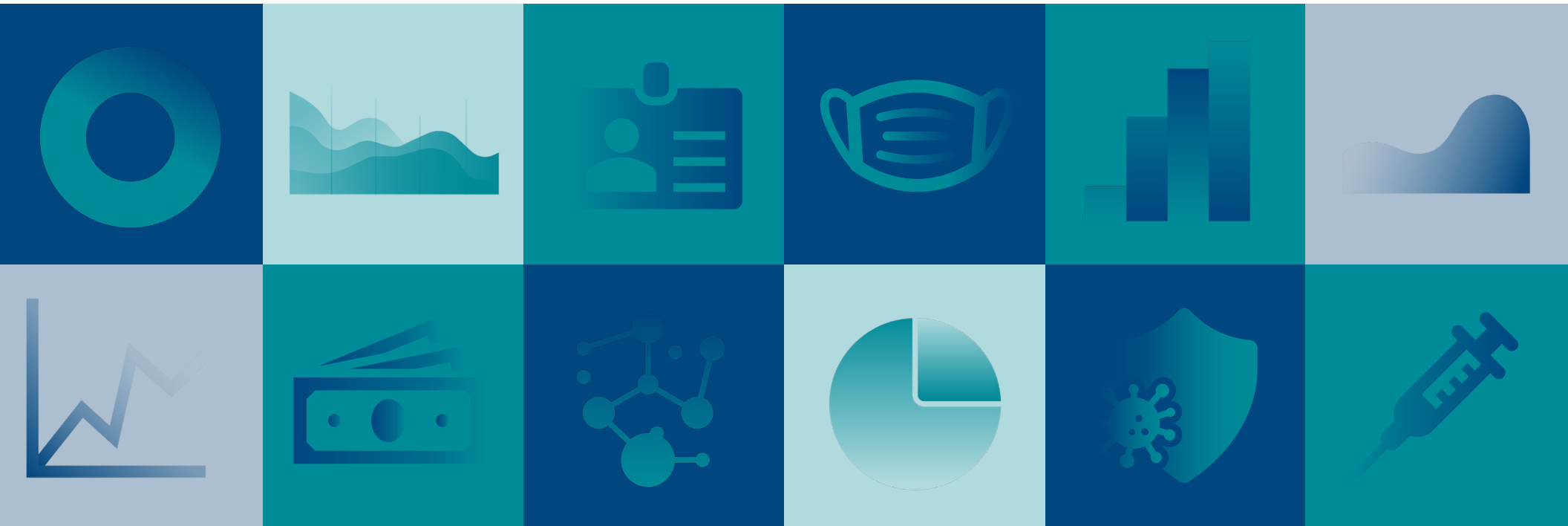


2023

IMMUNIZATION PROFILE STUDY

A look at immunization capacity
among local health departments



Acknowledgements

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01 | INTRODUCTION

In this section:

- Survey background
- Data collection, analysis, and reporting methods



Background

The National Association of County and City Health Officials (NACCHO) conducted a survey in 2023 to assess immunization capacity at local health departments (LHDs) nationwide.

The objectives of the survey were to:

- Provide insight into the status of immunization programs at the local level;
- Characterize their activities to control vaccine preventable diseases (VPDs) and provide immunization services; and,
- Identify current challenges and opportunities to strengthen LHD immunization programs.

NACCHO had previously surveyed LHDs about immunization practices in 2017, in partnership with the Association of Immunization Managers (AIM). Several items from the 2017 survey instrument were adapted for 2023 with the aim of identifying practice and capacity changes associated with the COVID-19 pandemic.

Methods

Study Population and Sampling

There are more than 3,300 agencies or units that meet the definition of an LHD. For the purposes of surveying, NACCHO utilizes a methodology to account for the most unique individuals in the U.S. at the level closest to the local level without “double counting.” For example, if a region has three counties served by three LHDs, all three LHDs are surveyed. However, if a region has three counties served by a city, two county, and a district LHD, only the district LHD may be surveyed. NACCHO uses a database of LHDs based on previous National Profile of Local Health Department (Profile) studies and consults with state health agencies and state associations of local health officials (SACCHOs) to identify the 2,512 LHDs included in the 2023 study population. Rhode Island was excluded from the study because the state has no sub-state public health units.

A stratified random sample of 1,020 LHDs were invited to complete the survey, with strata defined by three categories of population size served by the LHD (i.e., less than 50,000, 50,000–499,999, and more than 500,000 people).

Instrument Development and Fielding

The survey instrument was developed by NACCHO’s Research, Evaluation, and Immunization teams. Members of NACCHO’s Immunization Workgroup provided feedback that was incorporated into the final 27-question instrument. The instrument was reviewed by the Study Tracking and Reporting System (STARS) at the Centers for Disease Control and Prevention (CDC) Office of Science. The survey instrument can be found [here](#).

Data was collected online via Qualtrics for approximately seven weeks in January to February 2023. Survey invitations were e-mailed to immunization managers at those LHDs where NACCHO had identified an individual in that role; otherwise, they were sent to a director or other LHD top executive. A total of 422 LHDs completed the survey for a response rate of 41%.

Data Analysis

Survey data were analyzed using Stata 17. Nationally representative estimates were computed using post-stratification sampling weights. Some detail may be lost in the figures due to rounding.

Reporting

Throughout this report, results are described based on different subgroup analyses.

Size of Population Served

Statistics are compared across the size of the population served by the LHDs. 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.

Type of Governance

Data are also presented by type of governance, which refers to the LHD's relationship to their state agency. Locally governed LHDs are agencies of local government. State-governed LHDs are local or regional units of the state health agency. LHDs that are governed by both state and local authorities are referred to as shared governance.

United States Census Region

A final subgroup by which data are presented is [U.S. Census region](#). LHDs are designated as being in the Northeast, South, Midwest, or West, based on the state in which they are located, per the U.S. Census Bureau classifications.

Over Time Comparisons

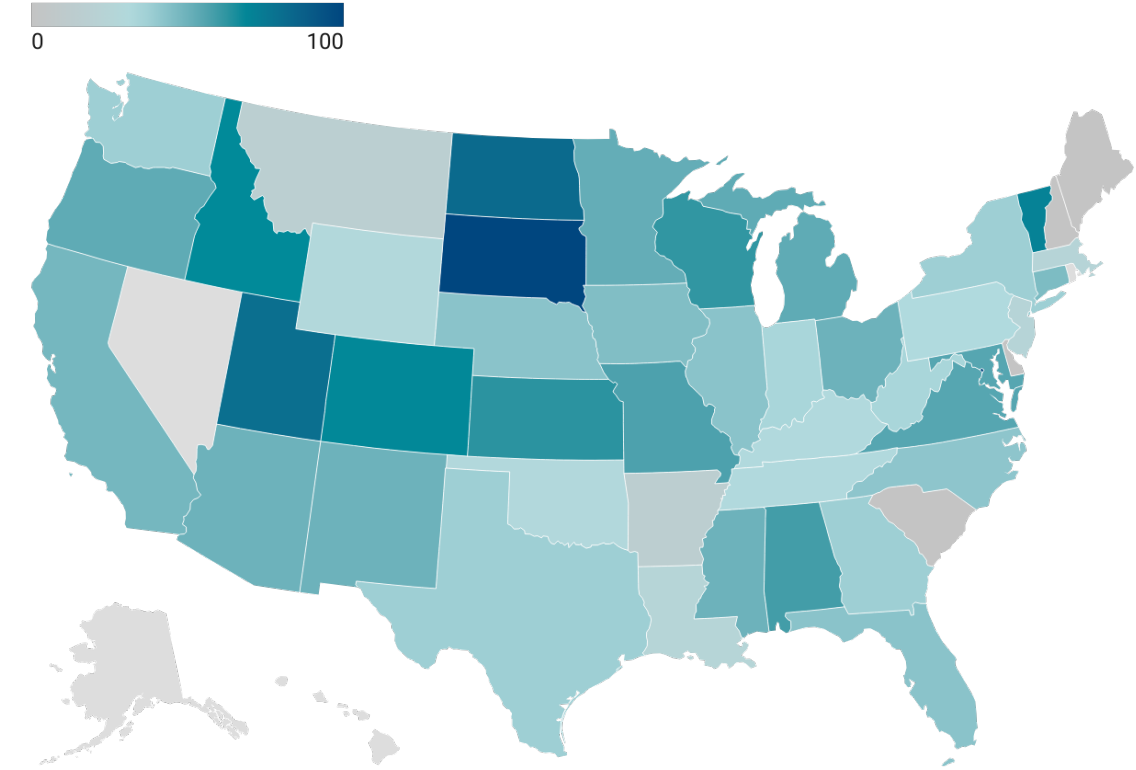
This report also includes data from the 2017 survey for several question items that also appeared in the 2023 assessment. Caution is advised when comparing these data due to methodological differences. Although both iterations of the survey were designed to be nationally representative, they employed different sampling strategies. Additionally, the post-stratification weighting strategy discussed in the methods was employed only in 2023.

Number of LHDs in study sample and number of respondents, by size of population served

Size of population served	Number of respondents	Number of LHDs in sample	Response rate
All	422	1,020	41%
<25,000	161	413	39%
25K-49,999	80	204	39%
50K-99,999	62	138	45%
100K-249,999	57	131	44%
250K-499,999	22	59	37%
500K-999,999	23	45	51%
1,000,000+	17	30	57%

In general, response rates from LHDs serving large populations were higher than those from LHDs in smaller jurisdictions. However, because more than half of the LHDs in the study denominator served populations under 50,000, these smaller jurisdictions represented a plurality of the survey responses.

Response rate, by state



n=422

Responses represented LHDs in 40 states and the District of Columbia.

Alaska, Hawaii, Nevada, and Rhode Island were not included in the sample.

Delaware, Maine, New Hampshire, and South Carolina were included in the sample, but no LHDs from these states responded to the survey.

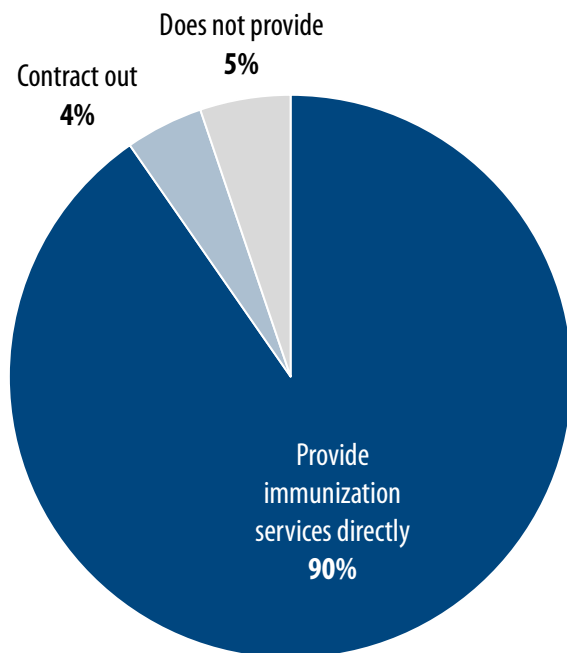
Geographic jurisdictions served by LHD respondents

Type of jurisdiction	Number of respondents	Percent
All	422	-
City	63	15%
City-county	4	1%
County	313	74%
Multi-city	13	3%
Multi-county	29	7%

Jurisdiction types represented by the LHDs responding to the survey included cities, counties, city-county, multi-county, and multi-city jurisdictions.

