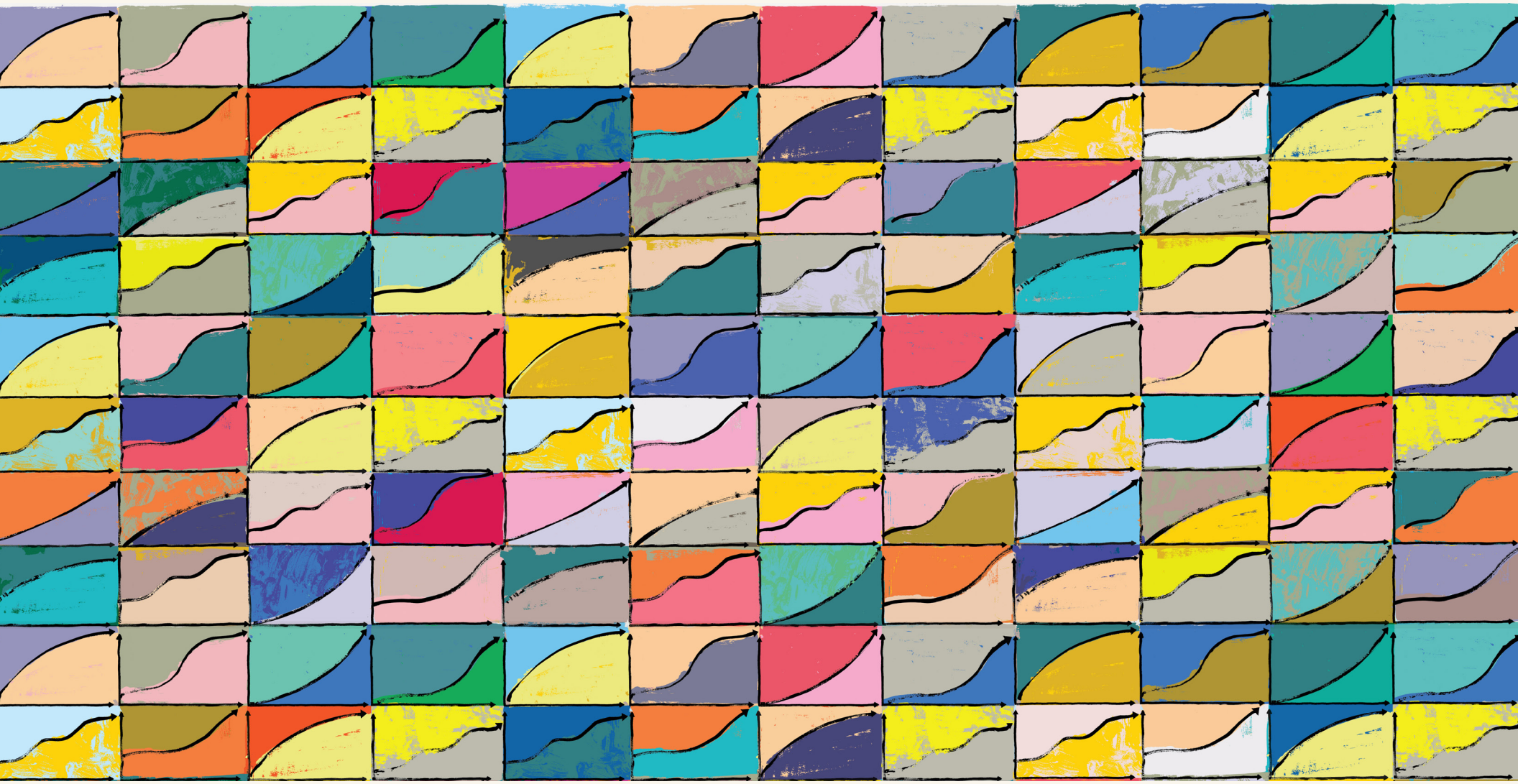
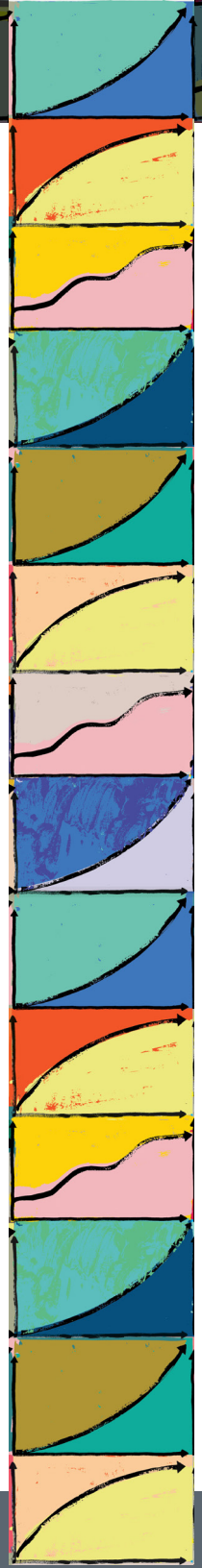
2022 NATIONAL PROFILE OF LOCAL HEALTH DEPARTMENTS



NACCHO
National Association of County & City Health Officials
The National Connection for Local Public Health

PROFILE



In the past year, the COVID-19 pandemic shuffled from the fore of public life to the occasional and passing mention in conversation. Not so in public health! Local health department leaders are still suffering from the waves of interpersonal harassment, political sidelining, and removal of critical public health authorities. Local health department staff continue to move from COVID-19 response reassignments back to pre-pandemic work. In the surrounding ecosystems, perennial public health scourges like opioid overdose, sexually transmitted infections, and mental health issues have altered or become far worse. Finally, public health has become politicized in ways that the field could never have imagined, resulting in new operating challenges and immense funding uncertainty at all levels of government.

During the pandemic, NACCHO's surveys led the way in understanding everything from harassment of local health officials to emergency response staffing. As we enter the post-COVID era, our research—anchored by the National Profile of Local Health Departments (Profile) study—continues to provide field-leading, nationally representative snapshots of the local health department landscape. The credibility and timeliness of our Profile study has led to news outlets, researchers, and congressional policymakers requesting the data at an unprecedented rate. Through generous and ongoing funding provided by the Centers for Disease Control and Prevention (CDC) and the Robert Wood Johnson Foundation (RWJF), these data will continue to be available for efforts vital to strengthening the public health system, such as the evaluation of federal public health infrastructure funding mechanisms and research on the workforce impacts of harassment.

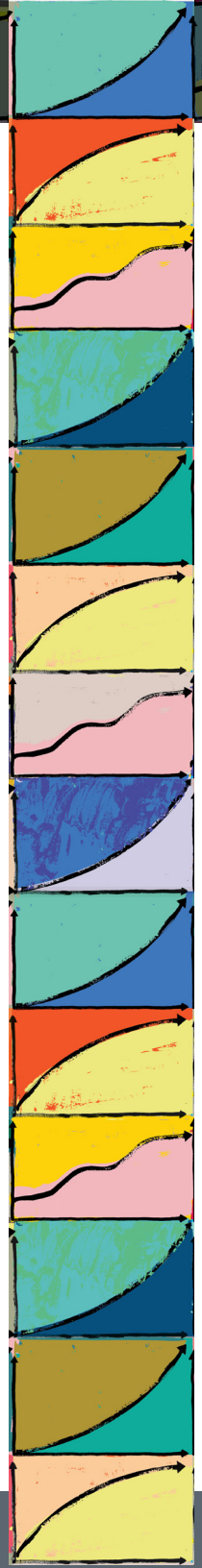
The NACCHO Profile Team is eternally grateful to the many local health officials that participated in our surveys while responding to and supporting recovery from COVID-19. Their fortitude allowed us to tell a national story about local public health during its finest hour and time of greatest need. We are thankful for the contributions of and continued collaboration with all local health departments in the United States.

Aaron Alford
Senior Director, Research & Evaluation

As a former local health department director, I know that local health departments (LHDs) are the backbone of our communities—responsible for protecting and promoting health and advancing evidence-based solutions to address our most pressing public health challenges that hinder health equity—including structural racism. Now more than ever, we understand how structural racism undermines the health of our communities in different but deleterious ways. To support our LHDs, we need data and that is exactly what NACCHO's Profile study provides us—a comprehensive picture of local health departments across the country. Policymakers and other leaders can use these data to allocate resources towards supporting the infrastructure, funding, staffing, and programming of LHDs to ensure everyone has equitable access to health resources and opportunities for well-being.

A stronger future for governmental public health is contingent upon transforming how public health data are collected, shared and used. By ensuring equity is at the center of data modernization and decision making, we can drive progress from inequality to justice.

Alonzo Plough, PhD, MPH, MA
Chief Science Officer Vice President, Research-Evaluation-Learning
Robert Wood Johnson Foundation



NACCHO Profile Team

Margaret Cunningham, MPH, RN

Krishna Patel, DrPH

Timothy C. McCall, PhD

Kellie Hall, MS

Chloe Garofalini, MPH

Joi Lee, BS; David Okereke, MSc

Aaron Alford, PhD, MPH, PMP

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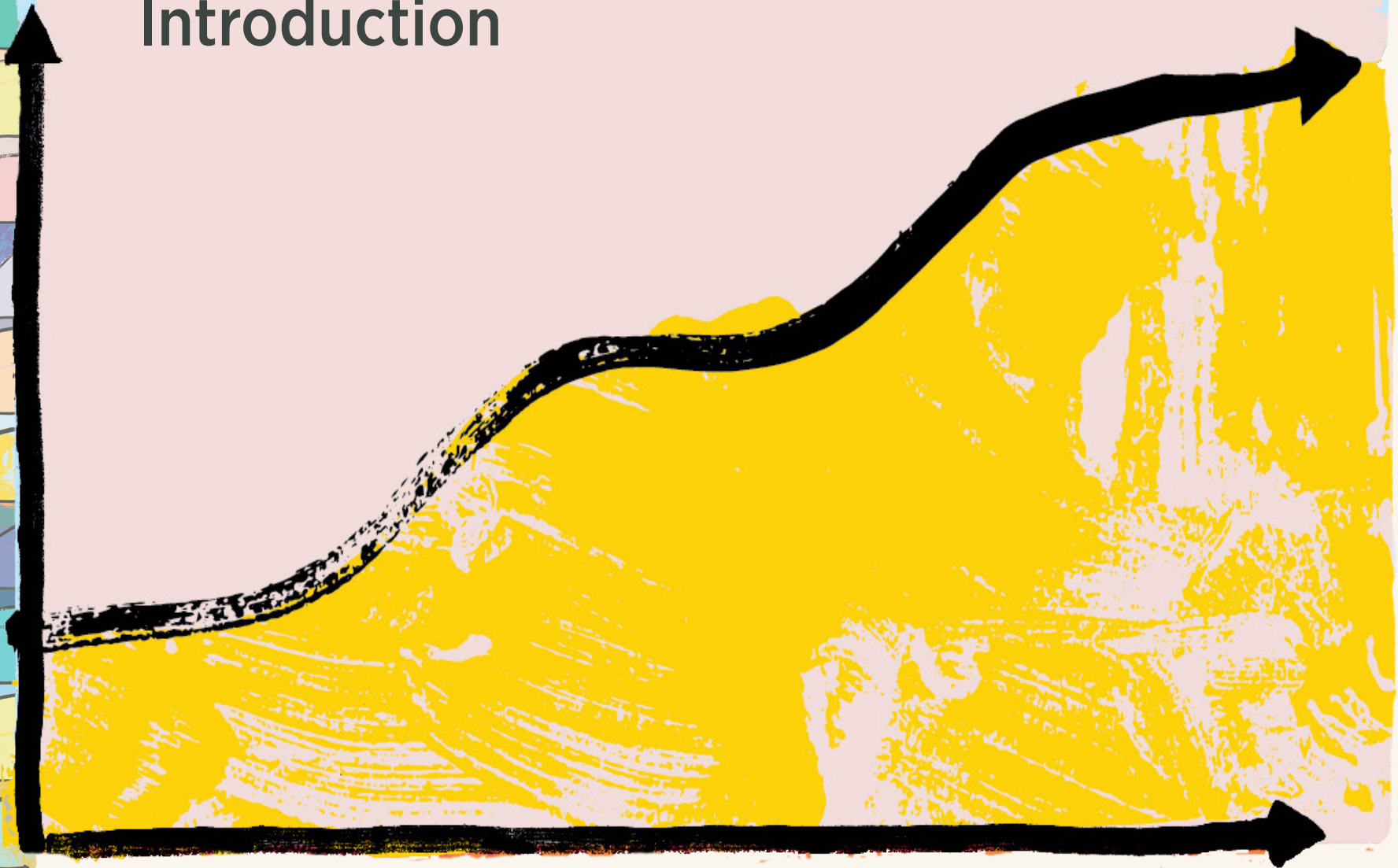
CHAPTER
01

Introduction



The National Association of County and City Health Officials (NACCHO) conducted the first National Profile of Local Health Departments (Profile) study from 1989 to 1990. This study helped to define a local health department (LHD) and describe how funding, staffing, governance, and activities of LHDs vary across the United States (U.S.). In the three decades since, NACCHO has conducted an additional nine Profile studies, including in 2022. All Profile studies have been funded by the Centers for Disease Control and Prevention (CDC); beginning with the 2008 Profile study, NACCHO has also received funding from the Robert Wood Johnson Foundation (RWJF).

Purpose

The purpose of the Profile study is to develop a comprehensive and accurate description of LHD infrastructure and practice. Data from the Profile study are used by many people and organizations across the U.S. For example, LHD staff members use the data to compare their LHD or those within their states to others nationwide; data are used to inform public health policy at the local, state, and federal levels and can support projects to improve local public health practice; and data are used in universities to educate future public health workforce members about LHDs and by researchers to address questions about public health practice. Users can also access Geographic Information System (GIS) shapefiles of Profile study LHD jurisdictions to support their research. NACCHO staff use Profile data to develop programs and resources that meet the needs of LHDs and to advocate effectively for LHDs.

Study Methodology

Study population

Every Profile study uses the same definition of an LHD: an administrative or service unit of local or state government, concerned with health, and carrying some responsibility for the health of a jurisdiction smaller than the state. There are more than 3,300 agencies or units that meet the Profile definition of an LHD. Some states have a public health system structure that includes both regional and local offices of the state health agency.

NACCHO uses a database of LHDs based on previous Profile studies and consults with state champions, which may include representatives of state health agencies and state associations of local health officials (SACCHOs) to identify LHDs for inclusion in the study population. For the 2022 Profile study, a total of 2,512 LHDs were included in the study population. Rhode Island was excluded from the study because the state health agency operates on behalf of local public health and has no sub-state units.

Sampling

All LHDs in the study population received the Core questionnaire. A randomly selected group of LHDs also received one of the two sets of supplemental questions (or modules). LHDs were selected to receive the Core questionnaire plus one of the two modules using stratified random sampling (without replacement), with strata defined by the size of the population served by the LHD. The module sampling process is designed to produce national estimates but not to produce state-level estimates.

Questionnaire development

The NACCHO Profile team developed the 2022 questionnaire by first reviewing the previous Profile questionnaire (i.e., 2019) to determine how each question performed among respondents and what questions should be kept, modified, or deferred to a future Profile questionnaire. The team also reviewed questionnaires from previous years (e.g., 2016, 2013, 2010) to identify whether any questions should be repeated in 2022. Lastly, the team explored developing new questions based on current public health topics. An advisory workgroup—comprising LHD leaders, staff from affiliate organizations, and researchers—and other subject matter experts within NACCHO provided input and feedback on new and revised survey questions. The Profile team piloted the questionnaire from March 14, 2022, to March 31, 2022, among 30 LHDs (15 completed it for a response rate of 50%). NACCHO interviewed select LHDs to assess whether certain sections and questions performed as expected. The Profile team revised the survey as needed and finalized it for distribution.

FIGURE 1.1

Questionnaire topics

Core	Module 1	Module 2
LHD top executive	Partnerships and collaboration	Quality improvement
Jurisdiction and governance	Cross-jurisdictional sharing of services	Public health informatics
Workforce	**Staffing up**	**Immunization**
Staffing changes	Emergency preparedness	Evaluation of Profile
Programs and services	Access to healthcare services	
Public health policy		
Community health assessment and planning		
Accreditation		
Funding		
Change in LHD budget		
Public health law		
Harassment and backlash		

- The 2022 Profile study questionnaire included a set of questions (Core questionnaire) sent to all LHDs in the U.S.; additional supplemental questions were grouped into two modules.
- LHDs were randomly assigned to receive the Core questionnaire plus one of the two modules.
- Many questions in the Core and module questionnaires have been used in previous Profile studies and provide an ongoing dataset for comparative analysis.

Questionnaire distribution

In May 2022, NACCHO sent an e-mail announcement to all LHDs in the study population. In the e-mail, LHDs were given the opportunity to designate another staff person as the primary contact to complete the Profile questionnaire. NACCHO launched the final questionnaire from June through September 2022 via an e-mail sent to a designated primary contact of every LHD in the study population. The e-mail included a link to a web-based questionnaire, individualized with preloaded identifying information specific to the LHD. LHDs could print a hard copy version of their Profile questionnaire by using a link in the introduction to the Web-based questionnaire or could request that NACCHO staff send a copy via e-mail or U.S. mail.

The Profile team conducted extensive efforts to encourage participants to complete the questionnaire. Before and during the administration period, NACCHO disseminated promotional materials about the survey via NACCHO's electronic publications (e.g., *Public Health Dispatch, NACCHO Connect*, *NACCHO Voice*) and social media channels. NACCHO staff and a nationwide group of Profile study advocates conducted follow-up with non-respondents using e-mail messages and telephone calls. NACCHO also offered technical support to survey respondents through an e-mail address and telephone hotline.

FIGURE 1.2

Number of LHDs in study population and number of respondents, by state

State	Total number of LHDs	Number of respondents	Response rate
All	**2,512**	**942**	**38%**
AL	66	66	100%
AK	2	0	0%
AR	75	17	23%
AZ	15	7	47%
CA	61	22	36%
CO	53	30	57%
CT	61	18	30%
DC	1	0	0%
DE	2	0	0%
FL	67	23	34%
GA	32	6	19%
HI	4	1	25%
IA	98	26	27%
ID	7	3	43%
IL	92	33	36%
IN	94	22	23%
KS	100	53	53%
KY	61	15	25%
LA	10	2	20%
MA	345	66	19%
MD	24	20	83%
ME	10	6	60%
MI	45	12	27%
MN	74	39	53%
MO	114	50	44%

State	Total number of LHDs	Number of respondents	Response rate
All	**2,512**	**942**	**38%**
MS	3	1	33%
MT	51	12	24%
NC	85	21	25%
ND	28	24	86%
NE	19	9	47%
NH	5	0	0%
NJ	98	29	30%
NM	4	2	50%
NV	3	3	100%
NY	58	39	67%
OH	113	57	50%
OK	70	24	34%
OR	32	9	28%
PA	13	5	38%
SC	4	4	100%
SD	5	2	40%
TN	94	37	39%
TX	63	28	44%
UT	13	7	54%
VA	35	11	31%
VT	12	12	100%
WA	35	6	17%
WI	85	50	59%
WV	48	10	21%
WY	23	3	13%

- Overall, the 2022 Profile study had 942 LHDs respond, for a response rate of 38%.
- With the exception of Alaska, Delaware, the District of Columbia, Georgia, Louisiana, Massachusetts, New Hampshire, Wyoming, and Washington, all states had a response rate of more than 20%.
- Alabama, Nevada, South Carolina, and Vermont had response rates of 100%.

FIGURE 1.3

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

Size of population served	Total number of LHDs	Number of respondents	Response rate
All	**2,512**	**942**	**38%**
<25,000	1,052	344	33%
25,000–49,999	497	192	39%
50,000–99,999	372	142	38%
100,000–249,999	303	138	46%
250,000–499,999	139	51	37%
500,000–999,999	95	45	47%
1,000,000+	54	30	56%

- LHDs serving smaller populations had lower response rates than did those serving larger populations.
- Because there are relatively few LHDs serving large populations, the higher response rates among LHDs serving larger populations are important to the analytic capacity of the study data.

Survey Weights and National Estimates

Unless otherwise stated, national statistics presented were computed using survey weights. Through weighting, the Profile study provides national estimates for all LHDs in the study population across the U.S. Beginning in 2019, we used post-stratification weighting (based population size) and utilizing finite population correction; the confidence intervals associated with some statistics may differ from items published in previous years due to this change.

Subgroup Analysis

Throughout this report, data are analyzed by various LHD jurisdiction characteristics, namely size of population served, type of governance, U.S. Census regions, and degree of urbanization.

- **Size of population served:** Statistics are compared across LHDs serving different population sizes in the LHD jurisdiction. LHDs are classified as small if they serve fewer than 50,000 people, medium if they serve populations between 50,000 and 500,000 people, and large if they serve 500,000 or more people. For certain statistics that are highly dependent on size of population served (e.g., finance and workforce statistics), a larger number of population subgroups are used.
- **Type of governance:** Statistics are compared across LHDs' relationship to their state health department. Some LHDs are agencies of local government (referred to as locally governed). Others are local or regional units of the state health department (referred to as state-governed). Some are governed by both state and local authorities (called shared governance).
- **Census region:** Statistics are also compared across U.S. Census regions. All LHDs in each state are classified being in the North, South, Midwest, or West, per the U.S. Census Bureau (http://www.Census.gov/econ/Census/help/geography/regions_and_divisions.html).
- **Degree of urbanization:** Statistics are compared across LHD jurisdiction degree of urbanization. Each LHD in the Profile study population was classified as serving either an urban or rural jurisdiction using the Census bureau classification system. Each LHD jurisdiction was classified as urban or rural based on whether the majority of people it served were from urban or rural settings (i.e., more than 50% urban were classified as urban), calculated for each Census tract the LHD serves. This classification system is new to the 2022 Profile study; the estimates associated with some statistics may differ from items published in previous years due to this change.

Study Limitations

The Profile study is a unique and comprehensive source of information on LHD finances, infrastructure, workforce, activities, and other important characteristics. However, several limitations should be considered when using the results of this study. Given the large scope of this study, the level of detail available does not provide extensive information on all dimensions of the topics addressed. For example, Profile provides information about whether or not an LHD provides a specific program or service but does not provide any information about the scope or scale of that program or service. 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.

While the Profile questionnaire includes definitions for many items, not every item or term is defined. For example, the questionnaire does not include definitions for each of the programs and services included in the Profile questionnaire. Consequently, respondents may have interpreted questions and items differently.

Responding to the Profile questionnaire is time-intensive; consequently, respondents may have skipped some questions because of time restrictions. In addition, responses to some questions may have been based on estimation to reduce burden. In particular, questions on finance were difficult for LHDs to answer and yielded large amounts of missing data.

Comparisons with data from prior Profile studies are provided for some statistics, but these comparisons should be viewed with caution because both the study population and the respondents are different for each Profile study. In addition, comparisons are not tested for statistically significant differences.

CHAPTER
02

Jurisdiction and Governance

This chapter includes the following:

- Population sizes served by local health departments (LHDs).
- Geographic jurisdictions served by LHDs.
- Governance of LHDs.
- Combined Health and Human Services Agencies.
- Local boards of health.

FIGURE 2.1

Size of population served, by LHDs

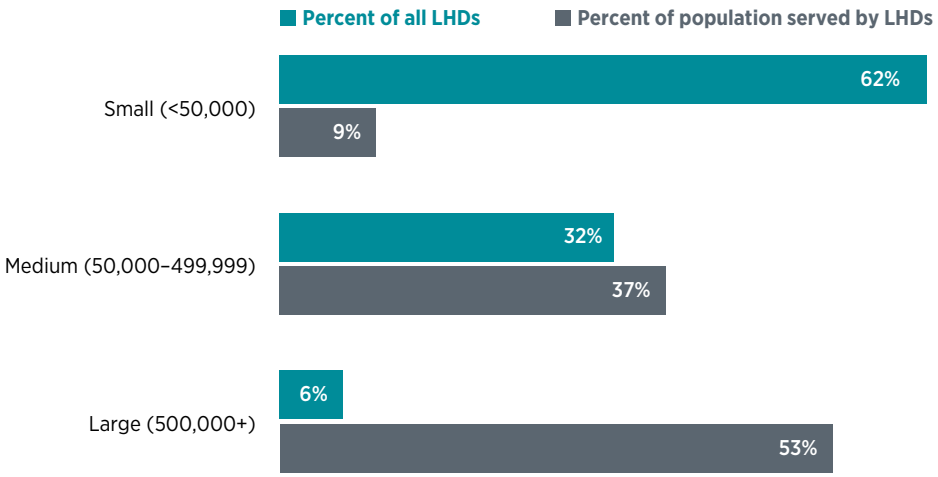
Size of population served	N	Percent
<25,000	1,052	42%
25,000—49,999	497	20%
50,000—99,999	372	15%
100,000—249,999	303	12%
250,000—499,999	139	6%
500,000—999,999	95	4%
1,000,000+	54	2%
Total	2,512	—

n=2,512

- There were more than 3,300 LHDs in the U.S., but not every unit was included in the Profile study. For the purposes of surveying and developing national estimates of the LHD landscape, NACCHO designed and utilizes a methodology to account for the most unique individuals in the U.S. population without "double counting." Therefore, the denominator of LHDs used for surveying and national estimation purposes will always be smaller than the actual number of LHDs in the U.S., while still covering all local jurisdictions uniquely. NACCHO is in frequent contact and consultation with state and local officials to update the denominator.
- 2,512 LHDs were included in the 2022 Profile study population.
- LHDs serve different sized jurisdictions across the United States. Of the 2,512 LHDs included in the 2022 Profile study population, 62% serve less than 50,000 people.

FIGURE 2.2

Percent of U.S. population served, by LHDs

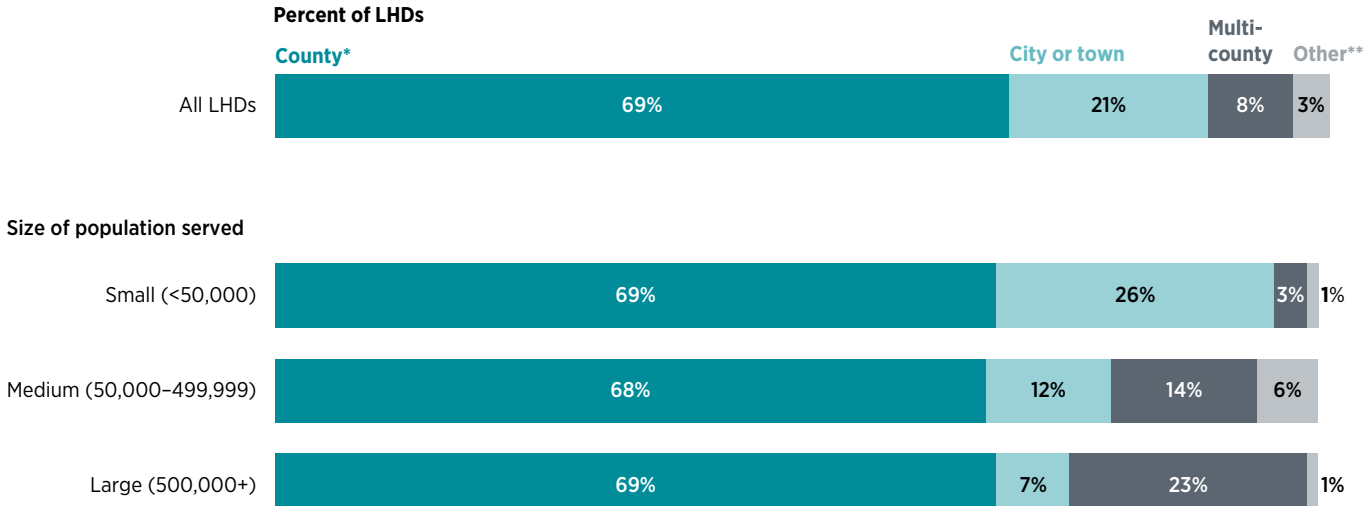


n=2,512

- Throughout this report, small LHDs are classified as those that serve populations of fewer than 50,000 people; medium LHDs serve populations of between 50,000 and 500,000 people; and large LHDs serve populations of 500,000 or more people.
- Although only 6% of all LHDs were classified as large, they served more than half of the U.S. population.
- The majority of LHDs were small, but together, they served less than 10% of the U.S. population.

FIGURE 2.3

Geographic jurisdictions served by LHDs, by size of population served



n=2,512

- Approximately two-thirds of LHDs were county-based and an additional 8% serve multiple counties. One-fifth of LHDs serve cities or towns.
- Large LHDs were less likely to serve cities or towns but were more likely to serve multiple counties than small LHDs.

Technical notes

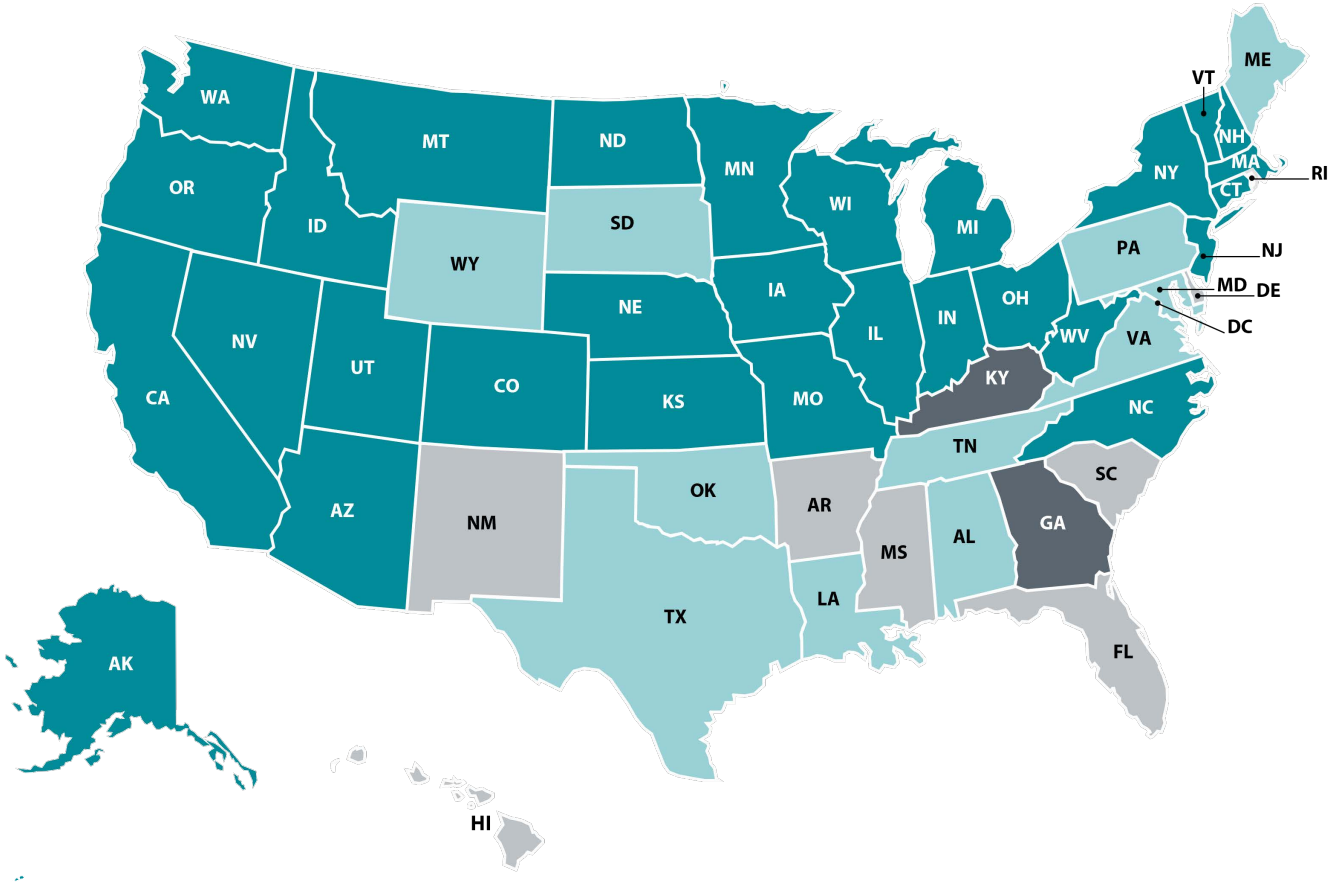
*County includes city-counties

**Other includes LHDs serving multiple cities or towns

FIGURE 2.4

Governance of LHDs, by state

- Local (all LHDs in state are units of local government)
- State (all LHDs in state are units of state government)
- Shared (all LHDs in state governed by both state and local authorities)
- Mixed (LHDs in state have more than one governance type)



RI non-participants

n=2,512

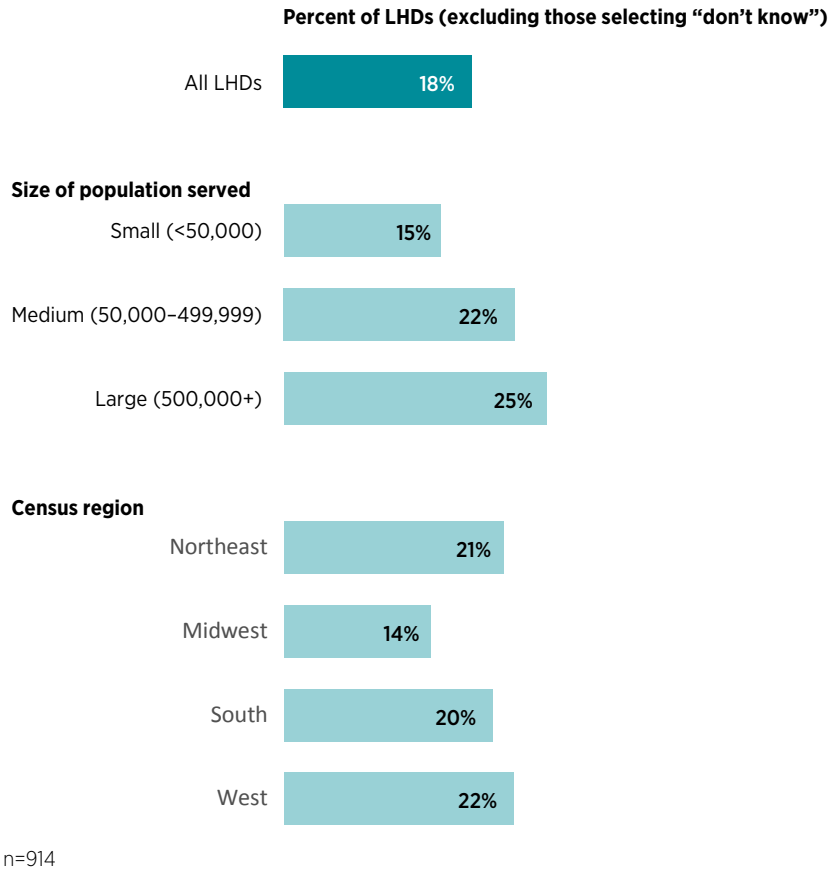
- Of the 2,512 LHDs included in the 2022 Profile study population, 1,928 were locally governed, 467 were units of the state health agency, and 117 have shared governance.
- In 30 states, all LHDs were locally governed.
- All LHDs in Arkansas, Delaware, Florida, Hawaii, Mississippi, New Mexico, South Carolina, South Dakota, and Virginia were units of the state health agency.
- All LHDs in Georgia and Kentucky have shared governance.
- In most states with mixed governance, units of the state health agency serve most parts of the state, while a small number of large metropolitan areas have locally governed LHDs.

Governance authority of LHDs

LHDs vary in their relationships with their state health agency. Some LHDs are local or regional units of the state health agency, others are agencies of local government, and others are governed by both state and local authorities (called shared governance). Some states include LHDs with more than one governance type (shown as mixed on the map). States in which all LHDs have state governance are referred to as centralized, and those in which all LHDs are locally governed are decentralized.

FIGURE 2.5

LHDs as a part of a combined Health And Human Services Agency (HHSA), by size of population served and Census regions



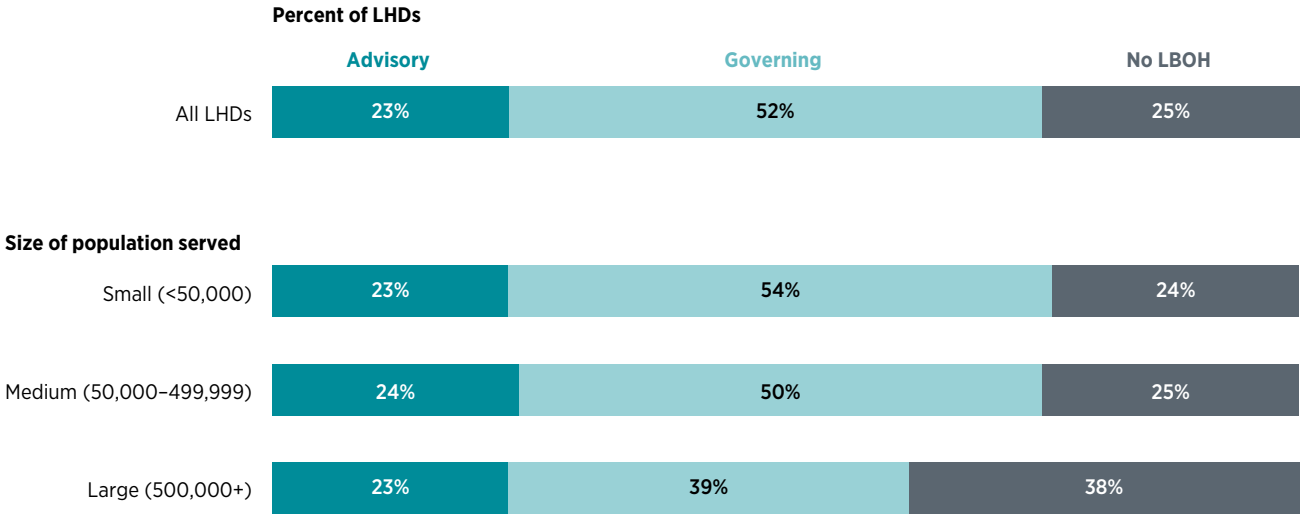
n=914

- Nearly one in five LHDs were part of a combined Health And Human Services Agency (HHSA).
- Large LHDs were most likely to be part of an HHSA, compared to medium and small LHDs.
- LHDs in the Midwest were less likely to be part of an HHSA.

Combined Health and Human Services Agency (HHSA)
A combined health and human services agency can be defined as an agency that administers all programs dealing with health and welfare. A combined health and human services agency provides a broad range of health and social services to promote wellness, self-sufficiency, and a better quality of life by integrating health and social services through a unified service-delivery system.

FIGURE 2.6

LHDs with a local board of health (LBOH), by size of population served

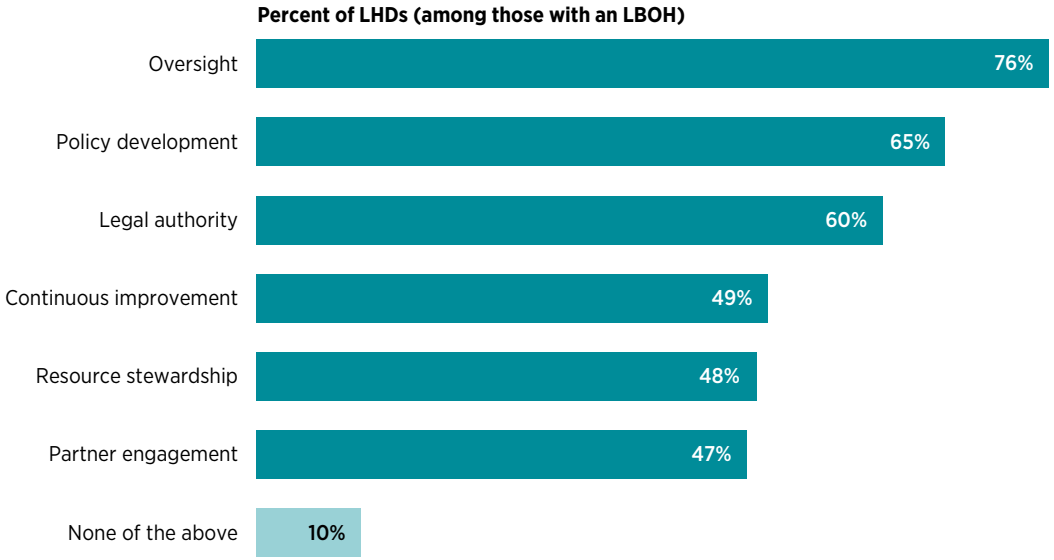


n=925

- Three in four LHDs have a local board of health (LBOH).
- A larger proportion of small and medium LHDs have LBOHs compared to large LHDs.
- A higher proportion of LHDs have LBOHs with a governing role compared to an advisory role.

FIGURE 2.7

Functions that local boards of health (LBOHs) utilize on a continuous basis

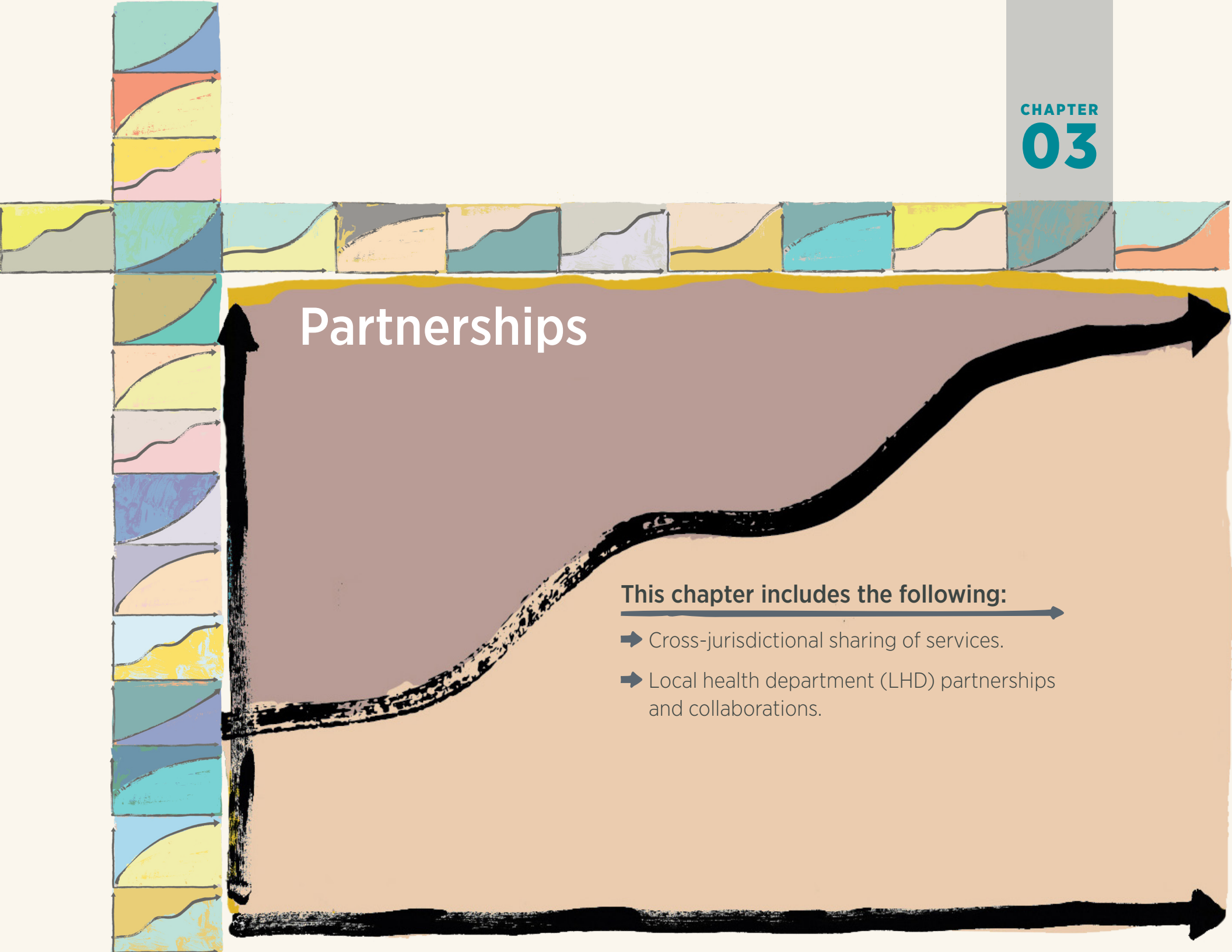


n=688

- The National Association for Local Boards of Health (NALBOH) identifies six functions of public health governance. More information about each function can be found at https://www.nalboh.org/page/GovernanceResources.
- The most common function used by LBOHs is oversight, while fewer have resource stewardship and partner engagement functions.

