2024 Preparedness Profile Study

NACCHO℠
National Association of County & City Health Officials

Acknowledgements

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Suggested citation
Garofalini, C., Perkins, K., Patel, K., Zavala, E., Hess, B., Pryor, J., Joseph, J., & Biesiadecki, L. (2026). 2024 Preparedness Profile Study. National Association of County and City Health Officials. Washington, DC. https://www.naccho.org/prepprofile

This publication was supported by grant #6 NU38PW000037-01-01 awarded to the National Association of County and City Health Officials and funded by the Centers for Disease Control and Prevention. The contents of this publication are solely the responsibility of the authors and do not necessarily represent the official views of the Centers for Disease Control and Prevention or the U.S. Department of Health and Human Services.

Table of Contents

Introduction

This chapter includes:

- Background and purpose for the 2024 Preparedness Profile Study
- Sampling, weighting, and other survey methods

Background

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

The importance of public health preparedness in enabling local health departments to respond quickly to emerging threats and effectively protect the health and safety of their communities has become increasingly evident. LHDs play a critical role in mobilizing public health actions to prevent the spread of infectious diseases, safeguard community well-being, and maintain essential public health services during emergencies.

Since 2015, the National Association of County and City Health Officials (NACCHO) has conducted the Preparedness Profile study every few years to provide a foundation for future public health preparedness initiatives.

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

Study population
Local health departments are 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 such agencies or units in the United States (U.S.) that meet this definition of an LHD. For the purposes of surveying, NACCHO utilizes a methodology to account for the most unique individuals in the U.S. at the level closest to the local level without "double counting" individuals. Some states have a public health system structure that includes both regional and local offices of the state health agency. In those states, the state health agency chooses to respond to the survey at either the regional or local level, but not at both levels.

Sampling
NACCHO used a database of LHDs based on prior National Profile of Local Health Departments and Forces of Change studies and consults with state health agencies and state associations of local health officials to identify LHDs for inclusion in the study population. For the 2024 Preparedness Profile, a stratified random sample of 1,200 LHDs were invited to complete the survey, with strata defined by seven categories of population size served by LHDs. Rhode Island was excluded from the study because the state has no sub-state public health units.

Methods

Survey distribution
The assessment was distributed online via Qualtrics Survey Software™ to individuals identified by LHDs as having a significant responsibility for preparedness planning and response activities. Respondents included preparedness coordinators and top executive staff. Responses were collected between October and December 2024.

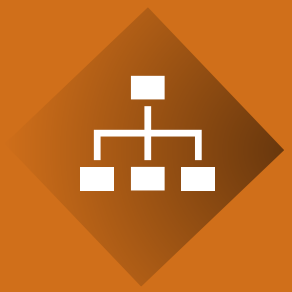
Survey weighting and national estimates
There were 486 responses included for analysis (41% response rate). Statistics were computed using post-stratification weighting with finite population correction. Therefore, results can be interpreted as nationally representative estimates based on seven category size of population served. Some detail may be lost in the figures within this report due to rounding.

Reporting
This report provides findings from the 2024 Preparedness Profile on a multitude of important topics in local preparedness, including administrative preparedness, training for staff, partnerships with local entities and communities, and at-risk and vulnerable populations served in preparedness planning.

For this report, small LHDs serve populations of less than 50,000 people. Medium LHDs serve populations of 50,000 to 499,999 people. Large LHDs serve populations of 500,000 people or more.