Provision of immunization services

Percent of LHDs



n=422

To determine whether LHDs were eligible to complete the assessment, the survey opened with a screening question: “Does your local health department provide immunization services?” Approximately 90% of LHDs reported immunization services were provided directly at their agencies. These LHDs (n=383) were deemed eligible for further survey participation and are represented in the following chapters of this report.



02 | PUBLIC HEALTH INFRASTRUCTURE FOR IMMUNIZATION

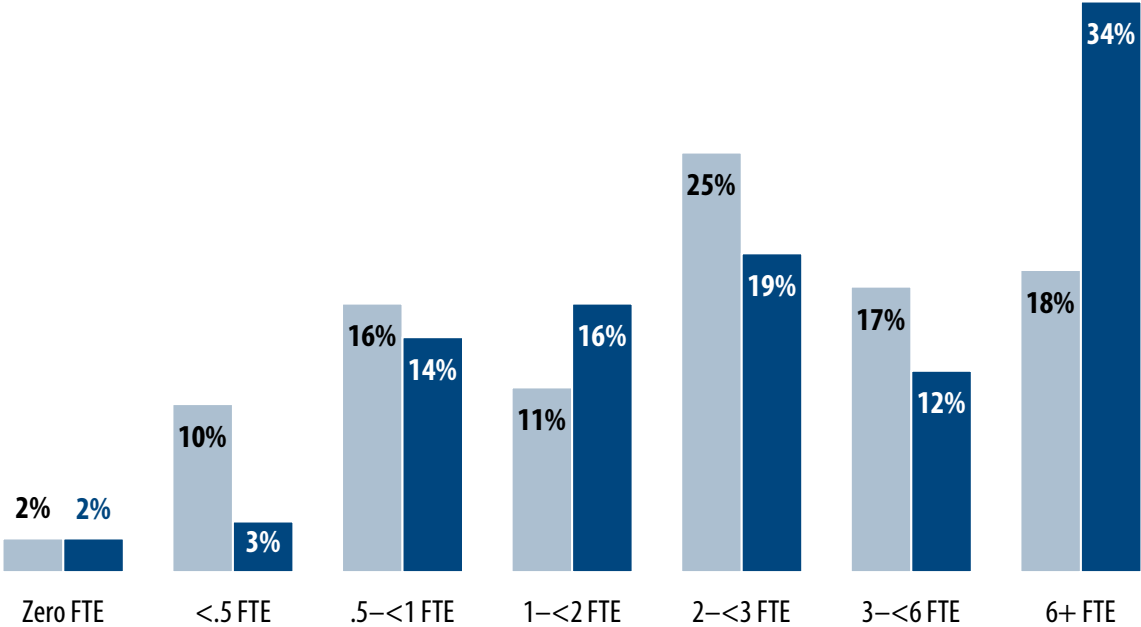
In this section:

- Current numbers of LHD staff
- Mean staff time spent on immunization activities
- Total annual LHD expenditures
- Funding sources
- Third-party billing practices

Number of full-time equivalents (FTEs) dedicated to immunization services, over time

Percent of LHDs, among those directly providing any immunization service

■ 2017 ■ 2023



n(2017)=485
n(2023)=379

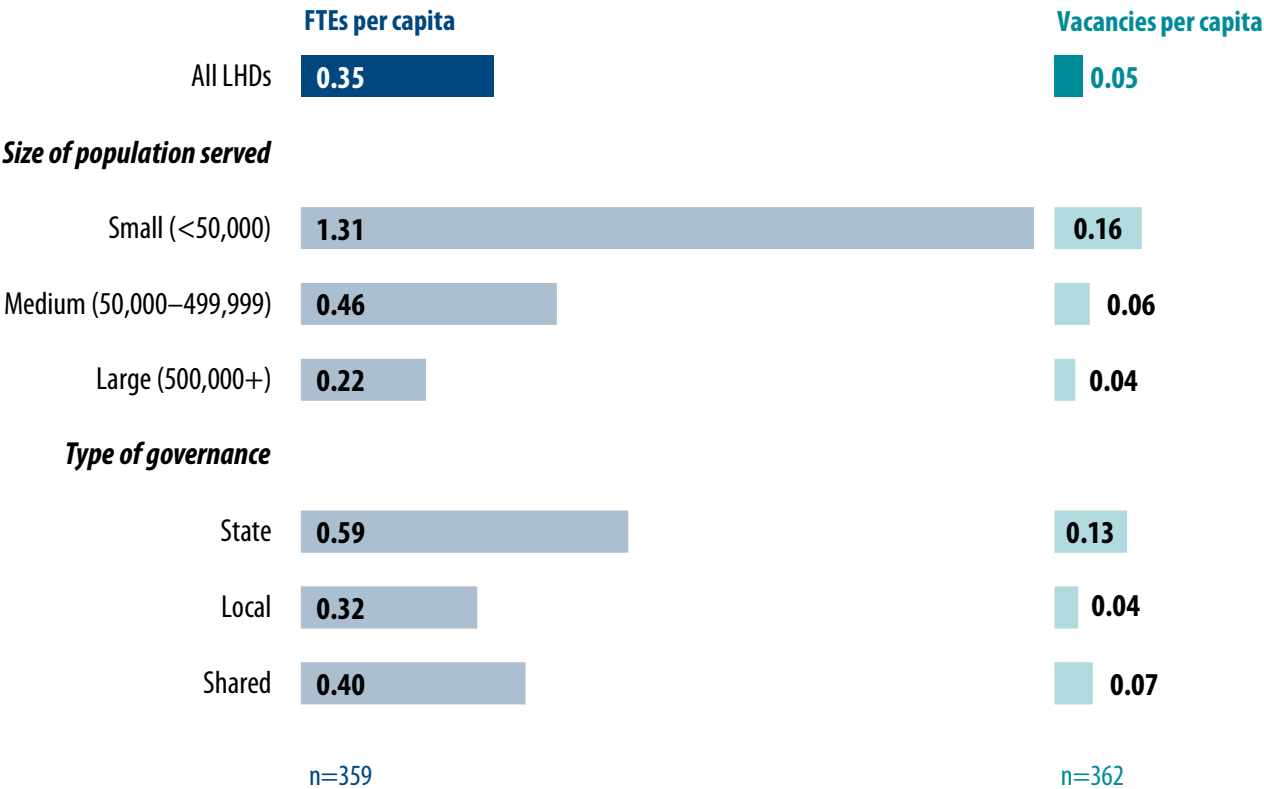
In 2023, approximately one in five LHDs (19%) had less than one FTE staff position dedicated to immunization – a decrease from 2017 (28%).

Meanwhile, the proportion of LHDs reporting six or more dedicated FTEs for immunization nearly doubled between 2017 and 2023.

On average, LHDs employed six FTEs dedicated to immunization services in 2023 (not shown).

Immunization-related full-time equivalents (FTEs) and vacancies, by LHD characteristics

Mean number per capita, among LHDs directly providing any immunization service



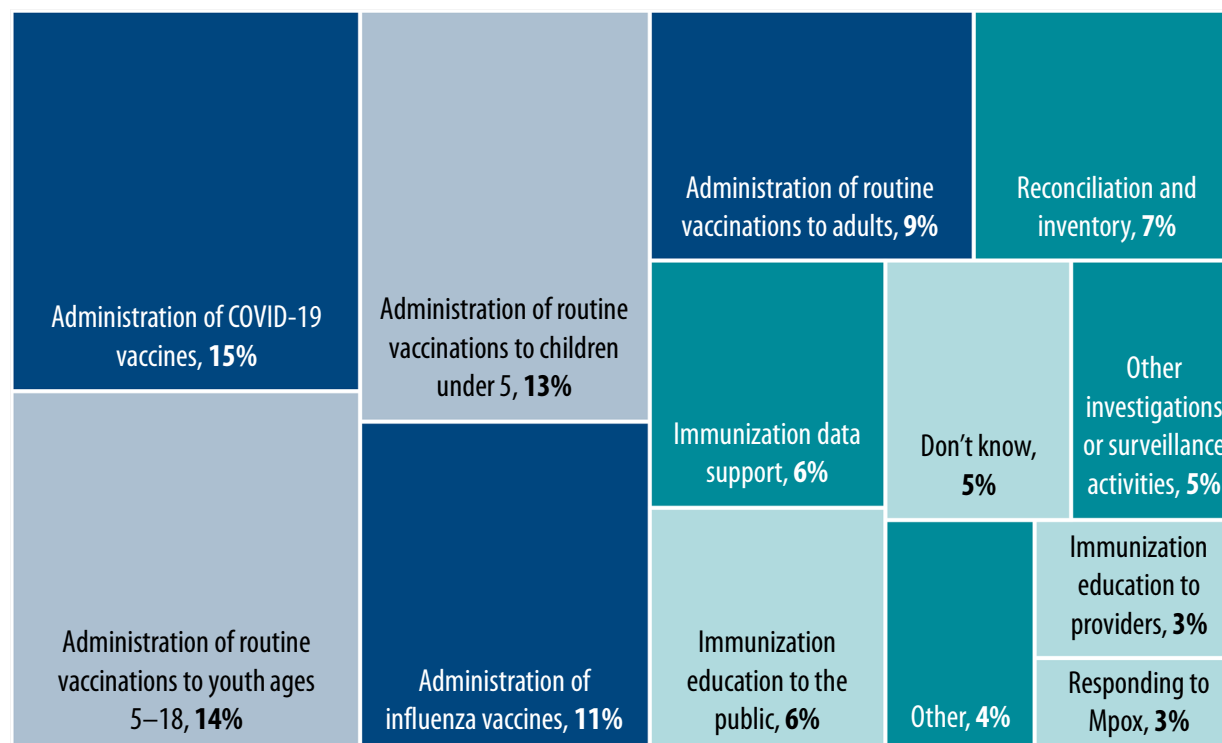
Among all LHDs, the overall immunization workforce capacity is one-third of an FTE per 10,000 people. However, this number varied by the population size served. Smaller LHDs employed a greater number of FTEs per capita than larger LHDs.

Similarly, small and state-governed LHDs reported more vacancies per capita than their peers.

Technical Note
 The number of FTEs per 10,000 people served by the LHD (i.e., per capita) is a useful way to measure workforce capacity and facilitates comparisons across LHDs serving different jurisdiction sizes.