CHAPTER
03

Partnerships

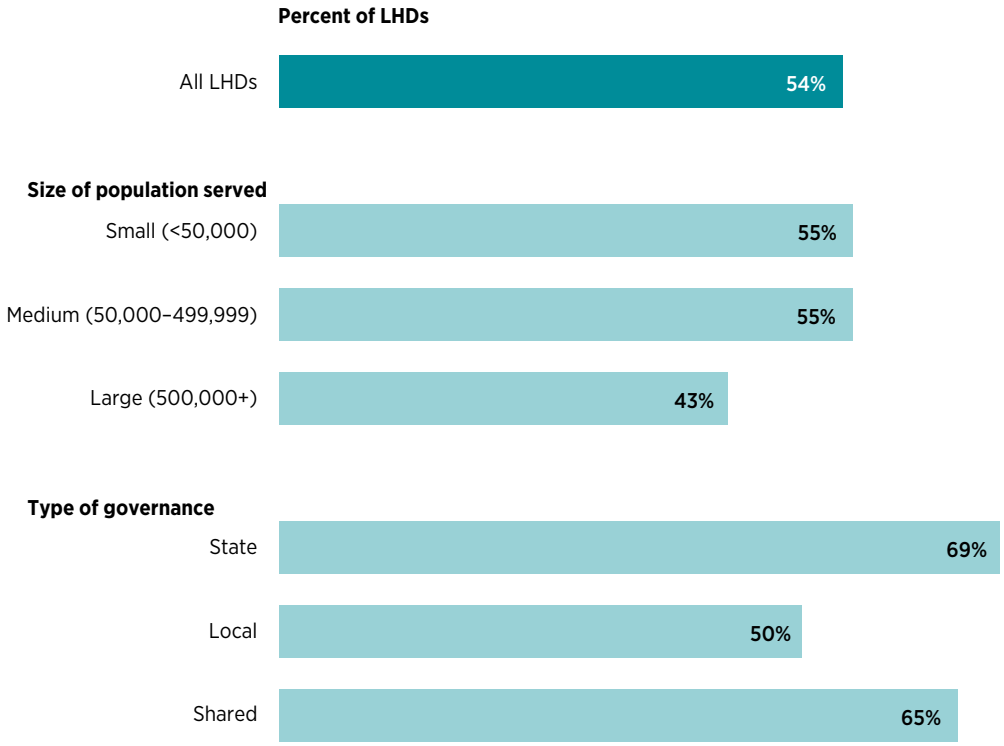


This chapter includes the following:

- Cross-jurisdictional sharing of services.
- Local health department (LHD) partnerships and collaborations.

FIGURE 3.1

Cross-jurisdictional sharing of services, by size of population served and type of governance

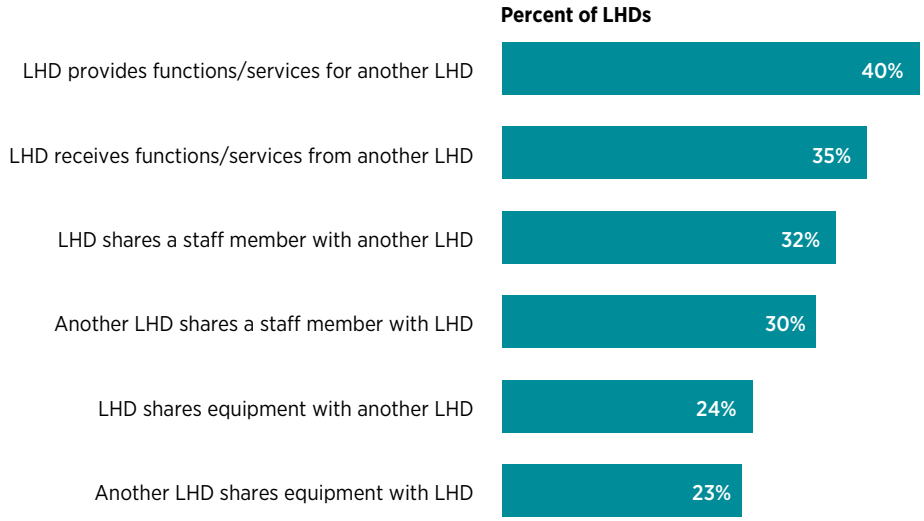


n=489

- More than half of LHDs share resources (such as funding, staff, or equipment) with other LHDs on a continuous, recurring, non-emergency basis, regardless of size.
- A smaller proportion of large LHDs shared resources in 2022 than in 2019 (not shown).
- A larger proportion of LHDs with shared governance share resources than locally governed LHDs.

FIGURE 3.2

Type of cross-jurisdictional sharing of services



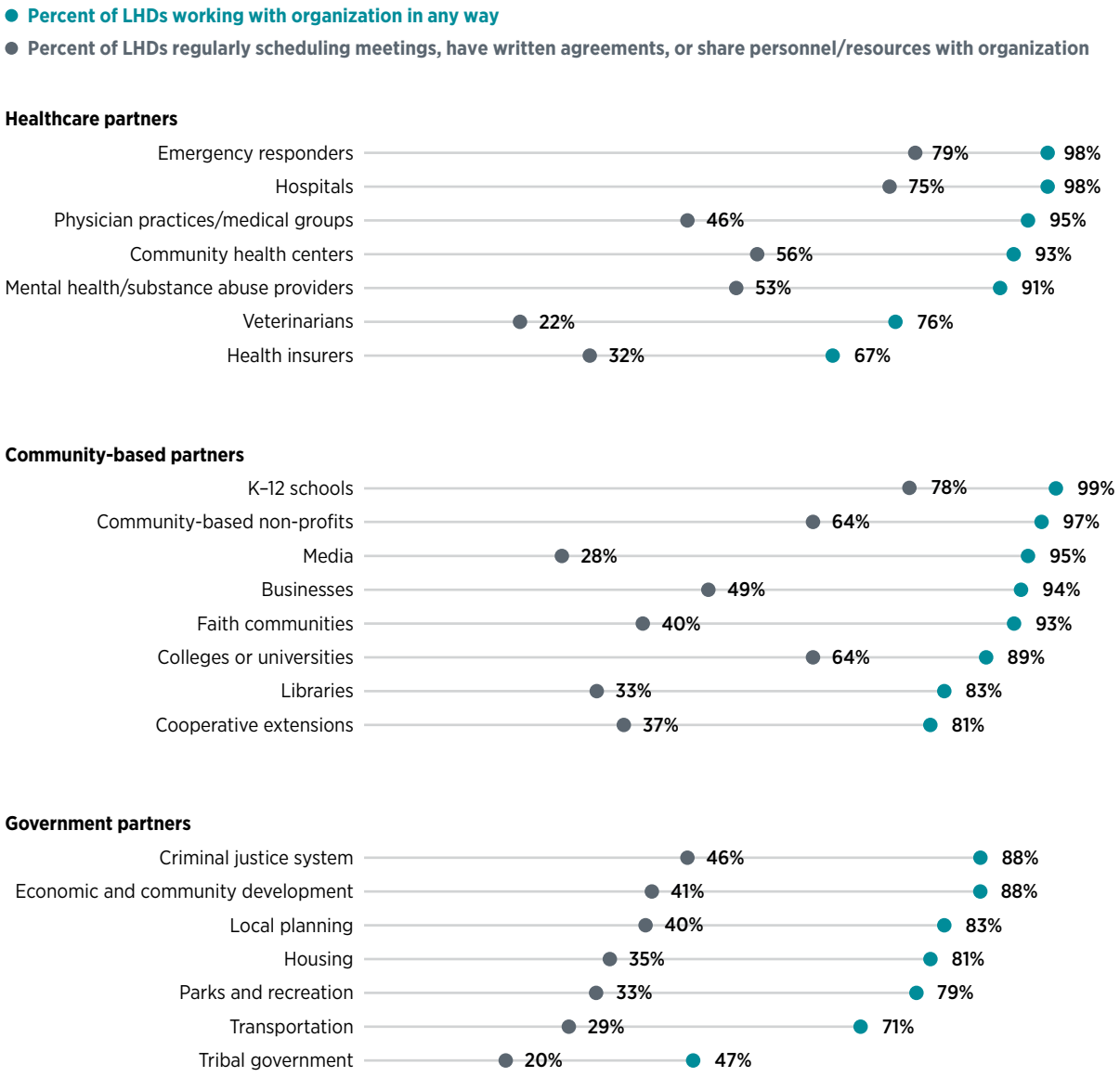
n=484–487

- More than one-third of LHDs receive functions or services from another LHD or provide functions or services for another LHD.
- LHDs were more likely to share resources with another LHD than they were to receive them. For example, 32% of LHDs share staff members with another LHD, while 30% have another LHD share a staff member with them.

Cross-jurisdictional sharing of services
Cross-jurisdictional sharing of services is a term used to refer to the various means by which jurisdictions work together to provide public health services. LHDs across the country are looking to cross-jurisdictional sharing as a way to help them more efficiently and effectively deliver public health services. The information provided in this section reflects sharing resources on a continuous, recurring, non-emergency basis.

FIGURE 3.3

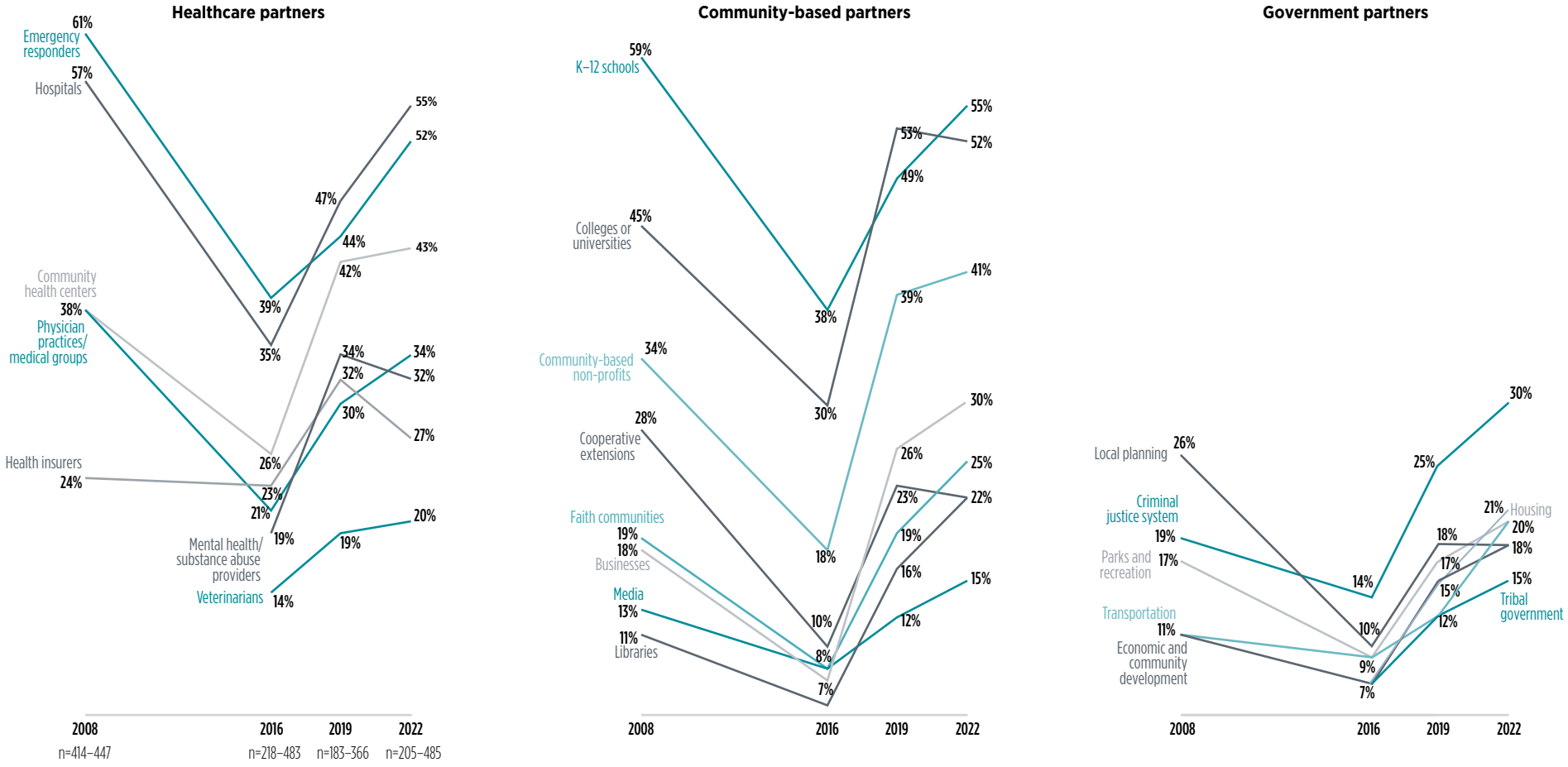
LHD partnerships and collaborations in the past year



- LHDs work with a variety of partners in their communities (including healthcare partners, government agencies, and community-based partners) in a variety of ways, such as sharing information, regularly scheduling meetings, establishing written agreements, and sharing personnel/resources.
- Nearly all LHDs work with some partners, including hospitals, emergency responders, K–12 schools, and community-based non-profits. Collaborations with other partners, including tribal governments and health insurers, were less universal.
- Overall, LHDs were less likely to collaborate in ways beyond exchanging information (i.e., regularly scheduling meetings, establishing written agreements, or sharing personnel/resources). This difference is particularly large for the media (only 28% collaborate beyond information exchange while 95% partner in any way) and veterinarians (only 22% collaborate beyond information exchange while 76% partner in any way).

FIGURE 3.4

Formal* LHD partnerships and collaborations, over time *Share personnel/resources and/or have written agreements



- Between 2008 and 2016, the proportion of LHDs reporting formal collaborations with many organization types decreased. Between 2016 and 2022, this proportion increased.
- Despite these increases, the proportion of LHDs reporting formal collaborations with many organization types has not recovered to 2008 results. In particular, formal partnerships with emergency responders and local planning agencies saw the greatest overall declines.
- Conversely, LHDs were much more likely to report formal partnerships with business, libraries, and the criminal justice system in 2022 compared to 2008.
- Overall, LHDs were generally less likely to have formal partnerships with government agencies than with either healthcare or other community-based partners.

CHAPTER
04

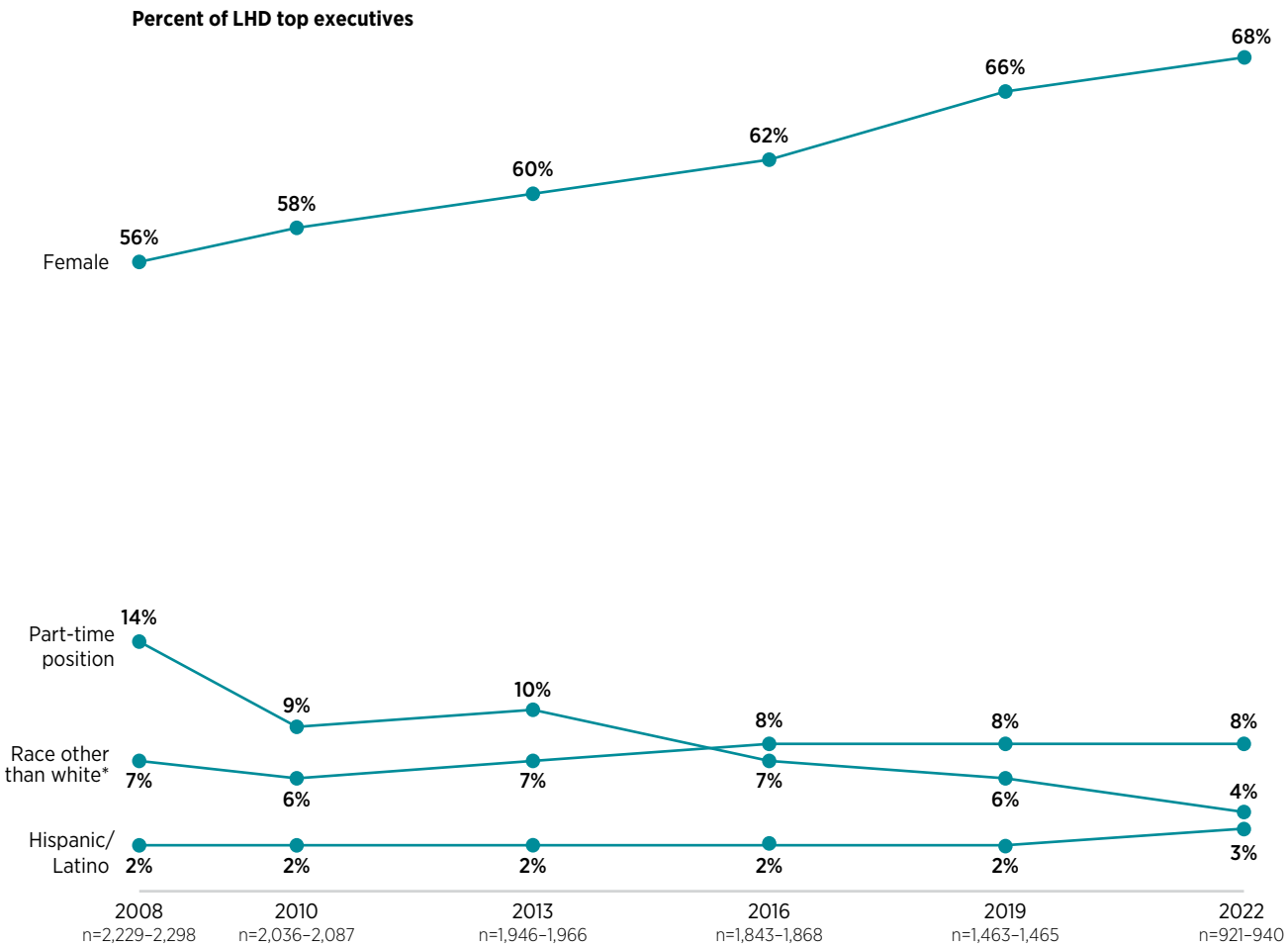
Leadership

This chapter includes the following:

- Characteristics of local health department (LHD) top executives, including age, tenure, positions held prior to top executive position, and degrees.

FIGURE 4.1

Characteristics of top executives

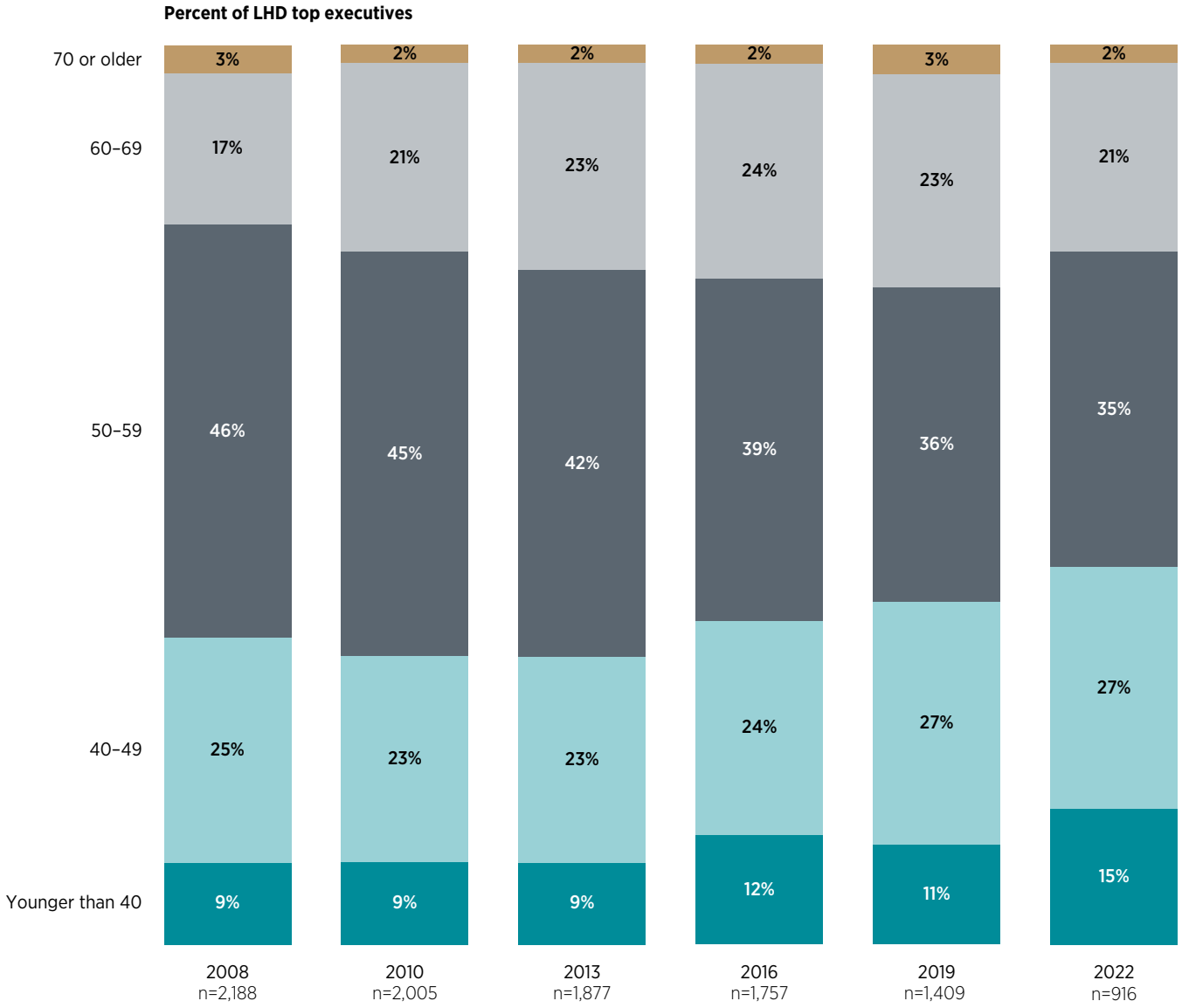


*Respondents could select multiple race categories; this proportion includes those that may have selected "white" and another category.

- More than two-thirds of top executives identify as female; since 2008, the percentage of female top executives has increased steadily, from 56% in 2008 to 68% in 2022.
- Less than 10% of top executives identify as Hispanic/Latino or a race other than white, and this percentage has remained low since 2008.
- The percentage of top executives that were in part-time positions has decreased by more than half since 2008, from 14% to 4% in 2022.

FIGURE 4.2

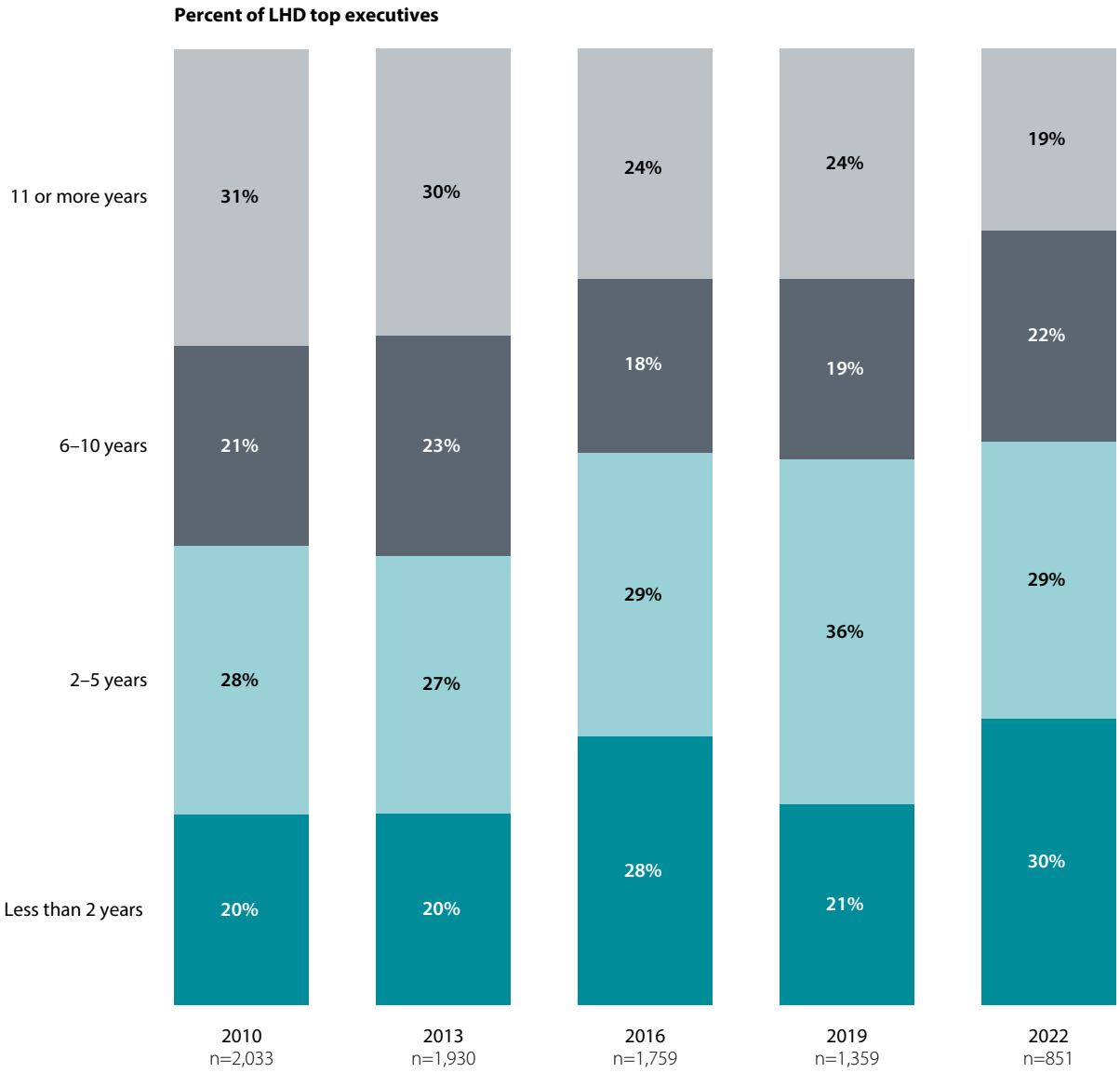
Age of top executives, over time



- More than half of top executives were 50 or older, and nearly one in four were 60 or older. Only 15% were younger than 40.
- Since 2008, the proportion of top executives in their fifties has declined. Meanwhile, the proportion of top executives younger than 50 has grown in recent years.

FIGURE 4.3

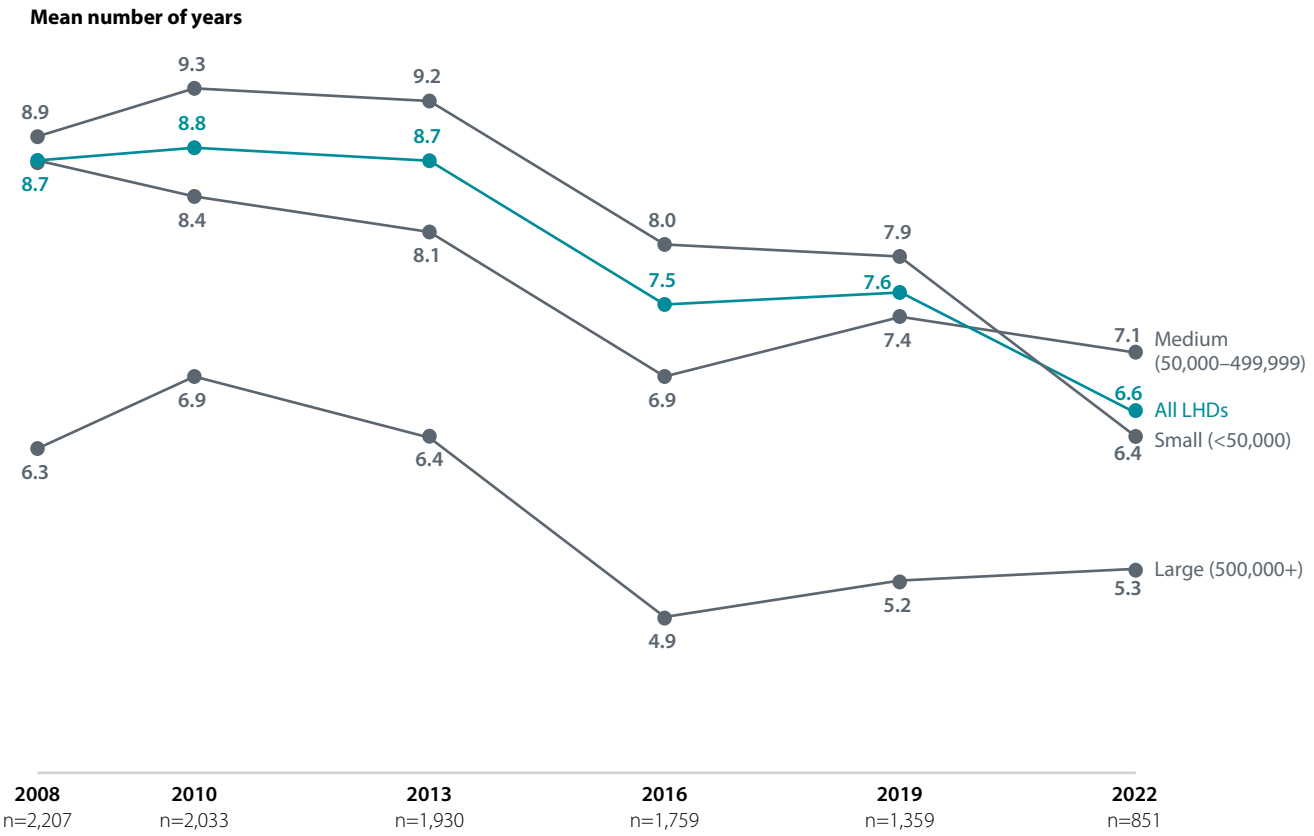
Top executive tenure, over time



➡ Compared to 2010 and 2013, top executives have been in their positions for fewer years. Since 2013, the percentage of top executives who have been in their positions less than five years has remained steady at nearly 60%.

FIGURE 4.4

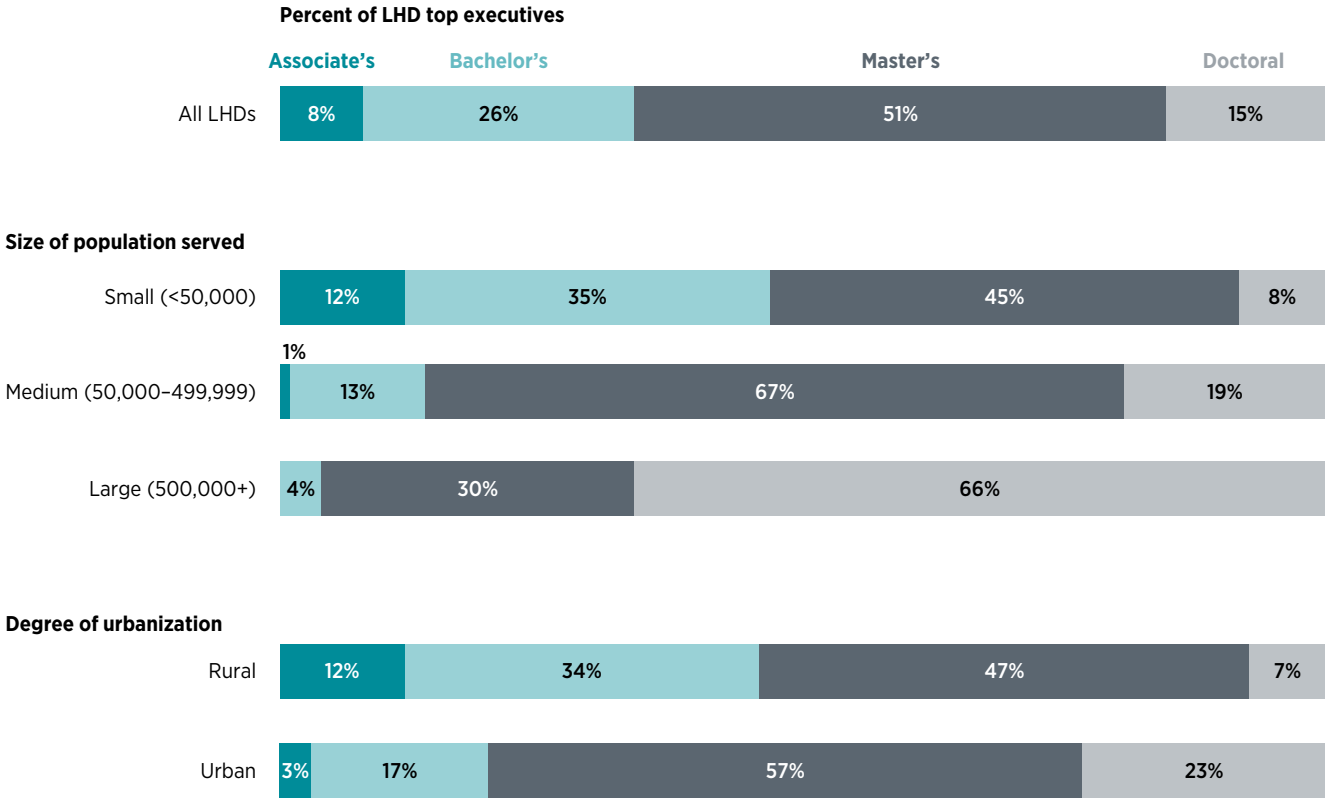
Top executive average tenure (in years), over time



- Since 2008, the average tenure for top executives decreased from 8.7 years to 6.6 years. However, the average tenure has remained steady for large LHDs over the past three years.
- Top executives at large LHDs remain in their positions for fewer years on average than top executives at medium or small LHDs.

FIGURE 4.5

Highest degree obtained, by top executive



n=925

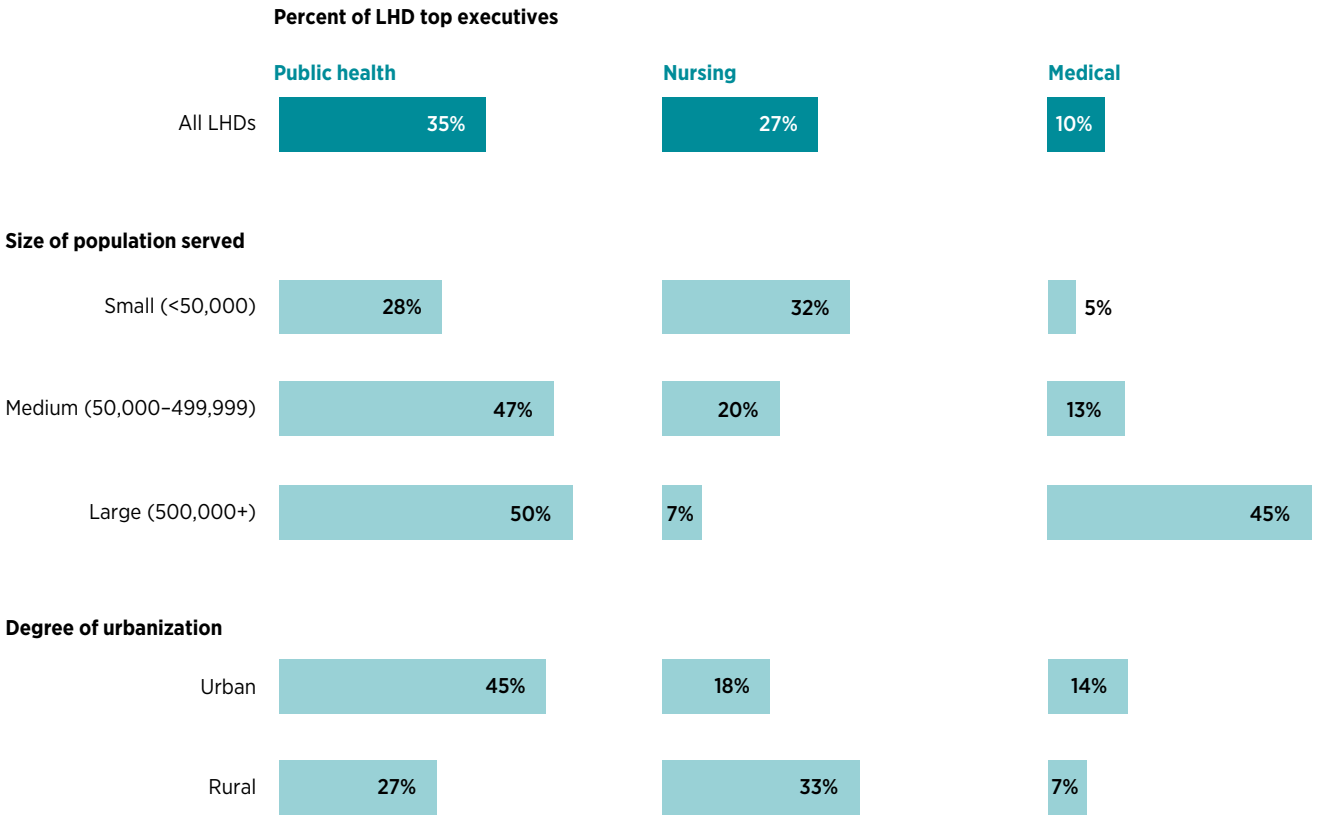
- The highest degree held by top executives is most often a Master's degree, followed by a Bachelor's degree. Fewer top executives hold Associate's or Doctoral degrees.
- Top executives at large LHDs were much more likely to have graduate degrees (96%) than top executives at small LHDs (53%).
- Similarly, top executives at LHDs serving urban areas were much more likely to have graduate degrees (80%) than top executives at LHDs serving rural areas (54%).

Technical note

A new schema for categorizing urban and rural LHDs was used for 2022 estimates. "Urban" refers to urban-majority areas, while "rural" refers to rural-majority areas. These data may not be comparable to previous year estimates. Refer to the subgroup analysis details on page 17 for more about the urban/rural categorization methodology.

FIGURE 4.6

Specialized degrees obtained, by top executive



n=935

- Slightly more than one-third of top executives hold a public health degree, more than one-quarter hold nursing degrees, and 10% hold medical degrees.
- Top executives at large LHDs were more likely to have public health or medical degrees than nursing degrees. On the other hand, top executives at small LHDs were more likely to have nursing degrees than public health or medical degrees.
- Top executives at LHDs serving rural areas were more likely to have nursing degrees than top executives at LHDs serving urban areas.

Technical note
A new schema for categorizing urban and rural LHDs was used for 2022 estimates. "Urban" refers to urban-majority areas, while "rural" refers to rural-majority areas. These data may not be comparable to previous year estimates. Refer to the subgroup analysis details on page 17 for more about the urban/rural categorization methodology.

CHAPTER
05

Workforce

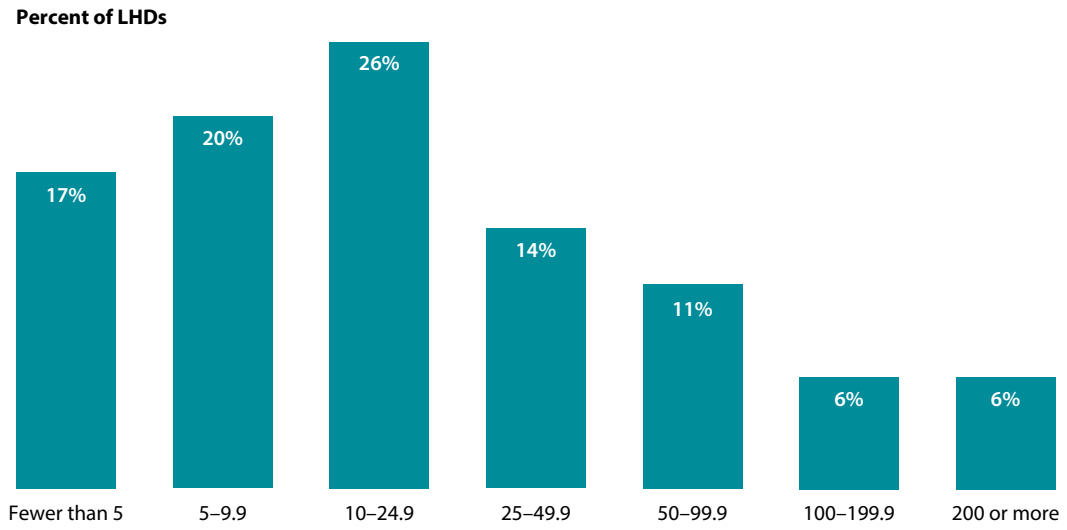
This chapter includes the following:

- Current numbers of local health department (LHD) staff (employees and full-time equivalents (FTEs)).
- Changes in numbers of LHDs staff (2008 to 2022).
- Annual LHD job losses and gains.
- Employees retiring from LHD workforce.
- Occupations employed by LHDs.

Technical note
Statistics were calculated using all valid data available, regardless of missing information in other occupations, total employees, and total FTEs.

FIGURE 5.1

Number of full-time equivalents (FTEs)



n=924

- More than three in four LHDs employ fewer than 50 FTEs, with 37% employing less than 10 FTEs and 41% employing between 10 and 50 FTEs.
- Only 11% of LHDs employ between 50 and 100 FTEs, and 12% employ 100 or more FTEs.

FIGURE 5.2

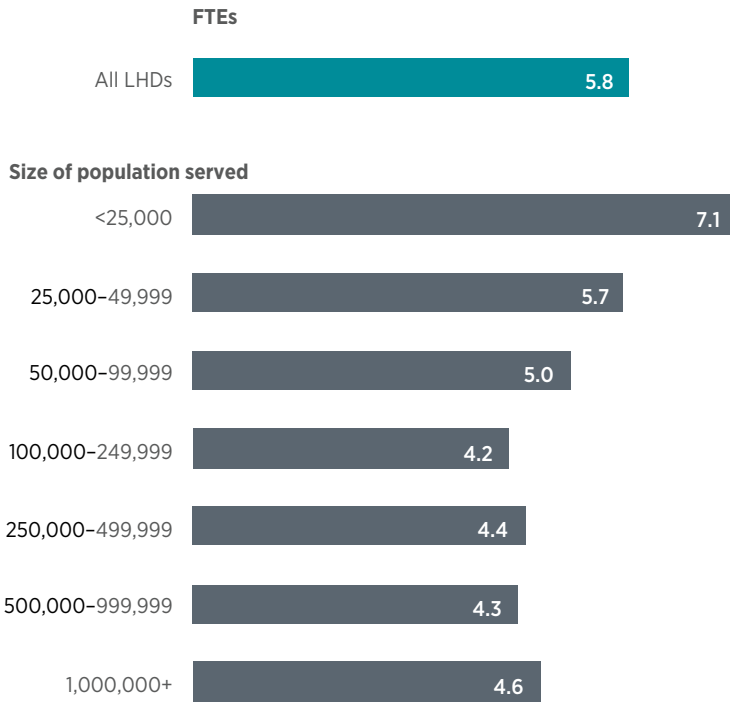
Mean and median number of employees and full-time equivalents (FTEs) by size of population served

	Number of employees n=929		Number of FTEs n=924	
	Mean	Median	Mean	Median
All LHDs	73	17	65	15
Size of population served				
<25,000	10	7	8	6
25,000–49,999	24	17	21	15
50,000–99,999	40	33	35	30
100,000–249,999	77	66	68	55
250,000–499,999	187	134	156	120
500,000–999,999	337	320	309	268
1,000,000+	1,187	724	1,105	714

- On average, LHDs employ 73 employees or 65 FTEs.
- However, these numbers vary greatly by the size of population served by the LHD. While LHDs that serve less than 25,000 people employ 10 employees or 8 FTEs on average, LHDs that serve over one million people employ 1,187 employees or 1,105 FTEs on average.