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

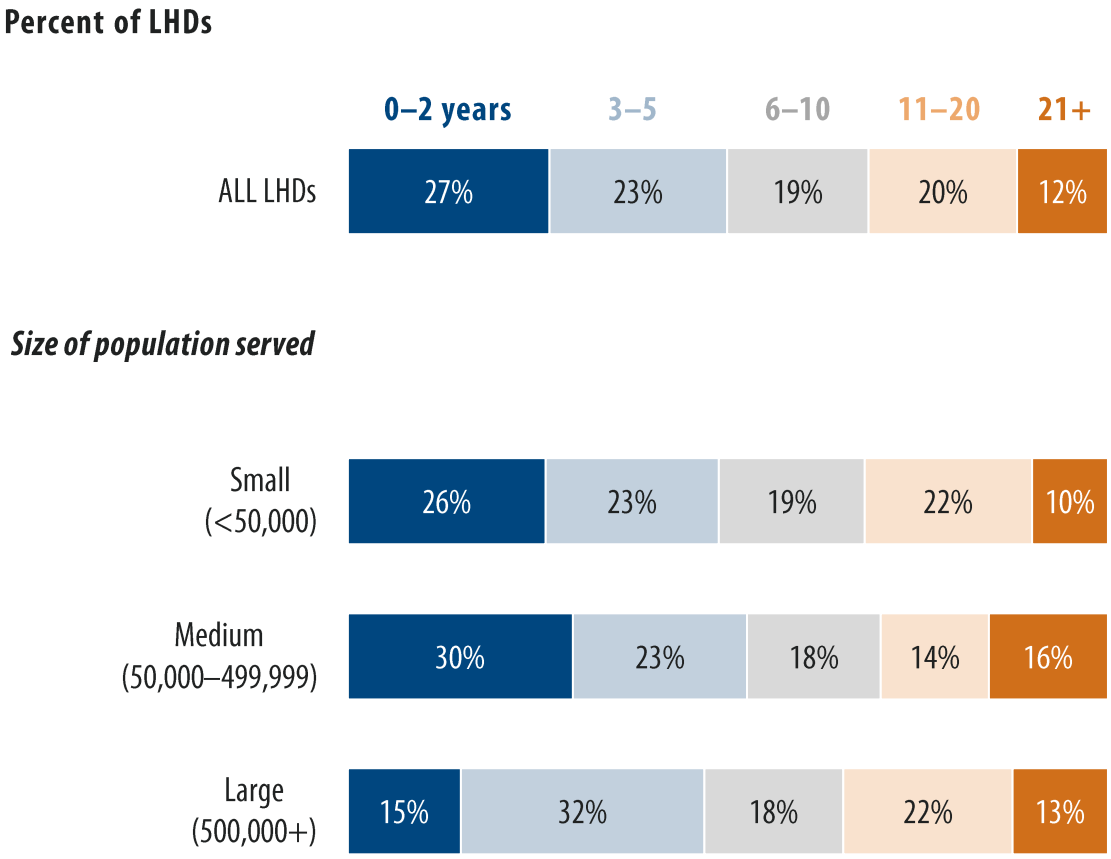
Preparedness Workforce



This chapter includes:

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

Years of experience as a preparedness coordinator or equivalent, by population size served

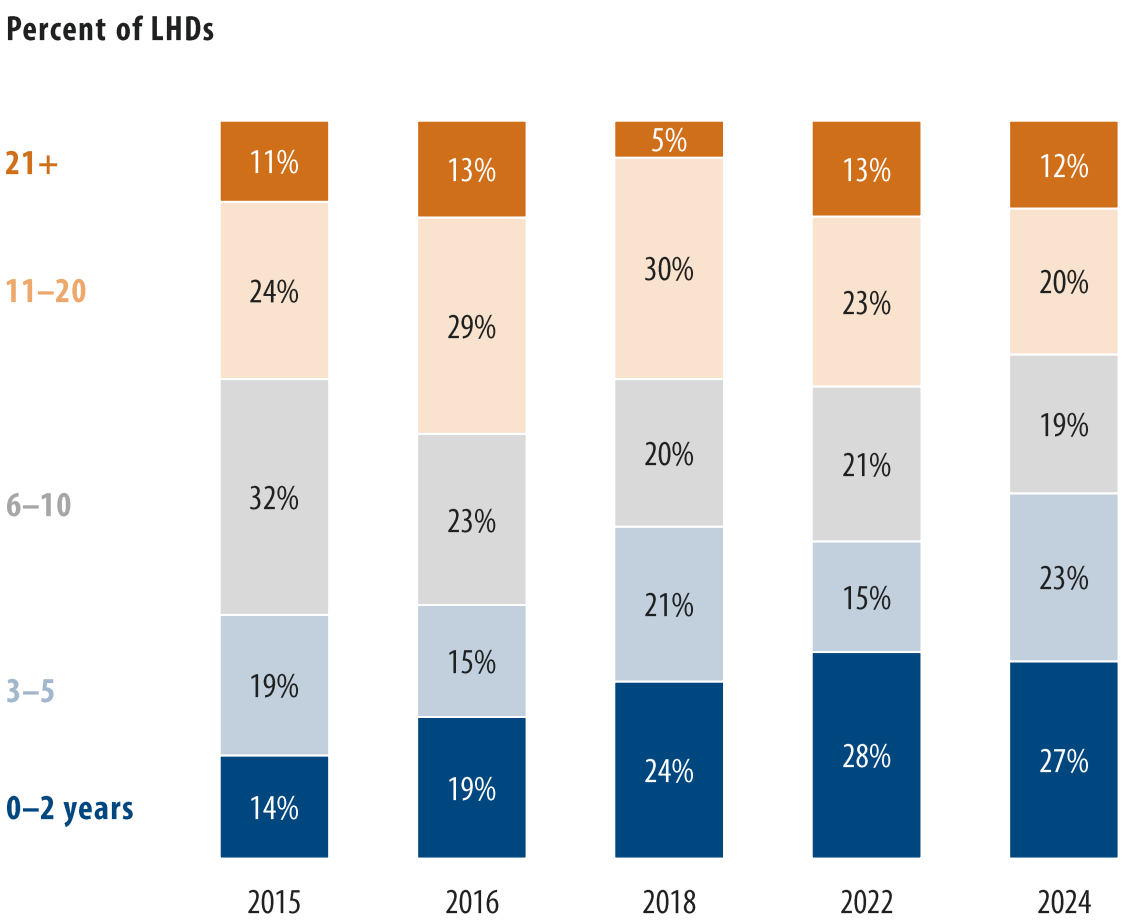


n=484

More than half of LHDs reported having a preparedness coordinator or equivalent staff member with at least six years of experience.

More than half of medium LHDs reported having preparedness coordinators with five or fewer years of preparedness experience. Fewer than half of large (47%) and small LHDs (49%) reported the same.