Mean LHD immunization staff time dedicated to services in calendar year 2022

Mean percent of staff time, among LHDs directly providing any immunization service



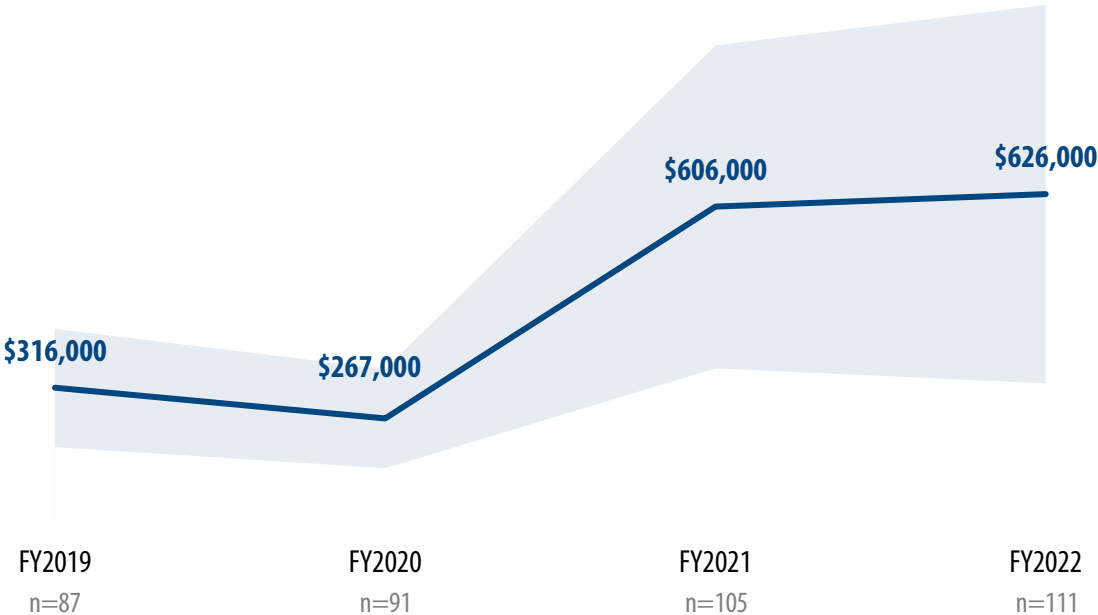
n=366

In 2022, LHDs dedicated an average of 61% of immunization staff time to the administration of COVID-19, influenza, and routine vaccines for children and adults.

Some other uses of staff time included reconciliation and inventory tasks, outreach to the public and medical providers, and surveillance/outbreak response activities.

Mean expenditures for immunization department or team activities, over time

Mean expenditures in each fiscal year (FY), among LHDs directly providing any immunization service
Shadow depicts 95% confidence interval



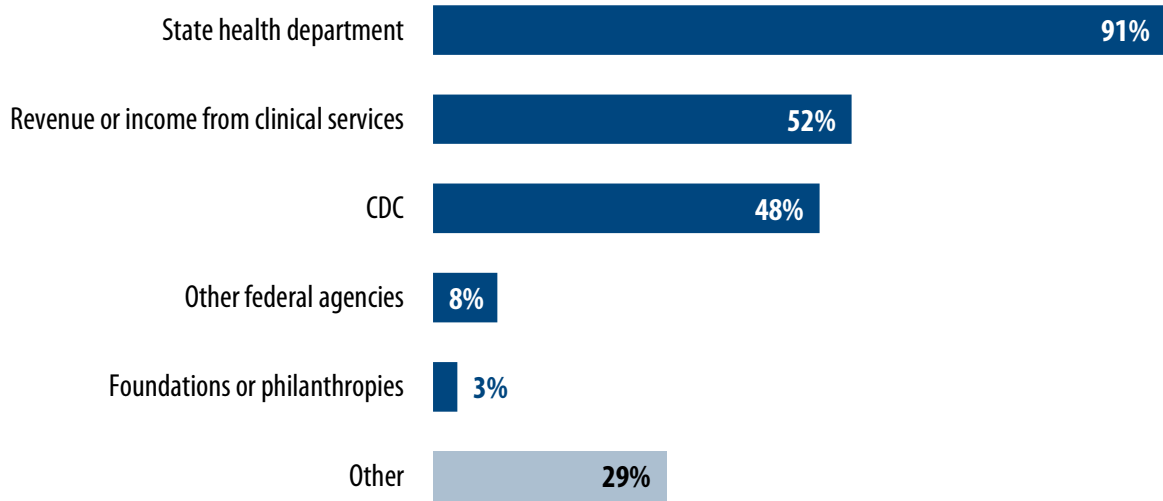
Average LHD spending on immunization declined from FY2019 to FY2020, then increased during the COVID-19 pandemic – more than doubling from FY2020 to FY2021.

In FY2022, average LHD spending on immunization was \$626,000. For comparison, LHDs reported spending [an average of \\$12.5 million in total annual expenditures in 2022](#), according to NACCHO’s National Profile of Local Health Departments Study.

Technical Note
The confidence intervals reflect the uncertainty of this estimate (because of incomplete data and great variability in numbers of LHD staff).

Funding sources for immunization services and programming

Percent of LHDs, among those directly providing any immunization service



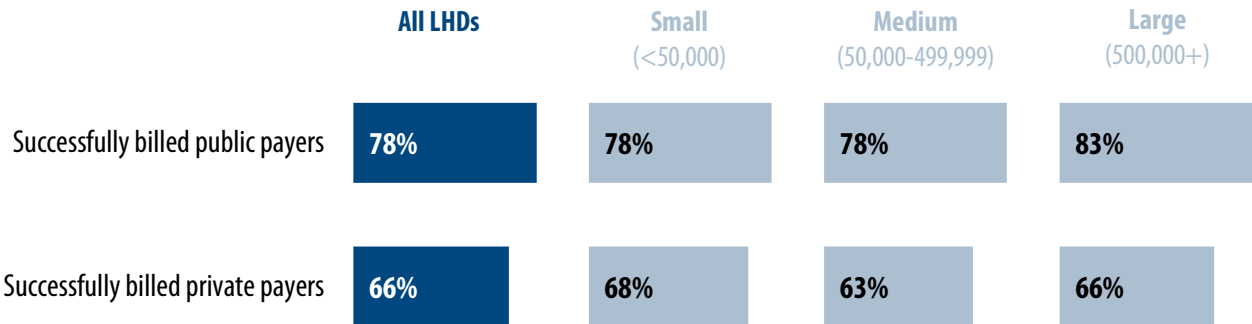
n=338

More than nine in 10 LHDs received funding from state health departments for their immunization programs. Approximately half of LHDs reported revenue from clinical services or CDC as funding sources. Of note, 29% of LHDs reported receiving funds from “other sources,” which most frequently included funding from tax levies and other local sources, as well as donations, state immunization coalitions, and unspecified grants.

Technical Note
Funding received from the state health department may have originated from CDC and been passed through to the LHD.

Third-party billing practices for vaccine administration and cost

Percent of LHDs, among those directly providing any immunization service



n=330-331

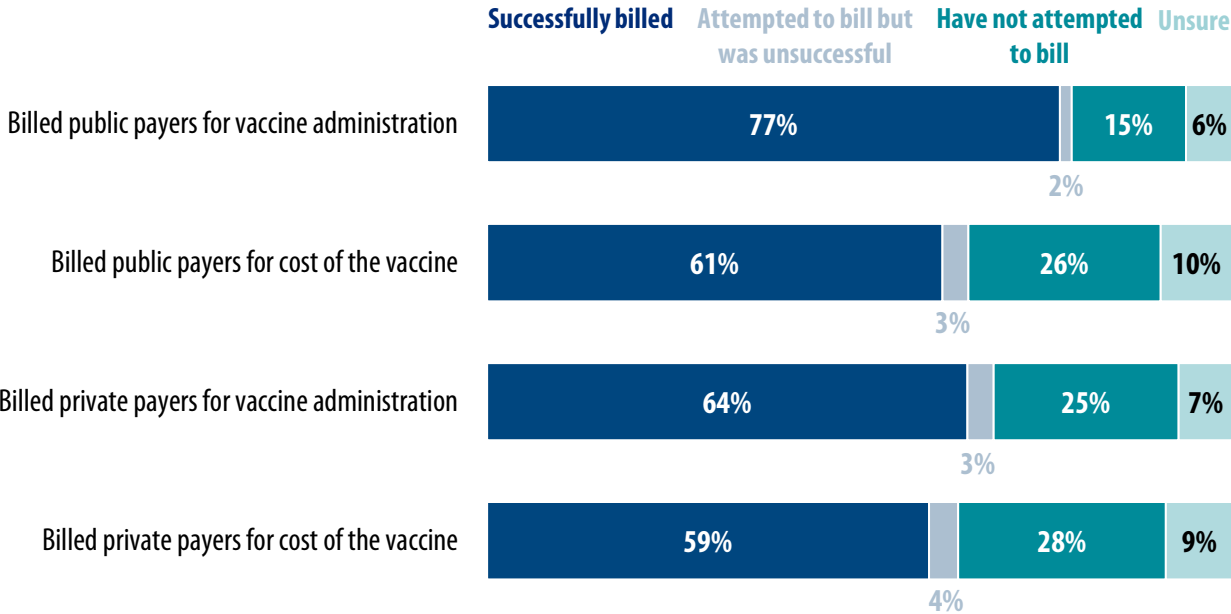
More than three in four LHDs successfully billed public payers (e.g., Medicaid, CHIP, Medicare) for vaccine administration or cost, while fewer LHDs successfully billed private payers.

Technical Notes
 The survey did not ask LHDs to indicate the reimbursement eligibility of specific vaccine products or age groups, so these estimates may not reflect practices in place for all services.

The proportion of LHDs successfully billing is higher than that receiving clinical revenue sources on page 17. Because state health departments may play a role in billing, LHDs may have categorized reimbursements as coming from the state rather than clinical revenue.

Third-party billing practices for vaccine services, by size of population served

Percent of LHDs, among those directly providing any immunization service



n=330

LHDs were more likely to successfully bill third-party payers for vaccine administration than for the cost of vaccines.

Technical Note
 The survey did not ask LHDs to indicate the reimbursement eligibility of specific vaccine products (e.g., COVID-19 vaccines) or age groups, so these estimates may not reflect practices in place for all services.