FIGURE 5.3

Full-time equivalents (FTEs) per 10,000 people, by size of population served



n=924

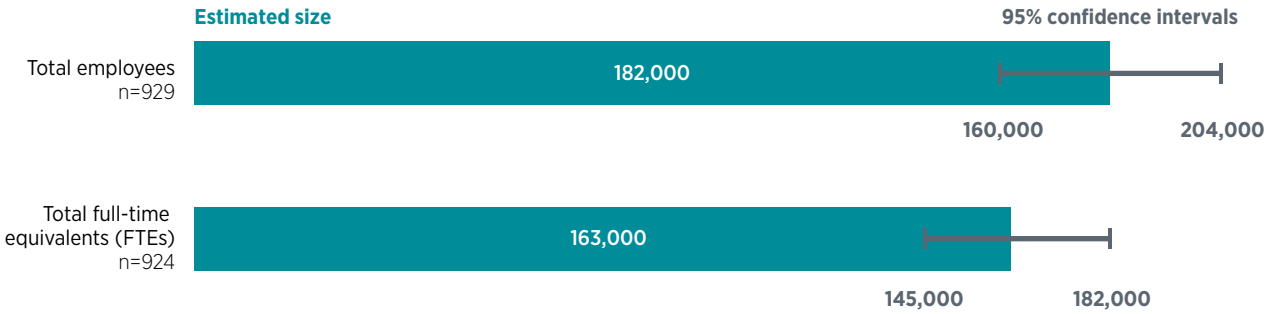
- Among all LHDs, the overall workforce capacity is 5.8 FTEs per 10,000 people.
- LHDs that serve smaller populations employ a greater number of FTEs per capita than LHDs that serve larger populations.

Technical note

The number of LHD staff per 10,000 people served by the LHD is a useful way to measure overall workforce capacity and facilitates comparisons across LHDs serving different jurisdiction sizes. These statistics are computed by summing the FTE staff (for all LHDs or for LHDs in specific jurisdiction size categories), dividing by the total population of those jurisdictions, and multiplying by 10,000.

FIGURE 5.4

Estimated size of the LHD workforce

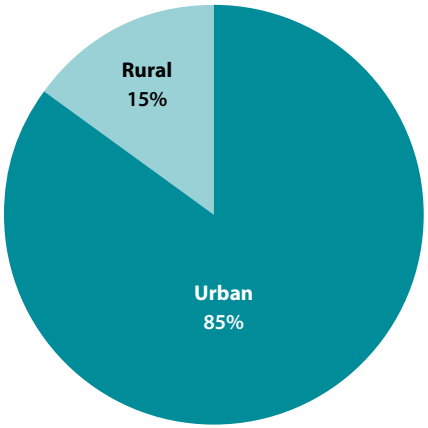


➡ LHDs employ approximately 182,000 employees or 163,000 FTEs.

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

FIGURE 5.5

Distribution of full-time equivalents (FTEs) urbanization



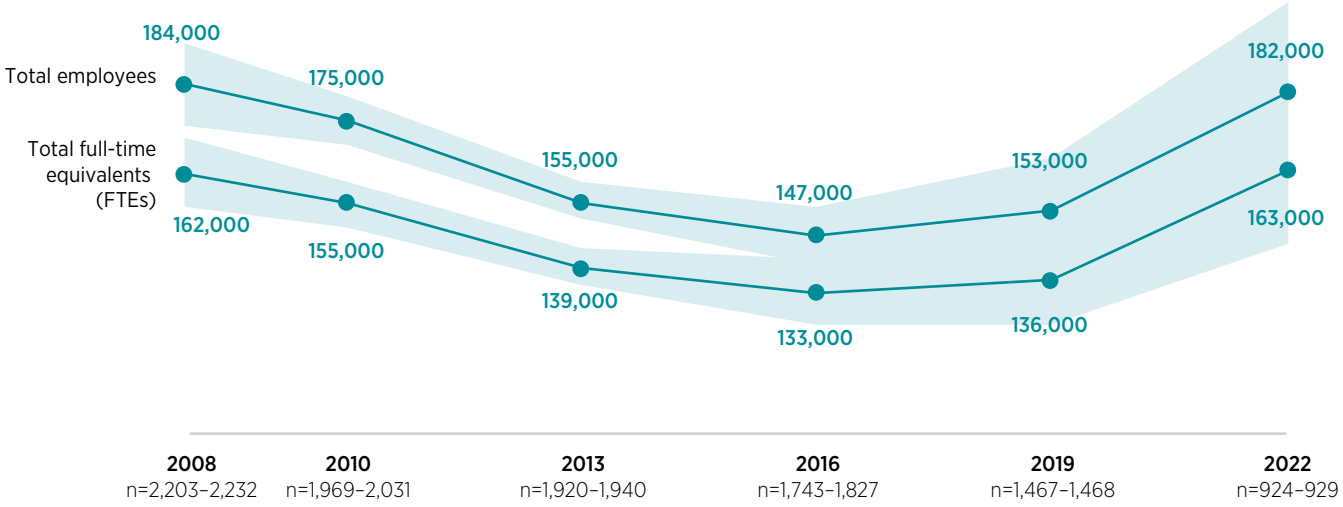
n=924

➡ Nearly nine in 10 LHD FTEs (85%, or 138,000 FTEs) were employed by LHDs that serve urban areas. Only 15% of LHD FTEs (25,000 FTEs) were employed by LHDs that serve rural populations.

Technical note
A new schema for categorizing urban and rural LHDs was used for 2022 estimates. "Urban" refers to urban-majority areas, while "rural" refers to rural-majority areas. These data may not be comparable to previous year estimates. Refer to the subgroup analysis details on page 17 for more about the urban/rural categorization methodology.

FIGURE 5.6

Estimated size of LHD workforce, over time



Light teal shading depicts 95% Confidence Interval.

- Overall, the LHD workforce grew by approximately 19% from 2019 to 2022—after continuously decreasing between 2008 and 2019.
- Notably, there was a national declaration of public health emergency in 2020 after the onset of the COVID-19 pandemic; supplemental funding efforts to temporarily bolster the LHD workforce occurred during this period. At the time data were collected, nearly $60 billion in short-term federal emergency supplemental funding was available to state, tribal, local, and territorial jurisdictions for the COVID-19 pandemic response. This may explain the large jump in workforce. This large influx in federal funding expires in 2024, and no further federal resources are expected.

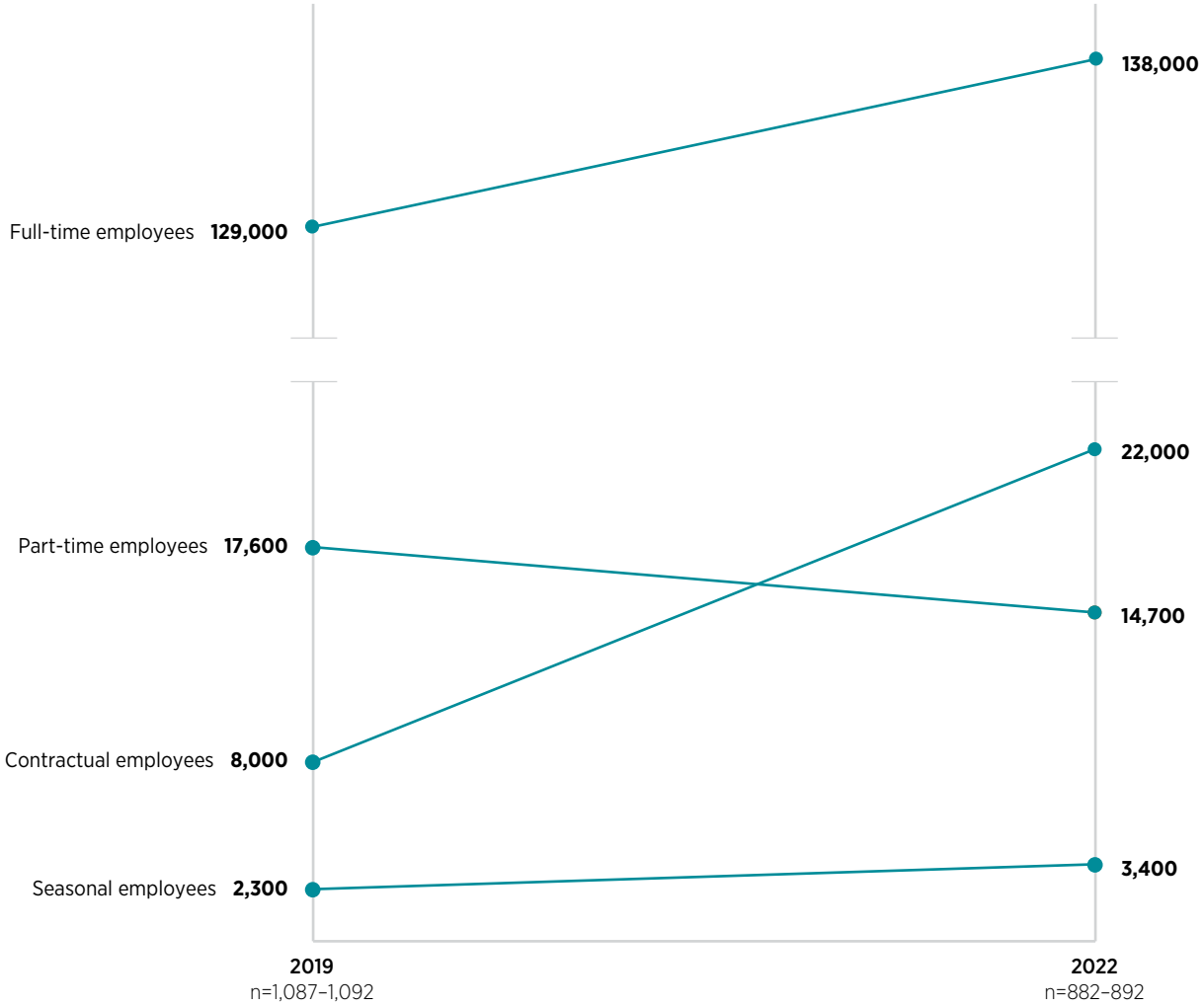
Technical notes

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

Estimates for 2008–2013 workforce are different from previous reports due to new weight and cleaning methodologies implemented beginning in 2019.

FIGURE 5.7

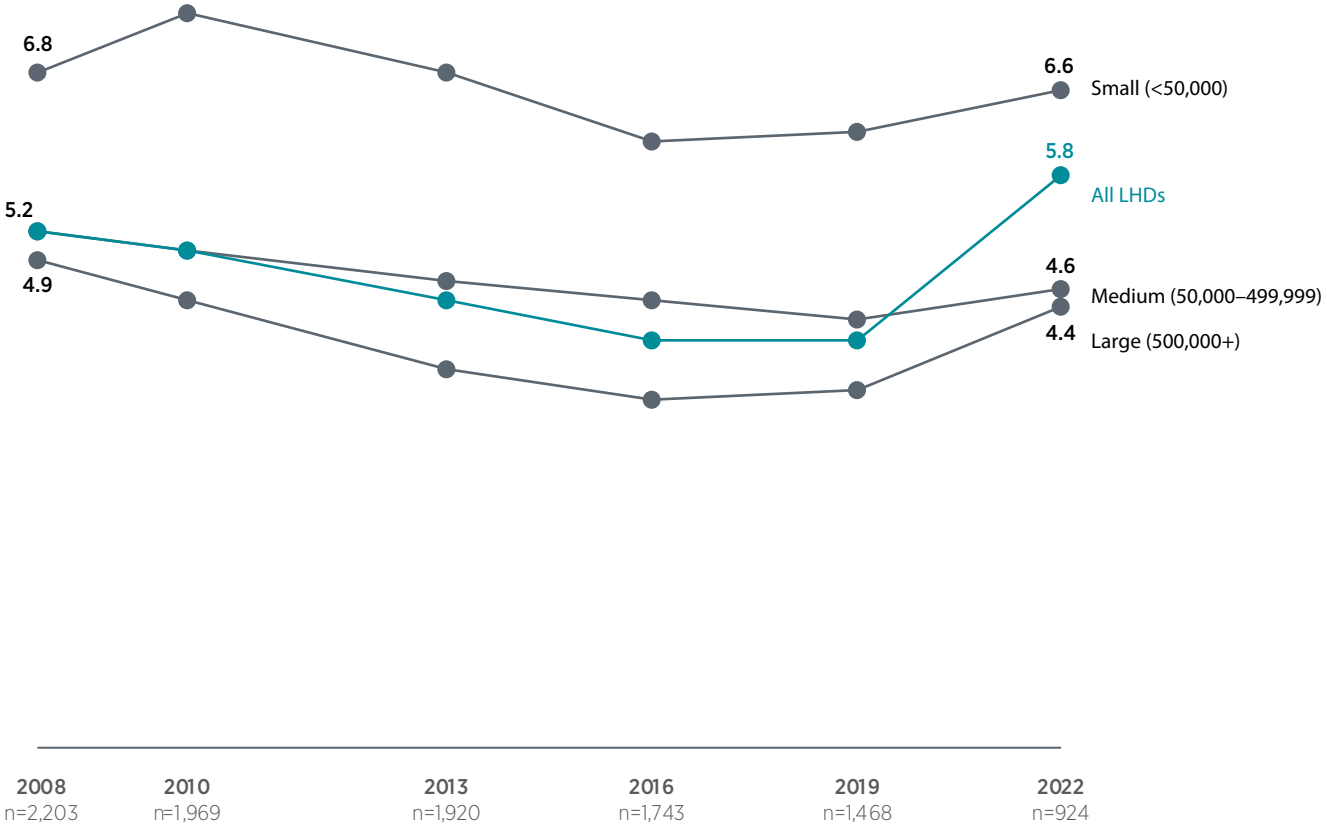
Change in estimated number of LHD employees since 2019



- Between 2019 and 2022, the number of contractual LHD employees increased by 175%—more than any other type of employee (i.e., full-time, part-time, seasonal).
- The percent change in contractual employees from 2019 to 2022 was higher for large LHDs (247%) than small or medium LHDs (4% and 126%, respectively) (not shown).
- The number of part-time LHD employees decreased by 16% during the COVID-19 pandemic.

FIGURE 5.8

Change in full-time equivalents (FTEs) per 10,000 people since 2008 by size of population served



- Overall, LHDs gained 11% of their workforce capacity since 2008. While 5.2 FTEs per capita were employed at LHDs in 2008, 5.8 FTEs per capita were employed in 2022.
- Medium and large LHDs have experienced a greater loss in workforce capacity than small LHDs.

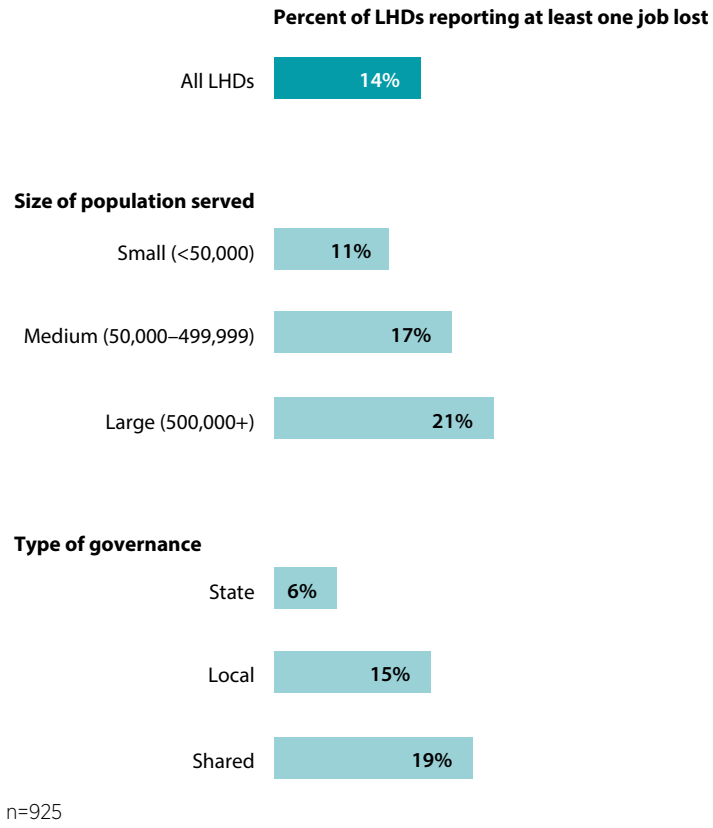
Technical notes

This figure shows changes in overall LHD workforce capacity (measured in FTEs per 10,000 people) between 2008 and 2022. See notes on Figure 5.3 for more information on how these statistics are computed.

Estimates for 2008–2013 workforce are different from previous reports due to new weight and cleaning methodologies implemented beginning in 2019.

FIGURE 5.9

Job losses due to layoffs and/or attrition in the past year, by size of population served and type of governance



n=925

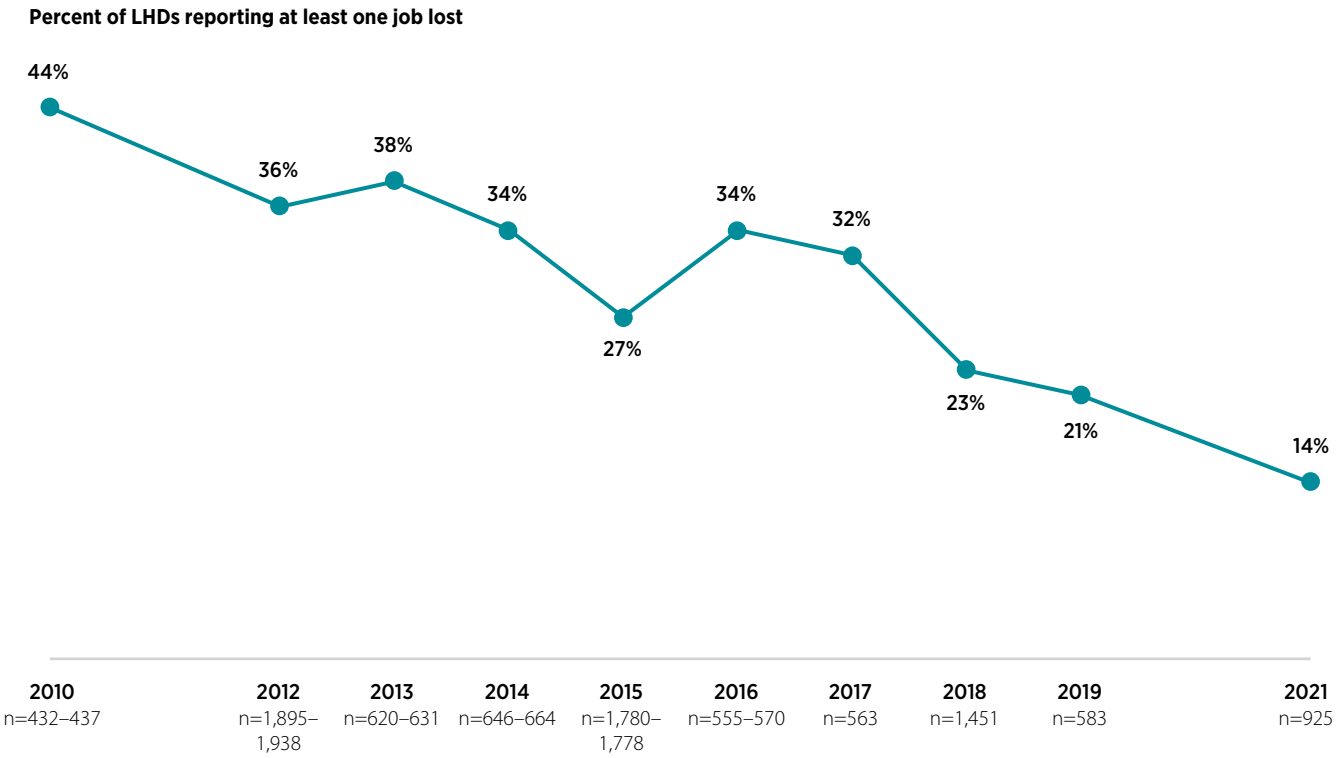
- Fourteen percent of LHDs reported at least one job lost during calendar year 2021 due to layoffs and/or attrition.
- A larger proportion of large and medium LHDs reported having lost at least one job compared to small LHDs.
- Similarly, LHDs with shared governance were more likely to report having lost at least one job compared to state-governed or locally governed LHDs.

Technical note

The 2022 Profile included questions about loss of LHD staff (by layoffs or attrition) during calendar year 2021. Similar questions have been included in several other NACCHO surveys administered periodically since the beginning of the Great Recession. Figures 5.9 through 5.11 present findings based on those data.

FIGURE 5.10

Job losses due to layoffs and/or attrition, over time



➡ Overall, the percentage of LHDs reporting at least one job lost due to layoffs and/or attrition has decreased. While 44% of LHDs reported having lost at least one job during the 2010 calendar year, 14% of LHDs reported the same during the 2021 calendar year.

Technical notes

The 2022 Profile included questions about loss of LHD staff (by layoffs or attrition) during calendar year 2021. Similar questions have been included in several other NACCHO surveys administered periodically since the beginning of the Great Recession. Figures 5.9 through 5.11 present findings based on those data.

N's vary because questions regarding layoffs and attrition were asked in separate questions with different numbers of observations across survey years.

FIGURE 5.11

Number of jobs lost and added, over time, by size of population served

	Number of positions eliminated	Number of positions added	Net Change
All LHDs			
Change in 2011	9,970	3,700	-6,270
Change in 2012	4,090	3,680	-410
Change in 2015	2,720	3,570	850
Change in 2017	730	900	170
Change in 2018	2,590	4,740	2,150
Change in 2019	1,520	5,870	4,350
Change in 2021	3,180	13,110	9,930
Small LHDs (<50,000)			
Change in 2011	2,200	600	-1,600
Change in 2012	820	620	-200
Change in 2015	620	720	100
Change in 2017	110	90	-20
Change in 2018	540	740	200
Change in 2019	540	1,000	460
Change in 2021	410	1,900	1,490
Medium (50,000–499,999)			
Change in 2011	4,500	1,350	-3150
Change in 2012	2,030	1,650	-380
Change in 2015	1,460	1,640	180
Change in 2017	380	320	-60
Change in 2018	900	400	-500
Change in 2019	740	3,400	2,660
Change in 2021	1,010	5,020	4,010
Large (500,000+)			
Change in 2011	3,270	1,740	-1,530
Change in 2012	1,240	1,400	160
Change in 2015	640	1,210	570
Change in 2017	250	490	240
Change in 2018	1,150	2,140	990
Change in 2019	240	1,470	1,230
Change in 2021	1,760	6,180	4,420

n(Jun 2011)=604 n(Jan 2012)=617 n(2012)=1,773 n(2015)=1,261 n(2017)=545 n(2018)=1,424 n(2019)=542 n(2021)=902

- Among all LHDs, there was a net loss of 6,270 jobs in the 2011 calendar year; the net job loss decreased to 410 jobs in 2012. In 2015, the number of jobs added exceeded the number of jobs eliminated for the first time—with a net increase of 850 jobs across all LHDs.
- During the 2021 calendar year, there was a net gain of 9,930 jobs among all LHDs. Small LHDs had net gains of nearly 1,500 jobs, while large and medium LHDs had net gains of more than 4,000 jobs.

Technical notes

This figure summarizes data on numbers of LHD positions added and eliminated during seven calendar years. The net change is the number of positions added minus the number of positions eliminated. **Net loss figures are shown in orange** and **net gain figures in green**.

The 2022 Profile included questions about loss of LHD staff (by layoffs or attrition) during calendar year 2021. Similar questions have been included in several other NACCHO surveys administered periodically since the beginning of the Great Recession. Figures 5.9 through 5.11 present findings based on those data.

NACCHO estimated 2011 statistics using data from two surveys in which LHDs reported jobs lost and added: in January through June 2011 (labeled as Jun 2011) and July through December (labeled as Jan 2012).

Estimates for 2008–2013 workforce are different from previous reports due to new weighting and cleaning methodologies.

Only LHDs who reported values for all variables on job cuts and additions are included in the analysis.

FIGURE 5.12

Occupations employed at LHDs, by size of population served

	All LHDs	Size of population served						
		<25,000	25,000–49,999	50,000–99,999	100,000–249,999	250,000–499,999	500,000–999,999	1,000,000+
Agency leadership	81%	70%	83%	88%	95%	98%	100%	97%
Animal control worker	6%	5%	6%	8%	5%	4%	16%	17%
Behavioral health staff	14%	4%	8%	23%	15%	42%	49%	50%
Business and financial operations staff	51%	31%	48%	63%	72%	90%	98%	100%
Community health worker	38%	22%	33%	45%	53%	72%	89%	80%
Environmental health worker	69%	52%	74%	83%	85%	92%	89%	77%
Epidemiologist/statistician	37%	12%	25%	53%	72%	84%	100%	100%
Health educator	59%	38%	64%	74%	80%	88%	89%	93%
Information systems specialist	19%	4%	13%	16%	35%	62%	84%	77%
Laboratory worker	15%	4%	10%	16%	24%	40%	56%	83%
Licensed practical or vocational nurse	34%	26%	30%	40%	40%	50%	71%	80%
Nursing aide and home health aide	19%	14%	20%	23%	15%	26%	27%	40%
Nutritionist	46%	24%	44%	62%	68%	76%	87%	97%
Office and administrative support staff	90%	85%	93%	92%	96%	98%	100%	100%
Oral health care professional	14%	5%	11%	17%	24%	24%	36%	67%
Preparedness staff	62%	43%	63%	75%	84%	92%	98%	100%
Public health physician	25%	9%	18%	32%	40%	60%	73%	97%
Public information professional	32%	16%	21%	34%	55%	76%	93%	83%
Registered nurse	92%	85%	95%	97%	98%	96%	100%	100%

n=922

- Almost all LHDs employ registered nurses, office and administrative support staff, and agency leadership. Fewer LHDs employ animal control workers, behavioral health staff, oral health care professionals, or laboratory workers.
- Large LHDs were much more likely than small LHDs to employ epidemiologists/statisticians, information systems specialists, laboratory workers, nutritionists, and public health physicians. LHDs of all jurisdiction sizes were approximately equally as likely to employ office and administrative support staff and registered nurses.

FIGURE 5.13

Estimated number of full-time equivalents (FTEs) in select occupations

Occupation	Number of FTEs	95% Confidence intervals	
Agency leadership	6,900	6,400	7,500
Animal control worker	700	400	900
Behavioral health staff	7,200	3,800	10,600
Business and financial operations staff	6,400	5,800	7,000
Community health worker	5,900	5,000	6,800
Environmental health worker	12,800	11,700	13,900
Epidemiologist/statistician	4,200	3,200	5,200
Health educator	6,100	5,400	6,800
Information systems specialist	1,800	1,400	2,200
Laboratory worker	1,600	1,300	1,800
Licensed practical or vocational nurse	2,200	1,800	2,500
Nursing aide and home health aide	1,100	900	1,400
Nutritionist	4,400	4,000	4,900
Office and administrative support staff	20,800	18,800	22,800
Oral health care professional	1,200	900	1,400
Preparedness staff	4,000	2,300	5,800
Public health physician	1,100	900	1,400
Public information professional	1,100	1,000	1,200
Registered nurse	20,700	18,900	22,400

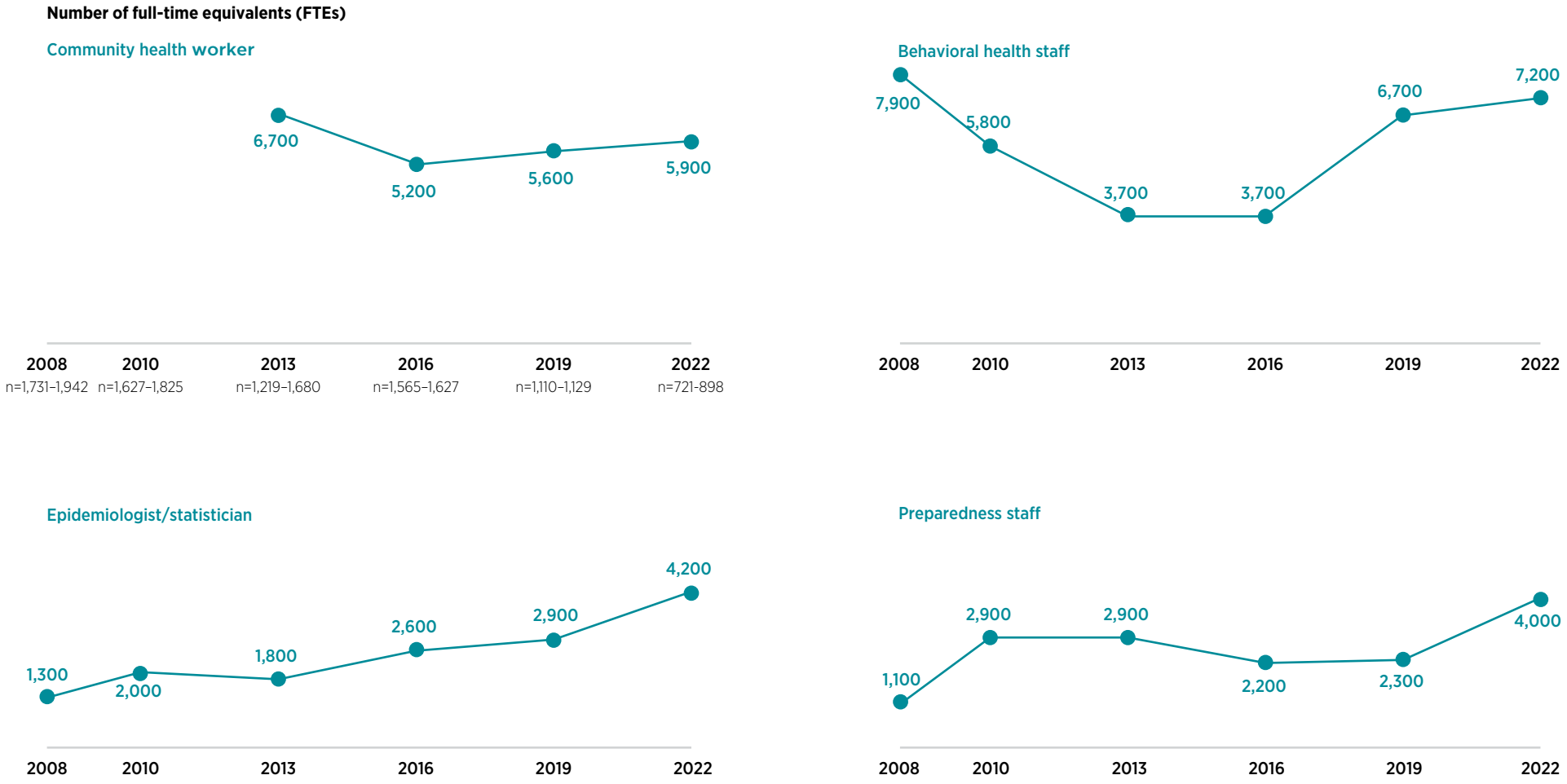
n=721–898

- Across all LHDs, more than 20,000 FTEs were office and administrative support staff or registered nurses.
- However, less than 1,500 FTEs were animal control workers, nursing/home health aides, public health physicians, public information professionals, or oral health care professionals.

Technical note
The number of FTEs across occupations does not add to the total number of FTEs in the LHD workforce listed on page 45 because the listed occupational categories were not exhaustive of all LHD occupations.

FIGURE 5.14

Estimated size of select occupations, over time



➡ The size of the LHD workforce in community health worker and behavioral health occupations has shrunk overall. However, the estimated number of employees in these occupations has increased since 2016.

➡ On the other hand, the estimated number of employees more than tripled from 2008 to 2022 for epidemiologist/statisticians and preparedness staff—with the largest increases occurring during the COVID-19 pandemic from 2019 to 2022.

CHAPTER
06

Finance

This chapter includes the following:

- Total annual local health department (LHD) expenditures.
- Annual per capita LHD expenditures and revenues, including expenditures over time.
- Per capita LHD expenditures and revenues related to COVID-19.
- LHD revenue sources.
- Changes in LHD budgets over time.

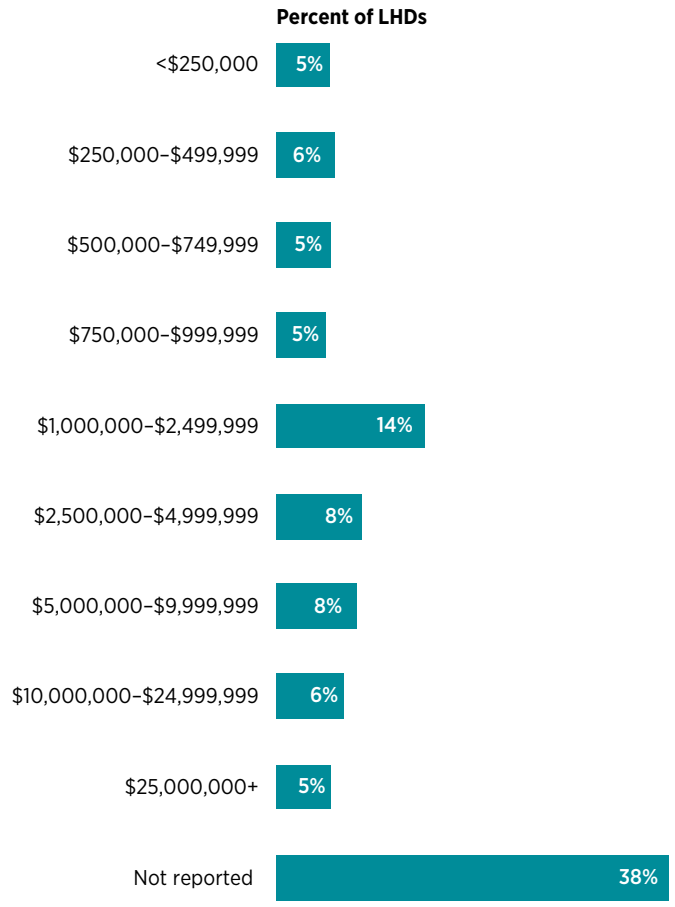
Technical Notes

The data reported in this chapter should be interpreted with some caution. Collecting error-free data on LHD financing across the United States remains challenging. Large amounts of missing data from the 2022 Profile study led to a greater degree of approximation than was necessary for other chapters of this report.

Comparisons with statistics from past Profile studies should be made with caution, especially for subgroups (e.g., state-governed LHDs, LHDs from certain states, or LHDs serving large jurisdictions). Some of the observed differences from year-to-year result from a large difference in the group of LHDs that provided financial data in each Profile year.

FIGURE 6.1

Total annual expenditures



n=942

- Total annual LHD expenditures range from less than $250,000 to $25 million or more.
- Twenty-one percent of LHDs report annual expenditures of less than $1 million; 5% of LHDs report expenditures of $25 million or more.
- Almost two in five LHDs were not able to report their annual expenditures.

FIGURE 6.2

Mean and quartiles of total annual expenditures

	Mean	25th percentile	50th percentile (Median)	75th percentile
All LHDs	$12,500,000	$598,000	$1,540,000	$5,700,000
Size of population served				
<25,000	$845,000	$313,000	$575,000	$1,100,000
25,000–49,999	$4,480,000	$872,000	$1,510,000	$2,810,000
50,000–99,999	$4,900,000	$1,940,000	$3,640,000	$5,830,000
100,000–249,999	$8,840,000	$4,640,000	$7,100,000	$10,300,000
250,000–499,999	$21,400,000	$11,500,000	$14,600,000	$24,600,000
500,000–999,999	$48,300,000	$22,800,000	$38,700,000	$64,800,000
1,000,000+	$302,000,000	$79,500,000	$127,000,000	$229,000,000

n=598

- On average, LHDs spent $12.5 million in 2022—an increase of $4.12 million from 2019.
- Comparing the 25th and 75th percentiles for each population category illustrates the great diversity in funding levels among LHDs serving jurisdictions of similar sizes.

FIGURE 6.3

Median and quartiles of annual per capita expenditures and revenues, by size of population served

	Expenditures (n=598)			Revenue (n=575)		
	25th percentile	Median	75th percentile	25th percentile	Median	75th percentile
All LHDs	$29	$49	$85	$29	$52	$86
Size of population served						
<25,000	$29	$53	$101	$31	$60	$112
25,000–49,999	$25	$43	$74	$25	$48	$83
50,000–99,999	$27	$54	$78	$23	$48	$72
100,000–249,999	$31	$45	$65	$28	$46	$67
250,000–499,999	$31	$42	$80	$31	$44	$84
500,000–999,999	$36	$49	$87	$34	$46	$75
1,000,000+	$41	$83	$105	$36	$43	$98

➡ Median annual per capita expenditures were similar to annual per capita revenues across LHDs.

FIGURE 6.4

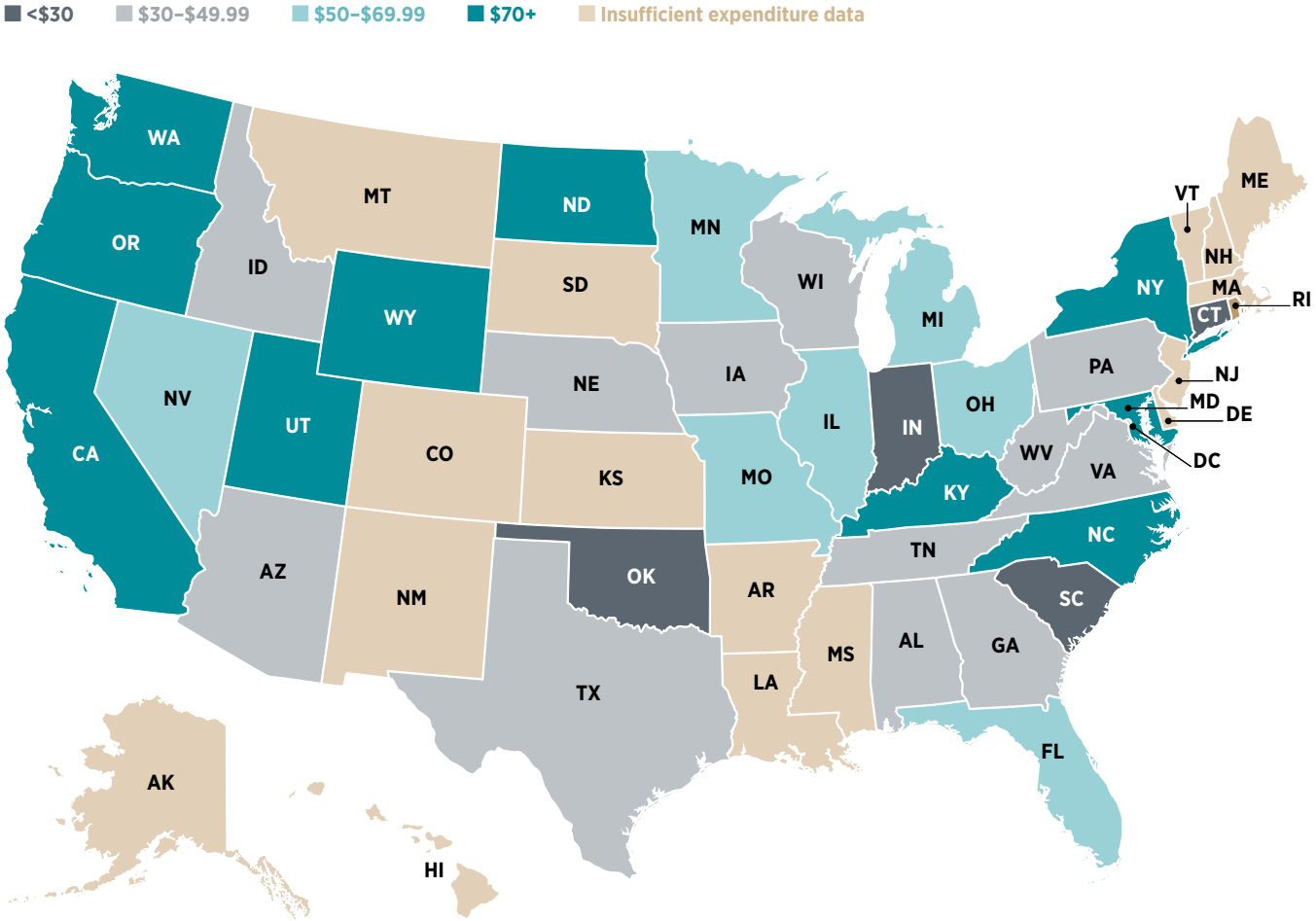
Median and quartiles of annual per capita expenditures and revenues related to COVID-19, by size of population served

	Expenditures (n=479)			Revenue (n=438)		
	25th percentile	Median	75th percentile	25th percentile	Median	75th percentile
All LHDs	$5	$10	$20	$6	$11	$20
Size of population served						
<25,000	$7	$12	$26	$9	$16	$29
25,000–49,999	$5	$11	$17	$5	$10	$17
50,000–99,999	$5	$9	$16	$5	$9	$15
100,000–249,999	$4	$8	$13	$4	$9	$12
250,000–499,999	$4	$10	$16	$5	$10	$17
500,000–999,999	$4	$9	$20	$4	$8	$20
1,000,000+	$10	$17	$31	$8	$13	$23

- On average, LHDs spent $3.10 million on COVID-19 in 2022, or 25% of the mean overall annual expenditures (not shown).
- Median annual per capita expenditures and revenues related to COVID-19 were similar, $10 and $11 respectively.

FIGURE 6.5

Median annual per capita expenditures, by state



- Overall, annual LHD expenditures per capita vary greatly by state, with LHDs in Indiana and Connecticut spending less than $20 per person and LHDs in Maryland and Washington spending more than $100 per person.
- Annual median LHD expenditures per capita were less than $30 in four states, $30 to $50 in 12 states, $50 to $70 in seven states, and more than $70 in 10 states.

Technical notes

A state is deemed to have insufficient expenditure data if more than one LHD in the state responded to the Profile questionnaire but fewer than 50% of those LHD respondents completed the expenditures item.

State estimates presented are not weighted.

FIGURE 6.6

Median and mean annual per capita expenditures, over time

- Average LHD expenditures per capita decreased between 2008 and 2019 (from $87 to $63) then increased between 2019 and 2022 (from $63 to $78). Although they increased substantially in recent years, average LHD expenditures per capita decreased 10% overall since 2008.
- Median per capita expenditures have remained steady overall—at $49 in both 2008 and 2022.