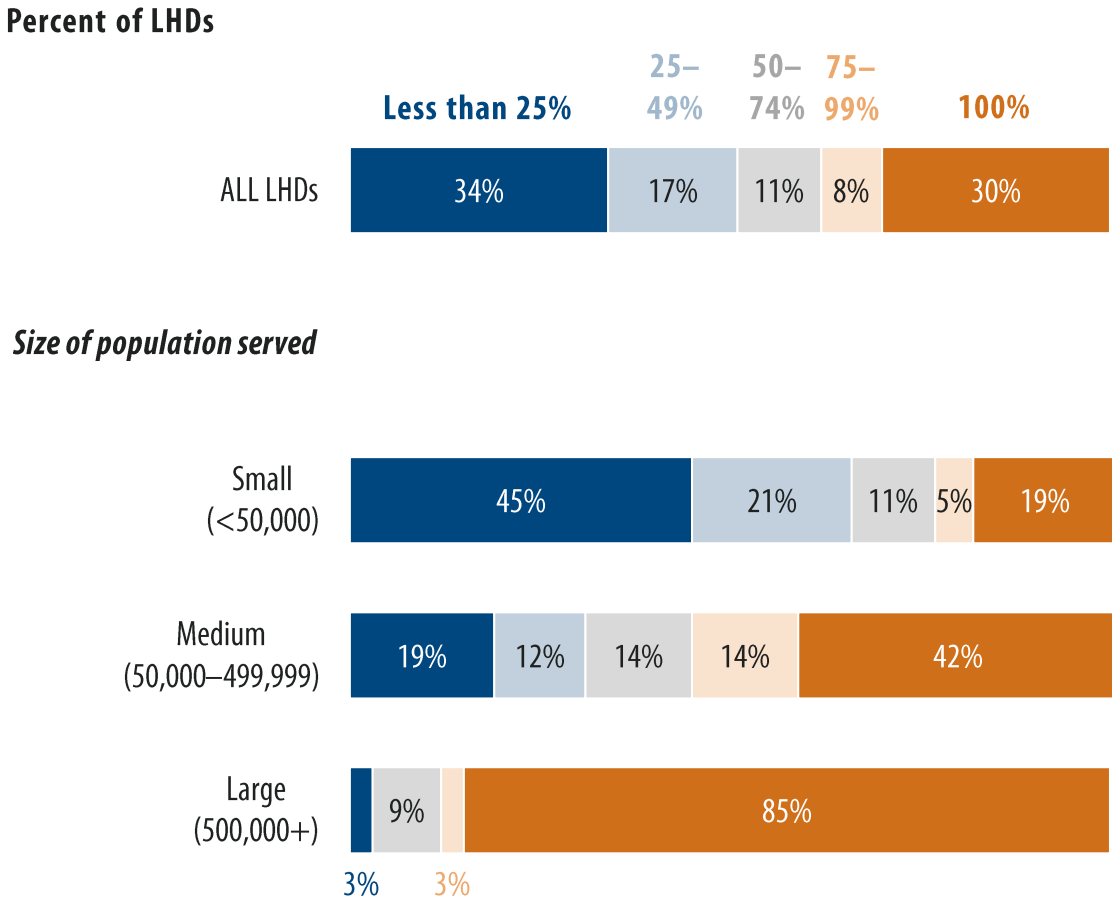
Years of experience as a preparedness coordinator or equivalent, over time



n(2024)=484
n(2022)=372
n(2018)=387
n(2016)=332
n(2015)=283

Over the past decade, the proportion of LHDs with an experienced preparedness coordinator (i.e., more than five years of experience) was lowest in 2024. In 2015 and 2016, two-thirds of LHDs reported their coordinators had more than five years of experience. In 2018 and 2022, less than 60% of LHDs reported the same. In 2024, only 51% reported this.