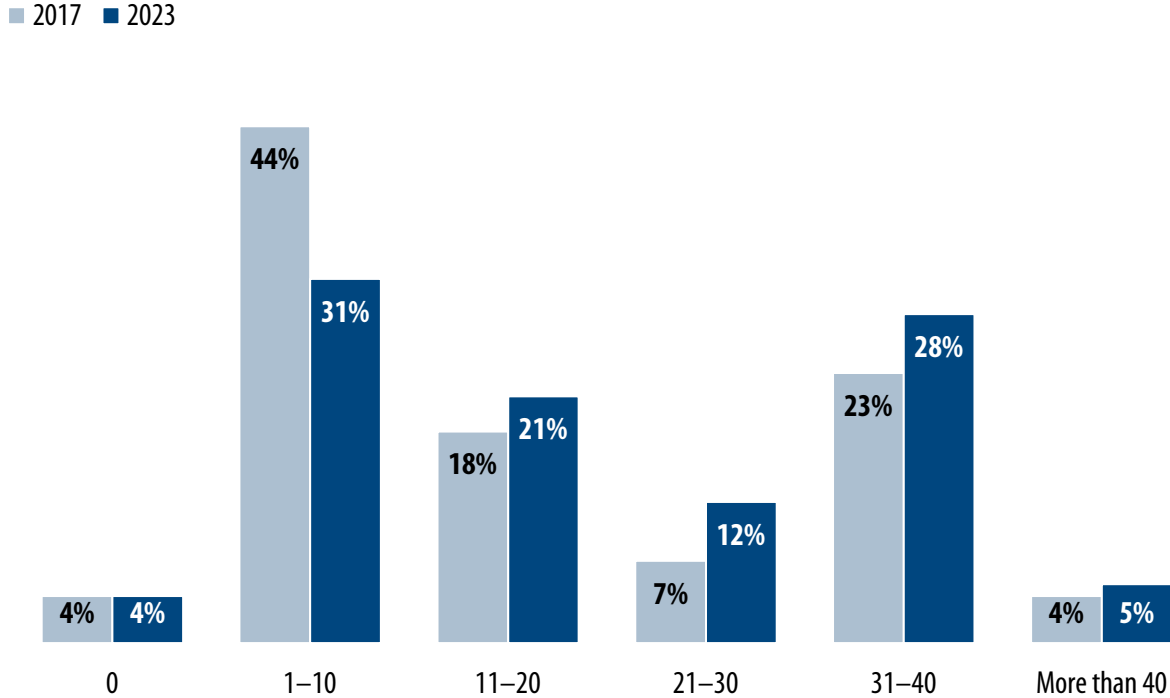
03 | IMMUNIZATION SERVICES AND ACTIVITIES

In this section:

- Number of hours per week services were provided
- Immunization services and activities
- Barriers to conducting immunization activities
- Status as a Vaccine for Children (VFC) provider
- Use of immunization data systems
- Capacity for communication activities
- Future program priorities

Average number of hours per week for direct immunization service provision, over time

Percent of LHDs, among those directly providing any immunization service



n(2017)=434
n(2023)=323

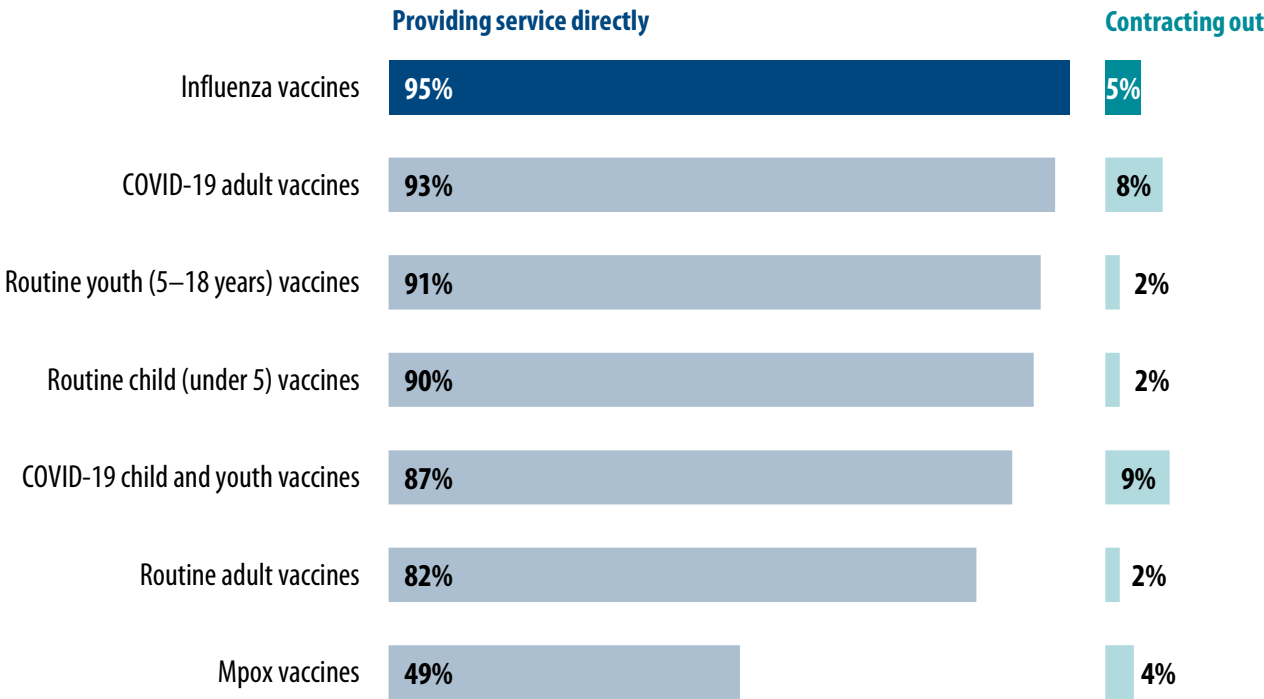
On average, LHDs dedicated 22 hours per week to direct immunization service provision in 2023. LHDs were more likely to report dedicating more than 20 hours per week to these services in 2023 than in 2017.

Although not shown, large LHDs reported more hours per week on average (39) than small (18) or medium LHDs (26) in 2023.

Technical Note
This question asked about how the number of hours averaged out per week over the course of a year. Therefore, an average of zero may indicate an LHD that only does immunizations seasonally (e.g., flu immunization or school clinics).

Immunization programs and services provided in calendar year 2022

Percent of LHDs, among those directly providing any immunization service



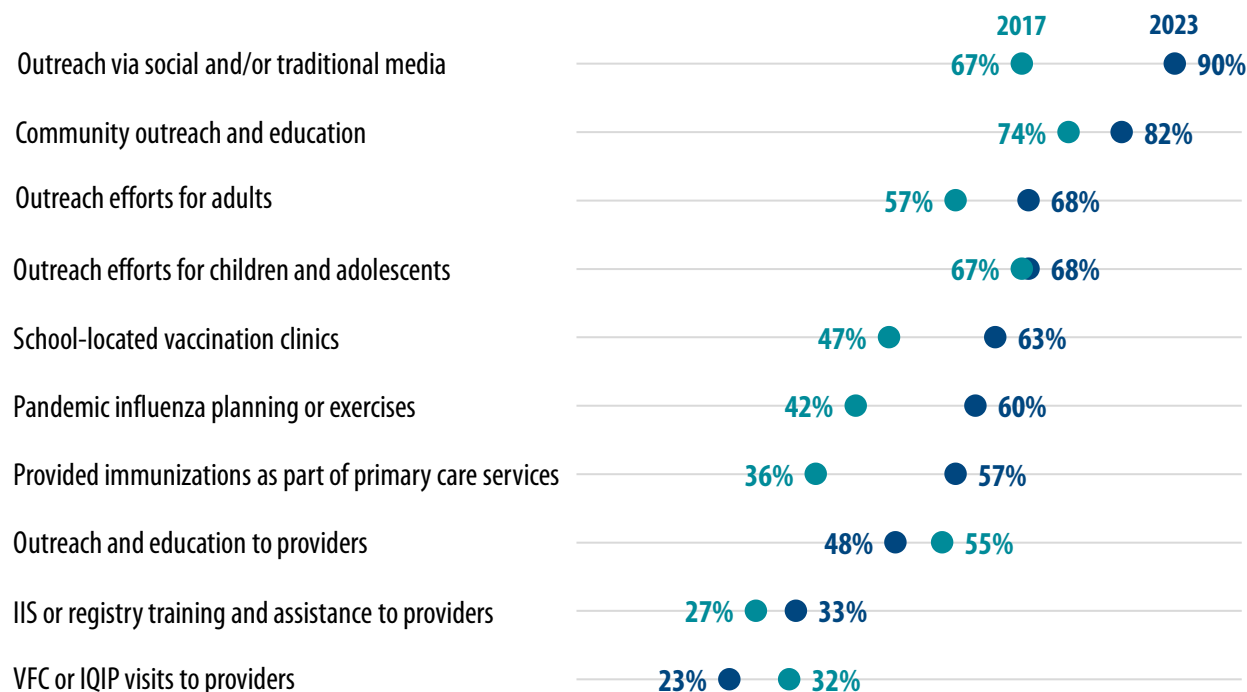
n=317–334

More than nine in 10 LHDs directly offered influenza vaccines, COVID-19 adult vaccines, and routine youth and child vaccines. Only slightly fewer LHDs directly offered COVID-19 vaccines for children and youth or routine adult vaccines.

Although not shown, nearly one-third of LHDs reported that Mpox vaccines were not available in their jurisdiction (32%) and another 6% did not know whether these vaccines were provided.

Immunization activities conducted in calendar year 2022

Percent of LHDs, among those directly providing any immunization service



n(2017)=432
n(2023)=336

LHDs were more likely to report conducting immunization services in 2023 than in 2017. The largest increases were in using social/traditional media, outreach efforts for adults, and providing immunizations as part of primary care services.

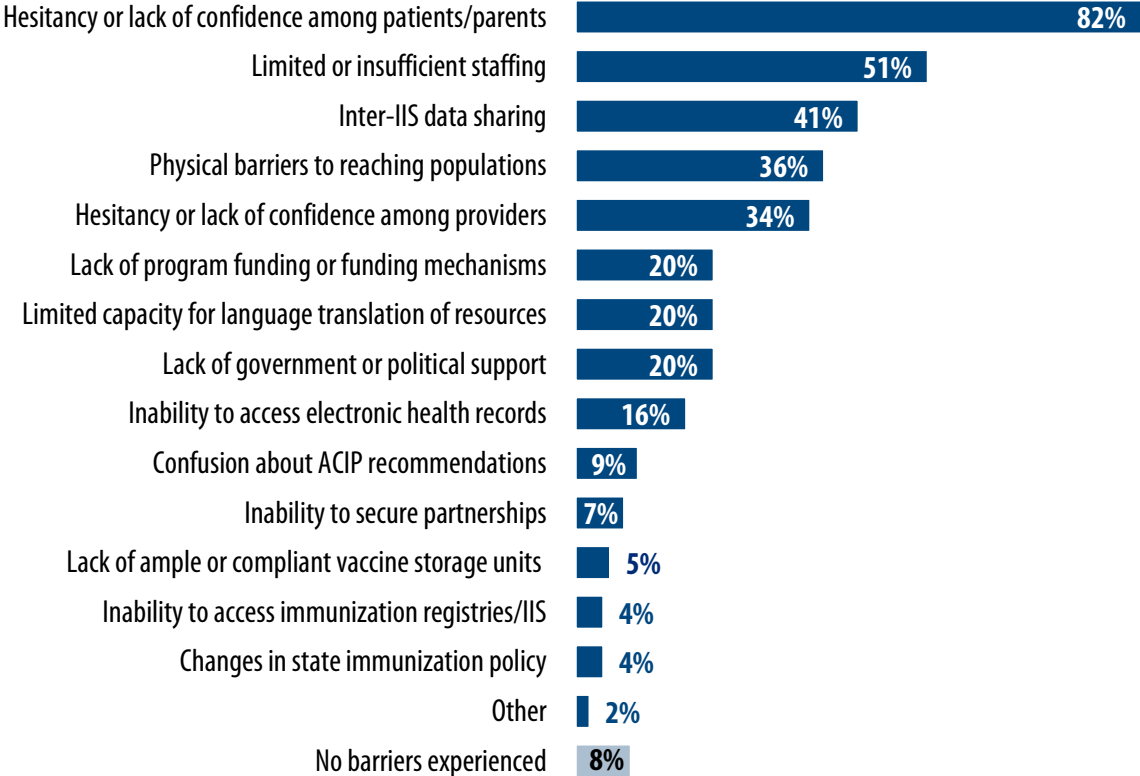
Notably, LHDs were less likely to conduct provider education and visits related to Vaccine for Children (VFC) or Immunization Quality Improvement for Providers (IQIP). This may be attributed to pauses in service delivery associated with the COVID-19 pandemic response.