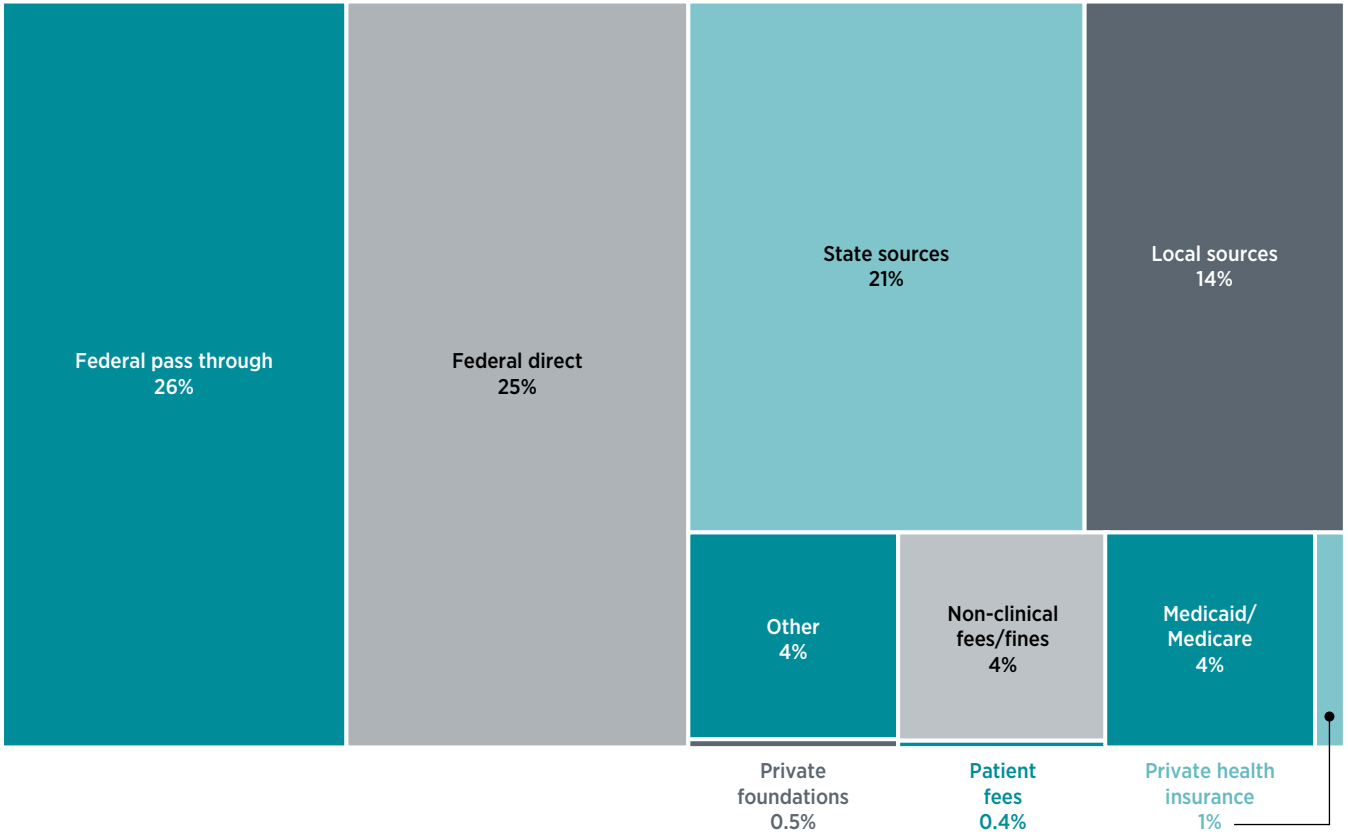
Technical notes

In 2019, we began using an updated post-stratification weighting method to improve upon estimates from previous years. This will result in some minor discrepancies between 2016 reporting of prior year data and 2022 reporting of the same data.

Additionally, the statistics for 2008, 2010, 2013, 2016, and 2019 are reestimated to reflect 2022 inflation rates based on the Bureau of Labor Statistics' Consumer Price Index. This will also result in some discrepancies in the 2022 reporting of prior years' data compared to prior Profile reports.

FIGURE 6.7

Revenue sources



n=134–380

- LHDs receive funding from a variety of sources, including local, state, federal, and clinical sources.
- Half of LHD revenues in 2022 came from federal sources, and 21% come from state sources. Notably, in prior years, a smaller proportion of revenues came from direct federal sources, while a larger proportion came from local sources (not shown).
- Only 6% of revenues were payments for clinical services (from Medicare, Medicaid, private insurers, or patient personal fees).

Technical note
This diagram depicts the overall composition of LHD revenue sources. The area of each box corresponds to the fraction of all revenues that source provides.

FIGURE 6.8

Median and mean annual per capita revenue sources, by LHD characteristics

	Local		State		Federal direct and pass-through		Clinical*	
	Median	Mean	Median	Mean	Median	Mean	Median	Mean
All LHDs	$14	$21	$7	$15	$18	$31	$4	$11
Size of population served								
Small (<50,000)	$16	$26	$8	$16	$18	$34	$5	$15
Medium (50,000–499,999)	$10	$14	$7	$12	$15	$22	$2	$6
Large (500,000+)	$6	$16	$7	$13	$26	$38	$1	$2
Degree of urbanization								
Urban	$12	$19	$5	$11	$15	$26	$1	$5
Rural	$15	$23	$9	$17	$21	$34	$6	$15
Region								
Northeast	$6	$10	$2	$11	$4	$8	$0	$1
Midwest	$17	$25	$6	$8	$21	$34	$5	$13
South	$9	$20	$13	$26	$15	$33	$5	$14
West	$11	$16	$9	$19	$30	$40	$1	$4

n=270–380

- On average, small LHDs receive more dollars per capita from local and clinical sources than medium and large LHDs.
- Rural LHDs receive more per capita from all sources than urban LHDs. The difference in clinical revenues among rural and urban LHDs is particularly striking (mean of $15 per capita for rural jurisdictions versus $5 per capita for rural jurisdictions).
- On average, LHDs in the Midwest receive more per capita from local sources than LHDs in other regions, while LHDs in the South receive more per capita from state sources than LHDs in other regions.

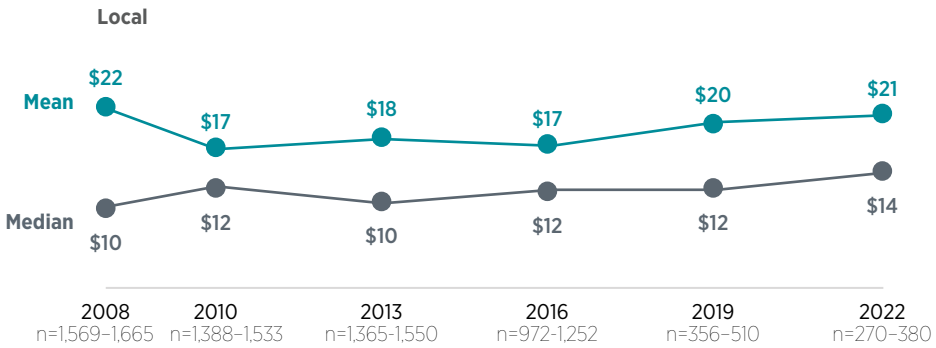
Technical notes

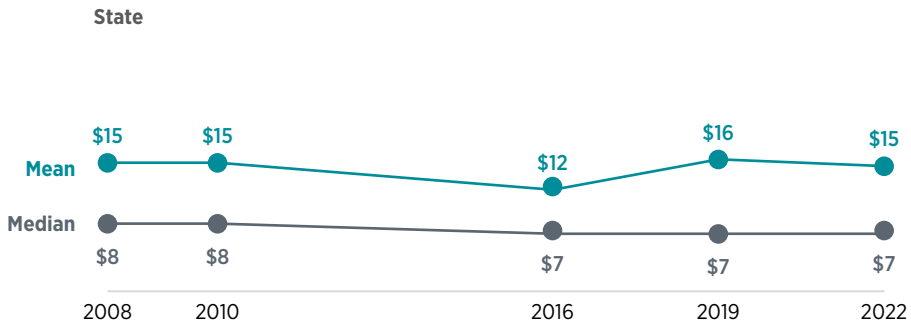
A new schema for categorizing urban and rural LHDs was used for 2022 estimates. "Urban" refers to urban-majority areas, while "rural" refers to rural-majority areas. These data may not be comparable to previous year estimates. Refer to the subgroup analysis details on page 17 for more about the urban/rural categorization methodology.

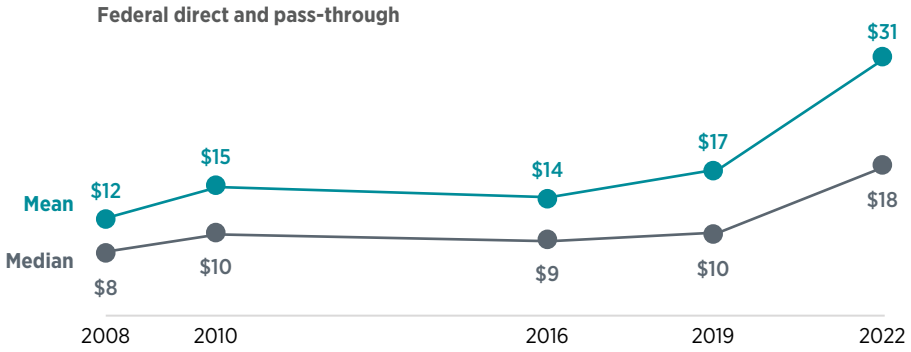
*Includes Medicaid/Medicare, private health insurance, and patient personal fees

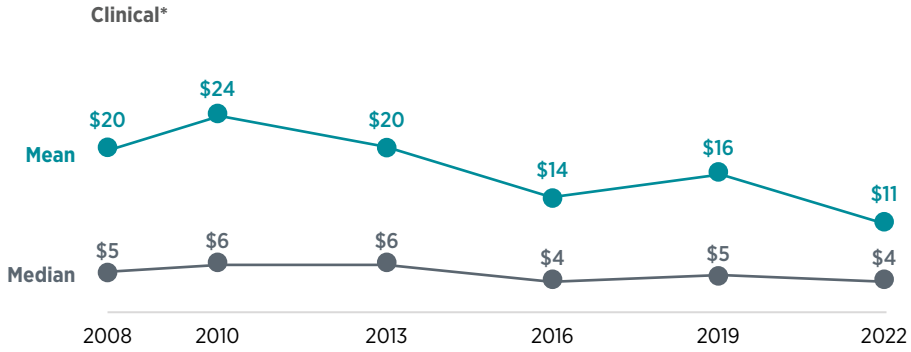
FIGURE 6.9

Median and mean annual per capita revenue sources, over time









- Overall, average per capita revenues from clinical sources decreased 45% (from $20 in 2008 to $11 in 2022).
- On the other hand, average per capita revenues from federal sources (direct and passed through from state agencies) remained relatively steady between 2010 and 2019 then nearly doubled between 2019 and 2022. At the time data were collected, **nearly $60 billion in short-term federal emergency supplemental funding was available** to state, tribal, local, and territorial jurisdictions for the COVID-19 pandemic response. This may explain the large jump in average per capita revenues from federal sources. This large influx in federal funding expires in 2024, and no further federal resources were expected.

Technical notes

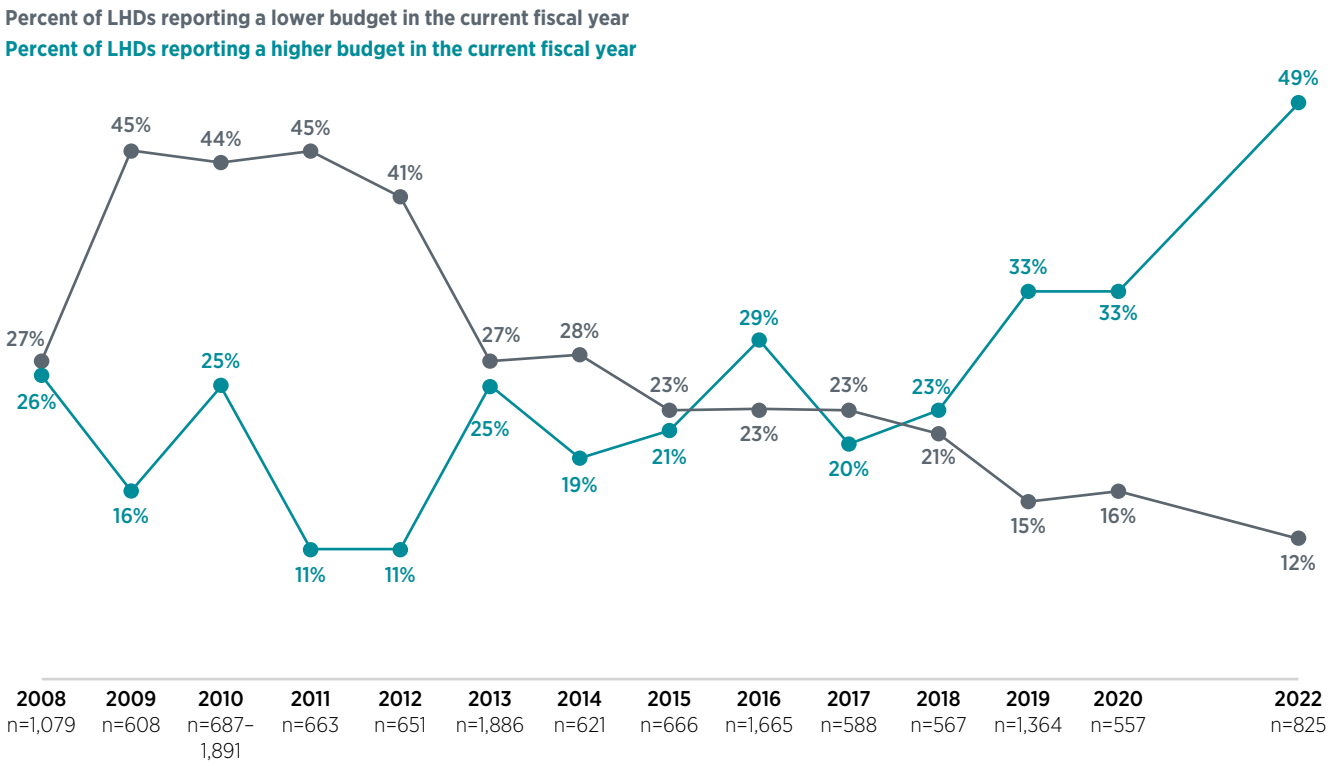
*Includes Medicaid/Medicare, private health insurance, and patient personal fees

In 2019, we began using an updated post-stratification weighting method to improve upon estimates from previous years. This will result in some minor discrepancies between 2016 reporting of prior year data and 2022 reporting of the same data.

Additionally, the statistics for 2008, 2010, 2013, 2016, and 2019 are reestimated to reflect 2022 inflation rates based on the Bureau of Labor Statistics' Consumer Price Index. This will also result in some discrepancies in the 2022 reporting of prior years' data compared to prior Profile reports.

FIGURE 6.10

Changes in LHD budgets, over time

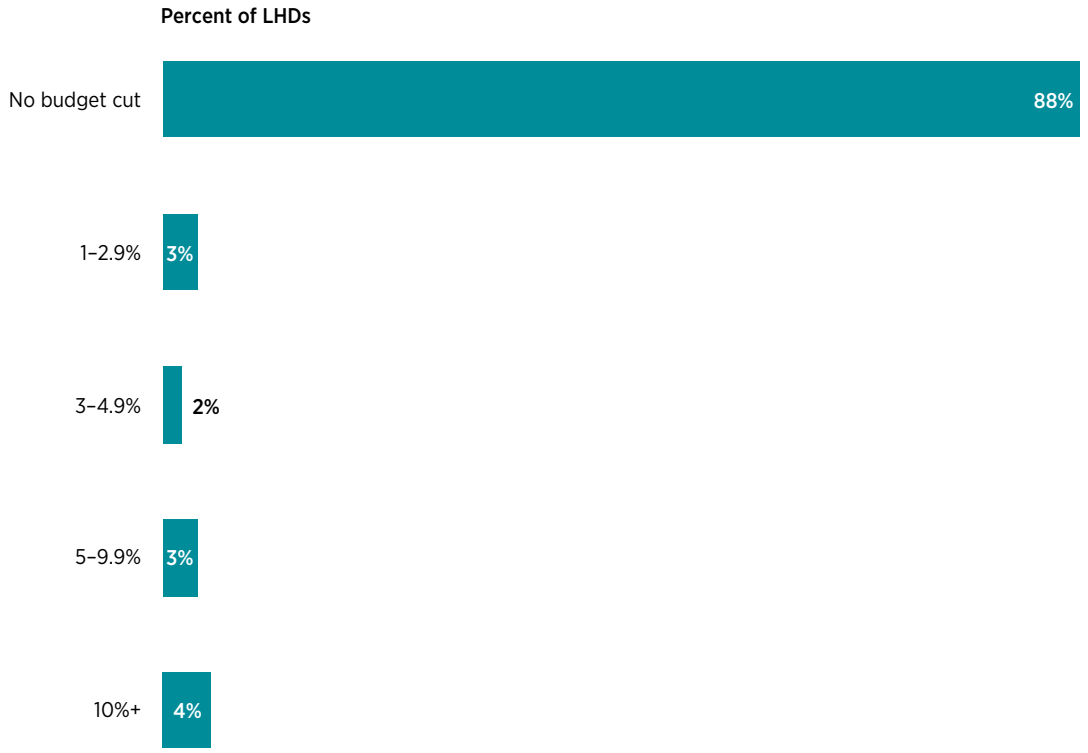


- From 2009 to 2012, between 41% and 45% of LHDs reported having a lower budget compared to the previous fiscal year. In recent years, fewer LHDs have reported budget cuts; only 12% of LHDs reported having a lower budget in 2022.
- On the other hand, the percent of LHDs reporting a higher budget compared to the previous fiscal year has slowly started to increase over time. While only 11% reported a higher budget in 2011 and 2012, 49% of LHDs reported a higher budget in 2022.

Technical note
The 2022 Profile included questions about budget changes relative to the previous fiscal year. Similar questions have been included in several other NACCHO surveys administered periodically since the beginning of the Great Recession. Figures 6.10, 6.11, and 6.12 present findings based on those data.

FIGURE 6.11

Percent of LHD's budget cut in the current fiscal year compared to the previous fiscal year



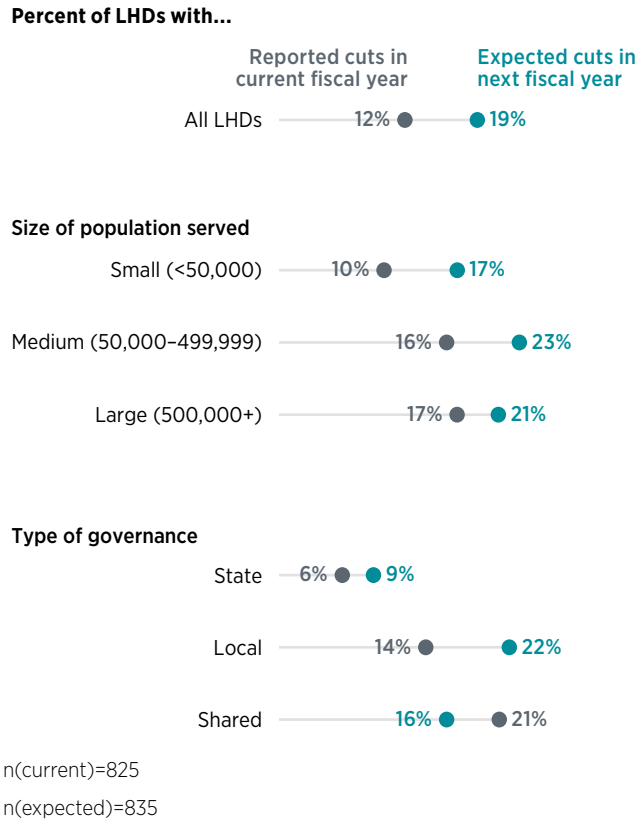
n=821

➡ While most LHDs did not report a lower budget compared to the previous fiscal year, 7% of LHDs reported a budget cut of 5% or more.

Technical note
The 2022 Profile included questions about budget changes relative to the previous fiscal year. Similar questions have been included in several other NACCHO surveys administered periodically since the beginning of the Great Recession. Figures 6.10, 6.11, and 6.12 present findings based on those data.

FIGURE 6.12

Current and expected budget cuts, by population size served and type of governance



n(current)=825

n(expected)=835

- Nearly one in five LHDs foresee budget cuts in their next fiscal year, while 12% reported budget cuts in their current fiscal year.
- LHDs serving larger populations were more likely to experience current and anticipate future budget cuts than small LHDs.
- Among LHDs with shared governance, fewer anticipate future cuts than experienced current cuts.

Technical note

The 2022 Profile included questions about budget changes relative to the previous fiscal year. Similar questions have been included in several other NACCHO surveys administered periodically since the beginning of the Great Recession. Figures 6.10, 6.11, and 6.12 present findings based on those data.

CHAPTER
07

Programs and Services

This chapter includes the following:

- Clinical and population-based programs and services provided directly in the past year.
- Programs and services provided most frequently via contracts.
- Programs and services provided by more or fewer local health departments (LHDs) over time.
- Change inlevel of service provision in the past year.

FIGURE 7.1

Clinical programs and services provided directly in the past year

Program/service	% of LHDs
Immunization	
COVID-19 adult immunizations	95%
Routine childhood immunizations	88%
Routine adult immunizations	87%
COVID-19 childhood immunizations	84%
Screening for diseases/conditions	
Tuberculosis	82%
Other STDs	65%
HIV/AIDS	58%
High blood pressure	52%
Body Mass Index (BMI)	43%
Diabetes	32%
Cancer	28%
Cardiovascular disease	21%

Program/service	% of LHDs
Treatment for communicable diseases	
Tuberculosis	81%
Other STDs	63%
HIV/AIDS	39%
Maternal and child health services	
Women, Infants, and Children (WIC)	64%
Early and periodic screening, diagnosis, and treatment	28%
Well child clinic	24%
Prenatal care	22%
Other clinical services	
Oral health	21%
Home health care	17%
Substance abuse	16%
Behavioral/mental health	12%
Comprehensive primary care	7%

n=927–931

- LHDs provide many different types of clinical programs and services directly, including adult and child immunizations, screening and treatment for chronic and communicable diseases or conditions, and maternal and child health services.
- Adult and child immunizations and tuberculosis screenings and treatment were the clinical services most often provided by LHDs in 2022.
- The proportion of LHDs providing the other clinical services varied greatly; only 7% provided comprehensive primary care services, while 65% provided screenings for sexually transmitted diseases (STDs) other than HIV/AIDS.

FIGURE 7.2

Population-based programs and services provided directly in the past year

Program/service	% of LHDs
Epidemiology and surveillance	
Communicable/infectious disease	92%
Environmental health	82%
Maternal and child health	67%
Syndromic surveillance	57%
Chronic disease	47%
Behavioral risk factors	45%
Injury	33%
Population-based primary prevention	
Nutrition	72%
Tobacco	70%
Chronic disease programs	55%
Physical activity	53%
Opioids	44%
Injury	36%
Substance abuse (other than opioids)	35%
Mental illness	20%

Program/service	% of LHDs
Regulation, inspection and/or licensing	
Food service establishments	75%
Schools/daycare	70%
Septic systems	62%
Recreational water (e.g., pools, lakes, beaches)	59%
Body art (e.g., tattoos, piercings)	54%
Hotels/motels	50%
Lead inspection	50%
Private drinking water	49%
Children's camps	47%
Campgrounds & RVs	43%
Tobacco retailers	36%
Food processing	36%
Health-related facilities	33%
Public drinking water	32%
Housing (inspections)	29%
Milk processing	9%

Program/service	% of LHDs
Other environmental health services	
Food safety education	73%
Public health nuisance abatement	66%
Vector control	48%
Indoor air quality	26%
Hazmat response	21%
Land use planning	18%
Air pollution	17%
Radiation control	14%
Noise pollution	12%
Other population-based services	
School health*	38%
Laboratory services**	35%
School-based clinics	32%
Animal control	15%
Emergency medical services	3%

n=923–928

- LHDs also provide many different types of population-based programs and services directly, including epidemiology and surveillance; primary prevention; regulation, inspection, or licensing; and environmental health services.
- In 2022, the most common population-based programs and services provided across LHDs included communicable/infectious disease surveillance, environmental health surveillance, regulation of food service establishments, food safety education, and population-based nutrition services.

Technical notes

*School health programs may include both clinical services and populated-based prevention programs.

**LHD laboratories may test clinical or environmental specimens; the Profile questionnaire includes a single item intended to include both types.

FIGURE 7.3

Adult and child immunization services provided directly in the past year

Program/service	All LHDs	Size of population served			Degree of urbanization	
		Small (<50,000)	Medium (50,000–499,999)	Large (500,000+)	Urban	Rural
Immunization						
COVID-19 adult immunizations	95%	94%	96%	99%	92%	97%
Routine childhood immunizations	88%	86%	92%	93%	82%	93%
Routine adult immunizations	87%	84%	91%	93%	83%	91%
COVID-19 childhood immunizations	84%	80%	90%	97%	83%	85%

n=927–931

➡ Most LHDs provide adult and child immunizations, regardless of jurisdiction size or degree of jurisdiction urbanization.

Technical note
A new schema for categorizing urban and rural LHDs was used for 2022 estimates. "Urban" refers to urban-majority areas, while "rural" refers to rural-majority areas. These data may not be comparable to previous year estimates. Refer to the subgroup analysis details on page 17 for more about the urban/rural categorization methodology.

FIGURE 7.4

Screening and treatment for diseases and conditions provided directly in the past year

Program/service	All LHDs	Size of population served			Degree of urbanization	
		Small (<50,000)	Medium (50,000–499,999)	Large (500,000+)	Urban	Rural
Screening for diseases/conditions						
Tuberculosis	82%	77%	90%	95%	78%	86%
Other STDs	65%	57%	74%	99%	63%	66%
HIV/AIDS	58%	47%	70%	97%	60%	56%
High blood pressure	52%	54%	42%	75%	52%	51%
Body Mass Index (BMI)	43%	44%	38%	62%	40%	46%
Diabetes	32%	30%	31%	62%	34%	31%
Cancer	28%	26%	29%	46%	27%	29%
Cardiovascular disease	21%	19%	22%	36%	22%	20%
Treatment for communicable diseases						
Tuberculosis	81%	76%	88%	93%	75%	86%
Other STDs	63%	55%	71%	94%	61%	64%
HIV/AIDS	39%	33%	44%	66%	39%	38%

n=928–930

➡ With the exception of screening for high blood pressure and Body Mass Index (BMI), medium and large LHDs were more likely to provide screening and treatment services than small LHDs.

Technical note
A new schema for categorizing urban and rural LHDs was used for 2022 estimates. "Urban" refers to urban-majority areas, while "rural" refers to rural-majority areas. These data may not be comparable to previous year estimates. Refer to the subgroup analysis details on page 17 for more about the urban/rural categorization methodology.

FIGURE 7.5

Maternal and child health services provided directly in the past year

Program/service	All LHDs	Size of population served			Degree of urbanization	
		Small (<50,000)	Medium (50,000–499,999)	Large (500,000+)	Urban	Rural
Maternal and child health services						
Women, Infants, and Children (WIC)	64%	60%	69%	76%	55%	72%
Early and periodic screening, diagnosis, and treatment (EPSDT)	28%	28%	29%	24%	23%	32%
Well child clinic	24%	24%	24%	31%	22%	26%
Prenatal care	22%	18%	29%	28%	22%	22%

n=929–930

- Many LHDs provide services to support the health of mothers and children, including Women, Infants, and Children (WIC) services.
- Fewer LHDs provide other direct clinical services to mothers and children, such as early and periodic screening, diagnosis, and treatment (EPSDT), well child clinics, and prenatal care.

Technical note
A new schema for categorizing urban and rural LHDs was used for 2022 estimates. "Urban" refers to urban-majority areas, while "rural" refers to rural-majority areas. These data may not be comparable to previous year estimates. Refer to the subgroup analysis details on page 17 for more about the urban/rural categorization methodology.

FIGURE 7.6

Other clinical services provided directly in the past year

Program/service	All LHDs	Size of population served			Degree of urbanization	
		Small (<50,000)	Medium (50,000–499,999)	Large (500,000+)	Urban	Rural
Other clinical services						
Oral health	21%	16%	25%	47%	25%	18%
Home health care	17%	18%	14%	12%	12%	21%
Substance abuse	16%	11%	22%	38%	21%	12%
Behavioral/mental health	12%	7%	16%	33%	16%	8%
Comprehensive primary care	7%	4%	11%	12%	8%	7%

n=928

- Few LHDs provide other clinical services, such as home health care, substance abuse services, behavioral/mental health services, or comprehensive primary care.
- With the exception of home health care, small LHDs were less likely to provide these services than medium or large LHDs.

Technical note
A new schema for categorizing urban and rural LHDs was used for 2022 estimates. "Urban" refers to urban-majority areas, while "rural" refers to rural-majority areas. These data may not be comparable to previous year estimates. Refer to the subgroup analysis details on page 17 for more about the urban/rural categorization methodology.

FIGURE 7.7

Epidemiology and surveillance services provided directly in the past year

Program/service	All LHDs	Size of population served			Degree of urbanization	
		Small (<50,000)	Medium (50,000–499,999)	Large (500,000+)	Urban	Rural
Epidemiology and surveillance						
Communicable/infectious disease	92%	89%	96%	99%	92%	92%
Environmental health	82%	78%	89%	85%	87%	78%
Maternal and child health	67%	59%	77%	91%	66%	68%
Syndromic surveillance	57%	44%	75%	90%	66%	49%
Chronic disease	47%	39%	57%	85%	51%	44%
Behavioral risk factors	45%	38%	53%	76%	49%	41%
Injury	33%	25%	44%	62%	39%	28%

n=926–928

- Almost all LHDs provide communicable/infectious disease surveillance; most provide environmental health surveillance, maternal child health surveillance, and syndromic surveillance.
- Large and medium LHDs were more likely to provide these services than small LHDs.

Technical note
A new schema for categorizing urban and rural LHDs was used for 2022 estimates. "Urban" refers to urban-majority areas, while "rural" refers to rural-majority areas. These data may not be comparable to previous year estimates. Refer to the subgroup analysis details on page 17 for more about the urban/rural categorization methodology.

FIGURE 7.8

Population-based primary prevention services provided directly in the past year

Program/service	All LHDs	Size of population served			Degree of urbanization	
		Small (<50,000)	Medium (50,000–499,999)	Large (500,000+)	Urban	Rural
Population-based primary prevention						
Nutrition	72%	65%	81%	89%	69%	74%
Tobacco	70%	67%	74%	85%	71%	70%
Chronic disease programs	55%	48%	63%	82%	58%	52%
Physical activity	53%	46%	62%	74%	55%	51%
Opioids	44%	35%	57%	72%	56%	34%
Injury	36%	30%	44%	57%	39%	33%
Substance abuse (other than opioids)	35%	29%	44%	46%	42%	29%
Mental illness	20%	15%	28%	29%	26%	16%

n=927–928

- Most LHDs provide population-based primary prevention services focused on nutrition, tobacco use, chronic diseases, and physical activity.
- Large LHDs were more likely to provide these services than small or medium LHDs.

Technical note

A new schema for categorizing urban and rural LHDs was used for 2022 estimates. "Urban" refers to urban-majority areas, while "rural" refers to rural-majority areas. These data may not be comparable to previous year estimates. Refer to the subgroup analysis details on page 17 for more about the urban/rural categorization methodology.

FIGURE 7.9

Regulation, inspection, or licensing services provided directly in the past year

Program/service	All LHDs	Size of population served			Degree of urbanization	
		Small (<50,000)	Medium (50,000–499,999)	Large (500,000+)	Urban	Rural
Regulation, inspection and/or licensing						
Food service establishments	75%	69%	84%	81%	82%	69%
Schools/daycare	70%	65%	78%	76%	77%	64%
Septic systems	62%	57%	72%	61%	68%	58%
Recreational water (e.g., pools, lakes, beaches)	59%	50%	73%	76%	71%	49%
Body art (e.g., tattoos, piercings)	54%	49%	64%	52%	62%	47%
Hotels/motels	50%	48%	55%	49%	52%	49%
Lead inspection	50%	44%	58%	65%	58%	43%
Private drinking water	49%	43%	58%	54%	52%	46%
Children's camps	47%	40%	58%	54%	55%	40%
Campgrounds & RVs	43%	36%	58%	37%	44%	42%
Tobacco retailers	36%	33%	40%	35%	46%	27%
Food processing	36%	36%	36%	35%	36%	35%
Health-related facilities	33%	31%	34%	44%	36%	30%
Public drinking water	32%	26%	41%	36%	35%	29%
Housing (inspections)	29%	27%	31%	34%	41%	19%
Milk processing	9%	9%	9%	9%	9%	9%

n=923–927

- LHDs were most likely to provide regulation, inspection, or licensing services of food service establishments, schools/daycares, septic systems, recreational water, and body art.
- LHDs serving urban jurisdictions were more likely to provide these services than LHDs serving rural jurisdictions.

Technical note
A new schema for categorizing urban and rural LHDs was used for 2022 estimates. "Urban" refers to urban-majority areas, while "rural" refers to rural-majority areas. These data may not be comparable to previous year estimates. Refer to the subgroup analysis details on page 17 for more about the urban/rural categorization methodology.

FIGURE 7.10

Environmental health services provided directly in the past year

Program/service	All LHDs	Size of population served			Degree of urbanization	
		Small (<50,000)	Medium (50,000–499,999)	Large (500,000+)	Urban	Rural
Other environmental health services						
Food safety education	73%	69%	80%	82%	78%	70%
Public health nuisance abatement	66%	60%	77%	65%	78%	56%
Vector control	48%	41%	58%	64%	61%	37%
Indoor air quality	26%	23%	31%	33%	38%	16%
Hazmat response	21%	18%	25%	36%	28%	15%
Land use planning	18%	12%	24%	36%	25%	12%
Air pollution	17%	14%	19%	37%	29%	7%
Radiation control	14%	12%	17%	21%	15%	13%
Noise pollution	12%	11%	13%	16%	22%	3%

n=924–926

- More than half of LHDs provide food safety education and public health nuisance abatement. Few provide noise pollution or radiation control.
- LHDs serving urban jurisdictions were more likely to provide these environmental health services than LHDs serving rural jurisdictions.

Technical note
A new schema for categorizing urban and rural LHDs was used for 2022 estimates. "Urban" refers to urban-majority areas, while "rural" refers to rural-majority areas. These data may not be comparable to previous year estimates. Refer to the subgroup analysis details on page 17 for more about the urban/rural categorization methodology.

FIGURE 7.11

Other population-based services provided directly in the past year

Program/service	All LHDs	Size of population served			Degree of urbanization	
		Small (<50,000)	Medium (50,000–499,999)	Large (500,000+)	Urban	Rural
Other services						
School health*	38%	38%	38%	48%	37%	40%
Laboratory services**	35%	30%	36%	71%	34%	35%
School-based clinics	32%	34%	29%	26%	28%	34%
Animal control	15%	15%	15%	18%	19%	12%
Emergency medical services	3%	2%	4%	11%	5%	1%

n=926–927

- More than one-third of LHDs provide school health services. Meanwhile, only 3% of LHDs provide emergency medical services.
- With the exception of school-based clinics, large LHDs were more likely to provide these services than small or medium LHDs.

Technical notes

A new schema for categorizing urban and rural LHDs was used for 2022 estimates. "Urban" refers to urban-majority areas, while "rural" refers to rural-majority areas. These data may not be comparable to previous year estimates. Refer to the subgroup analysis details on page 17 for more about the urban/rural categorization methodology.

*School health programs may include both clinical services and populated-based prevention programs.

**LHD laboratories may test clinical or environmental specimens; the Profile questionnaire includes a single item intended to include both types.

FIGURE 7.12

Programs and services provided most frequently via contracts

Program/service	Percent of LHDs contracting service
COVID-19 adult immunizations	13%
COVID-19 childhood immunizations	12%
Laboratory services*	10%
HIV/AIDS treatment	9%
HIV/AIDS screening	7%
Population-based tobacco prevention services	7%
Behavioral/mental health services	7%
Environmental health surveillance	7%
Other STDs screening	7%
Cancer screening	7%

n=927–931

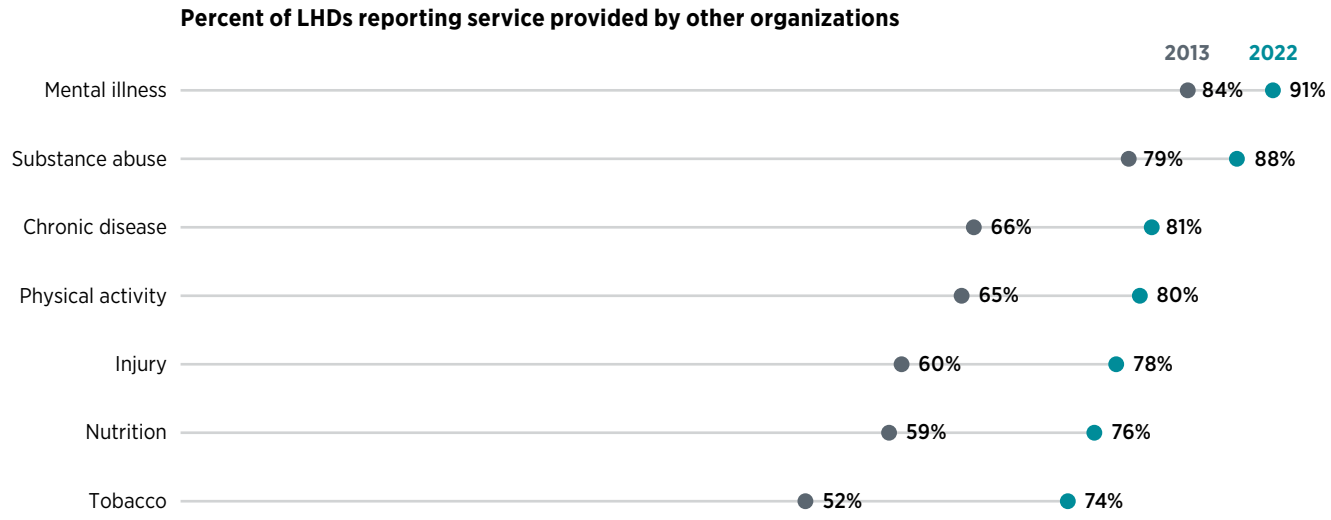
- LHDs were most likely to contract out their COVID-19 immunization services.
- Five of these services (laboratory services, HIV/AIDS treatment, STD screening, population-based tobacco prevention services, and cancer screening) have been among the top 10 services most likely to be contracted out since 2005 (not shown).

Technical note

*LHD laboratories may test clinical or environmental specimens; the Profile questionnaire includes a single item intended to include both types.

FIGURE 7.13

Provision of population-based primary prevention services, by other organizations independent of LHD funding

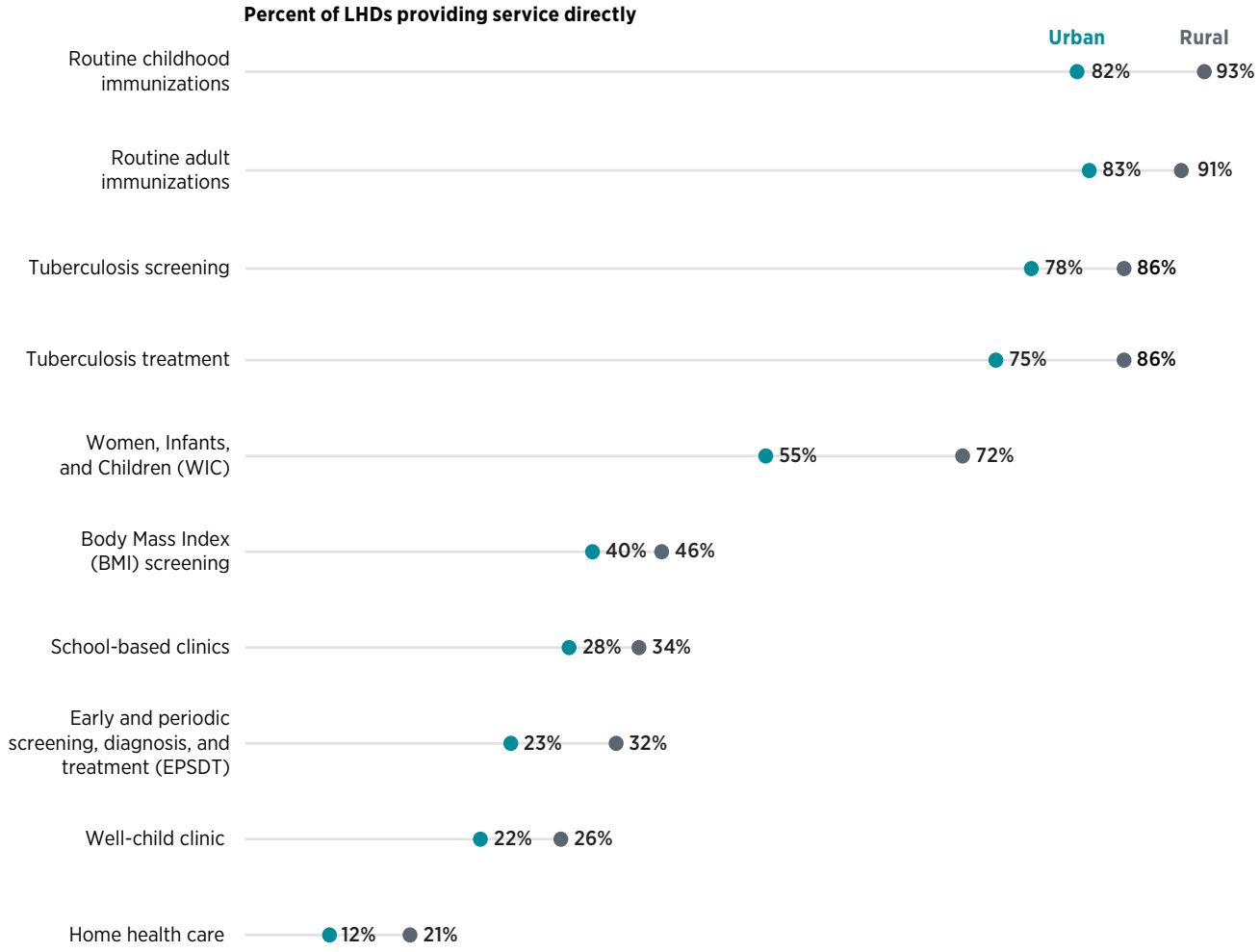


n(2013)=1,910–1,959
n(2022)=927–928

➡ Since 2013, the proportion of LHDs reporting that primary prevention services were provided by other organizations independent of LHD funding increased for every activity, from a low of a 7-percentage point increase for mental illness prevention to a high of a 22-percentage point increase for tobacco prevention.