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



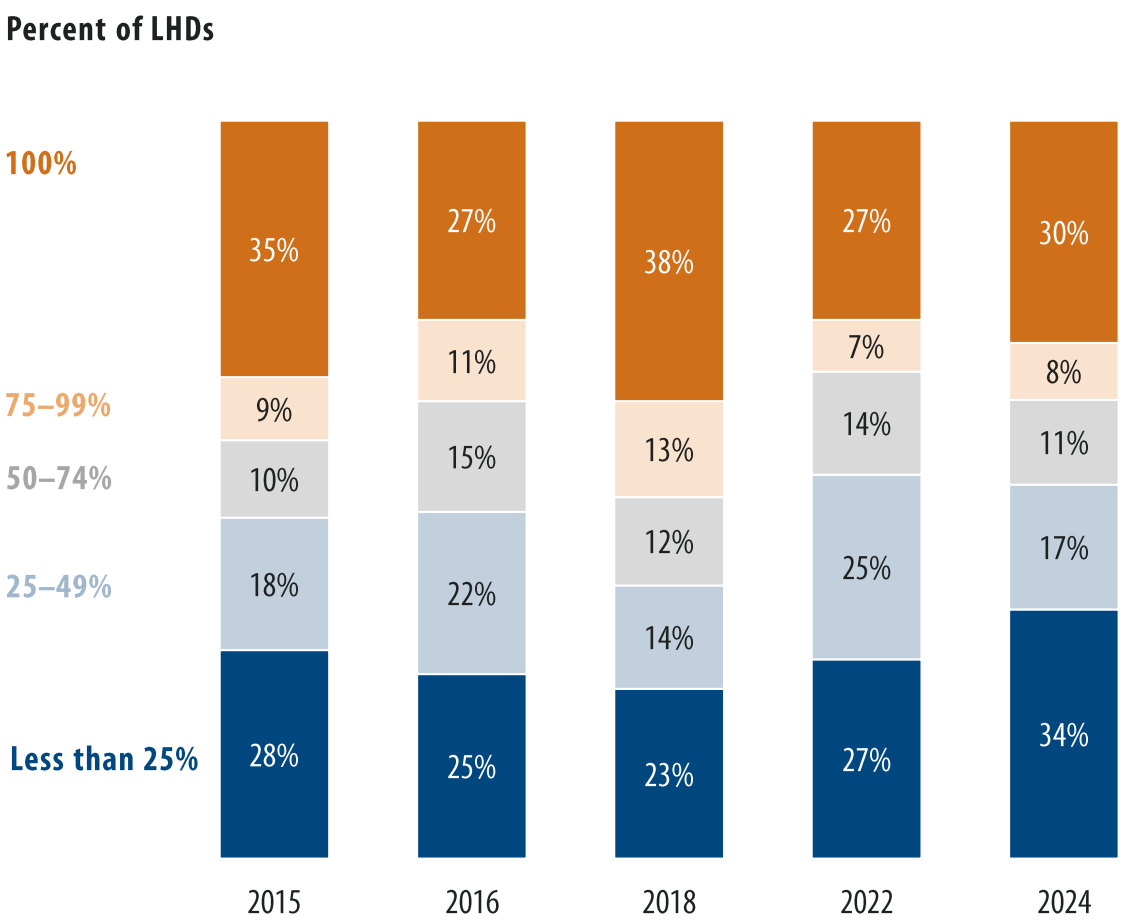
n=484

More than half of LHDs have a preparedness coordinator or equivalent that spends less than 50% of their job duties on preparedness.

However, nearly one-third have this staff member spending all of their time on preparedness-related duties. This appears to be driven by large LHDs, which are twice as likely as medium and four times as likely as small LHDs to have an employee who solely focuses on preparedness work.

In contrast, 45% of small LHDs reported that less than a quarter of their coordinator/equivalent's job duties are dedicated to preparedness.

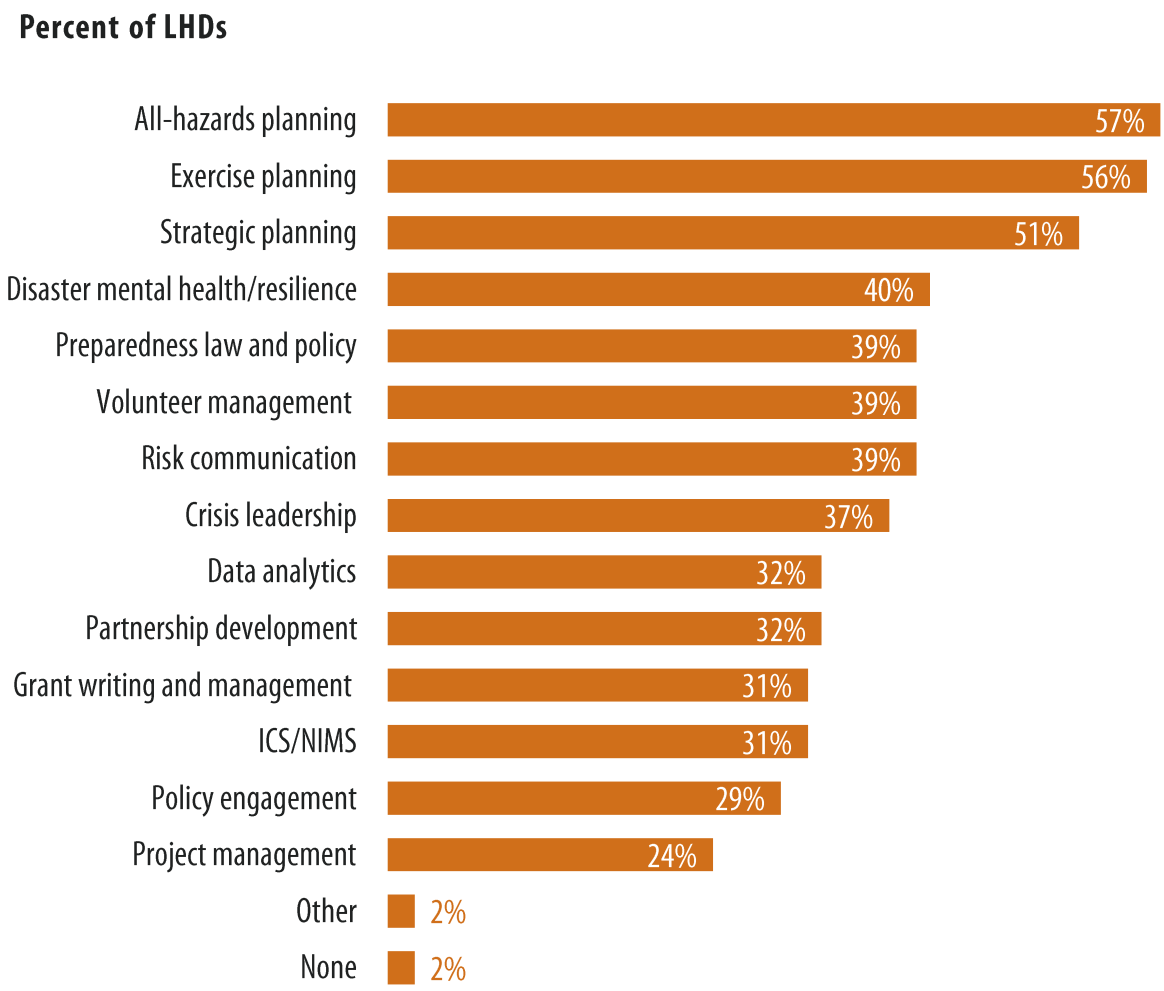
Percentage of coordinator/equivalent's time on the job dedicated to preparedness duties, over time