Technical Note

The 2017 survey referred to the Assessment, Feedback, Incentives, and Exchange (AFIX) program, which was replaced by IQIP in 2019.

Barriers to conducting immunization-related activities in calendar year 2022

Percent of LHDs, among those directly providing any immunization service



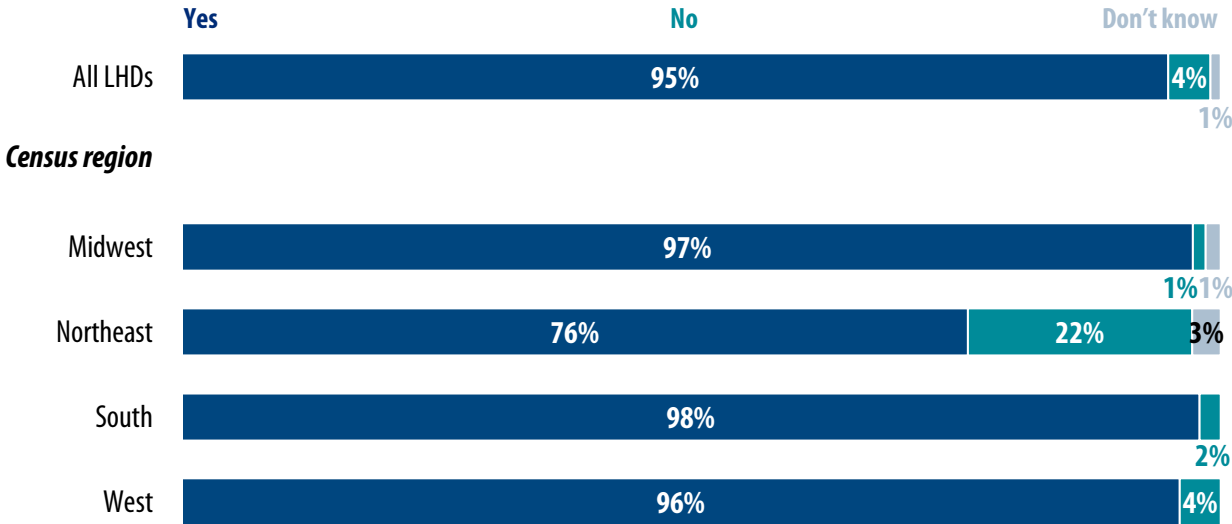
n=332

Eighty-two percent of LHDs cited patient and parent vaccine hesitancy as a challenge to program operations in calendar year 2022. Other common barriers included insufficient staffing (51%) and interjurisdictional data sharing (41%). Only 8% of LHDs experienced no immunization programming barriers or challenges.

Although not shown, the proportion of LHDs reporting challenges was consistent between the 2017 and 2023 surveys, except for vaccine hesitancy which saw a 46% increase from 2017 to 2023 (56% of LHDs vs. 82%, respectively).

Registration as a Vaccines for Children (VFC) provider, by Census region

Percent of LHDs, among those directly providing any immunization service



n=333

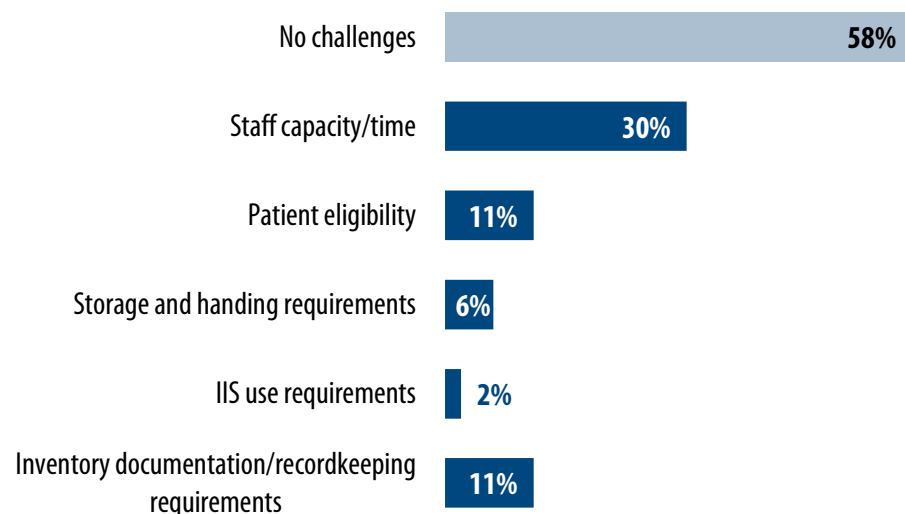
In 2023, 95% of LHDs were registered Vaccines for Children (VFC) providers. Although not shown, this is relatively the same proportion as in 2017 (97%).

In 2023, LHDs in the Northeast were less likely to report VFC participation than LHDs in other regions.

Technical Note
 Though not verified through this survey, the low proportion of VFC providers in the Northeast region may be due to many New England states being universal vaccine assessment states, where the state provides all vaccines to the LHD and does not separate out VFC from other stock.

Barriers associated with Vaccines for Children (VFC) requirements in calendar year 2022

Percent of LHDs, among those directly providing any immunization service and registered as a VFC provider

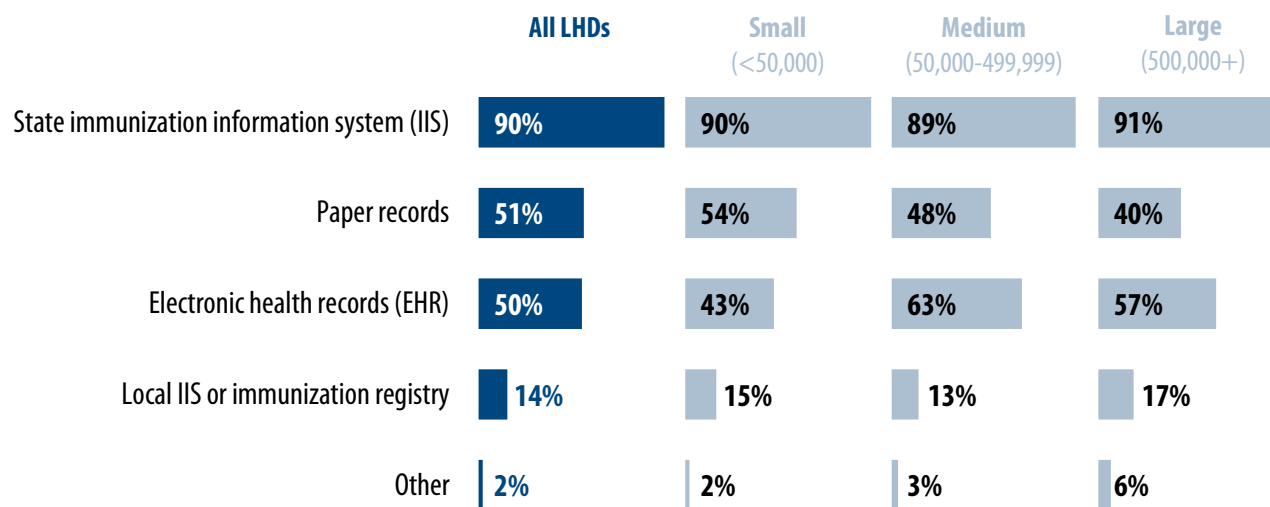


n=314

Among VFC-participating LHDs, more than half had not experienced any challenges related to VFC requirements in 2022. The most frequent challenges cited were staff capacity and time, inventory documentation, and patient eligibility requirements.

Use of systems to manage immunization records and inventory, by size of population served

Percent of LHDs, among those directly providing any immunization service



n=333

Nine in 10 LHDs use a statewide IIS to manage immunization records and vaccine inventory, while 14% use a local (i.e., city or regional) IIS or immunization registry.

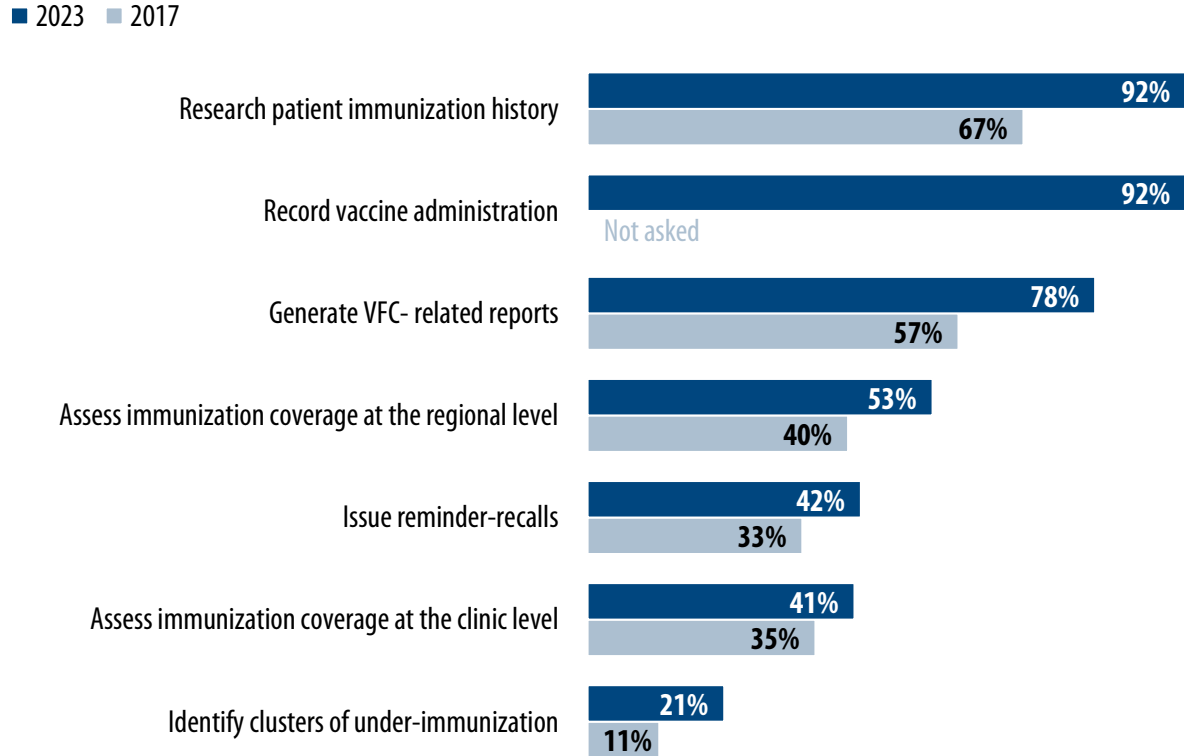
Large and medium LHDs were more likely to report using EHRs than small LHDs. In contrast, small LHDs were more likely to report using paper records than LHDs of other sizes.

Technical Note

Some LHDs that selected “local IIS or immunization registry” may not necessarily use a formal IIS but rather have their own systems for managing immunization records and vaccine inventory.