FIGURE 7.14

Programs and services more likely to be provided in rural jurisdictions



n=926–931

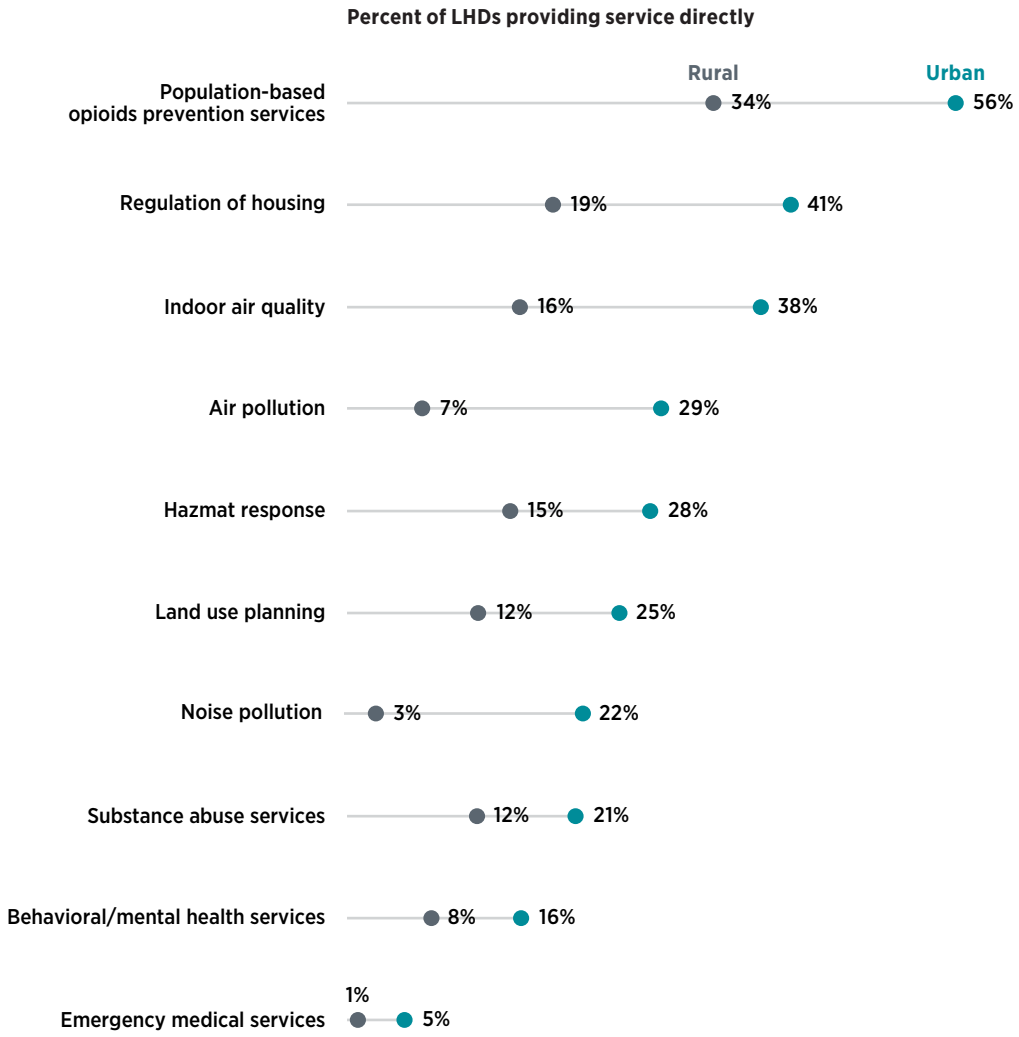
- This figure displays the 10 services with the highest relative difference between the proportions of rural and urban LHDs directly providing the service.
- Notably, LHDs serving rural jurisdictions were more likely to provide certain clinical services, including immunizations, tuberculosis screening and treatment, WIC, EPSDT, screening for BMI, and home health care.

Technical note

A new schema for categorizing urban and rural LHDs was used for 2022 estimates. "Urban" refers to urban-majority areas, while "rural" refers to rural-majority areas. These data may not be comparable to previous year estimates. Refer to the subgroup analysis details on page 17 for more about the urban/rural categorization methodology.

FIGURE 7.15

Programs and services more likely to be provided in urban jurisdictions



n=926–930

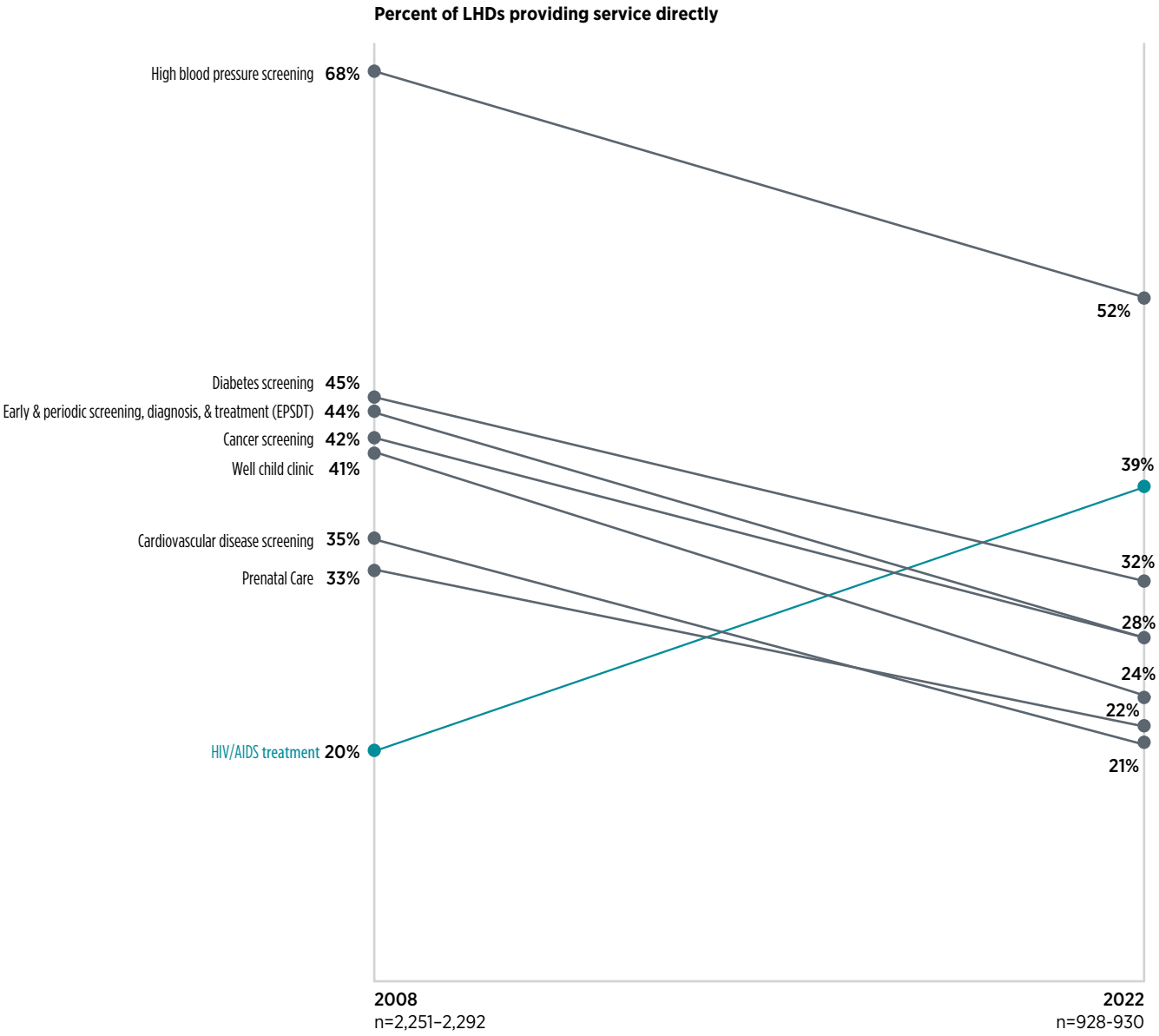
- This figure displays the 10 services with the highest relative difference between the proportions of urban and rural LHDs directly providing the service.
- LHDs serving urban jurisdictions were more likely to provide many population-based programming, including environmental health services.

Technical note

A new schema for categorizing urban and rural LHDs was used for 2022 estimates. "Urban" refers to urban-majority areas, while "rural" refers to rural-majority areas. These data may not be comparable to previous year estimates. Refer to the subgroup analysis details on page 17 for more about the urban/rural categorization methodology.

FIGURE 7.16

Change in percent of LHDs providing clinical programs and services since 2008



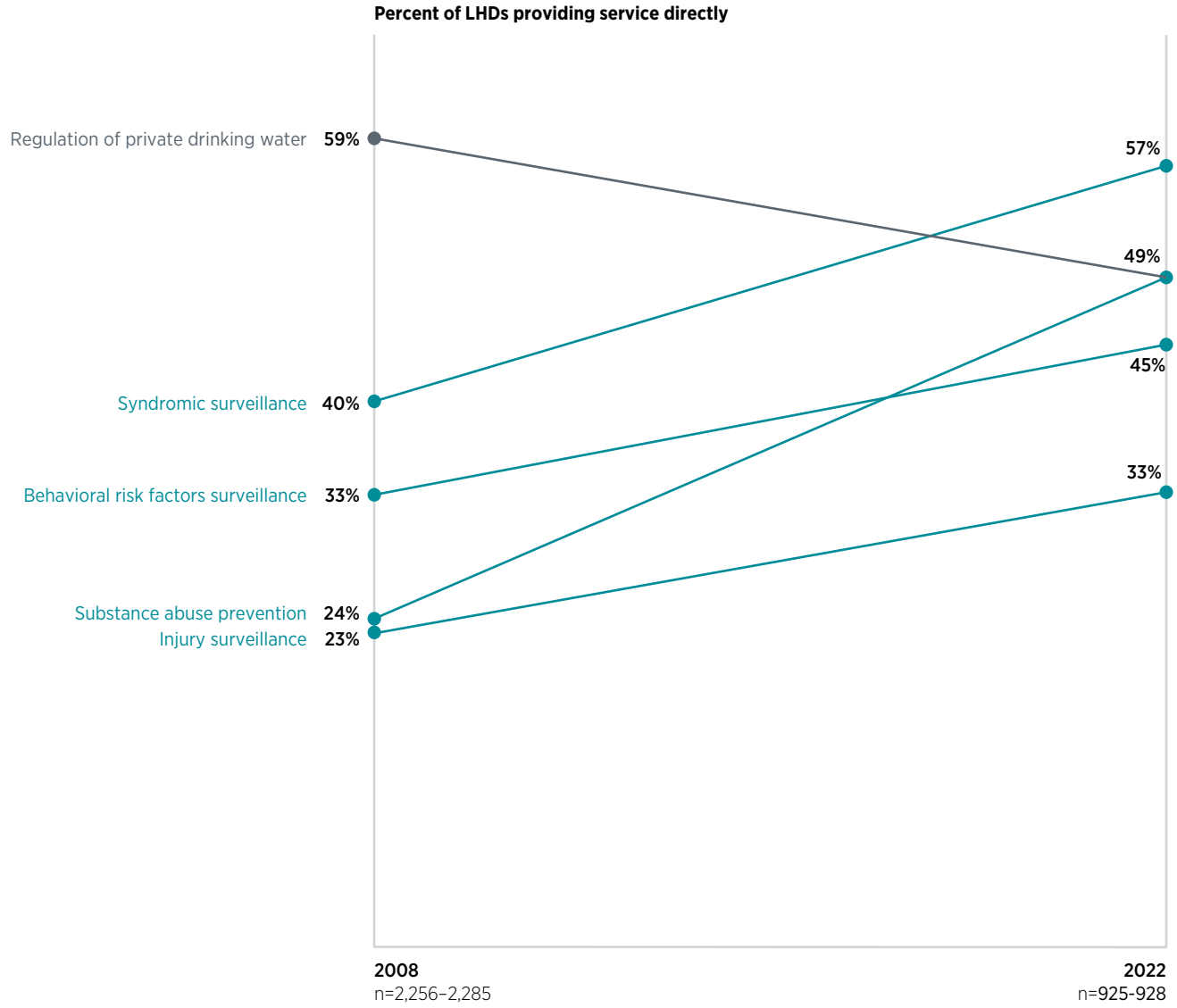
- The following table shows the eight clinical services for which the percentage of LHDs providing that service directly changed by at least 10 percentage points since 2008.
- The percentage of LHDs providing seven of these eight services decreased. In particular, 68% of LHDs directly provided high blood pressure screening in 2008. This has decreased by 17 percentage points, to 52% of LHDs providing this service directly in 2022.
- Conversely, the proportion of LHDs providing one of the services—HIV/AIDS treatment—nearly doubled from 20% in 2008 to 39% in 2022.

Technical note

The Profile questionnaire includes two sections on LHD programs and services. One section asks LHDs to indicate whether or not they provide that service (regardless of scale or scope) and a second asks LHDs to indicate how the level of provision for specific service areas have changed (i.e., increased, reduced, did not change). Figures 7.16 and 7.17 show the change in the overall percentage of LHDs who indicated they provided that service over time. Figures 7.18, 7.19, and 7.20 show the percentage of LHDs who reported how service areas have changed in scale or scope since the previous fiscal year.

FIGURE 7.17

Change in percent of LHDs providing population-based programs and services since 2008



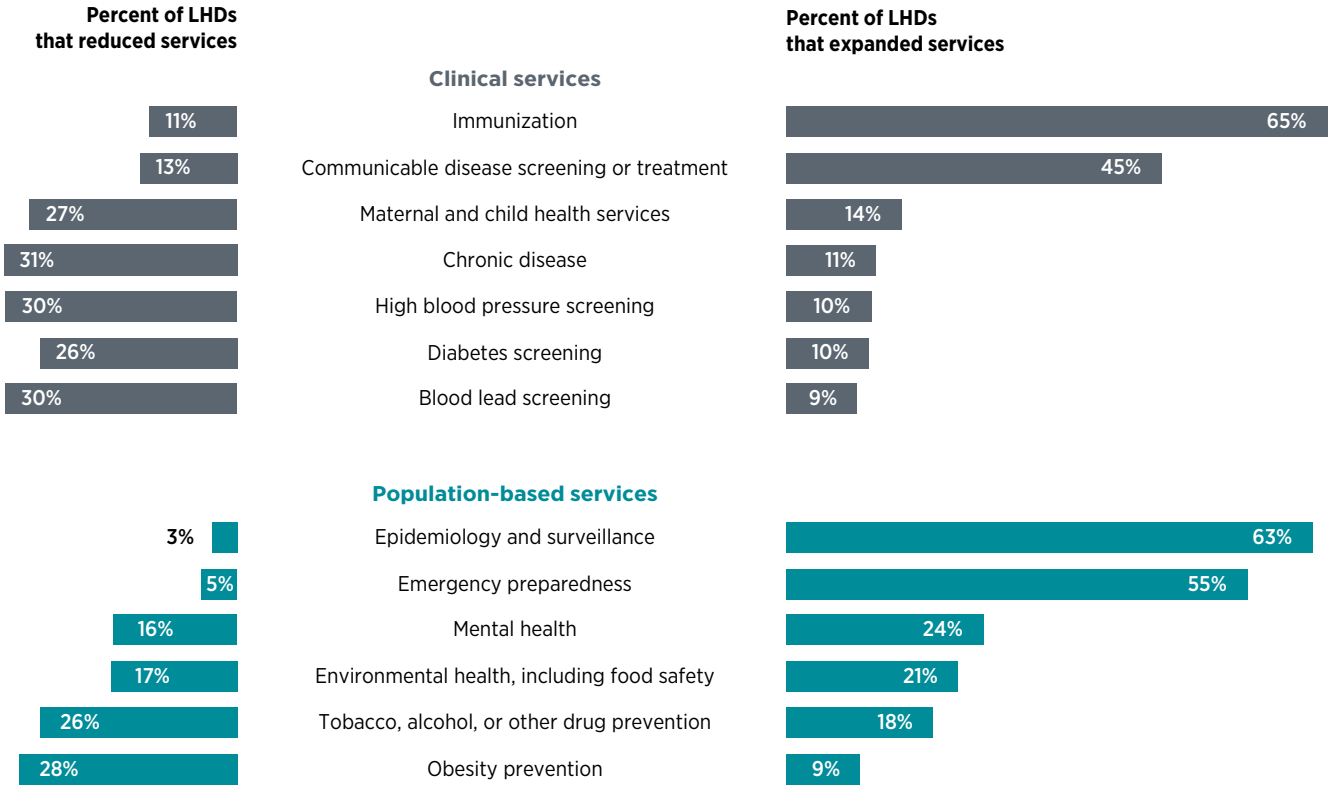
- The following table shows the five population-based services for which the percentage of LHDs providing that service directly changed by at least 10 percentage points since 2008.
- For four of the services, the percentage of LHDs providing them directly increased. In particular, syndromic surveillance provision increased by 17 percentage points, with 40% of LHDs providing this service directly in 2008, compared to 57% in 2022.
- Conversely, the percentage of LHDs providing regulation, inspection, and licensing of private drinking water decreased from 59% in 2008 to 49% in 2022.

Technical note

The Profile questionnaire includes two sections on LHD programs and services. One section asks LHDs to indicate whether or not they provide that service (regardless of scale or scope) and a second asks LHDs to indicate how the level of provision for specific service areas have changed (i.e., increased, reduced, did not change). Figures 7.16 and 7.17 show the change in the overall percentage of LHDs who indicated they provided that service over time. Figures 7.18, 7.19, and 7.20 show the percentage of LHDs who reported how service areas have changed in scale or scope since the previous fiscal year.

FIGURE 7.18

Changes in provision of services in the past year



n=365–895

- The difference between the proportions of LHDs expanding versus reducing services in the past year compared to the previous year is larger for clinical services than for population-based services.
- In particular, a larger proportion of LHDs expanded than reduced clinical and population-based services related to addressing COVID-19 (i.e., immunization, communicable disease screening/treatment, epidemiology and surveillance, emergency preparedness).

Technical note

The Profile questionnaire includes two sections on LHD programs and services. One section asks LHDs to indicate whether or not they provide that service (regardless of scale or scope) and a second asks LHDs to indicate how the level of provision for specific service areas have changed (i.e., increased, reduced, did not change). Figures 7.16 and 7.17 show the change in the overall percentage of LHDs who indicated they provided that service over time. Figures 7.18, 7.19, and 7.20 show the percentage of LHDs who reported how service areas have changed in scale or scope since the previous fiscal year.

FIGURE 7.19

Changes in provision of services in the past year, over time

	2022 n=365–895		2020 n=65–224		2019 n=602–1,407	
	Reduced	Expanded	Reduced	Expanded	Reduced	Expanded
Immunization	11%	65%	47%	11%	9%	21%
Epidemiology and surveillance	3%	63%	15%	67%	2%	16%
Emergency preparedness	5%	55%	10%	71%	5%	15%
Communicable disease screening or treatment	13%	45%	N/A	N/A	4%	19%
Environmental health, including food safety	17%	21%	48%	18%	3%	20%
Tobacco, alcohol, or other drug prevention	26%	18%	65%	3%	5%	39%
Maternal and child health services	27%	14%	60%	3%	11%	18%
High blood pressure screening	30%	10%	67%	1%	7%	14%
Diabetes screening	26%	10%	64%	0%	9%	21%
Blood lead screening	30%	9%	61%	0%	6%	15%
Obesity prevention	28%	9%	75%	0%	8%	16%

- LHDs were much more likely to report reducing their provision of many services in 2020, compared to 2019. In particular, 65% of LHDs reduced tobacco, alcohol, or other drug prevention services in 2020, while only 5% reduced these services in 2019.
- Although many LHDs continued reporting service reductions in 2022, the proportions were much smaller than in 2020.
- In 2022, many LHDs also expanded their provision of services, especially immunization services, which were expanded by 65% of LHDs compared to 21% and 11% in 2019 and 2020.

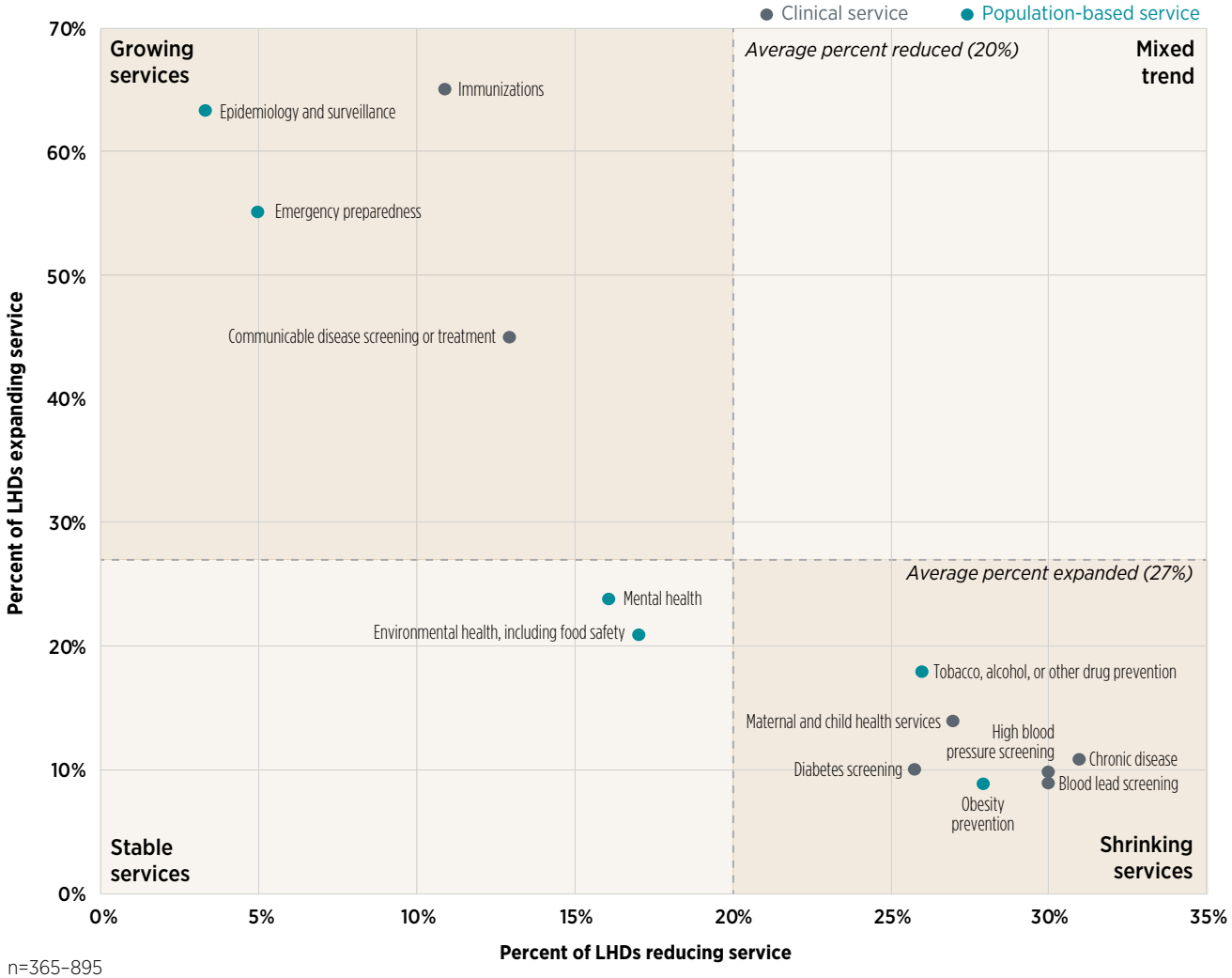
Technical notes

The Profile includes questions about service provision changes. A similar question was included in another NACCHO survey administered in 2020. Figure 7.19 presents findings based on those data.

The Profile questionnaire includes two sections on LHD programs and services. One section asks LHDs to indicate whether or not they provide that service (regardless of scale or scope) and a second asks LHDs to indicate how the level of provision for specific service areas have changed (i.e., increased, reduced, did not change). Figures 7.16 and 7.17 show the change in the overall percentage of LHDs who indicated they provided that service over time. Figures 7.18, 7.19, and 7.20 show the percentage of LHDs who reported how service areas have changed in scale or scope since the previous fiscal year.

FIGURE 7.20

Growing, stable, and shrinking services in the past year



n=365–895

This diagram illustrates how LHDs are changing their levels of service provision in 13 programmatic areas. The horizontal and vertical lines represent the average percentages of LHDs expanding and reducing services across these areas. The direction and distance from the average lines illustrate the overall trend in service provision changes.

- Programs in the lower left quadrant are *stable* services—(i.e., few LHDs are expanding or reducing). These include environmental health and mental health.
- Programs in the upper left quadrant are *growing* services (i.e., relatively few LHDs are reducing and more are expanding). These include epidemiology and surveillance, emergency preparedness, immunization, and communicable disease screening/treatment.
- Programs in the lower right quadrant are *shrinking* services (i.e., more LHDs are reducing and few are expanding). These include services in seven of the 13 programmatic areas assessed—with more clinical services in this category than population-based services.
- Programs in the upper right quadrant are services where the trends are *mixed* (i.e., high percentages of LHDs are expanding and reducing). There were no services in 2022 that fit into this category.

Technical note

The Profile questionnaire includes two sections on LHD programs and services. One section asks LHDs to indicate whether or not they provide that service (regardless of scale or scope) and a second asks LHDs to indicate how the level of provision for specific service areas have changed (i.e., increased, reduced, did not change). Figures 7.16 and 7.17 show the change in the overall percentage of LHDs who indicated they provided that service over time. Figures 7.18, 7.19, and 7.20 show the percentage of LHDs who reported how service areas have changed in scale or scope since the previous fiscal year.

CHAPTER
08

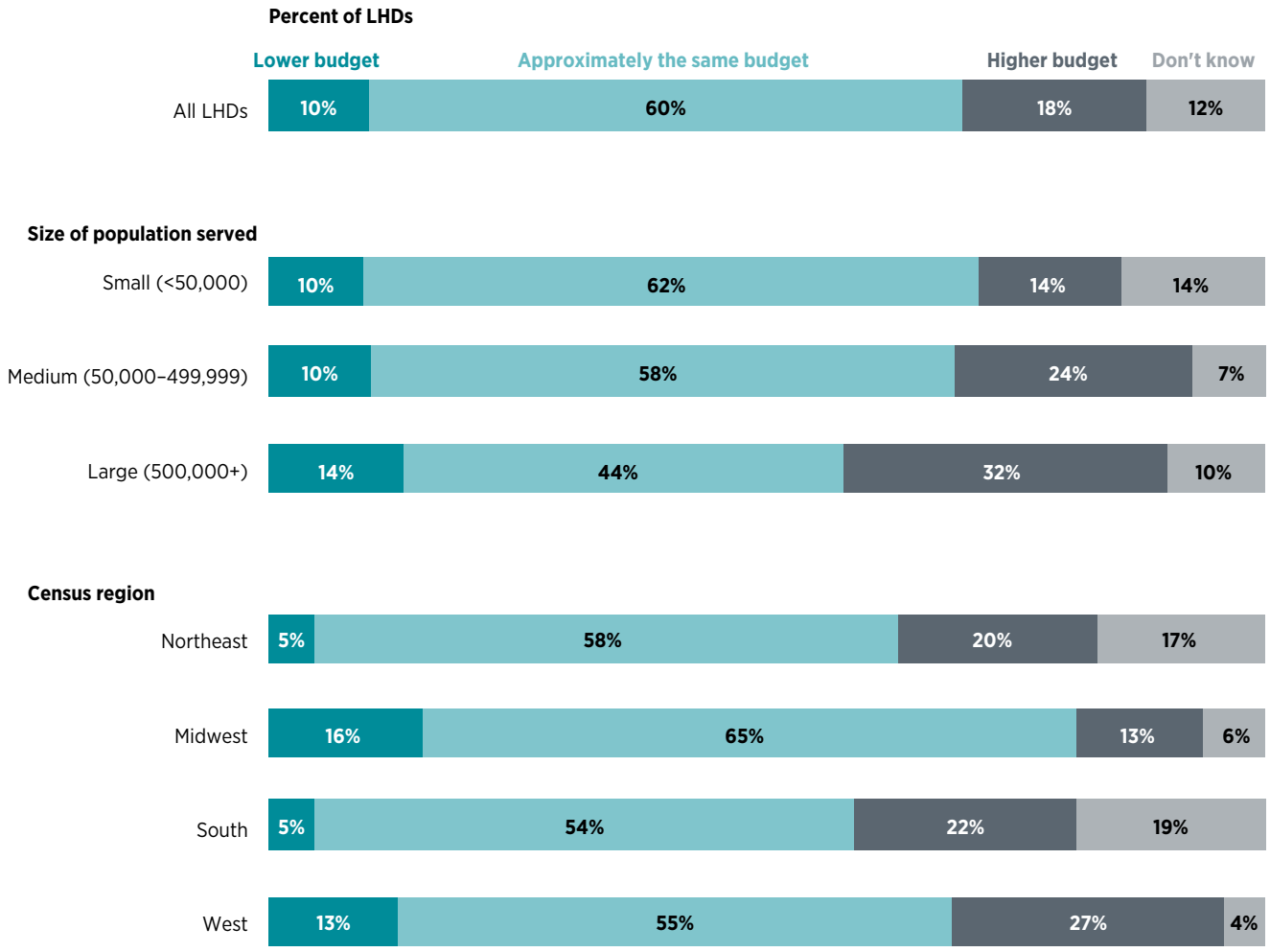
Emergency Preparedness and Response

This chapter includes the following:

- Local health department (LHD) budget changes for emergency preparedness activities.
- Response to all-hazards events.
- Source and use of volunteers in emergency preparedness activities and emergencies.

FIGURE 8.1

LHD budgets changes for emergency preparedness activities, by size of population served and Census region

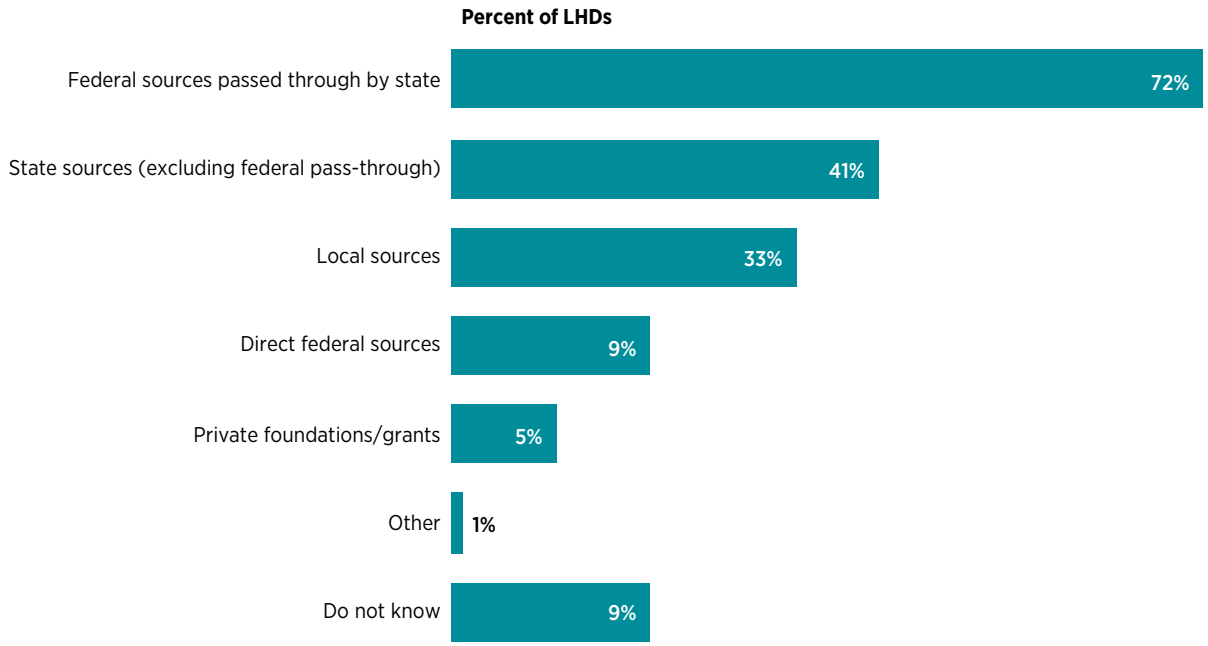


n=485

- One in 10 LHDs report a lower budget for emergency preparedness in the current fiscal year compared to the previous fiscal year, while approximately two in 10 report a higher budget.
- The proportion of LHDs reporting a higher emergency preparedness budget increases as population size served increases.
- LHDs in the West and Midwest were more likely than LHDs in the South and Northeast to report a lower budget for emergency preparedness.

FIGURE 8.2

Funding sources for preparedness activities

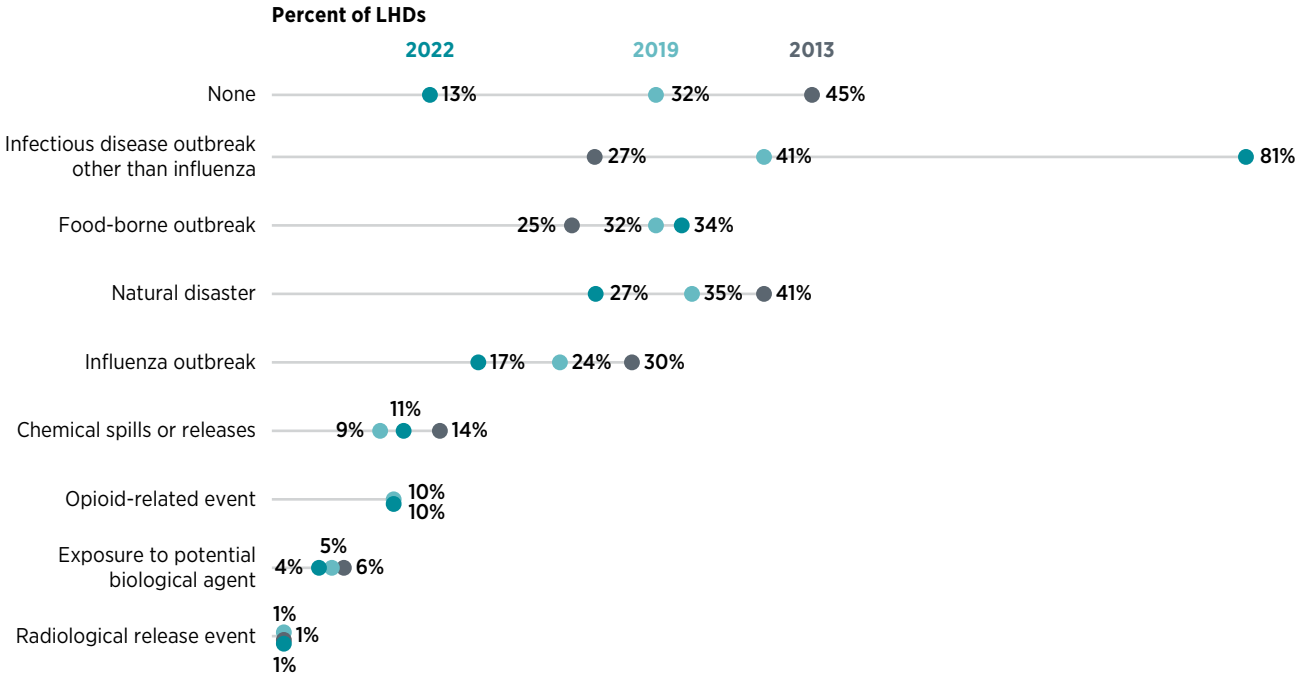


n=486

- The majority of LHDs received funding from federal sources passed through the state for emergency preparedness activities.
- Few LHDs received funding directly from the federal government or through private foundations/grants.

FIGURE 8.3

Response to specific all-hazards events, over time



n(2013)=484–495

n(2019)=353

n(2022)=486

- In 2022, 87% of LHDs reported responding to at least one all-hazards event in the past year. This proportion continues to increase—from 55% in 2013 and 68% in 2019.
- LHDs most frequently responded to outbreaks of infectious disease (other than influenza), and the proportion of LHDs responding to this type of event nearly doubled from 2019 to 2022.
- In 2022, LHDs were less likely to have responded to a natural disaster, influenza outbreaks, and exposures to potential biological agents than in 2019.

FIGURE 8.4

Response to specific all-hazards events in past year, by size of population served

	All LHDs	Size of population served		
		Small (<50,000)	Medium (50,000–499,999)	Large (500,000+)
None	13%	16%	7%	7%
Infectious disease outbreak other than influenza	81%	78%	84%	90%
Food-borne outbreak	34%	23%	47%	64%
Natural disaster	27%	21%	33%	58%
Influenza outbreak	17%	14%	19%	32%
Chemical spills or releases	11%	7%	17%	20%
Opioid-related event	10%	5%	16%	26%
Exposure to potential biological agent	4%	2%	5%	16%
Radiological release event	1%	1%	1%	4%

n=486

➡ Medium and large LHDs were more likely than small LHDs to have responded to an all-hazards event in the past year. In particular, 64% of large LHDs and 47% of medium LHDs responded to a food-borne outbreak, compared to 23% of small LHDs. Similarly, 58% of large LHDs and 33% of medium LHDs responded to a natural disaster event, compared to 21% of small LHDs.

FIGURE 8.5

Response to specific all-hazards events in past year, by Census region

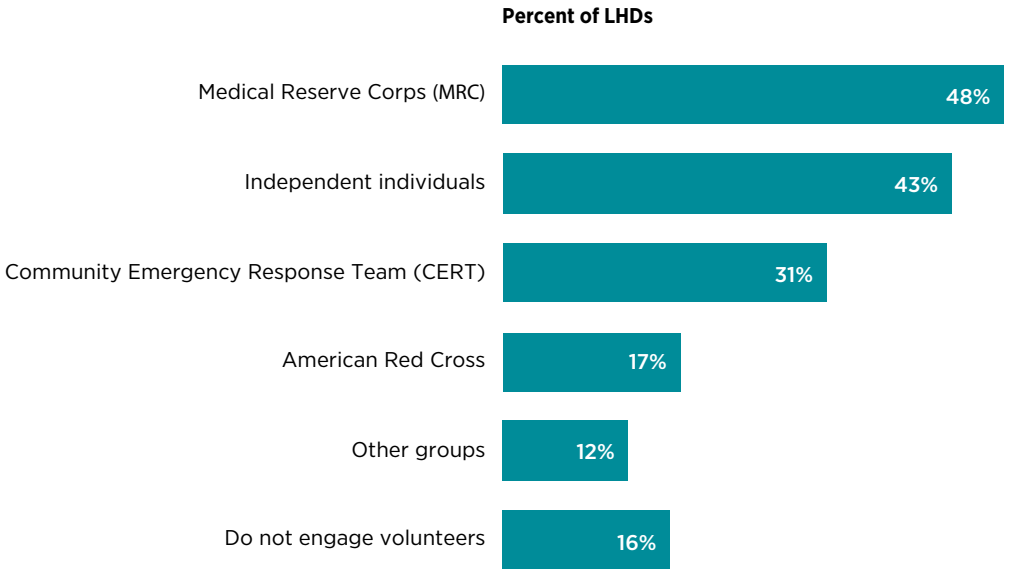
		Census region			
	All LHDs	Northeast	Midwest	South	West
None	13%	13%	15%	13%	5%
Infectious disease outbreak other than influenza	81%	75%	83%	80%	87%
Food-borne outbreak	34%	44%	25%	34%	47%
Natural disaster	27%	24%	17%	36%	48%
Influenza outbreak	17%	20%	12%	19%	23%
Chemical spills or releases	11%	23%	7%	5%	22%
Opioid-related event	10%	14%	7%	9%	18%
Exposure to potential biological agent	4%	4%	3%	4%	9%
Radiological release event	1%	0%	1%	2%	1%

n=486

➡ LHDs in the West were more likely to have responded to an all-hazards event in the past year, compared to LHDs in other regions. In particular, these LHDs were approximately twice as likely to respond to natural disasters than LHDs in the Northeast or Midwest.

FIGURE 8.6

Use of volunteer groups in emergency preparedness activities

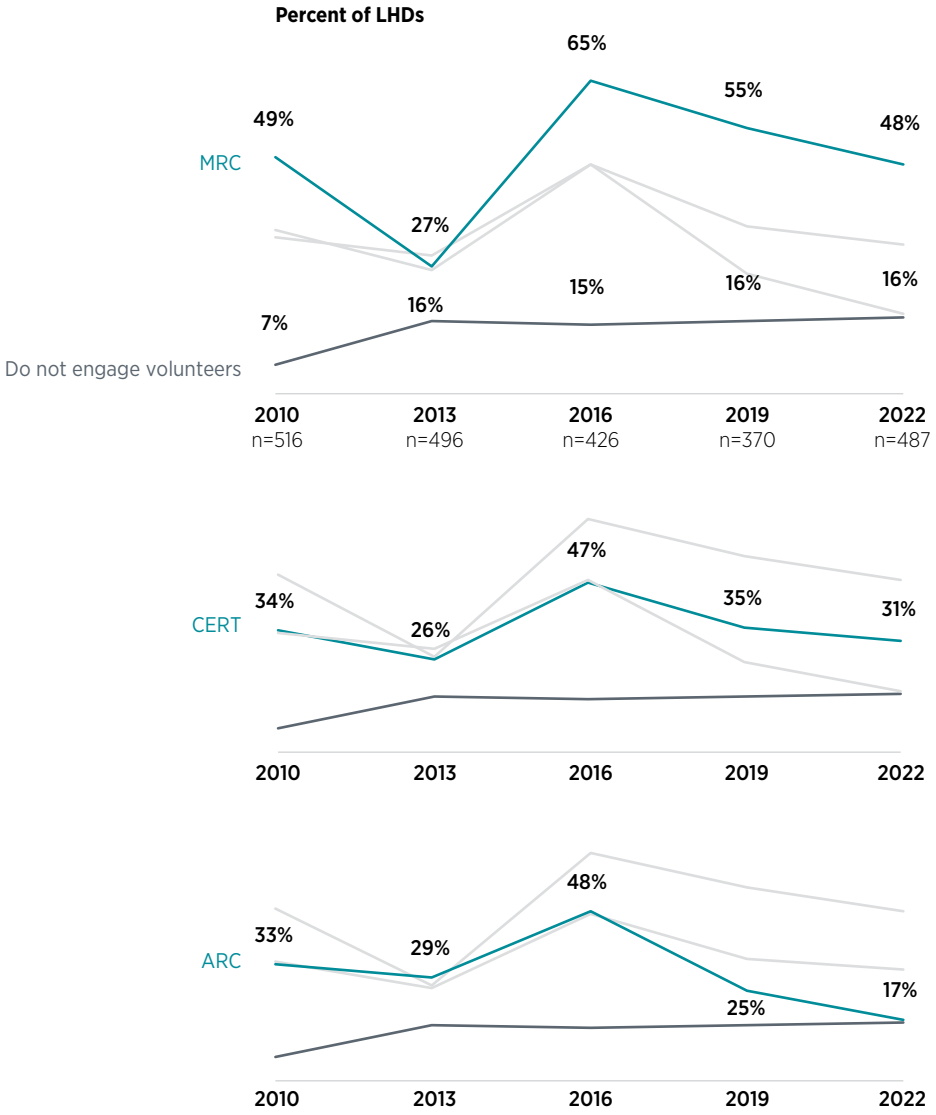


n=487

- LHDs were most likely to engage volunteers from the Medical Reserve Corps (MRC) for emergency preparedness activities.
- A similar proportion of LHDs engage volunteers from the MRC and independent individuals recruited by LHDs.
- Sixteen percent of LHDs do not engage volunteers in emergency preparedness activities.

FIGURE 8.7

Use of select volunteer groups in emergency preparedness activities, over time



- Compared to 2019, LHDs were less likely to engage volunteers from formal programs (i.e., MRC, CERT, American Red Cross) in 2022.
- The proportion of LHDs that engaged volunteers from the MRC or CERT remained about the same overall from 2010 to 2022. However, the proportion of LHDs that engaged volunteers from the American Red Cross decreased 16 percentage points from 2010 to 2022.