More than one-third of LHDs reported their coordinator was fully dedicated to preparedness duties in 2015 (35%) and 2018 (38%), while less than one-third reported this in 2016 (27%), 2022 (27%), and 2024 (30%).

n(2024)=484
n(2022)=372
n(2018)=387
n(2016)=430
n(2015)=335

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



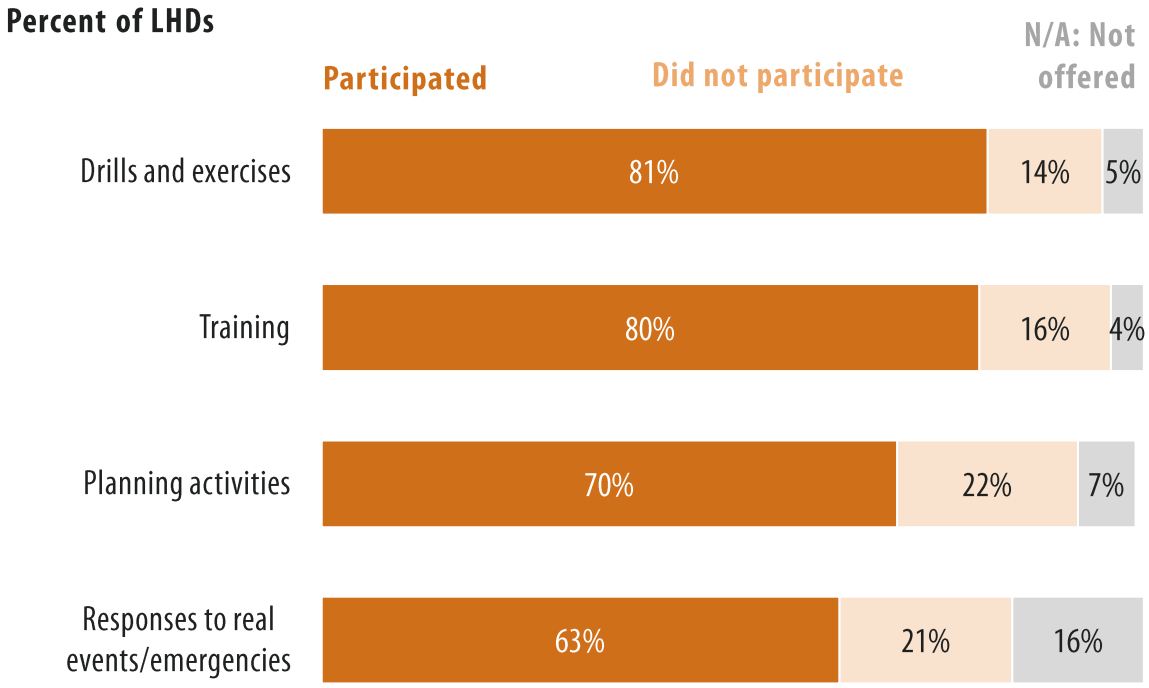
n=482

Overall, the most common areas of training needs were all-hazards planning and exercise/strategic planning.

The areas within the top three needs did not vary when stratified by population size served (not shown in the figure). However, large LHDs had a stronger focus on project management, small LHDs focused more on volunteer management, and medium LHDs focused more on risk communications compared to departments of other sizes.

Although not shown in the figure, LHDs that selected preparedness law and policy were most interested in emergency powers/ authorities, emergency declarations, and immunity and liability.

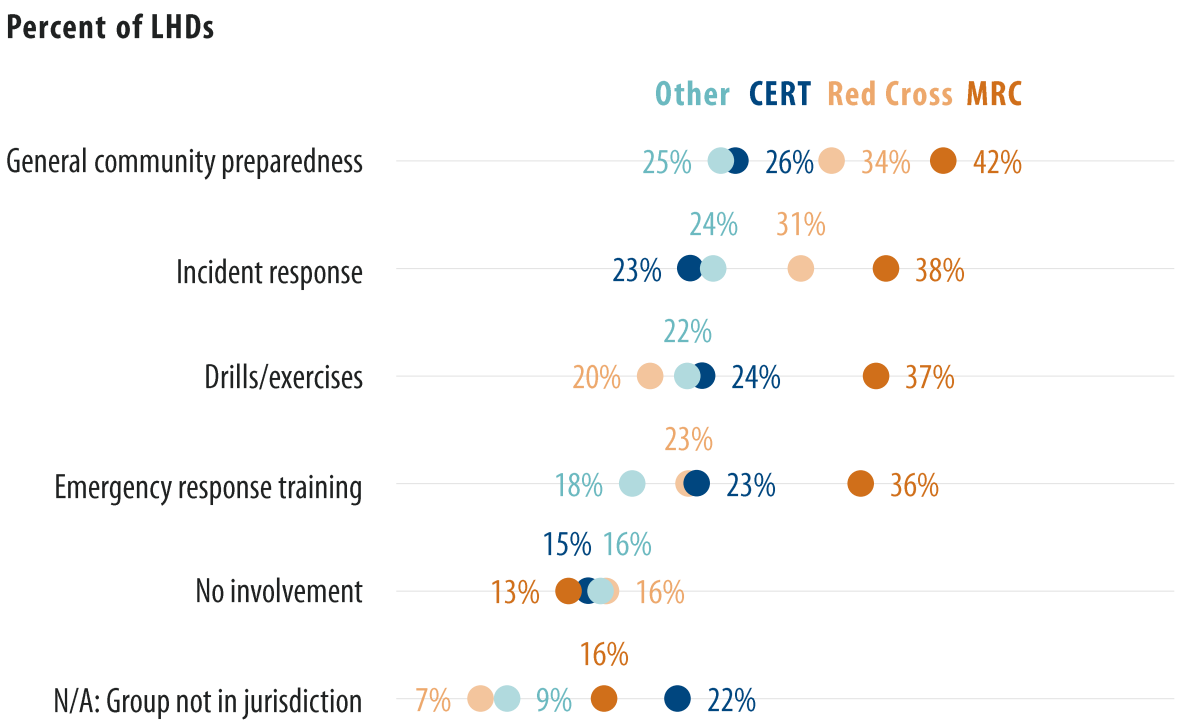
Preparedness activities in which non-preparedness LHD staff participated in the past year