Uses of the immunization information system (IIS) or other immunization record data

Percent of LHDs, among those directly providing any immunization service



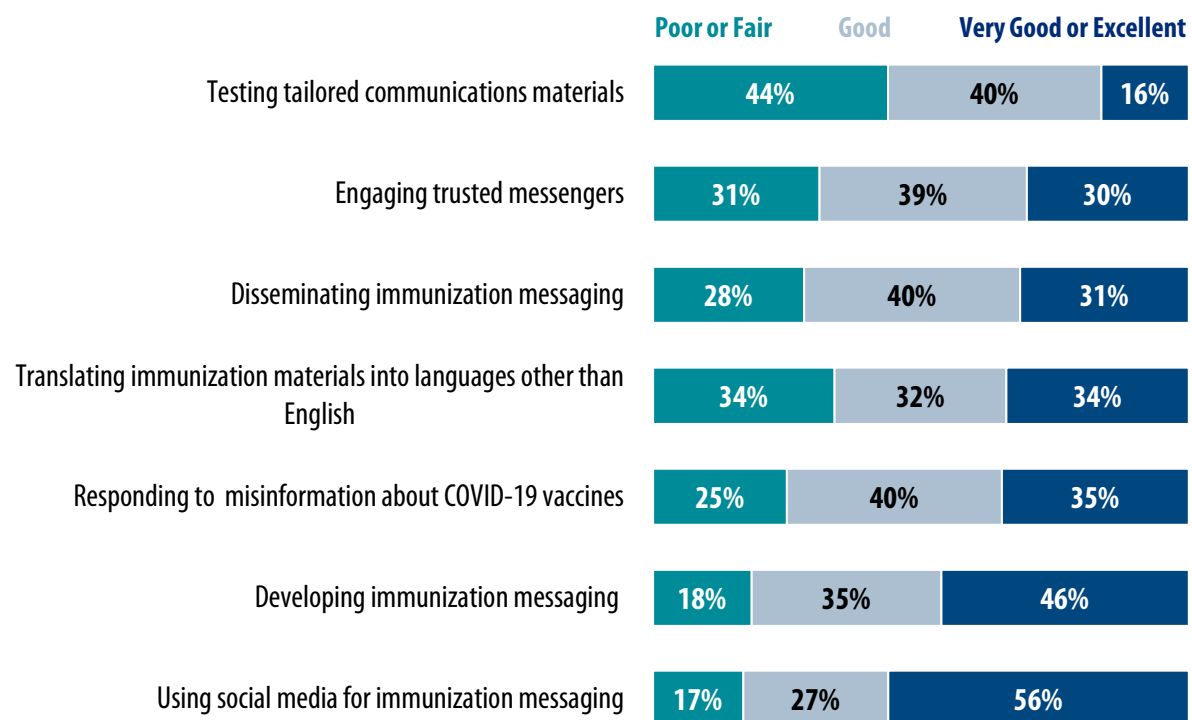
n(2017)=335
n(2023)=332

LHDs most frequently used IIS data to look up immunization history and documenting vaccine administration. Most LHDs also used IIS data for generating VFC program-related reports and to assess regional coverage rates.

Fewer than half of LHDs used IIS data to issue reminder-recalls, for clinic-specific coverage assessments, or to identify under-immunized population clusters. When comparing the 2017 and 2023 surveys, results suggest that LHDs have increased their data use practices.

LHD capacity to conduct public communications activities

Percent of LHDs, among those directly providing any immunization service



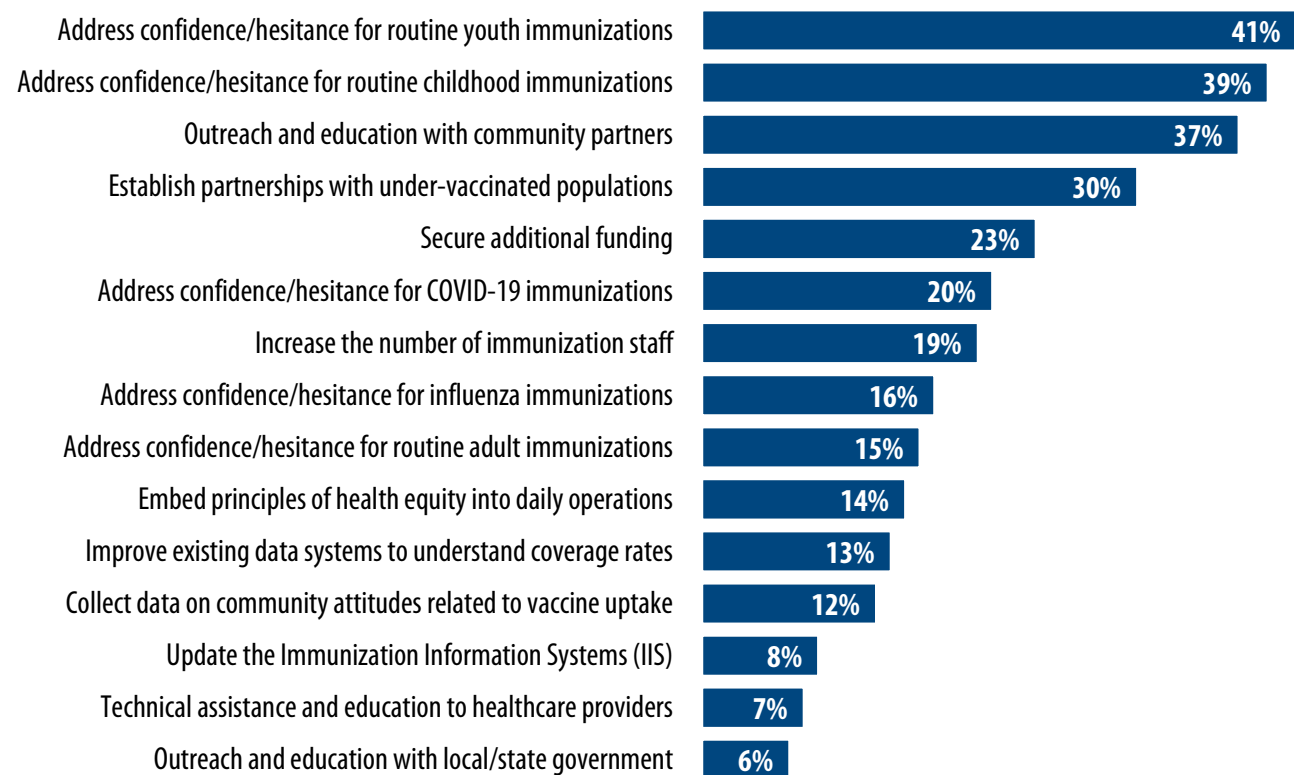
n=327-331

More than half of LHDs rated their social media capacity as “very good” or “excellent”, while only 16% gave this rating to their capacity to test communications materials tailored for specific audiences.

Without data from message testing, LHDs will have trouble ensuring their efforts are addressing the correct barriers and motivations behind vaccine hesitancy.

Top three immunization program priorities for the next three years

Percent of LHDs, among those directly providing any immunization service



n=332

LHDs more frequently cited addressing vaccine confidence/hesitancy for routine immunizations and community outreach as priorities for 2023–2025. More than half of LHDs (56%) prioritized addressing confidence/hesitance among patients and/or parents, especially for routine youth (ages 5–18) or early childhood (under 5) immunizations.

Fewer than 10% of LHDs cited IIS updates, technical assistance to medical providers, or outreach to government agencies among their top priorities.



04 | IMPROVING IMMUNIZATION ACCESS

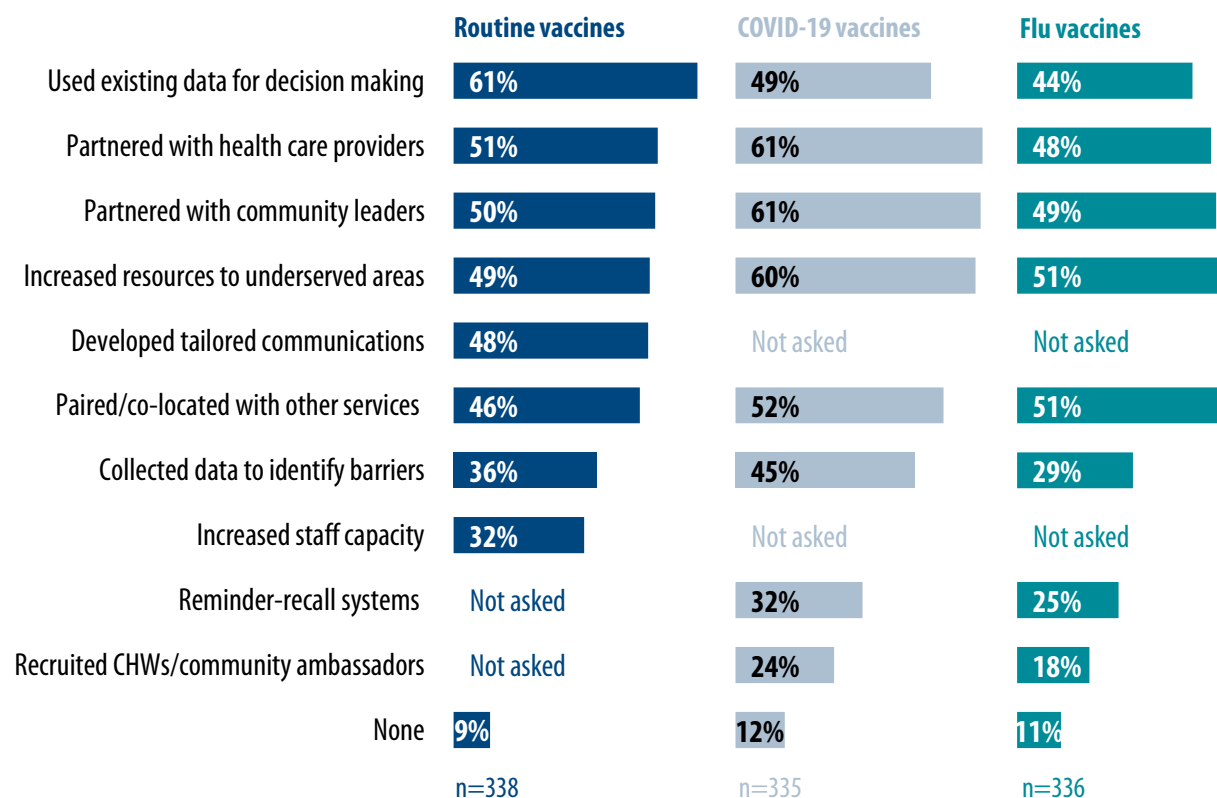
In this section:

- Use of strategies to increase vaccination uptake
- Changes to immunization services to improve vaccine access



Use of strategies to increase vaccination uptake among un/under-vaccinated populations