CHAPTER
09

Assessment, Planning, and Accreditation

This chapter includes the following:

- Local health department (LHD) participation in a community health assessment (CHA) and/or community health improvement plan (CHIP).
- Impact of COVID-19 pandemic on CHA timeline.
- Use of tools for most recent CHA or CHIP.
- Actions taken to implement or sustain a CHIP.
- Types of collaboration with non-profit hospitals on a community health needs assessment (CHNA).
- Level of engagement with Public Health Accreditation Board (PHAB) accreditation.
- Reasons for not pursuing PHAB accreditation.

FIGURE 9.1

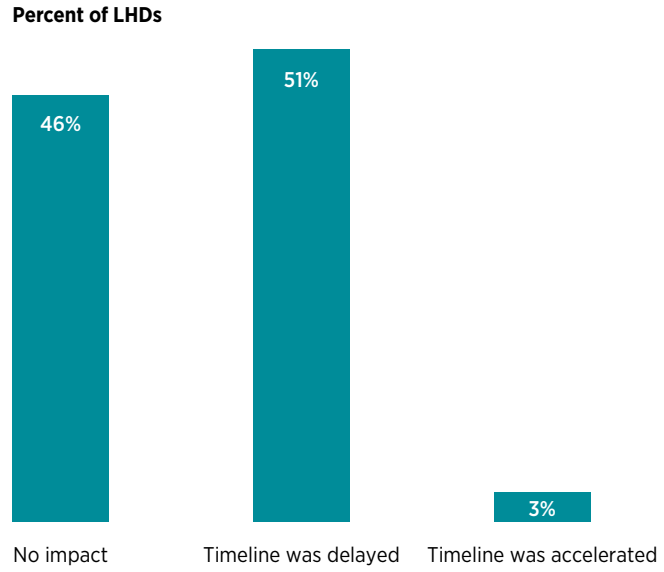
Participation in a community health assessment (CHA) and/or community health improvement plan (CHIP) within five years, by size of population served

n=926–927

- In 2022, 62% of LHDs completed both a CHA and CHIP within the past 5 years. LHDs were more likely to participate in a CHA than a CHIP—with 74% completing a CHA within five years, compared to 65% completing a CHIP.
- Medium and large LHDs were more likely to complete a CHA and CHIP, while small LHDs were less likely.

FIGURE 9.2

Impact of COVID-19 pandemic on community health assessment (CHA) timeline

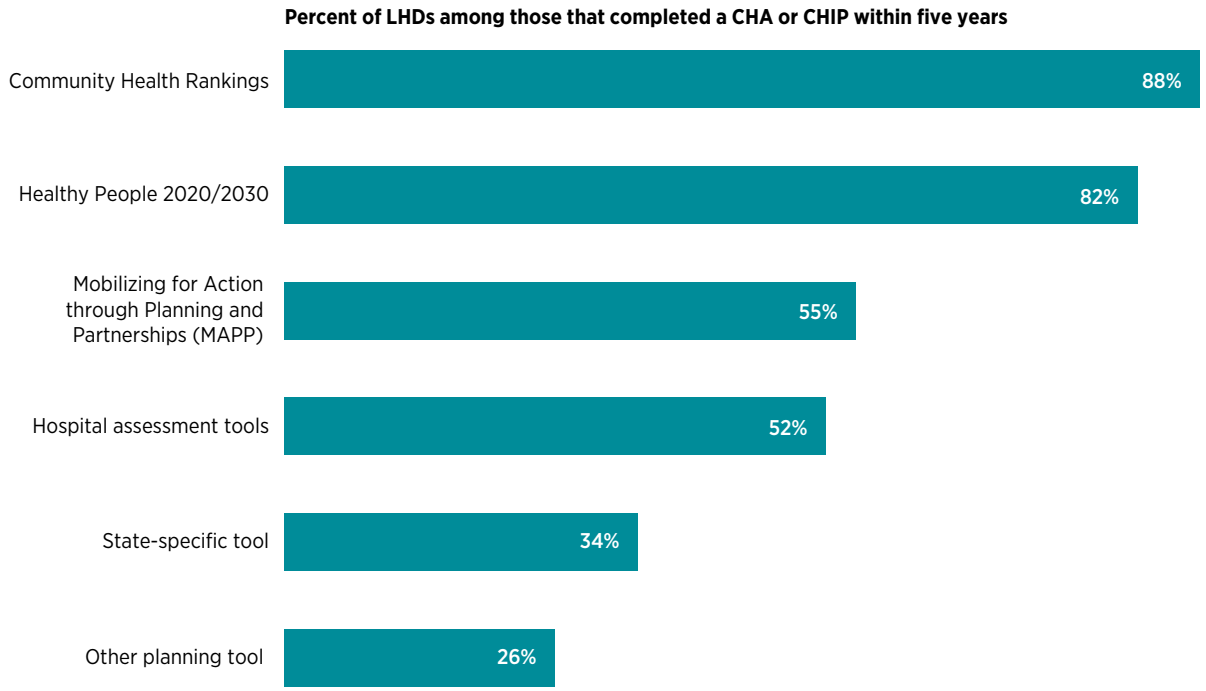


n=918

➡ LHDs reported their CHA timeline was either not impacted or delayed because of the COVID-19 pandemic.

FIGURE 9.3

Use of tools for most recent community health assessment (CHA) or community health improvement plan (CHIP)

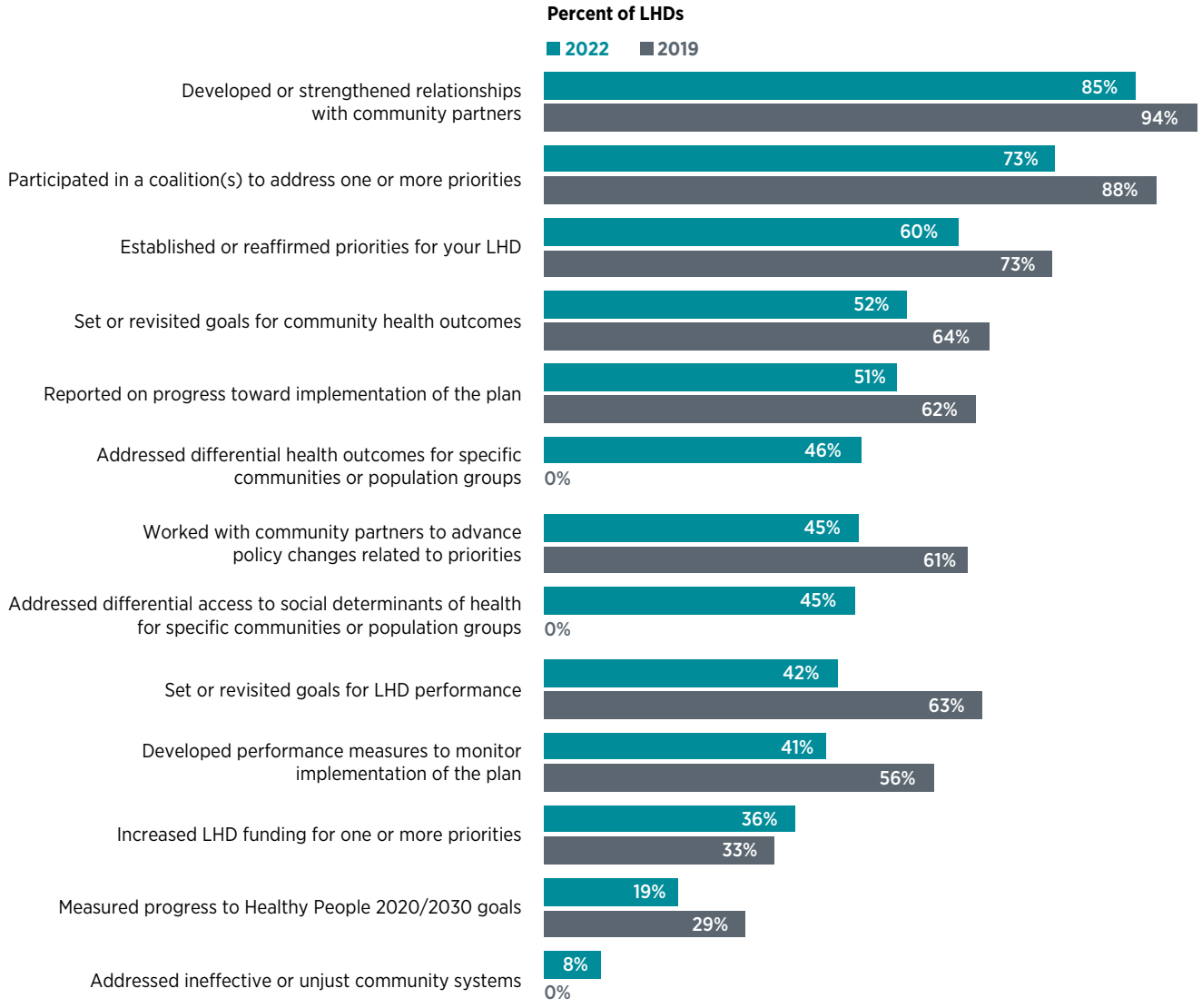


n=576–704

- LHDs most frequently used Community Health Rankings and Healthy People 2020/2030 for their most recent CHA or CHIP.
- More than half of LHDs with a CHA or CHIP used MAPP, while fewer LHDs used state-specific or other planning tools.
- Approximately one in four LHDs used MAPP as a reference tool. Meanwhile, large LHDs were much more likely to implement MAPP—rather than just refer to it—than small or medium LHDs (not shown).

FIGURE 9.4

Actions taken in the past three years to implement or sustain a community health improvement plan (CHIP)

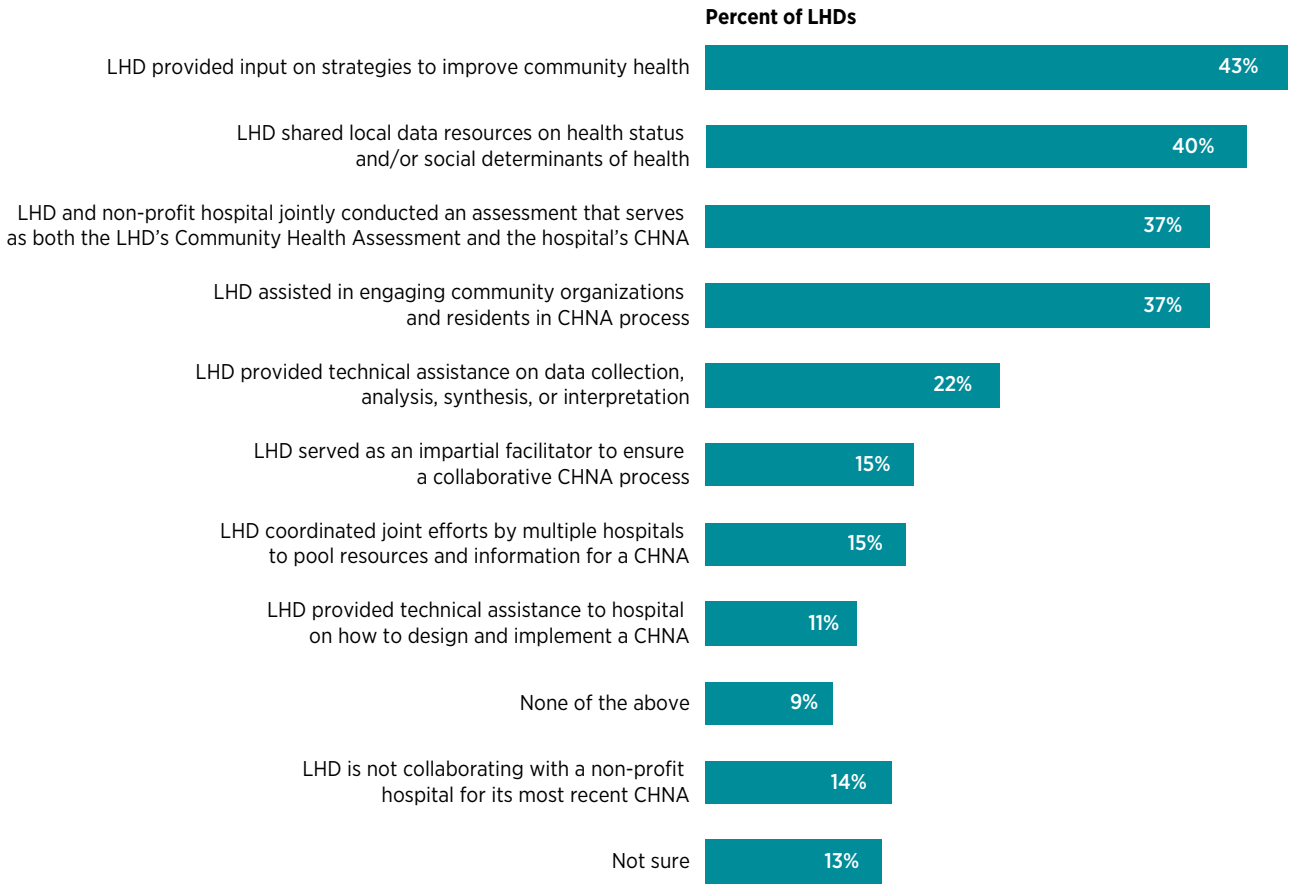


n(2022)=283 n(2019)=301

- LHDs take a variety of actions to implement or sustain their CHIPs, including developing or strengthening relationships with community partners, participating in a coalition to address one or more priorities, and establishing or reaffirming priorities for LHDs.
- With the exception of increasing funding, smaller proportions of LHDs have taken these actions in 2022 than in 2019.

FIGURE 9.5

Types of collaboration with non-profit hospitals on most recent community health needs assessment (CHNA)

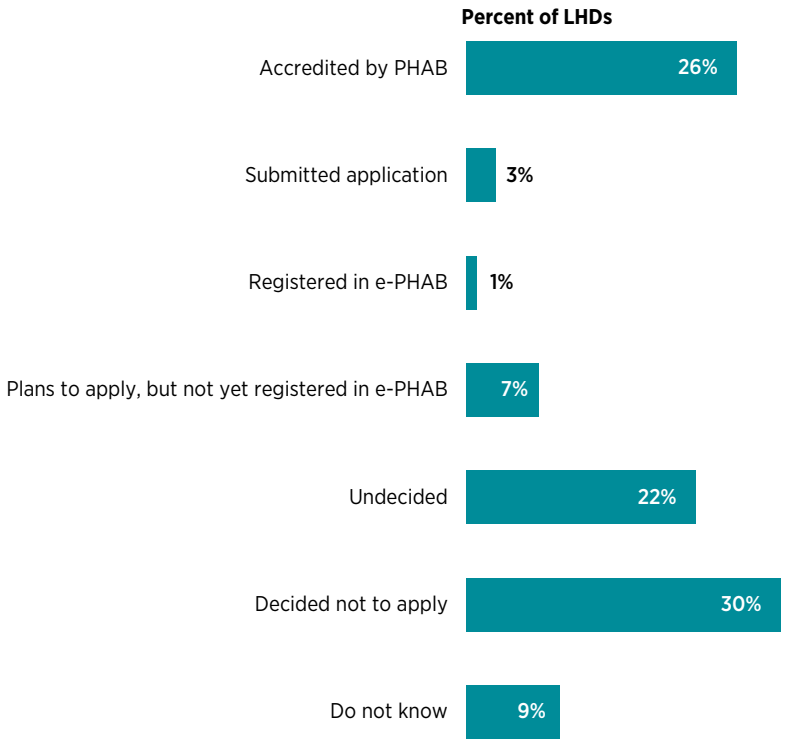


n=432

- Only 14% of LHDs were not collaborating with a non-profit hospital on a CHNA.
- The most common types of collaboration between LHDs and non-profit hospitals on a CHNA include providing input on strategies to improve community health, sharing local data resources, jointly conducting an assessment, and assisting in engaging community organizations and residents in the CHNA process.

FIGURE 9.6

Level of engagement with Public Health Accreditation Board (PHAB) accreditation



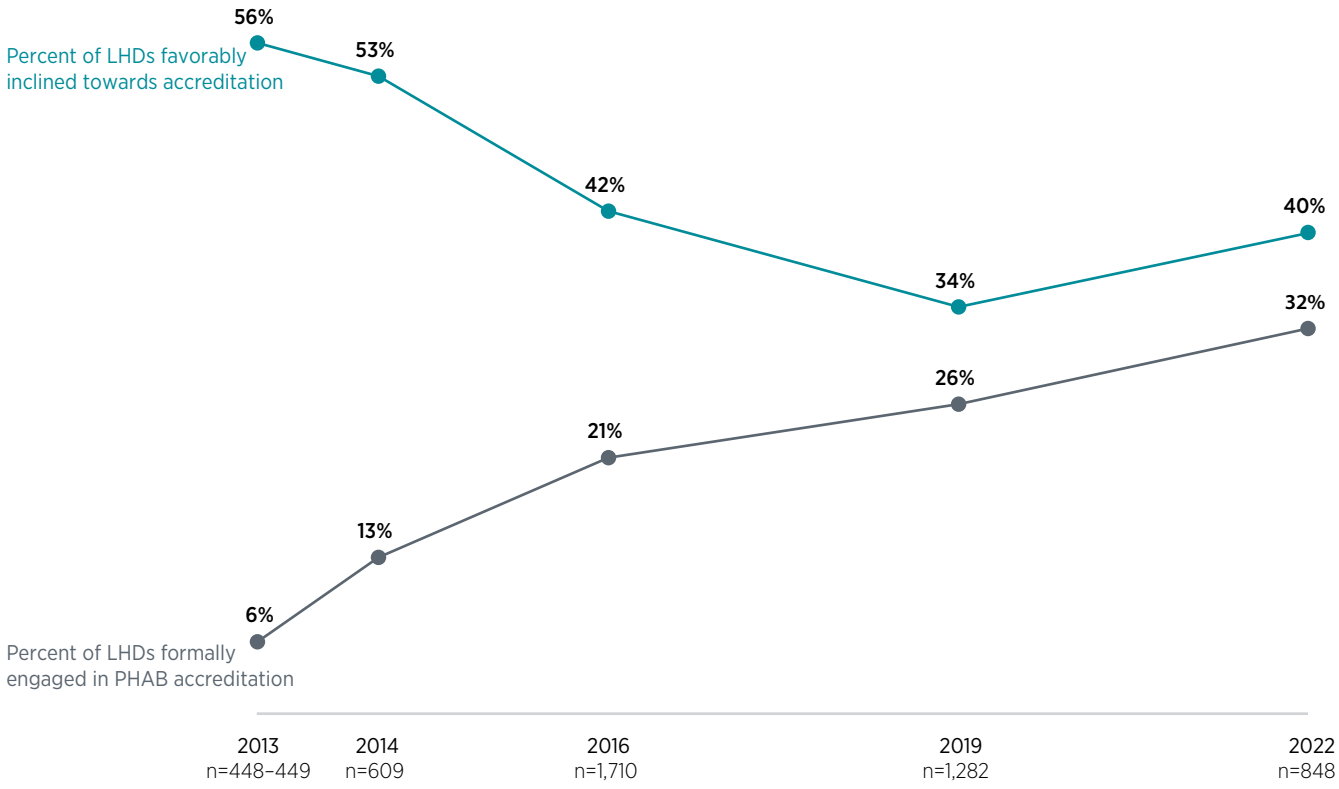
n=928

- In 2022, more than one in four LHDs were accredited by PHAB, while another 3% had submitted an application to become accredited.
- Twenty-two percent of LHDs were undecided about PHAB accreditation, and 30% decided not to apply.

Technical note
The level of engagement is based on the LHD's perception at the time of data collection and may not reflect PHAB's most recently accredited health departments.

FIGURE 9.7

Level of engagement with Public Health Accreditation Board (PHAB) accreditation, over time



- The percentage of LHDs favorably inclined towards PHAB accreditation has decreased from 56% in 2013 to 40% in 2022.
- However, the percentage of LHDs formally engaged in PHAB accreditation has increased from 6% in 2013 to 32% in 2022.

Level of engagement in PHAB accreditation

Formally engaged in PHAB accreditation: LHDs that are accredited, have submitted application or registered in e-PHAB

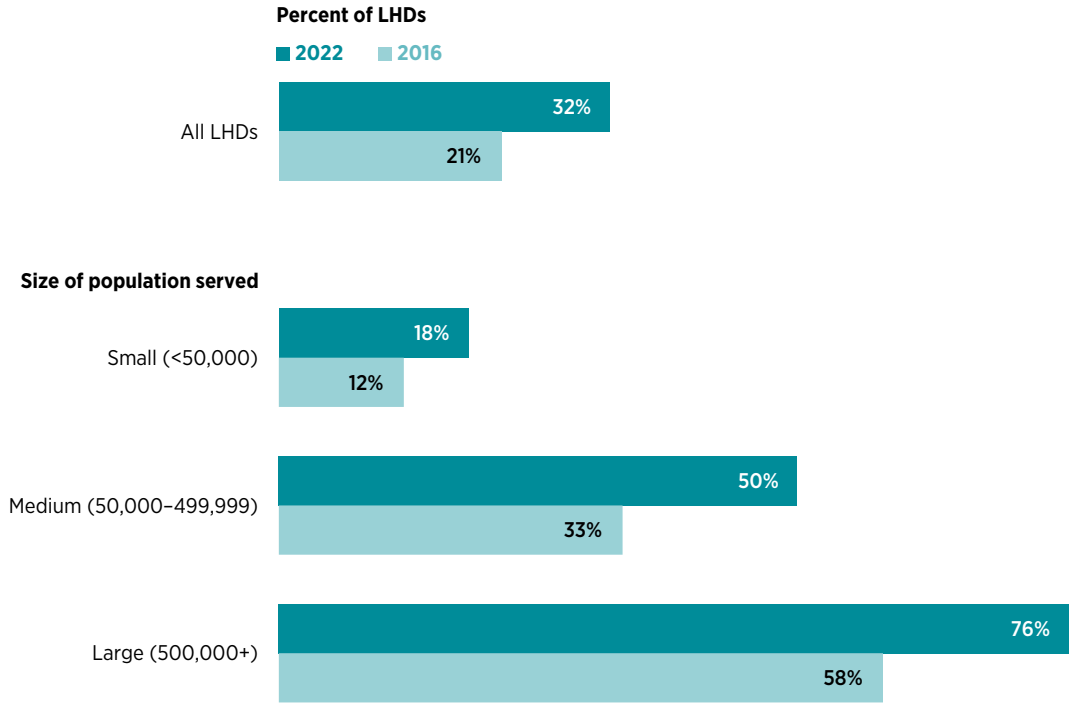
Favorable inclined towards PHAB accreditation: LHDs that are formally engaged in PHAB accreditation or plan to apply (all LHDs except those that are undecided or decided not to apply for PHAB)

Technical note

N's exclude LHDs reporting "do not know" for level of engagement with PHAB accreditation

FIGURE 9.8

Formal engagement in Public Health Accreditation Board (PHAB) accreditation, by size of population served, over time



n(2016)=1,710

n(2022)=848

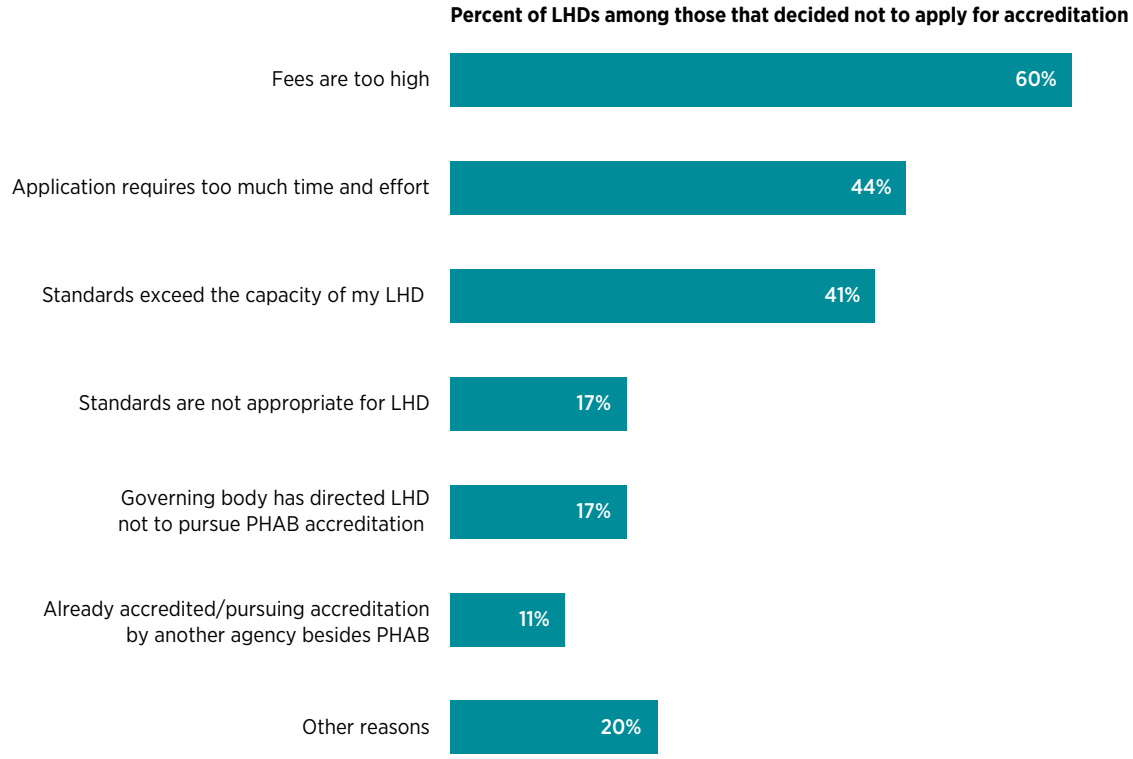
- Large LHDs were more likely to be formally engaged in PHAB accreditation than small and medium LHDs.
- The proportion of medium and large LHDs formally engaged has increased by 17 and 18 percentage points (respectively) from 2016 to 2022, compared to only a 6-percentage point increase for small LHDs.

Level of engagement in PHAB accreditation
Formally engaged in PHAB accreditation: LHDs that are accredited, have submitted application or registered in e-PHAB

Technical note
N's exclude LHDs reporting "do not know" for level of engagement with PHAB accreditation

FIGURE 9.9

Reasons for not pursuing Public Health Accreditation Board (PHAB) accreditation



n=270

- In 2022, LHDs reported the fees for accreditation were too high—the most common reason indicated for not pursuing PHAB accreditation.
- LHDs were more likely to report each reason as a factor in not pursuing PHAB accreditation in 2022 than in 2019 (not shown). In particular, 41% of LHDs reported that standards exceed the LHD's capacity in 2022 compared to 36% in 2019.

CHAPTER
10

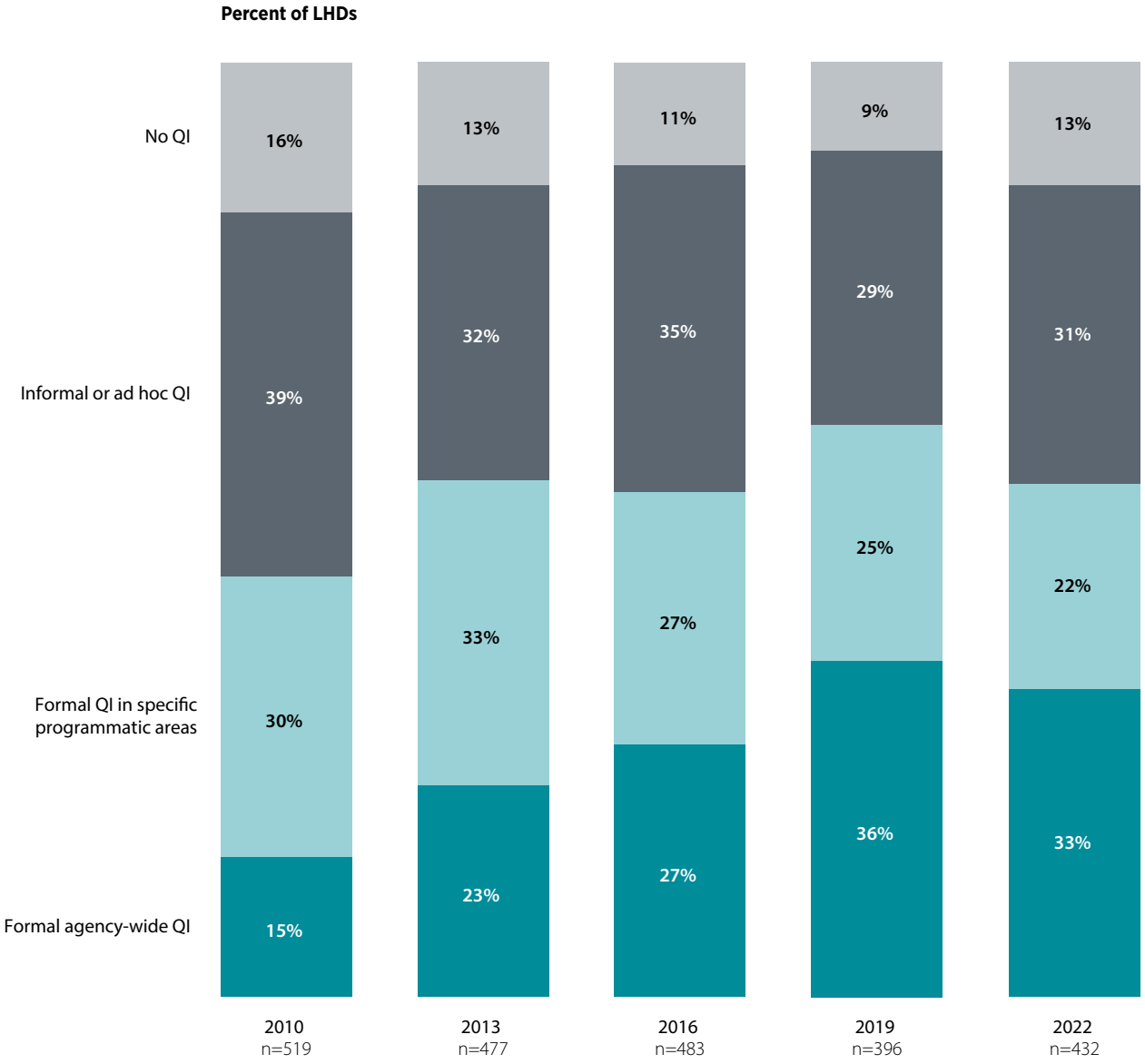
Quality Improvement and Workforce Development

This chapter includes the following:

- Level of quality improvement implementation at local health departments (LHDs).
- Elements used in quality improvement efforts.
- Use of core competencies for public health workers.
- Current level of activity in approaches to retention and career pathways/ladders.

FIGURE 10.1

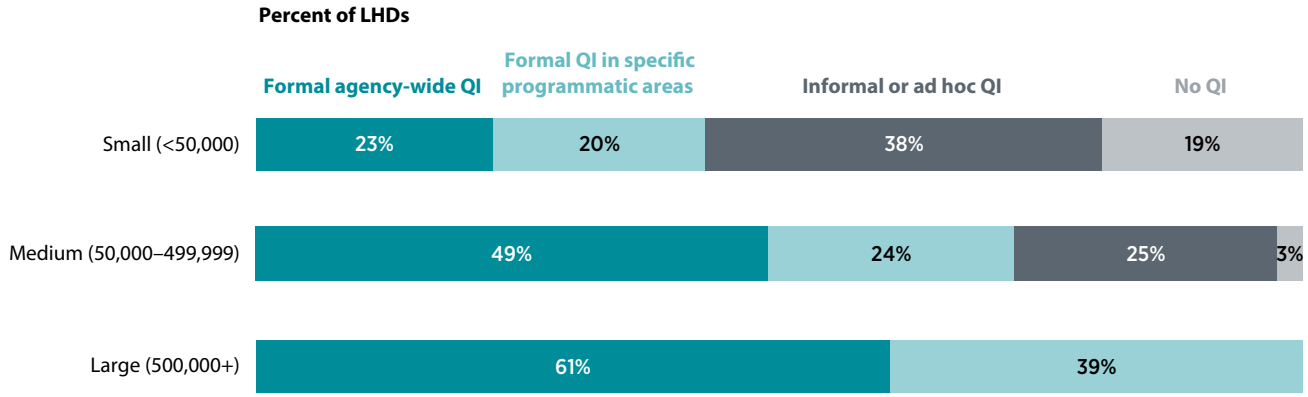
Level of quality improvement (QI) implementation, over time



- The proportion of LHDs reporting informal or no QI has remained consistent since 2013.
- Between 2019 and 2022, the proportion of LHDs engaged in formal QI (agency-wide or specific areas within LHD) decreased by 6 percentage points.

FIGURE 10.2

Level of quality improvement (QI) implementation, by size of population served

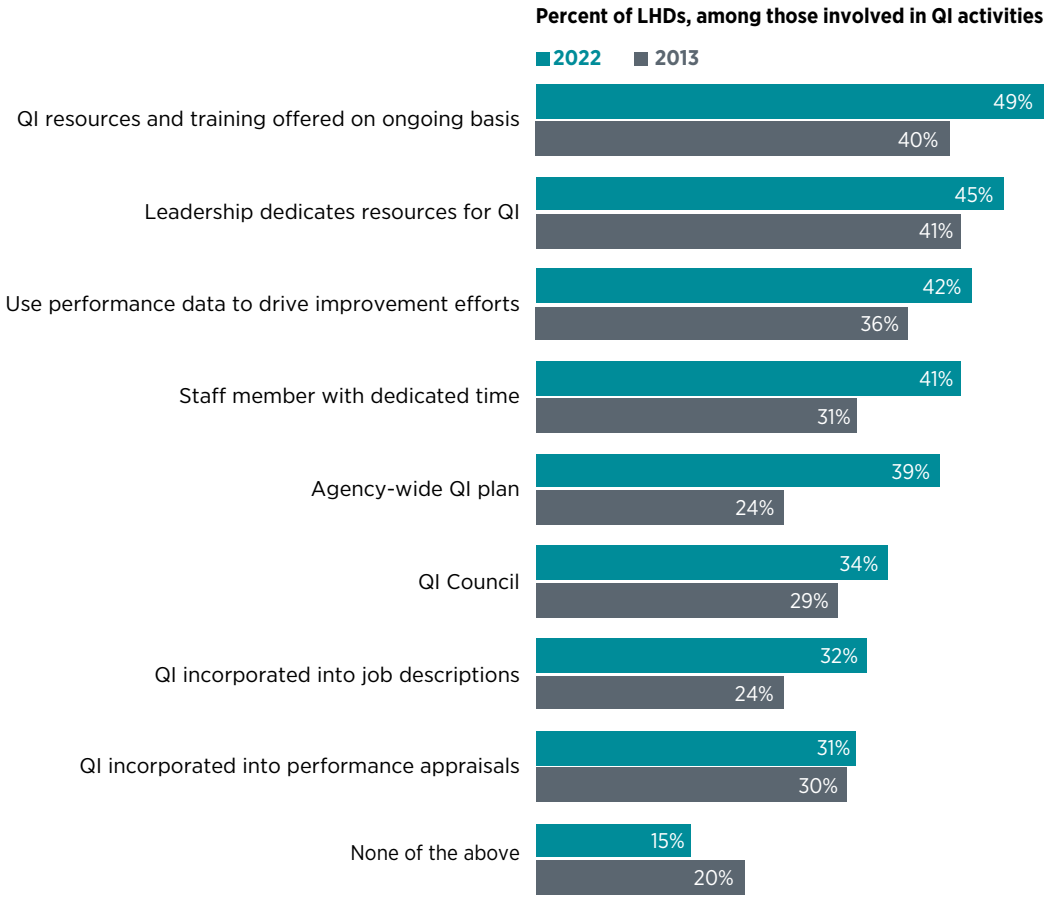


n=432

- Large LHDs were more likely to be involved in formal QI activities than small or medium LHDs.
- Nineteen percent of small LHDs were not involved in any QI at their agency—formal or informal.

FIGURE 10.3

Elements of a formal agency-wide quality improvement (QI) program currently in place at LHD



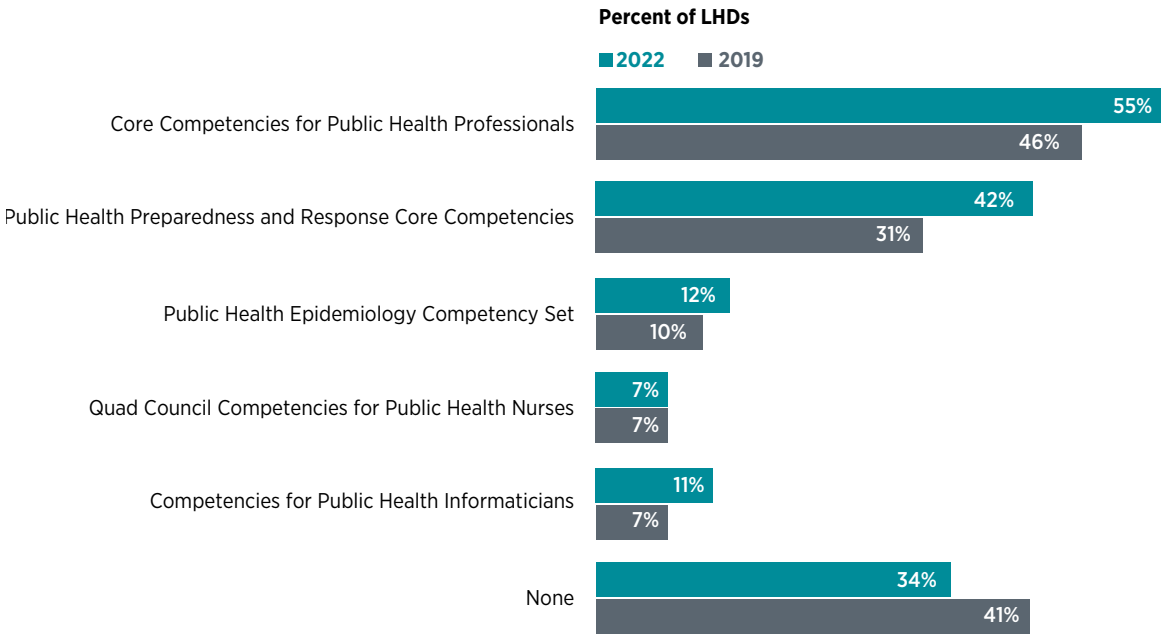
n(2013)=426

n(2022)=379

- Approximately half of LHDs have QI resources and training offered on an ongoing basis at their agency and have leadership that dedicates resources for QI. Fewer LHDs have QI incorporated into job descriptions or performance appraisals.
- The proportion of LHDs with these elements in place has increased since 2013.

FIGURE 10.4

Use of any competency sets for workforce development, planning, and action, over time



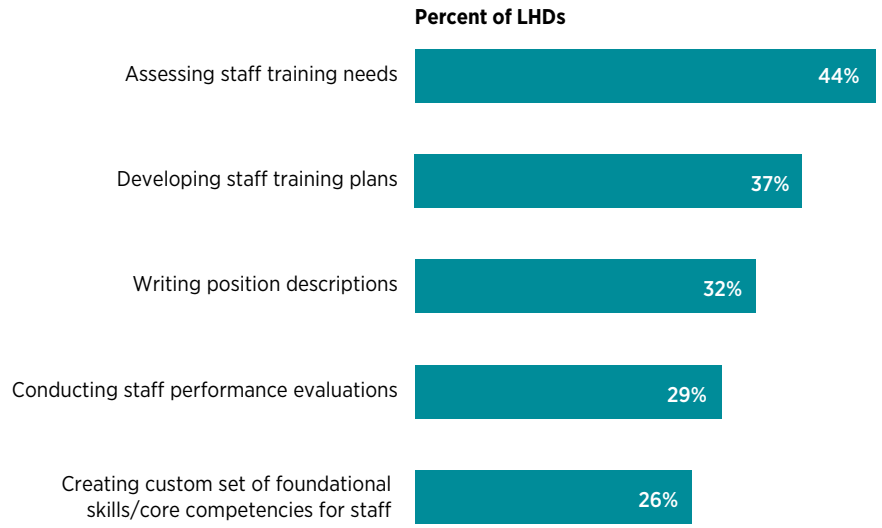
n(2019)=395

n(2022)=430

- The most commonly used competency set for workforce development, planning, and action is the Core Competencies for Public Health Professionals, with more than half of LHDs using it. Few LHDs use occupation-specific competency sets (e.g., Quad Council Competencies for Public Health Nurses, Competencies for Public Health Informaticians).
- Notably, 34% of LHDs do not use any competency set for workforce development. Medium and large LHDs were more likely to have used core competency sets than small LHDs (not shown).
- With the exception of Quad Council Competencies for Public Health Nurses, the proportion of LHDs using these core competency sets has increased since 2019. In particular, 42% of LHDs reported using Public Health Preparedness and Response Core Competencies in 2022, compared to 31% in 2019.

FIGURE 10.5

Use of the Core Competencies for Public Health Professionals

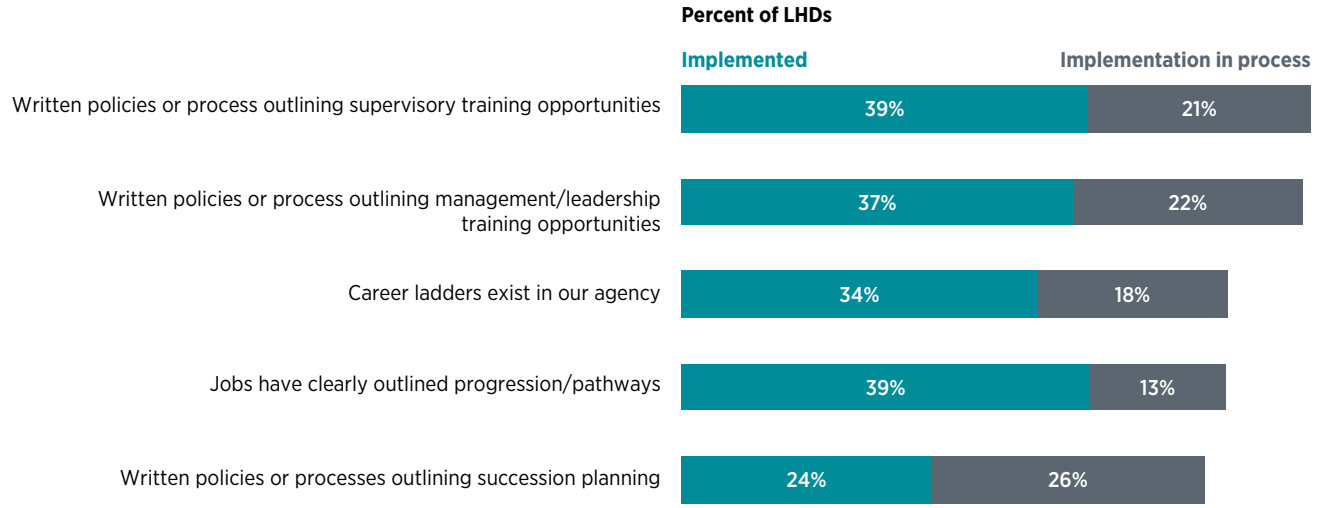


n=423

➡ Most commonly, LHDs used the Core Competencies for Public Health Professionals for staff training purposes (i.e., assessing training needs and developing training plans).