Non-preparedness staff at approximately four in five LHDs participated in drills and exercises and preparedness training. Additionally, more than half of LHDs reported these staff participated in planning activities and responses to real events/emergencies.

n=484–488

Preparedness activities in which LHDs work with volunteer groups

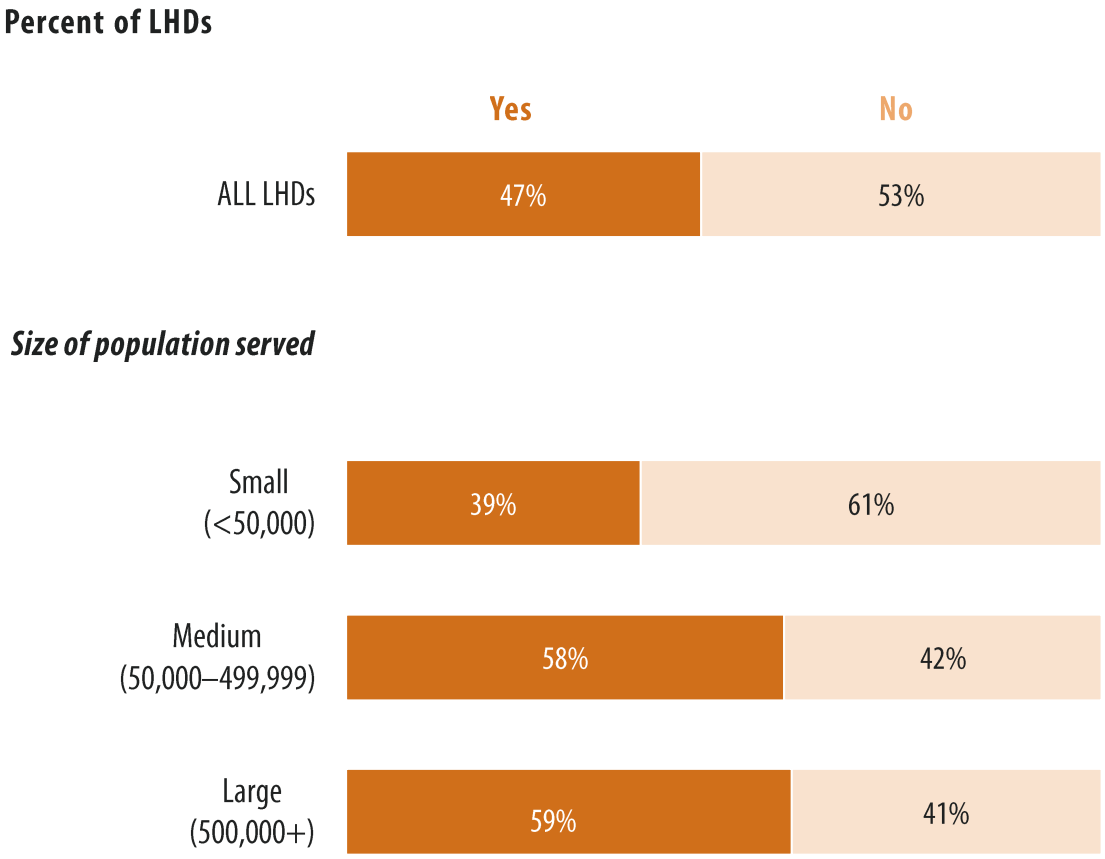


n=254–309

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

Although not shown in the figure, large LHDs were more likely to work with MRC, compared to small and medium LHDs.