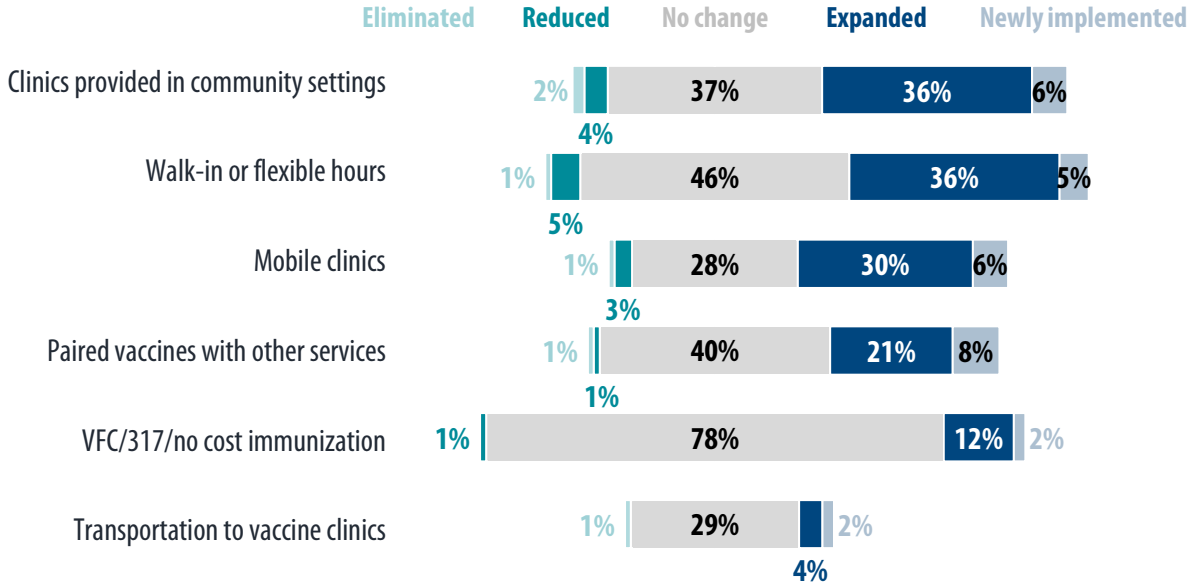
Percent of LHDs using strategies in calendar year 2022, among those directly providing any immunization service



In 2023, LHDs reported on the strategies they had employed in calendar year 2022 to improve access to routine, influenza, and COVID-19 immunizations. LHDs were more likely to report implementing many of the strategies to improve COVID-19 immunization access than other types of immunizations, except for using existing data for decision making. Notably, fewer than one in three LHDs collected data to identify barriers to influenza immunizations.

Immunization services changed in calendar year 2022 to improve access to routine vaccines

Percent of LHDs, among those directly providing any immunization service
(Percent of LHDs not providing services not displayed)



n=313-326

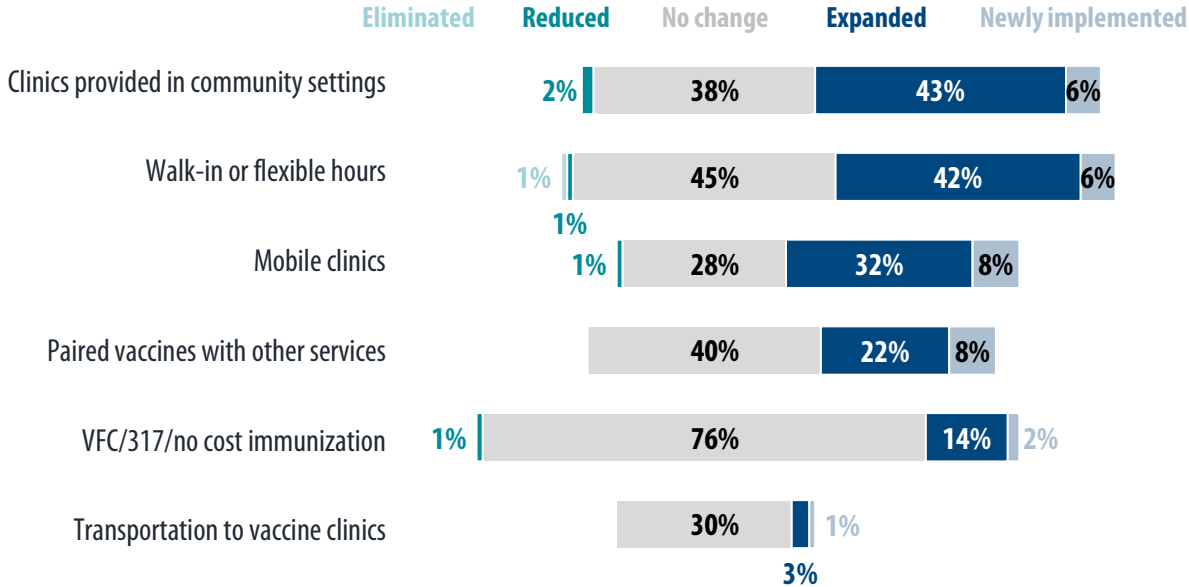
Most (93%) LHDs provided routine immunizations at no cost in calendar year 2022. Fourteen percent introduced or expanded this service in 2022, and more than three in four reported no change to this service.

More than 40% of LHDs expanded or newly implemented use of walk-in immunization hours or offering vaccines in community settings.

Technical Note
LHDs reporting do not know (<10%) were excluded from the analysis.

Immunization services changed in calendar year 2022 to improve access to influenza vaccines

Percent of LHDs, among those directly providing any immunization service
(Percent of LHDs not providing services not displayed)



n=306-319

More than half of LHDs improved access to influenza vaccines through clinics in community settings and expanded walk-in or flexible hours.

Overall, LHDs were more likely to expand services for influenza immunizations than for routine immunizations.

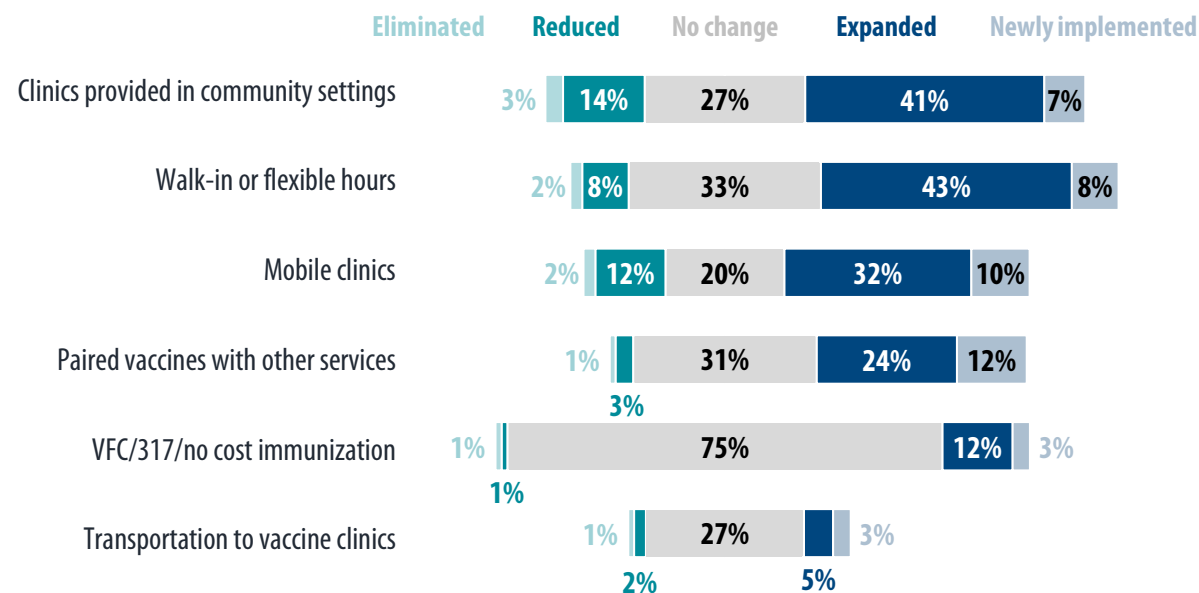
None of these services were reduced or eliminated by more than 2% of LHDs.

Technical Note
LHDs reporting do not know (<10%) were excluded from the analysis.

Immunization services changed in calendar year 2022 to improve access to COVID-19 vaccines

Percent of LHDs, among those directly providing any immunization service

(Percent of LHDs not providing services not displayed)



n=307-321

Nearly half of LHDs increased or newly introduced clinics in community settings, while more than half expanded or offered new walk-in/flexible hours to improve COVID-19 vaccine access.

More than one in seven LHDs introduced or increased the provision of no-cost COVID-19 vaccines, while an additional 2% provided no-cost COVID-vaccines at a lower frequency as in 2021.

Technical Note

LHDs reporting do not know (<10%) were excluded from the analysis.



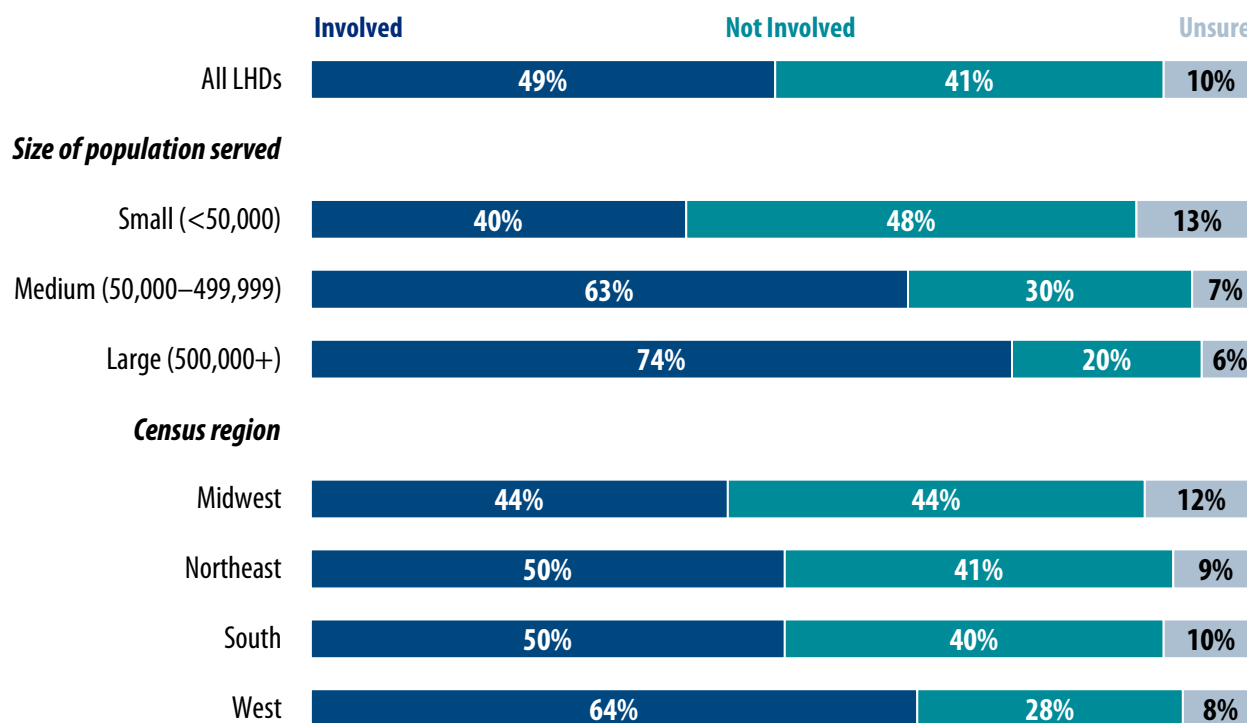
05 | IMMUNIZATION PARTNERSHIPS

In this section:

- Involvement in immunization-focused coalitions or collaboratives
- Types of partners represented in coalitions or collaboratives