FIGURE 10.6

Current level of activity in approaches to retention and career pathways/ladders



n=910–912

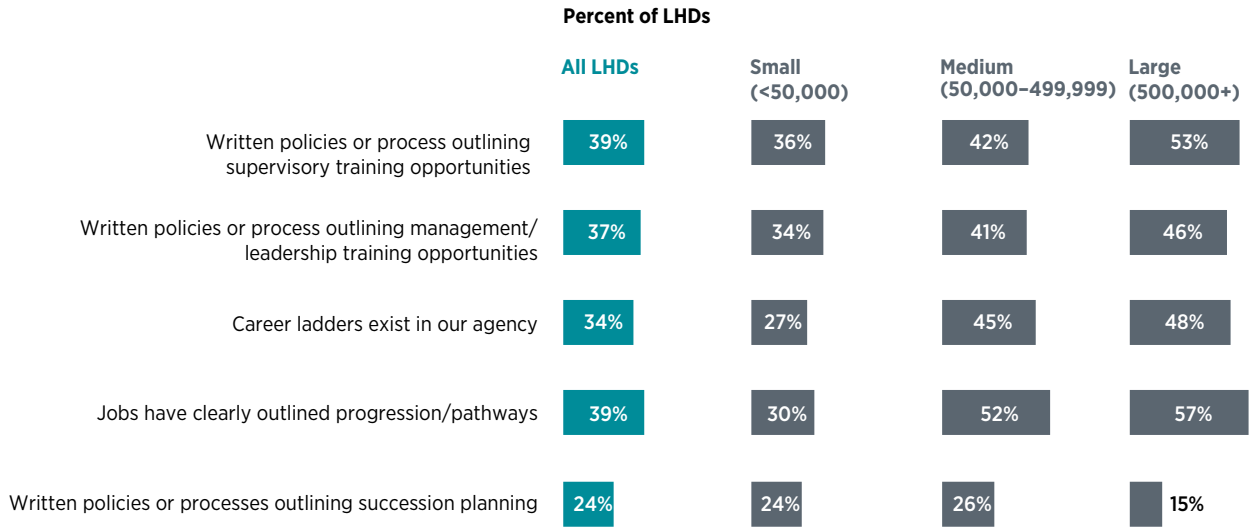
- At least half of LHDs have implemented or were in the process of implementing approaches to retention and career pathways/ladders.
- A higher proportion of LHDs reported current activity in having written policies or processes outlining training opportunities for supervisors or management/leadership, compared to other approaches.

Career ladders
Career ladders are clearly defined opportunities to move to higher levels of responsibility and pay

Technical note
These statistics include a number of "no activity" and "don't know" responses not being displayed

FIGURE 10.7

Current implementation of approaches to retention and career pathways/ladders, by size of population served



n=910–912

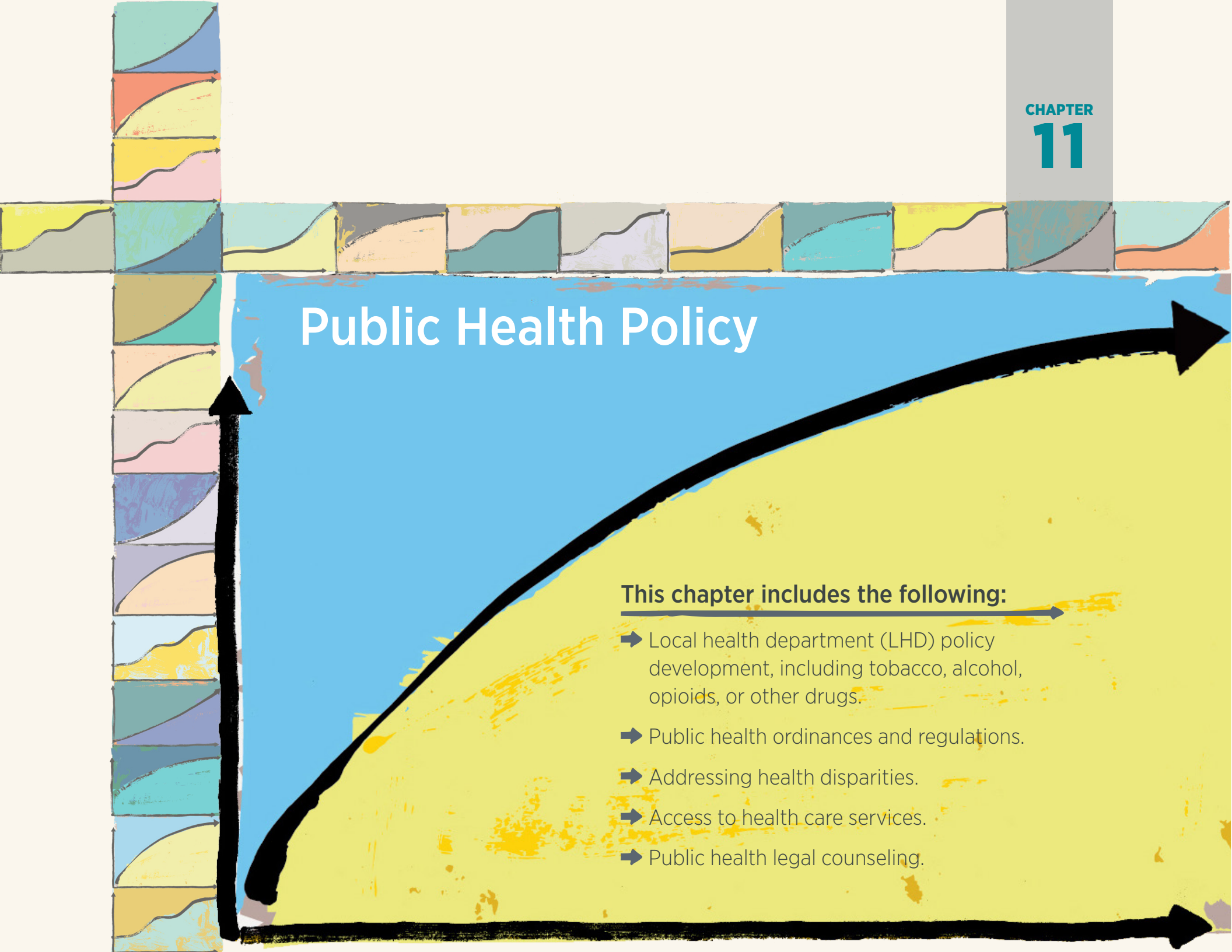
- With the exception of written policies or processes outlining succession planning, large LHDs were more likely to have implemented approaches to retention and career pathways/ladders than small and medium LHDs.
- In particular, large LHDs were nearly twice as likely as small LHDs to have jobs with clearly outlined progression/ pathways.

Career ladders
Career ladders are clearly defined opportunities to move to higher levels of responsibility and pay

Technical note
These statistics include a number of "no activity" and "don't know" responses not being displayed

CHAPTER
11

Public Health Policy



This chapter includes the following:

- Local health department (LHD) policy development, including tobacco, alcohol, opioids, or other drugs.
- Public health ordinances and regulations.
- Addressing health disparities.
- Access to health care services.
- Public health legal counseling.

FIGURE 11.1

Involvement in policy areas in the past two years, by size of population served

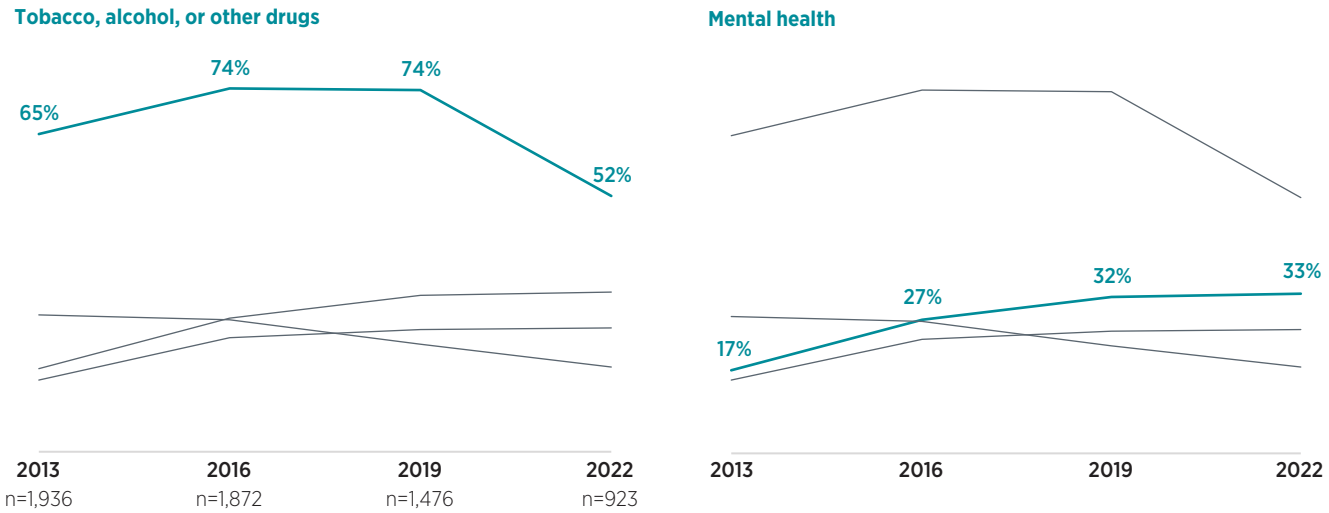
Policy area	All LHDs	Size of population served		
		Small (<50,000)	Medium (50,000–499,999)	Large (500,000+)
COVID-19 Emergency preparedness and response	91%	90%	93%	94%
COVID-19 Infectious disease (e.g., vaccination, mask requirement)	85%	84%	85%	92%
Funding for local public health	61%	55%	69%	81%
Non-COVID-19 Emergency preparedness and response	61%	60%	61%	72%
Non-COVID-19 Infectious disease (e.g., vaccination)	57%	57%	54%	69%
Tobacco, alcohol, opioids, or other drugs	52%	47%	58%	76%
Food safety	45%	42%	48%	60%
Waste, water, or sanitation	38%	38%	38%	48%
Applying health in all policies	37%	33%	41%	63%
Mental health	33%	29%	38%	41%
Applying a health equity lens to internal budgeting practices	30%	22%	39%	68%
Obesity/physical activity	29%	24%	34%	52%
Safe and healthy housing	25%	20%	31%	44%
Injury and violence prevention	22%	17%	27%	47%
Oral health	19%	16%	22%	32%
Funding for access to health care	18%	12%	22%	48%
Reforms related to community policing	15%	8%	24%	45%
Land use planning	12%	10%	15%	21%
Occupational health and safety	10%	10%	10%	17%
Climate change	10%	5%	14%	34%
Planning external resource allocation using an equity lens	5%	3%	6%	15%
Other environment health	32%	30%	33%	45%
Other policy areas	11%	8%	14%	23%
None	5%	6%	3%	1%

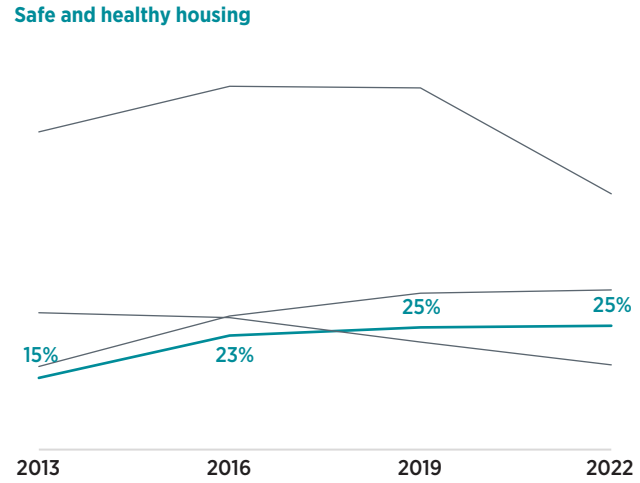
n=923

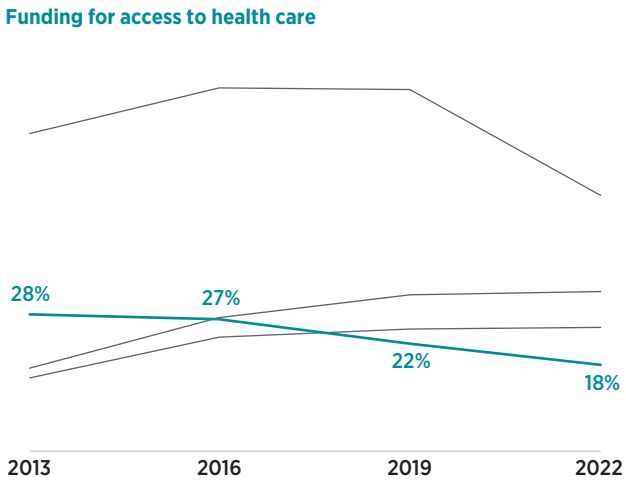
- LHDs were involved in a variety of policy areas in the past two years. LHDs were more likely to be involved in traditional public health policy areas (e.g., tobacco, alcohol, opioids, or other drugs; emergency preparedness and response; infectious disease) than policy areas related to social determinants of health (e.g., safe and healthy housing, funding for access to health care, climate change).
- Large LHDs were more likely to be involved in all policy areas than small LHDs. This difference is greater for areas related to health equity than for other areas. For example, large LHDs were five times more likely than small LHDs to be involved in policy activities related to community policing and resource allocation.

FIGURE 11.2

Involvement, over time, in select policy areas







- Since 2013, a larger proportion of LHDs have been involved in many policy areas. For example, LHDs were nearly twice as likely to be involved in mental health policy activities in 2022 than in 2013.
- However, LHD involvement in some areas has experienced little change more recently. The proportion of LHDs involved in policy activities related to safe and healthy housing has increased overall since 2013 but remained steady in recent years.
- Notably, LHD involvement in policy activities related to funding for access to health care decreased by 10 percentage points since 2013.

FIGURE 11.3

Involvement in policy areas related to tobacco, alcohol, opioids, or other drugs in the past two years, by size of population served

Policy area	All LHDs	Size of population served		
		Small (<50,000)	Medium (50,000–499,999)	Large (500,000+)
Increasing use of medications to prevent drug overdose (e.g., Naloxone, Buprenorphine)	36%	28%	45%	65%
Reducing sale of tobacco to minors	31%	25%	37%	52%
Smoke-free indoor air (e.g., workplace, multi-unit residential)	28%	25%	29%	48%
Regulating e-cigarettes or other electronic smoking devices	25%	21%	30%	41%
Smoke-free outdoor air (e.g., parks, beaches, playgrounds, sporting events)	21%	19%	23%	36%
Increasing access to clean syringes	15%	10%	19%	45%
Reducing exposure to alcohol or tobacco advertising	14%	11%	17%	23%
Diverting certain drug offenders into treatment rather than incarceration	12%	6%	18%	36%
Reducing alcohol or drug impaired driving	11%	10%	13%	15%
Raising cigarette taxes	6%	5%	6%	12%
Raising alcohol taxes	0.3%	0%	0.3%	3%

n=892

- In the past two years, more than one-third of all LHDs were involved in policies to increase the use of medications to prevent drug overdoses.
- Large LHDs were more likely to be involved in these policy areas than small LHDs, especially areas related to drug use. For example, large LHDs were more than four times as likely as small LHDs to be involved in policy activities related to increasing access to clean syringes and diverting certain drug offenders into treatment rather than incarceration.
- A smaller proportion of LHDs were involved in these policy areas compared to 2019 (not shown). In particular, LHDs were much less likely to be involved in smoke-free air policies, regulating e-cigarettes, and reducing the sale of tobacco to minors.

FIGURE 11.4

Involvement in policy areas related to tobacco, alcohol, opioids, or other drugs in the past two years, by urbanization

Policy area	All LHDs	Degree of urbanization	
		Urban	Rural
Increasing use of medications to prevent drug overdose (e.g., naloxone, buprenorphine)	36%	43%	30%
Reducing sale of tobacco to minors	31%	41%	22%
Smoke-free indoor air (e.g., workplace, multi-unit residential)	28%	35%	22%
Regulating e-cigarettes or other electronic smoking devices	25%	35%	17%
Smoke-free outdoor air (e.g., parks, beaches, playgrounds, sporting events)	21%	26%	17%
Increasing access to clean syringes	15%	20%	10%
Reducing exposure to alcohol or tobacco advertising	14%	17%	11%
Diverting certain drug offenders into treatment rather than incarceration	12%	17%	7%
Reducing alcohol or drug impaired driving	11%	13%	10%
Raising cigarette taxes	6%	7%	5%
Raising alcohol taxes	0.3%	1%	0%

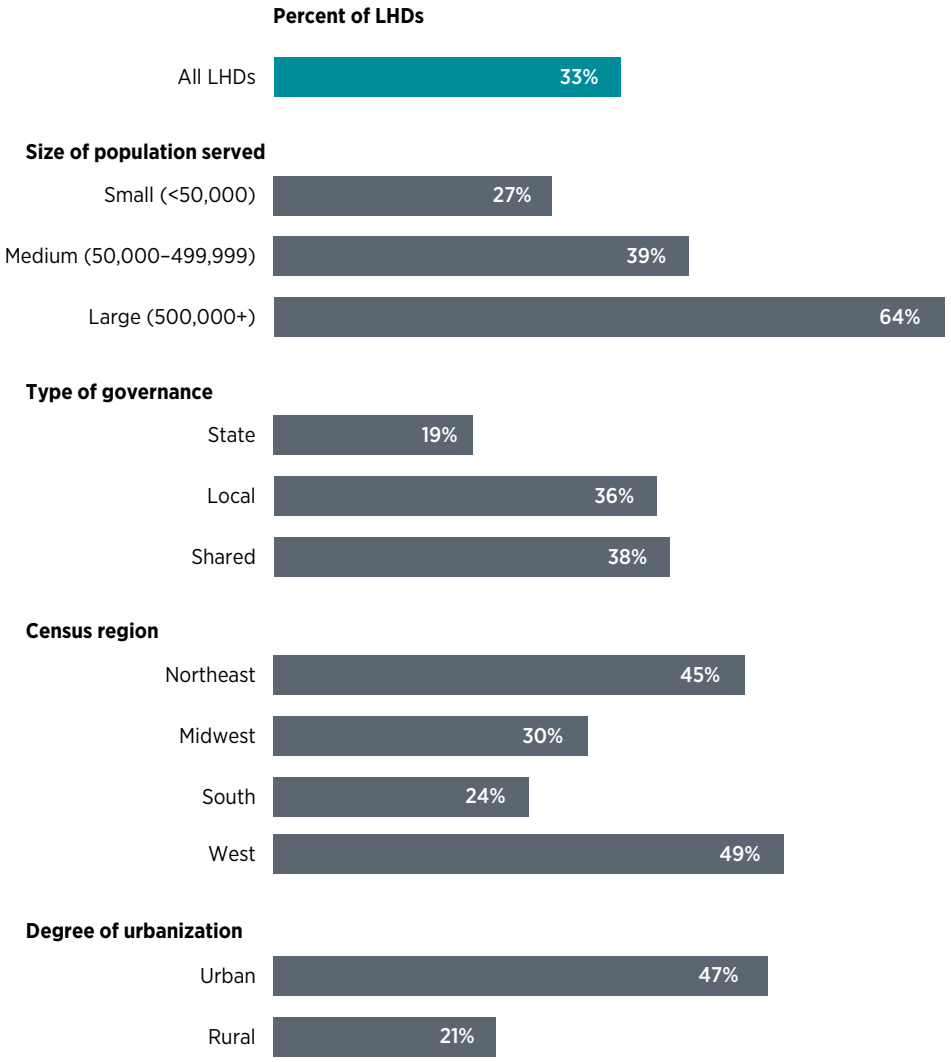
n=892

- A greater proportion of LHDs in urban than rural jurisdictions were involved in these policy areas. In particular, LHDs in urban areas were much more likely to be involved in policies to reduce the sale of tobacco to minors and regulating e-cigarette or other electronic smoking devices.
- Regardless of the jurisdiction's degree of urbanization, approximately the same proportion of LHDs were involved in raising alcohol and cigarette taxes.

Technical note
A new schema for categorizing urban and rural LHDs was used for 2022 estimates. "Urban" refers to urban-majority areas, while "rural" refers to rural-majority areas. These data may not be comparable to previous year estimates. Refer to the subgroup analysis details on page 17 for more about the urban/rural categorization methodology.

FIGURE 11.5

Involvement in developing new or revising existing ordinances in the past two years, by size of population served, type of governance, and Census region



n=923

- One-third of LHDs reported that a new local public health ordinance or regulation was adopted or substantially revised in their jurisdiction during the past two years.
- Large LHDs were more likely to report new or substantially revised ordinances or regulations than medium or small LHDs.
- LHDs governed by state authorities were less likely to report new or revised ordinances or regulations than LHDs governed by local authorities or LHDs with shared governance.
- LHDs in the West and in the Northeast were more likely to report new or revised ordinances or regulations than LHDs in other regions.
- LHDs in urban areas were more likely to report new or revised ordinances than LHDs in rural areas.

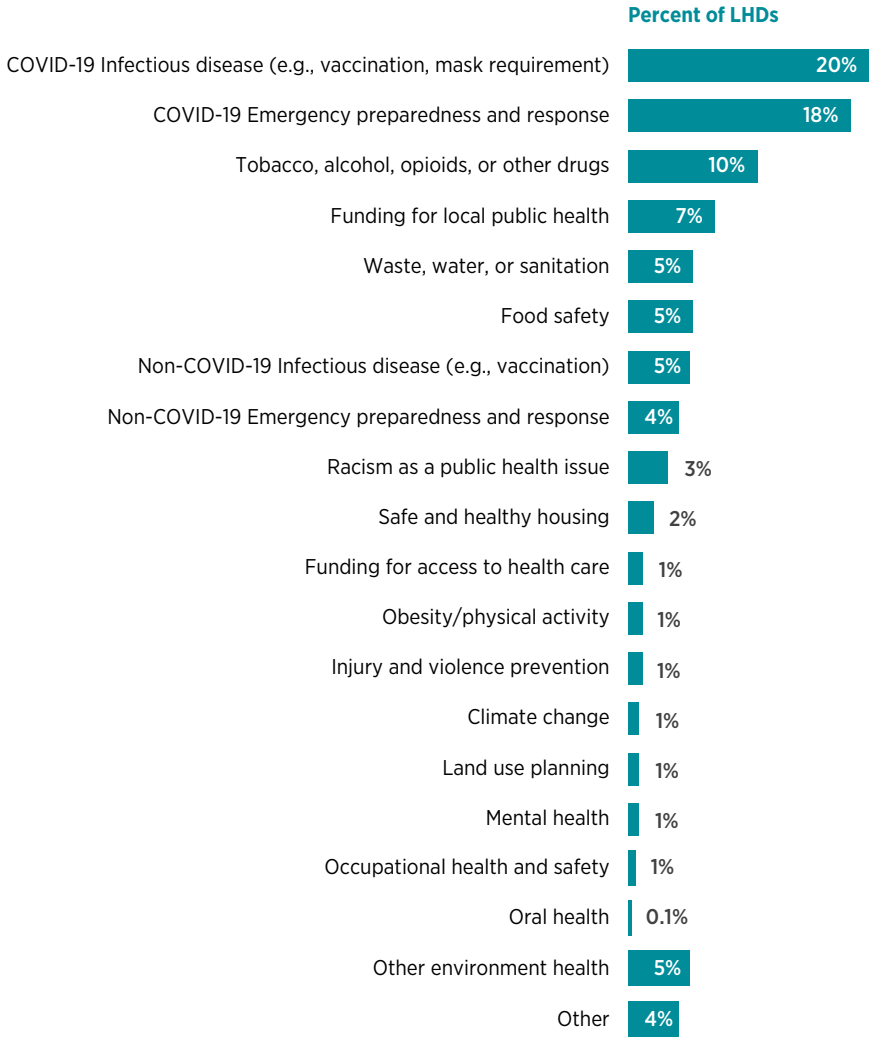
Technical notes

A new schema for categorizing urban and rural LHDs was used for 2022 estimates. "Urban" refers to urban-majority areas, while "rural" refers to rural-majority areas. These data may not be comparable to previous year estimates. Refer to the subgroup analysis details on page 17 for more about the urban/rural categorization methodology.

"Don't know"was added as a response option for this question in 2022.

FIGURE 11.6

Topic areas of new or revised ordinances in the past two years



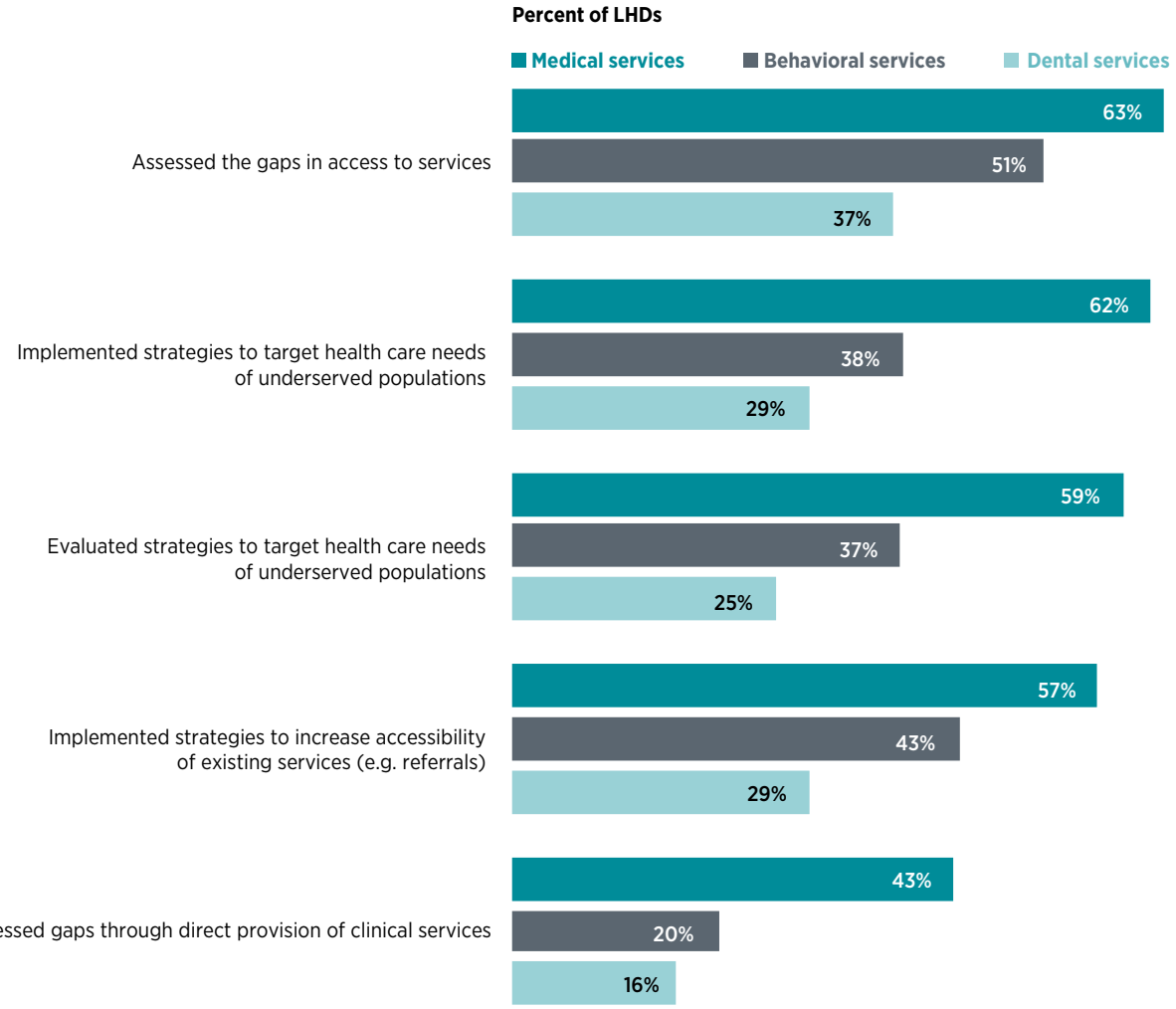
n=847

- Approximately one in five LHDs created new or substantially revised ordinances for infectious disease or emergency preparedness related to COVID-19 in the past two years.
- Ten percent of LHDs reported new or revised ordinances related to tobacco, alcohol, opioids, or other drugs—a decrease of 17 percentage points from 2019 (not shown).

Technical note
N excludes LHDs that selected "don't know" for both related questions

FIGURE 11.7

Engagement in assuring access to health care services in the past year

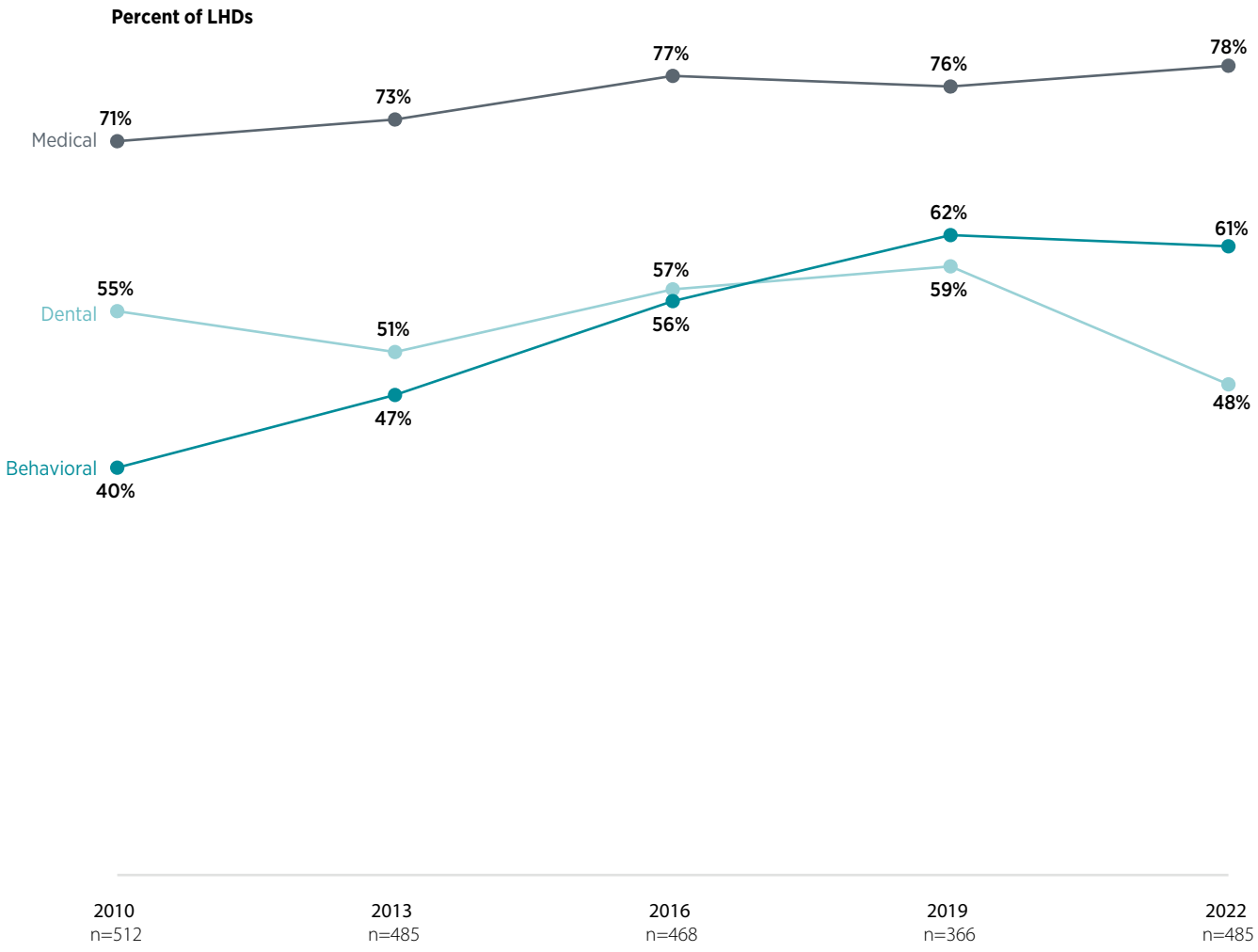


n=484–485

➡ LHDs were more likely to assure access to medical services than dental or behavioral health services. For example, 63% of LHDs assessed gaps in access to medical services, while 51% assessed gaps in access to behavioral services and 37% to dental services.

FIGURE 11.8

Engagement in assuring access to health care services, over time



- The proportion of LHDs engaged in assuring access to behavioral health care services increased from 40% in 2010 to 61% in 2022.
- On the other hand, the proportion of LHDs engaged in assuring access to dental services decreased slightly from 55% in 2010 to 48% in 2022.

FIGURE 11.9

Services provided by LHD legal counsel, by size of population served

	All LHDs	Size of population served		
		Small (<50,000)	Medium (50,000–499,999)	Large (500,000+)
Represents LHD in all legal matters pertaining to the agency's activities	60%	51%	74%	73%
Provides formal opinions on laws, statutes, regulations, enforcement policies and enforcement actions for use in possible litigation or other legal actions involving the LHD	56%	48%	68%	70%
Informally advises LHD on the legality/constitutionality of various laws, statutes, regulations, enforcement policies and enforcement actions	55%	49%	62%	74%
Assists in drafting the LHD's laws, statutes, regulations, enforcement policies and enforcement actions	49%	41%	61%	70%
Determines which entities to litigate or prosecute for violation of the LHD's regulatory responsibilities to uphold statutes, regulations, or ordinances	35%	30%	43%	54%
Participates in programmatic activities, including but not limited to the identification of public health interventions based on law and policy	20%	17%	21%	42%
None of the above	3%	4%	2%	0%
My LHD does not have a legal counsel	19%	24%	11%	7%

n=910

- Approximately three in five LHDs reported that their legal counsel represents their organization in all legal matters pertaining to its activities.
- Less than one in five LHDs did not have a legal counsel. While 24% of small LHDs did not have a legal counsel, only 11% of medium and 7% of large LHDs reported the same.

CHAPTER
12

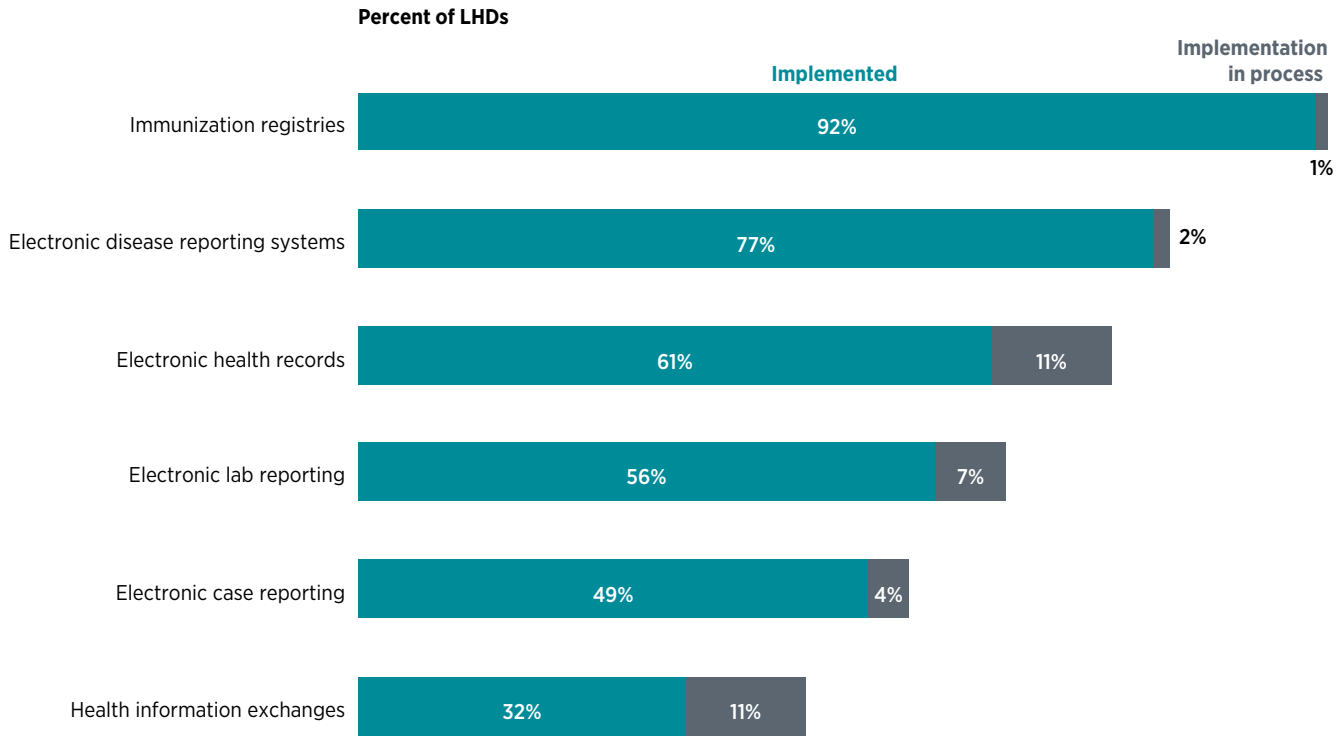
Informatics

This chapter includes the following:

- Level of implementation in information technology systems at local health departments (LHDs).
- Use of communication channels for general announcements or emergency response communications.

FIGURE 12.1

Current level of activity in information technology systems



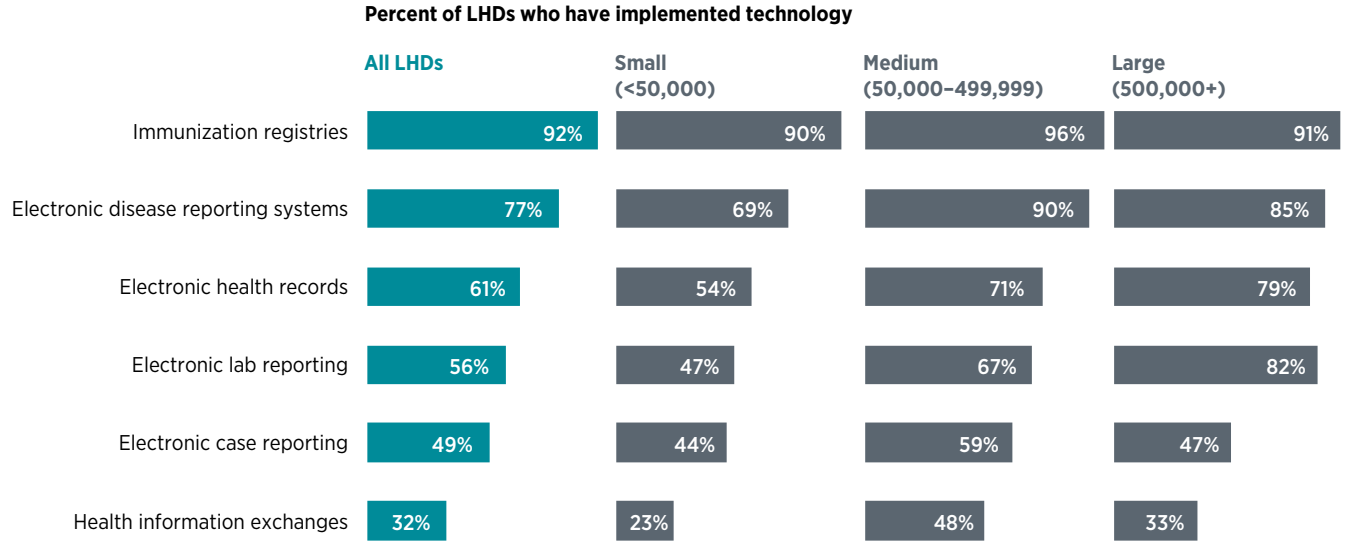
n=429–434

- Most LHDs use immunization registries and electronic disease reporting systems; LHDs were less likely to use electronic case reporting and health information exchanges.
- In addition, relatively large proportions of LHDs were in the process of implementing electronic health records and health information exchanges, when compared to other systems.

Technical note
These statistics include a number of "no activity" and "don't know" responses not displayed.

FIGURE 12.2

Current implementation in information technology systems by size of population served

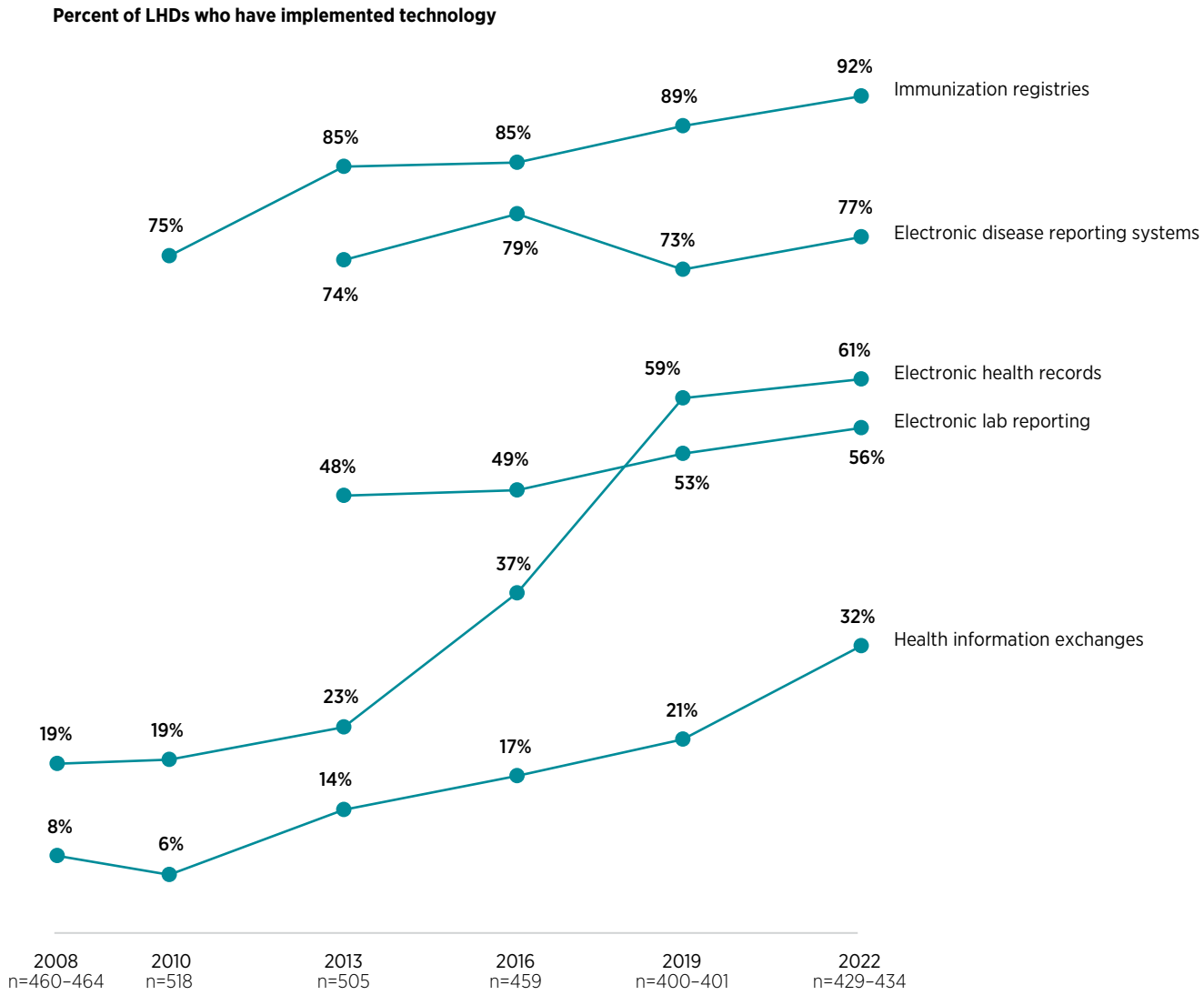


n=429–434

- With the exception of electronic health records and electronic lab reporting, medium LHDs were more likely to have implemented these technology systems than large or small LHDs.
- The differences in implementation between LHDs serving small and large jurisdictions were greatest for electronic health records and electronic lab reporting.