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



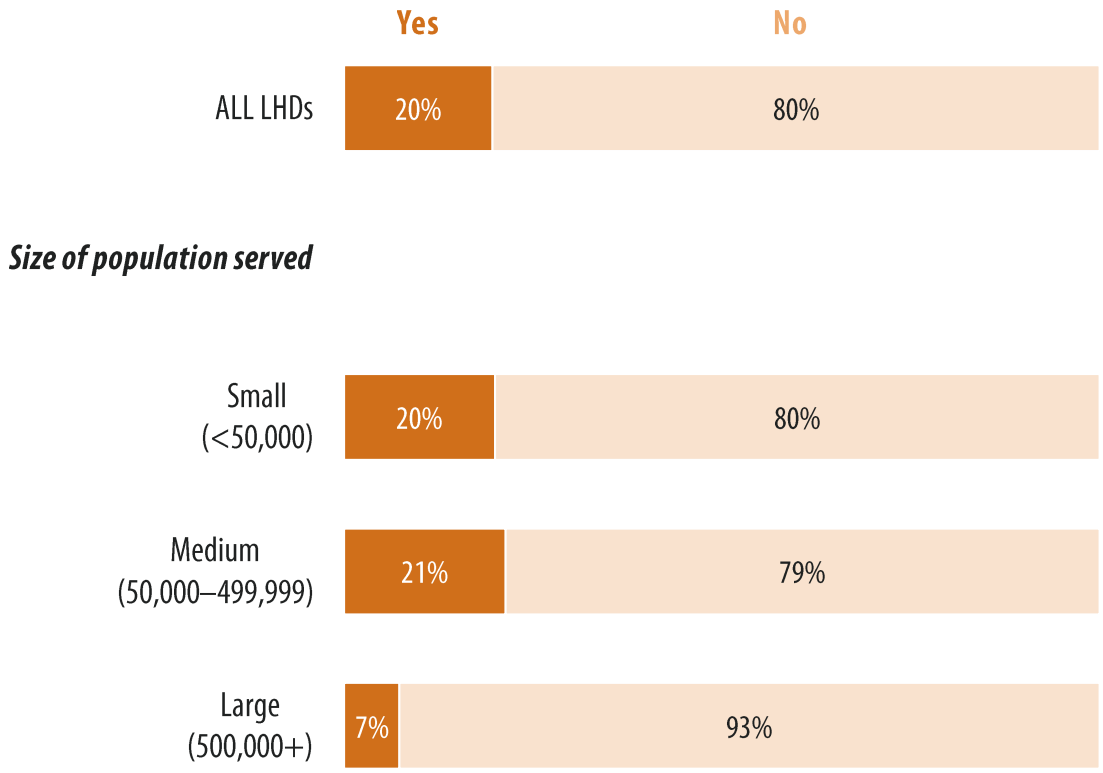
n=487

Many LHDs reported engaging MRC units in preparedness activities, but 47% reported sponsoring a unit to support preparedness and response plans and workforce surge needs. More than half of medium and large LHDs reported sponsorship, compared to fewer than two in five small LHDs.

Although not shown in the figure, the most common challenges to MRC unit sponsorship were limited staff capacity and limited resources for management. Small and rural LHDs also reported limited availability of volunteers.

LHD interest in sponsorship of a Medical Reserve Corps unit, by population size served

Percent of LHDs *(of those that did not already sponsor a unit)*



n=235

Of LHDs that did not sponsor a MRC unit, one in five indicated that they would like their area's MRC unit to be sponsored by the agency. Small and medium LHDs were nearly three times as likely to want to sponsor a unit than large LHDs.