Involvement in immunization-focused coalitions or collaboratives, by LHD characteristics

Percent of LHDs, among those directly providing any immunization service



n(2017)=244

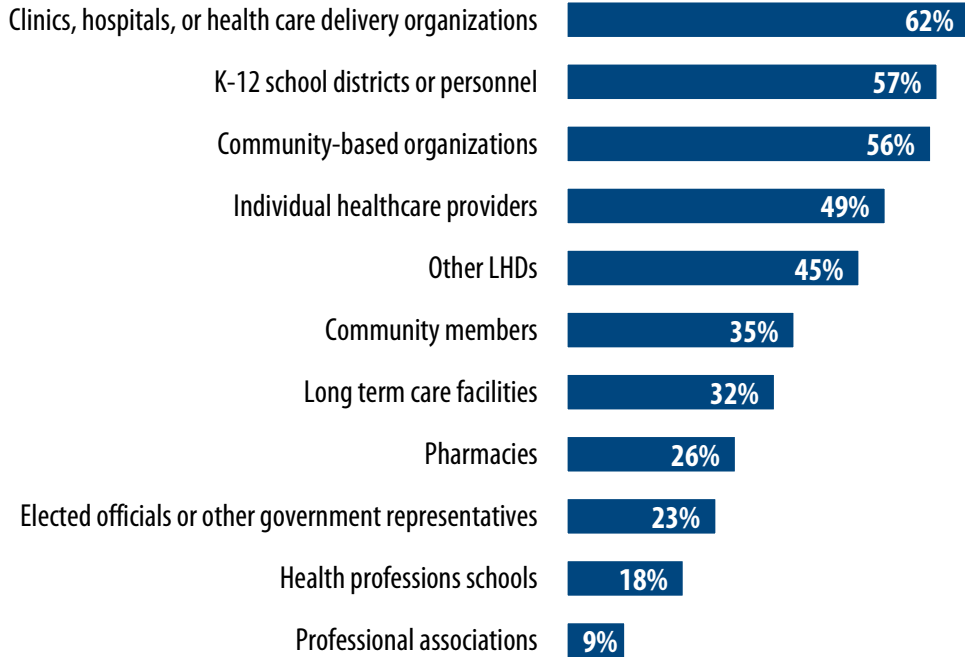
n(2023)=201

Just under half of LHDs were involved in immunization coalitions in the previous year. Although not shown, this represents a decrease from 2017, when 58% of LHDs reported coalition-related involvement in the previous year.

In 2023, large LHDs and those in the West were more likely to report coalition participation, compared to their peer LHDs.

Types of partners represented in immunization-focused coalitions or collaboratives

Percent of LHDs, among those directly providing immunization services and involved with any immunization-focused coalitions or collaboratives



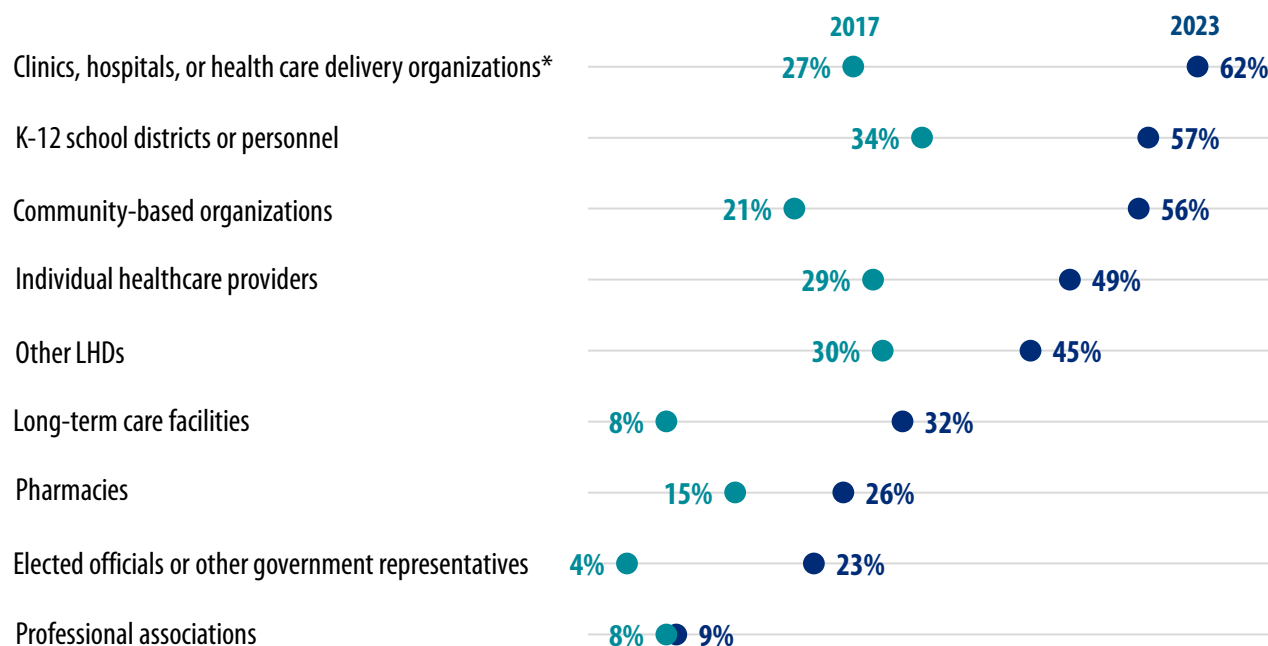
n(2017)=232
n(2023)=201

In 2023, LHDs most frequently reported that healthcare organizations, schools, and community-based organizations participated in their immunization-focused coalitions. Fewer LHDs collaborated with professional associations, health professions schools, or elected officials.

Technical Notes
This analysis does not include the 51% of LHDs that were not involved or were unsure about involvement in a coalition.

Types of partners represented in immunization-focused coalitions or collaboratives, over time

Percent of LHDs, among those directly providing any immunization service and involved with any immunization-focused coalitions or collaboratives



n(2017)=232
n(2023)=201

Despite the small decline in LHD coalition involvement since 2017, participation among other types of organizations have increased. In particular, LHD reports of representation from community-based organizations more than doubled from 21% to 56%, and participation by long-term care facilities quadrupled from 8% to 32%.

Technical Notes

This analysis does not include the 51% of LHDs that were not involved or were unsure about involvement in a coalition.

**Response option language changed for this item from 2017 to 2023.*



06 | SUMMARY OF FINDINGS AND RECOMMENDATIONS

In this section:

- Staffing capacity
- Addressing vaccine hesitancy
- Using data for planning
- Outreach and building trust
- Leveraging partnerships

Staffing Capacity

Half of LHDs reported staffing as a challenge, and this is despite the recent unprecedented growth in the overall workforce driven by COVID-related funding as reported by the 2022 National Profile of Local Health Departments Study. In 2023, LHDs employed an average of six FTEs dedicated to immunization services, equating to only one-third of an FTE per 10,000 people served. In addition, approximately 45% of LHDs reported an average of more than 20 hours per week dedicated to direct immunization services, an increase from the 34% in 2017. LHDs are reporting spending more time on immunization-related activities, and while immunization staffing may have increased for some agencies, that increase is insufficient.

NACCHO is committed to a competent and resilient workforce in LHDs, which includes a better understanding of challenges related to recruitment, retention, and capacity building. Across NACCHO's programs, a variety of trainings are offered to support and promote leadership development and core public health competencies among LHD staff. In addition, NACCHO continues to engage in national policy discussions to address pressing public health workforce issues.

Addressing Vaccine Hesitancy

As seen in other data sources, vaccine hesitancy increased over the course of the COVID-19 pandemic. In calendar year 2022, 82% of LHDs were faced with lack of confidence or vaccine hesitancy as a challenge – an increase from the 56% reporting this challenge in the 2017 survey. LHDs reporting hesitancy among healthcare providers also increased from 20% to 34% over that same timeframe. When reporting on their top priorities for the coming year, addressing hesitancy for childhood and youth vaccinations were at the top of the list. To address the major increase in vaccine hesitancy, LHDs need support through funding, increased data accessibility, and workforce development opportunities to enhance the skill set of LHD staff.

NACCHO strives to share the most up-to-date and accessible educational and communications materials with LHDs from CDC and our partners. However, mis- and disinformation continue to circulate widely in communities and online. Building LHD capabilities in countering misinformation and increasing vaccine confidence amongst priority populations continues to be a key focus for NACCHO's Immunization team.

Using Data for Planning

While many LHDs reported conducting outreach activities, fewer LHDs reported collecting data that could help to inform these activities. Additionally, while most LHDs indicated addressing vaccine hesitancy as one of their top priorities in the coming three years, very few prioritized collecting data or improving data systems. However, accurate data is needed to ensure efforts are successful and address the appropriate barriers or motivations behind vaccine hesitancy.

Local data can be hard to access and requires funding, staff time, and more data partnerships to have accurate counts of local vaccine coverage. Many LHDs reported they have used immunization information systems (IIS) to look up patient history, allowing them to see which individuals are vaccinated, but only one in five reported using IIS to identify under-immunized population clusters. Using IIS in this manner, along with GIS mapping for the jurisdiction, could help LHDs to identify under-immunized populations.

However, possible barriers exist in taking this next step in data analysis and connecting it to program planning for outreach, such as challenges with data modernization, LHDs' lack of access to IIS data, and IIS interoperability with other data systems.

NACCHO recognizes that data modernization is a priority at the national and state levels and is committed to supporting LHDs as they look to implement or expand IIS and build workforce capacity in data collection and analysis. NACCHO and state-level partners are also committed to working together to improve local access to data that can increase the effectiveness of outreach and concentration of efforts.

Outreach and Building Trust

Approximately one-third of LHDs rated themselves with excellent capacity for communications activities that support vaccine uptake. Though marketing and communications are not always included responsibilities in immunization programs, being able to effectively communicate with communities about the benefits of vaccination and address misinformation are vital skills for LHDs in establishing trust within their communities. Nearly half of LHDs rated themselves poor or fair for their capacity to test their communications materials, and one quarter had fair or poor ability to translate materials. Improving capacity in these skills will help to ensure messaging is relevant, reaching the right audience, and improving LHD relationships with the communities.

NACCHO, along with our key partner organizations, remains committed to increasing the communications capacity of LHDs and ensuring public health workers have the skills and resources required for creating, tailoring, and disseminating information that educates and informs communities across the United States.

Leveraging Partnerships

LHDs reported an increase in coalition representation from community-based organizations (CBOs), which more than doubled from 2017 to 2023, and long-term care facilities, which quadrupled. Because COVID-19 disproportionately affected older adults, including those in long-term care facilities, increasing outreach efforts to long-term care was crucial, with partnerships playing a large role in reaching this group. Additionally, use of trusted messengers, which many CBOs are within their communities, was shown to be an effective way to communicate about and promote both COVID-19 and other routine vaccinations. These partnerships proved vital during the pandemic, and LHDs are working to continue leveraging them for outreach.

NACCHO continues to support LHDs in their efforts to build new and sustain collaborations, as well as recognizes the importance of including individuals from the community in decisions and plans related to their health. The use of trusted messengers and community health workers with lived experience are best practices for conducting outreach to specific populations and assuring that information is relevant and resonates with those that would benefit most.



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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