FIGURE 12.3

Implementation of information technology systems, over time

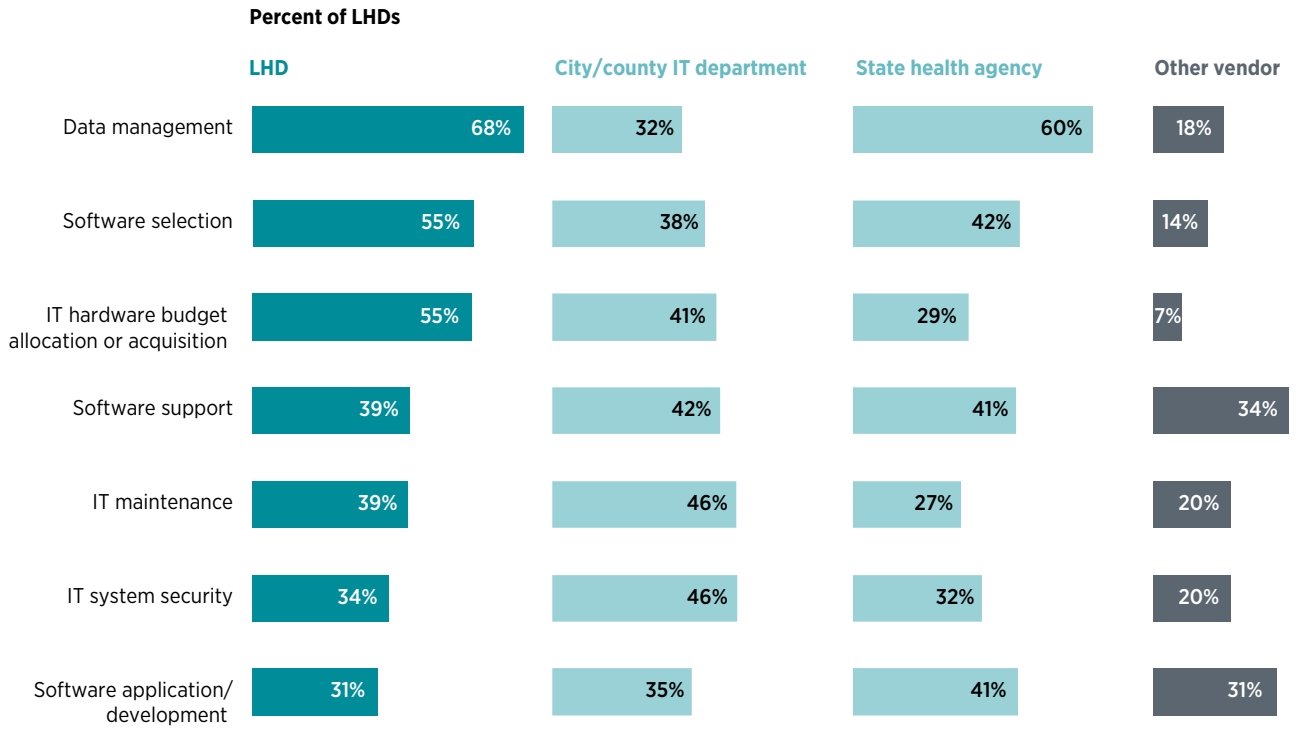


- For these information technology systems, implementation has increased since 2008.
- Notably, implementation of electronic health records increased by 42 percentage points between 2008 and 2022.
- Implementation of immunization registries and electronic lab reporting have shown relatively little change since 2008, although increasing overall.

Technical note
Missing trend data is due to items not being included in the Profile questionnaire for the specified year.

FIGURE 12.4

Organizations involved in information management for LHDs



n=429–430

- Several organizations were involved in information technology (IT) management for LHDs. More than half of LHDs perform their own data management, software selection, and IT hardware budget allocation or acquisition.
- The city or county IT department most commonly performs functions related to LHD IT maintenance and system security.
- For many LHDs, the state health agency is also involved in data management.

Technical note
These statistics include a number of "no activity" and "don't know" responses not displayed.

FIGURE 12.5

Use of communication channels for general or emergency response communications

Communication channel	Any use	Use for general announcements	Use for emergency response
Facebook	88%	86%	71%
LHD website	84%	82%	63%
Print media	84%	83%	49%
E-mail	79%	75%	50%
Health Alert Network	60%	36%	52%
Broadcast media	59%	54%	46%
Text messaging	55%	45%	31%
Other social media (e.g., YouTube, Instagram, Nextdoor)	43%	42%	28%
Automated phone calling	38%	15%	31%
X (formerly Twitter)	34%	33%	26%
Fax broadcast/fax blast	29%	22%	22%
Hotline or call center	29%	15%	27%
LinkedIn	14%	13%	2%
Custom app for phone or tablet	11%	8%	7%
Blogs	7%	6%	2%

n=424–432

- LHDs use a variety of information technology channels for communicating with the public. Facebook, LHD websites, print media, and e-mail were most commonly used overall and were more likely to be used for general announcements than for emergency response. On the other hand, LHDs were more likely to use the Health Alert Network, automated phone calling, and a hotline or call center for emergency communications than for general announcements.
- Few LHDs use LinkedIn, a custom application for phones or tablets, or blogs to communicate with the public.

FIGURE 12.6

Any use of communication channels, by size of population served

Communication channel	All LHDs	Size of population served		
		Small (<50,000)	Medium (50,000–499,999)	Large (500,000+)
Facebook	88%	85%	92%	94%
LHD website	84%	76%	97%	94%
Print media	84%	80%	88%	97%
E-mail	79%	72%	90%	94%
Health Alert Network	60%	52%	70%	94%
Broadcast media	59%	45%	80%	85%
Text messaging	55%	51%	61%	64%
Other social media (e.g., YouTube, Instagram, Nextdoor)	43%	27%	63%	94%
Automated phone calling	38%	34%	43%	42%
X (formerly Twitter)	34%	18%	53%	94%
Fax broadcast/fax blast	29%	21%	42%	42%
Hotline or call center	29%	14%	48%	88%
LinkedIn	14%	7%	19%	55%
Custom app for phone or tablet	11%	9%	13%	18%
Blogs	7%	3%	10%	21%

n=432

- Large LHDs were more likely to use the communication channels listed than small LHDs. In particular, a much greater proportion of large LHDs use LinkedIn, other social media channels, and a hotline or call center to communicate with the public.
- Conversely, approximately the same proportion of LHDs use Facebook and automated phone calling, regardless of the size of the population they serve.

FIGURE 12.7

Any use of communication channels, by type of governance

Communication channel	All LHDs	Type of governance		
		State	Local	Shared
Facebook	88%	58%	95%	100%
LHD website	84%	61%	89%	100%
Print media	84%	77%	85%	95%
E-mail	79%	61%	84%	80%
Health Alert Network	60%	64%	59%	64%
Broadcast media	59%	52%	59%	91%
Text messaging	55%	50%	57%	47%
Other social media (e.g., YouTube, Instagram, Nextdoor)	43%	24%	45%	76%
Automated phone calling	38%	21%	42%	46%
X (formerly Twitter)	34%	23%	35%	62%
Fax broadcast/fax blast	29%	12%	33%	39%
Hotline or call center	29%	19%	30%	59%
LinkedIn	14%	16%	12%	27%
Custom app for phone or tablet	11%	11%	11%	5%
Blogs	7%	4%	7%	15%

n=432

- State-governed LHDs were less likely to use many of the communication channels listed than LHDs with local or shared governance.
- LHDs with shared governance were much more likely to use broadcast media, X (formerly Twitter), other social media, and a hotline or call center than LHDs with state or local governance.

FIGURE 12.8

Any use of communication channels, by degree of urbanization

Communication channel	All LHDs	Degree of urbanization	
		Urban	Rural
Facebook	88%	92%	85%
LHD website	84%	92%	77%
Print media	84%	86%	82%
E-mail	79%	89%	71%
Health Alert Network	60%	62%	58%
Broadcast media	59%	69%	50%
Text messaging	55%	59%	52%
Other social media (e.g., YouTube, Instagram, Nextdoor)	43%	59%	28%
Automated phone calling	38%	44%	31%
X (formerly Twitter)	34%	49%	21%
Fax broadcast/fax blast	29%	36%	24%
Hotline or call center	29%	43%	17%
LinkedIn	14%	20%	8%
Custom app for phone or tablet	11%	11%	10%
Blogs	7%	13%	1%

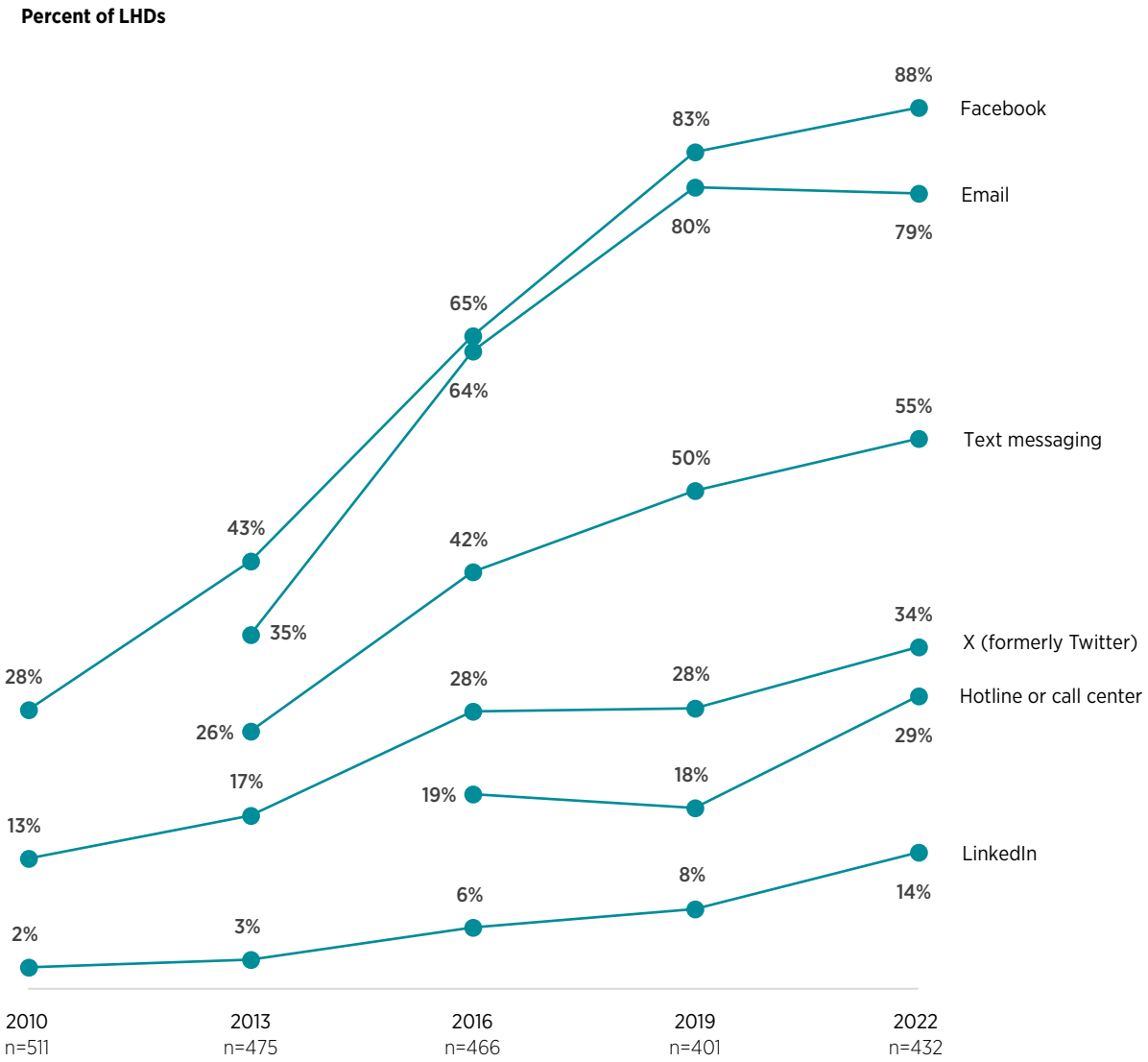
n=432

➡ LHDs in urban areas were more likely to use the communication channels listed. In particular, a much greater proportion of LHDs in urban areas use X (formerly Twitter), other social media, and a hotline or call center to communicate with the public.

Technical note
A new schema for categorizing urban and rural LHDs was used for 2022 estimates. "Urban" refers to urban-majority areas, while "rural" refers to rural-majority areas. These data may not be comparable to previous year estimates. Refer to the subgroup analysis details on page 17 for more about the urban/rural categorization methodology.

FIGURE 12.9

Use of select communication channels, over time



➡ Use of newer technology to communicate with the public has increased since 2010. For instance, LHDs were much more likely to use Facebook (28% in 2010 and 88% in 2022). Similarly, use of X (formerly Twitter) increased from 13% in 2010 to 34% in 2022.

Technical note
Missing trend data is due to items not being included in the Profile questionnaire for the specified year.

CHAPTER
13

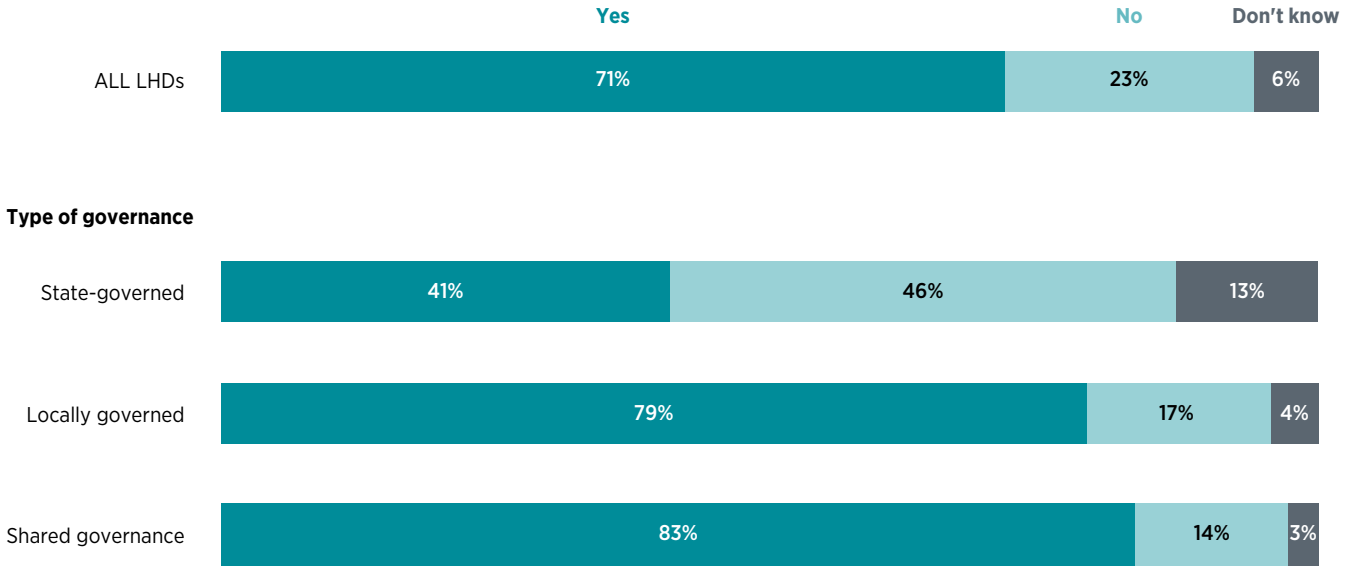
Harassment against Local Health Departments

This chapter includes the following:

- Experiences of harassment among local health departments (LHDs), agency leadership, or other agency personnel during COVID-19.
- Types of harassment LHDs experienced during COVID-19.
- Protections received by LHDs in response to harassment.
- Reassignments and/or firings of personnel due to conflicts between public and political leaders.

FIGURE 13.1

Experiences of harassment among LHDs, agency leadership, or other agency personnel in response to COVID-19 since March 2020

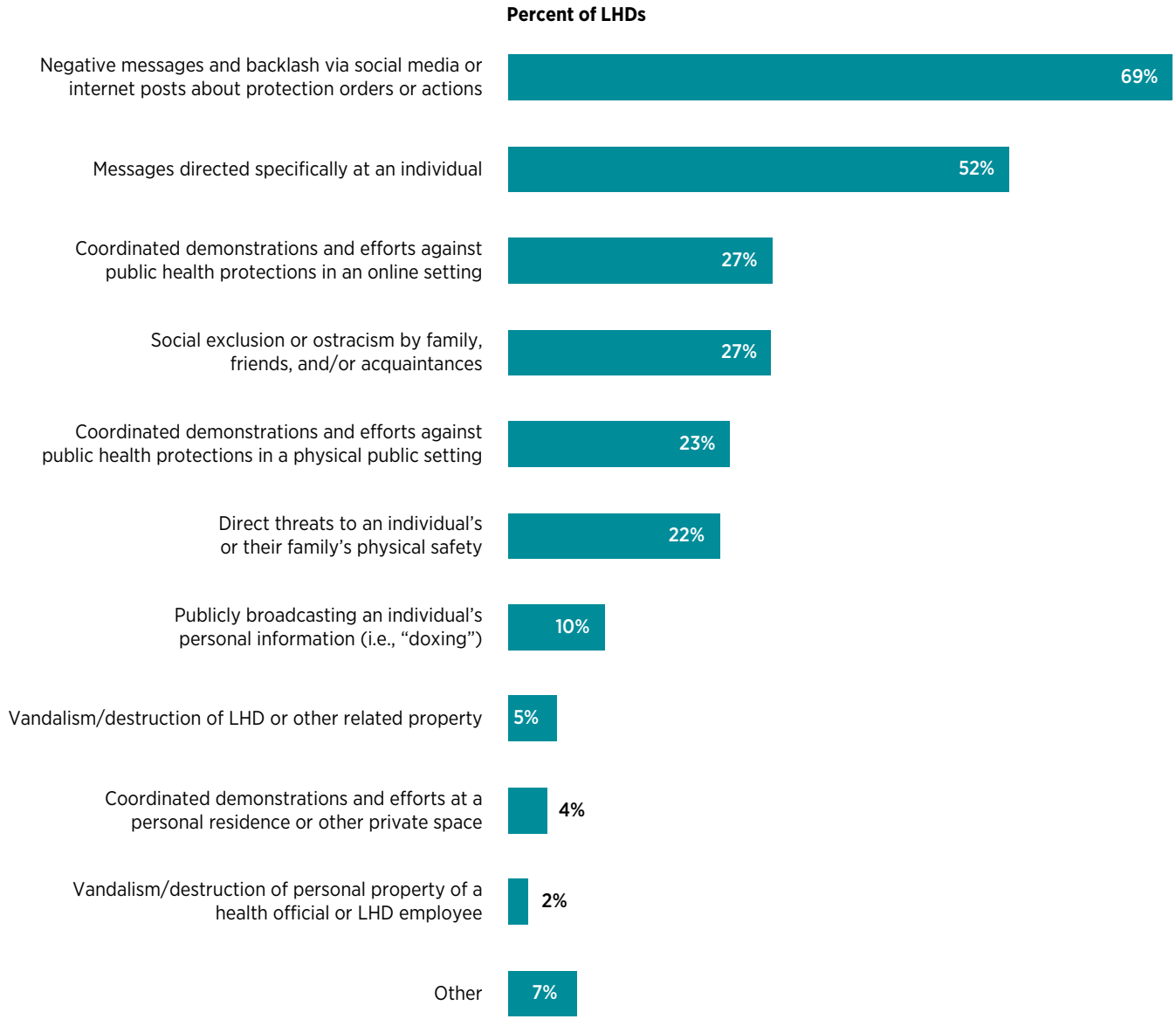


n=925

- Seven in 10 LHDs reported that their agency, leadership, or personnel experienced harassment since March 2020 because of COVID-19 response activities.
- Experiences of harassment varied by type of governance. Specifically, state-governed LHDs were less likely to report experiencing harassment—with 41% reporting instances compared to approximately 80% of agencies with local or shared governance.

FIGURE 13.2

Types of harassment LHDs experienced during COVID-19

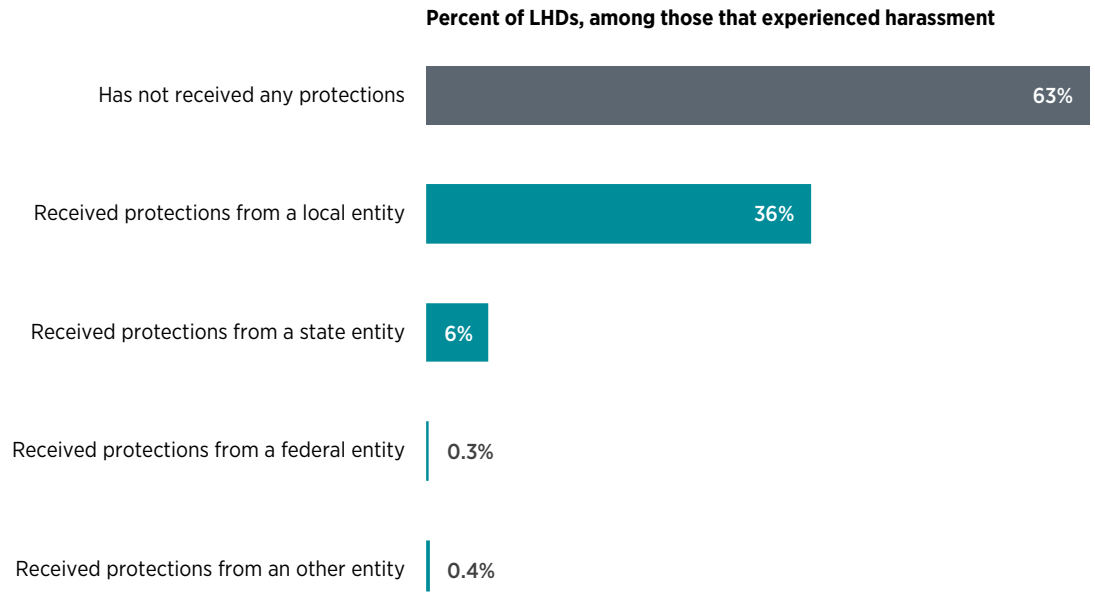


n=869

- The most common form of harassment targeting agencies, leadership, or other personnel was negative messages and backlash via social media—with 69% of LHDs reporting one of these groups being targeted in this way.
- A higher proportion of large LHDs reported experiences of direct messages and threats to an individual, as well as instances of public broadcasting of an individual's personal information, compared to small and medium LHDs (not shown).

FIGURE 13.3

Protections received by LHDs in response to harassment

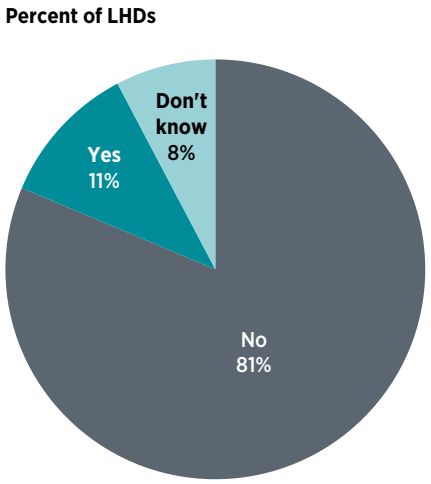


n=643

- Of LHDs reporting instances of harassment, 63% did not receive any protections. The most common source of protections was local entities.
- Notably, almost no LHDs experiencing harassment reported receiving protections from a federal entity.

FIGURE 13.4

Reassignments and/or firings of personnel due to conflicts between public and political leaders

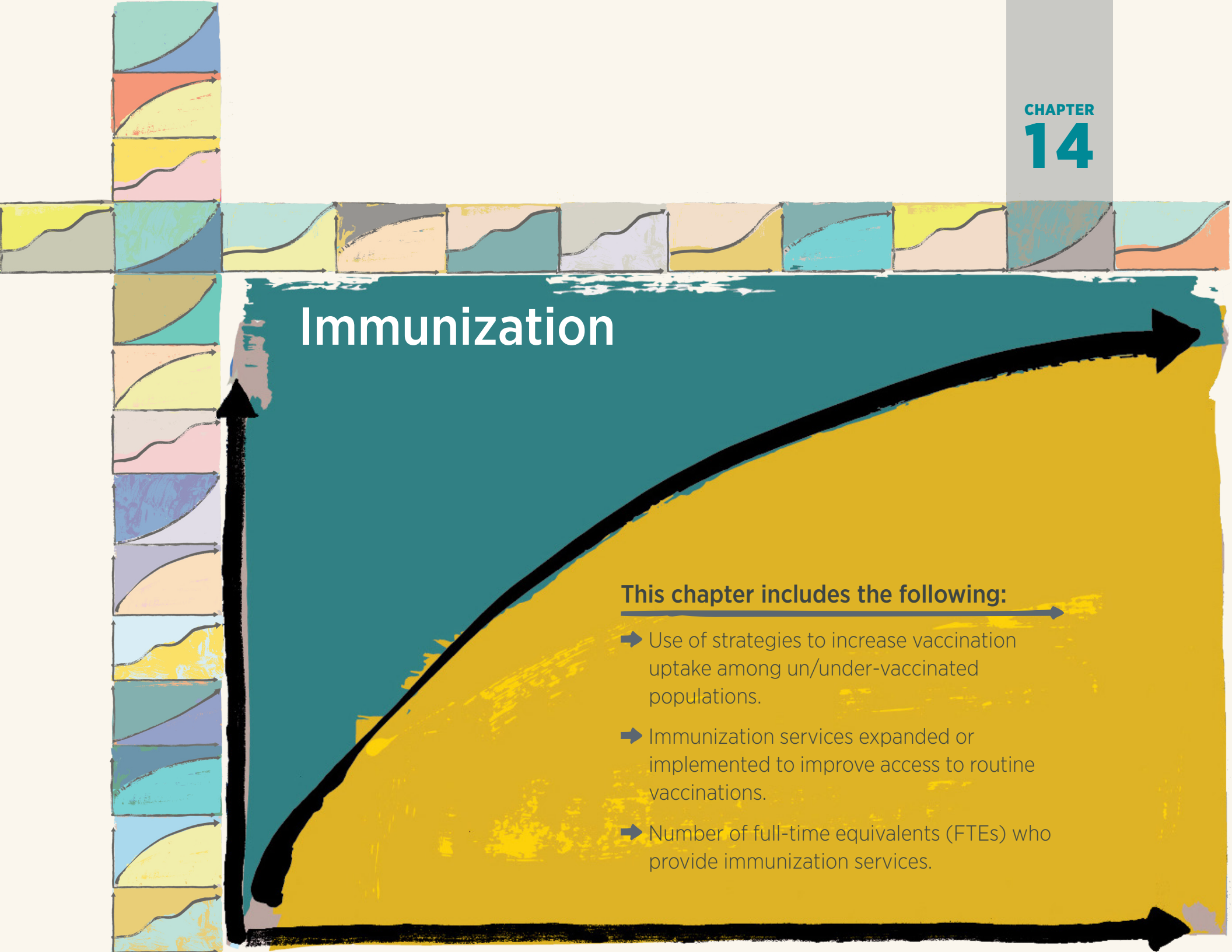


n=922

➡ Eight in 10 LHDs reported that agency leaders or other personnel did not resign, were not reassigned, or were not fired because of conflicts between public and political figures or political pressure due to covid response. However, 11% of LHDs did lose personnel due to those factors.

CHAPTER
14

Immunization

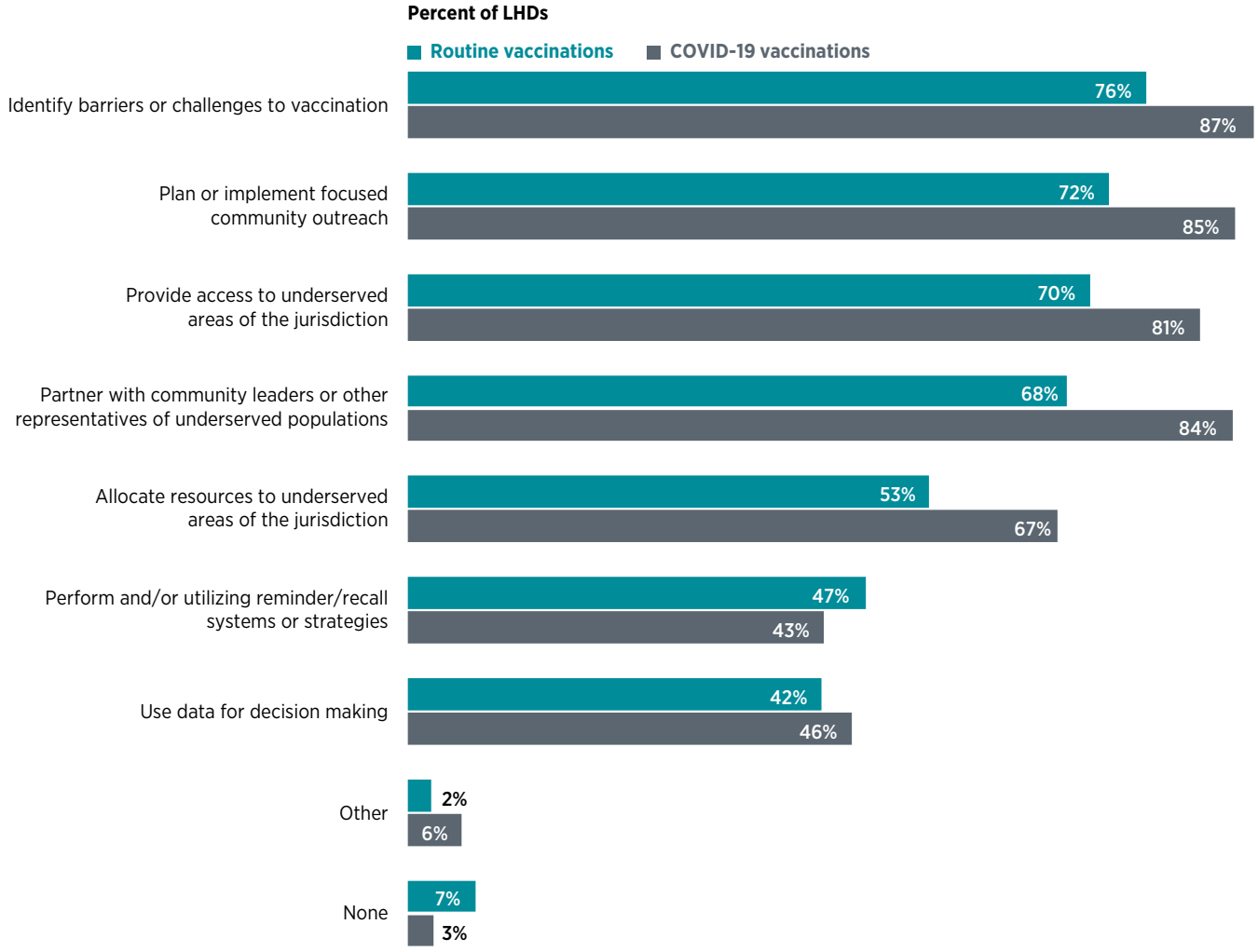


This chapter includes the following:

- Use of strategies to increase vaccination uptake among un/under-vaccinated populations.
- Immunization services expanded or implemented to improve access to routine vaccinations.
- Number of full-time equivalents (FTEs) who provide immunization services.

FIGURE 14.1

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



n(routine)=425

n(COVID)=427

- More than three in four LHDs made efforts to identify barriers to vaccination as a strategy for improving routine vaccination uptake among un/under vaccinated populations in their communities.
- With the exception of performing and/or utilizing reminder/recall systems, LHDs were more likely to use strategies to increase COVID-19 vaccination uptake than routine vaccination uptake.
- LHDs also frequently cited focused community outreach, providing vaccine access to underserved areas, and partnering with community leaders in underserved populations to increase vaccination uptake.

FIGURE 14.2

Use of strategies to increase routine vaccination uptake among un/under-vaccinated populations, by size of population served

Strategies	All LHDs	Size of population served		
		Small (<50,000)	Medium (50,000–499,999)	Large (500,000+)
Identify barriers or challenges to vaccination	76%	69%	84%	93%
Plan or implement focused community outreach	72%	64%	81%	96%
Provide access to underserved areas of the jurisdiction	70%	65%	75%	90%
Partner with community leaders or other representatives of underserved populations	68%	61%	76%	90%
Allocate resources to underserved areas of the jurisdiction	53%	46%	60%	86%
Perform and/or utilizing reminder/recall systems or strategies	47%	44%	50%	53%
Use data for decision making	42%	32%	55%	83%
Other	2%	2%	1%	10%
None	7%	8%	6%	0%

n=425

➡ Large LHDs were more likely to use strategies to increase routine vaccination uptake than small and medium LHDs. In particular, 83% of large LHDs used data for decision making relevant to vaccine uptake improvement, compared to only 32% of small LHDs.

FIGURE 14.3

Use of strategies to increase COVID-19 vaccination uptake among un/under-vaccinated populations, by size of population served

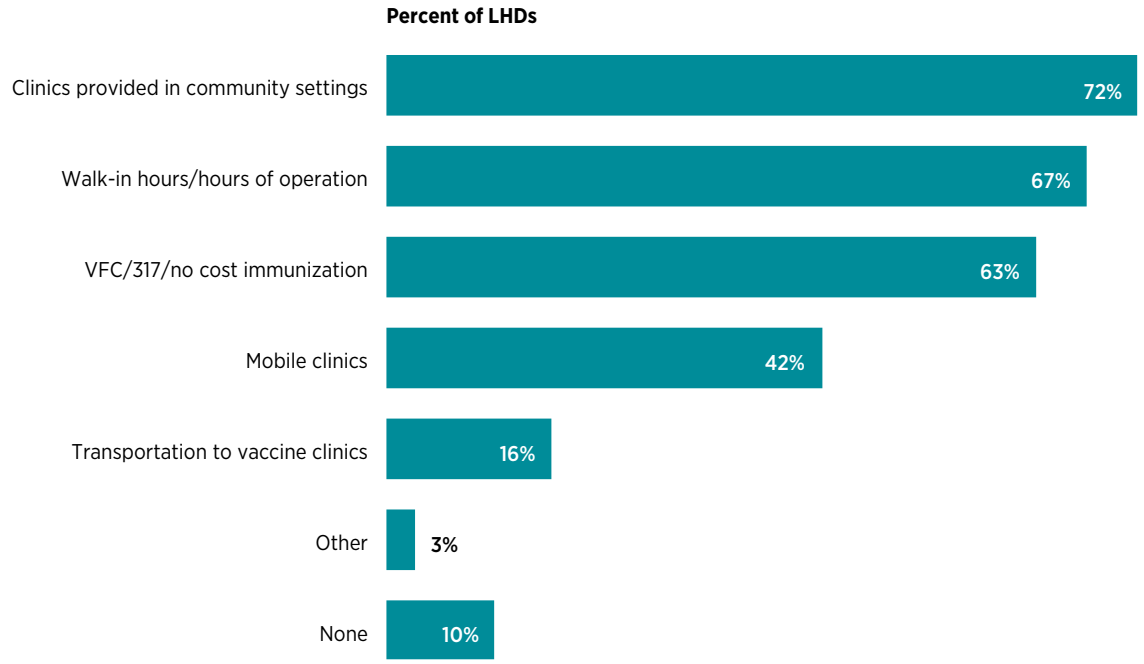
Strategies	All LHDs	Size of population served		
		Small (<50,000)	Medium (50,000–499,999)	Large (500,000+)
Identify barriers or challenges to vaccination	87%	83%	92%	100%
Plan or implement focused community outreach	85%	78%	94%	100%
Provide access to underserved areas of the jurisdiction	81%	74%	91%	97%
Partner with community leaders or other representatives of underserved populations	84%	78%	95%	94%
Allocate resources to underserved areas of the jurisdiction	67%	56%	81%	97%
Use data for decision making	46%	32%	62%	94%
Perform and/or utilizing reminder/recall systems or strategies	43%	37%	48%	64%
Other	6%	4%	7%	16%
None	3%	4%	1%	0%

n=427

- Regardless of population size served, nearly all LHDs identified barriers or challenges to COVID-19 vaccination among un/under-vaccinated populations.
- However, large and medium LHDs were more likely than small LHDs to address barriers or challenges through focused community outreach, providing access to underserved areas, partnering with community leaders, and allocating resources.

FIGURE 14.4

Immunization services expanded or implemented to improve access to routine vaccinations

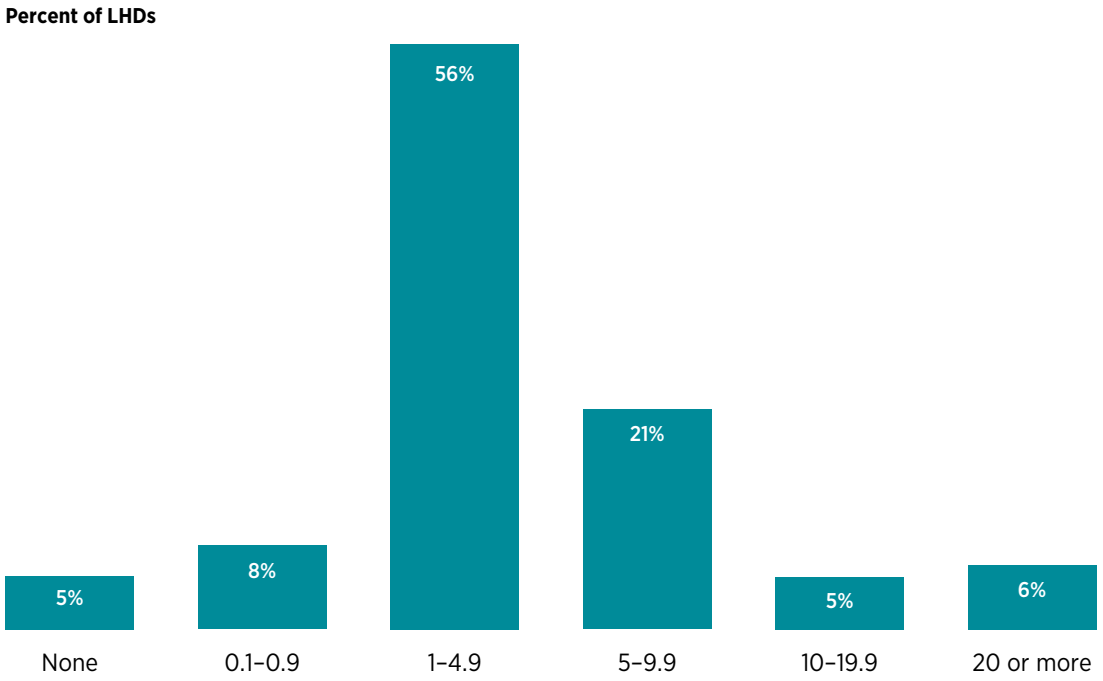


n=425

- LHDs offer a variety of immunization services to improve access to routine vaccinations. The most commonly expanded or implemented services were clinics in community settings, walk-in hours/hours of operation, and no-cost immunizations.
- Only one in 10 LHDs did not expand or implement services to improve access to routine vaccinations.

FIGURE 14.5

Number of full-time equivalents (FTEs) who provide routine immunization services

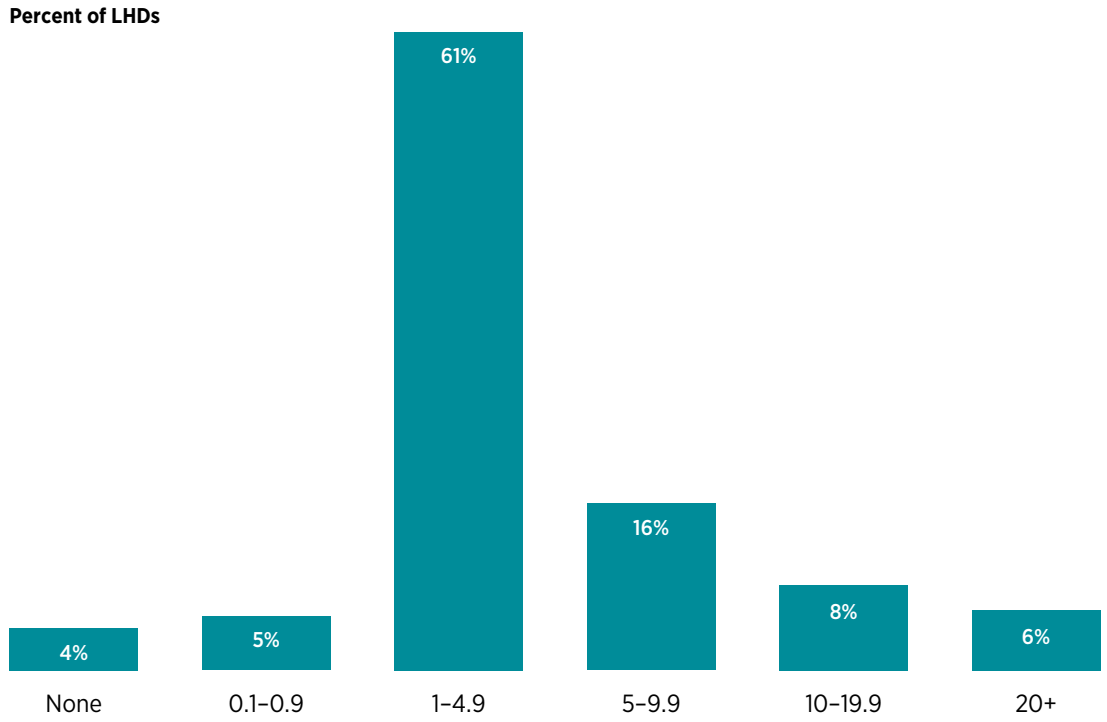


n=332

- Sixty-nine percent of LHDs employed fewer than five FTEs who provided routine immunization services, including 5% that did not employ any FTEs.
- Only 11% of LHDs employed 10 or more FTEs to provide routine immunization services.

FIGURE 14.6

Number of full-time equivalents (FTEs) who conduct vaccine preventable disease (VPD) investigations, outbreak containment, or surveillance activities



n=343

- Seventy percent of LHDs employed fewer than five FTEs who conducted VPD investigations, outbreak containment, or surveillance activities. This included 4% that did not employ any FTEs.
- Only 14% of LHDs employed 10 or more FTEs to conduct VPD investigations, outbreak containment, or surveillance activities.

FIGURE 14.7

Number of full-time equivalents (FTEs) who provide or conduct immunization-related services, by type of employee

Number of FTEs	Provide routine immunization services		Conduct VPD investigations, outbreak containment, or surveillance activities	
	Regular staff (n=329)	Contractual/seasonal (n=267)	Regular staff (n=340)	Contractual/seasonal (n=267)
None	6%	64%	5%	62%
0.1–0.9	7%	9%	5%	6%
1–4.9	61%	20%	67%	20%
5–9.9	18%	3%	15%	4%
10–19.9	3%	2%	6%	4%
20 or more	4%	2%	2%	4%

➡ LHDs were more likely to report employing regular staff than contractual or seasonal staff for immunization-related activities. Approximately 60% of LHDs did not have any contractual or seasonal staff, while only 5% did not have regular staff.