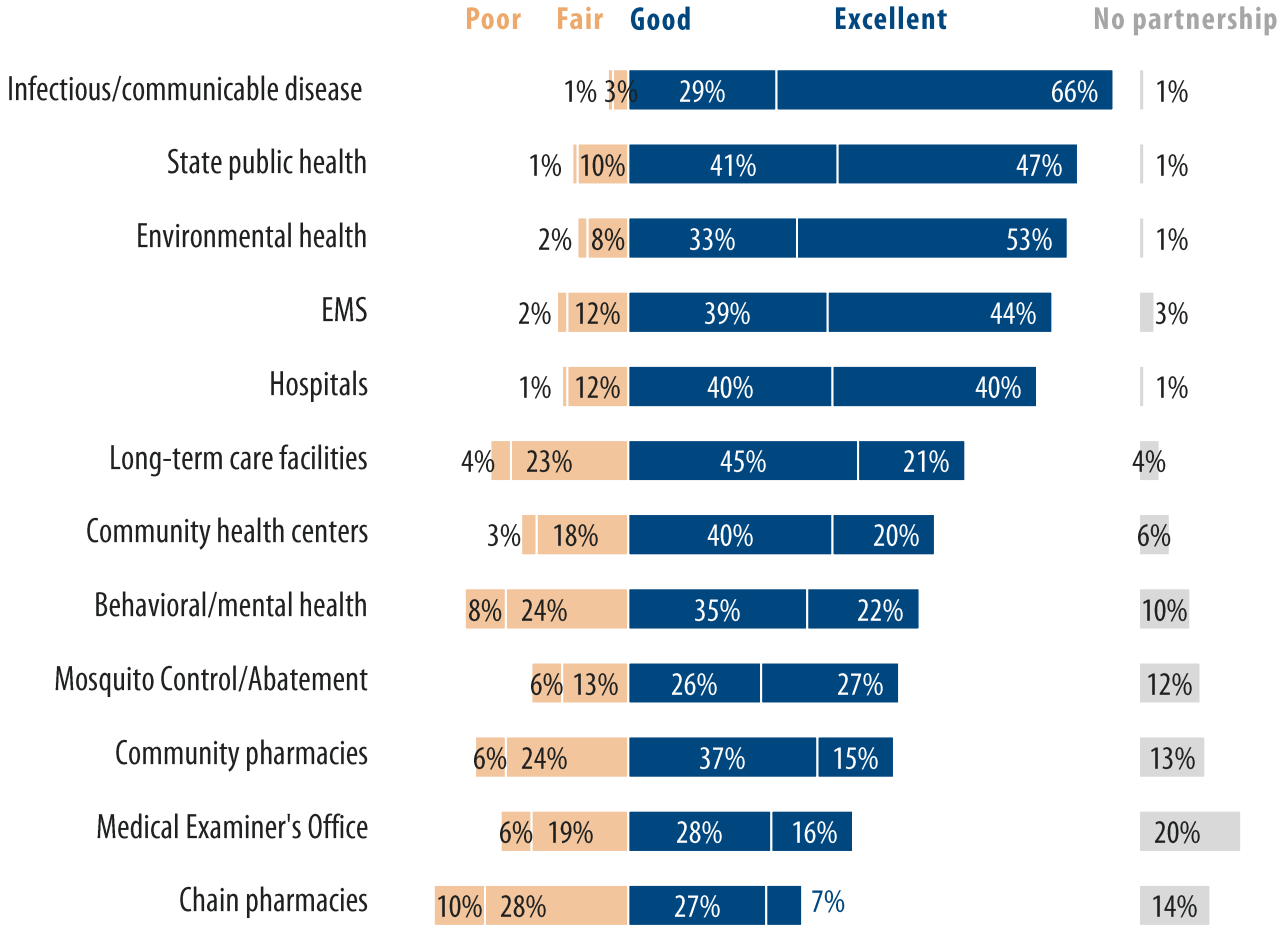
Partnerships & Collaboration

This chapter includes the following:

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

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

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

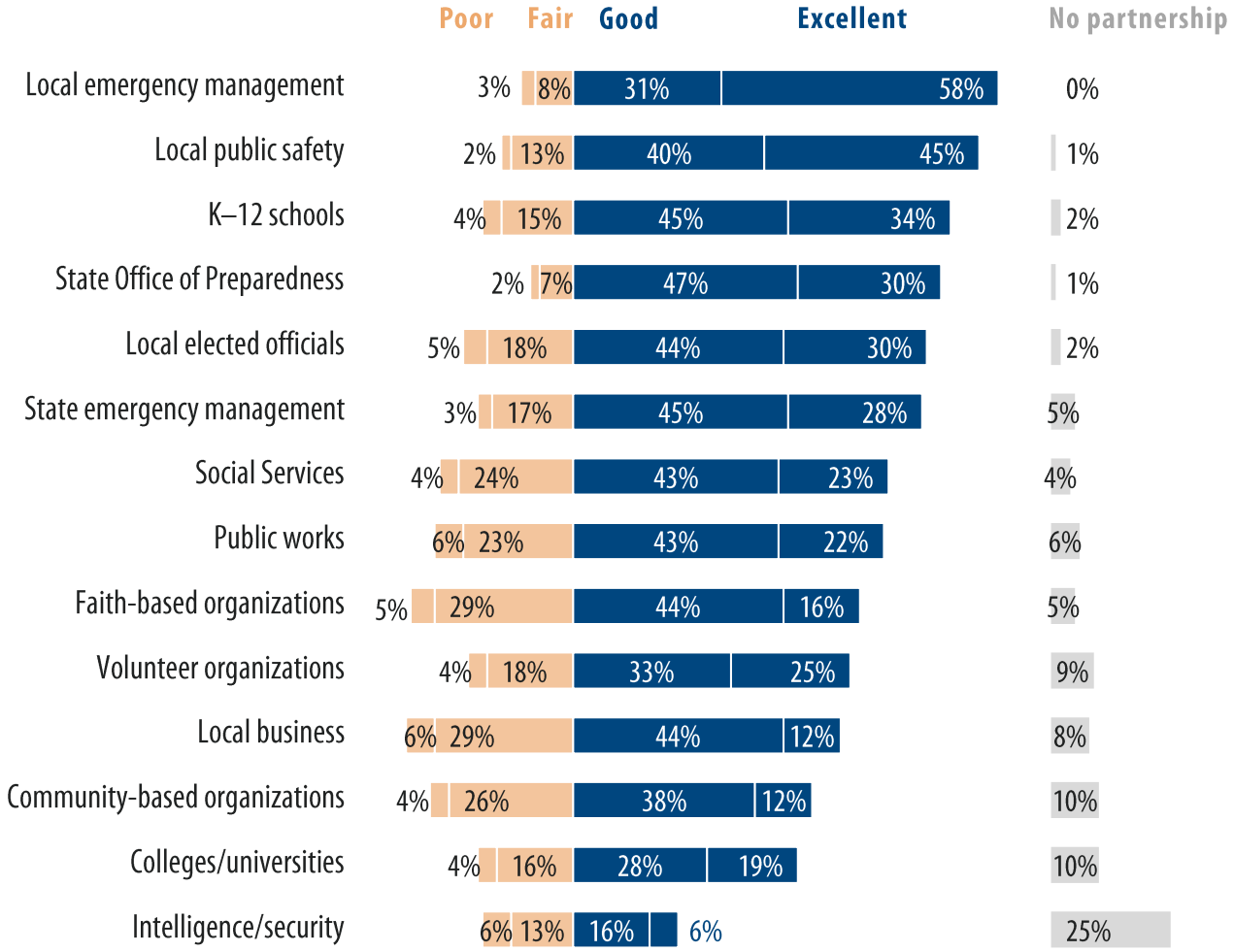


n=485–489

More than 75% of LHDs noted strong relationships (i.e., "good" or "excellent") with state public health, environmental health, emergency medical services (EMS), or hospital partners.

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

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



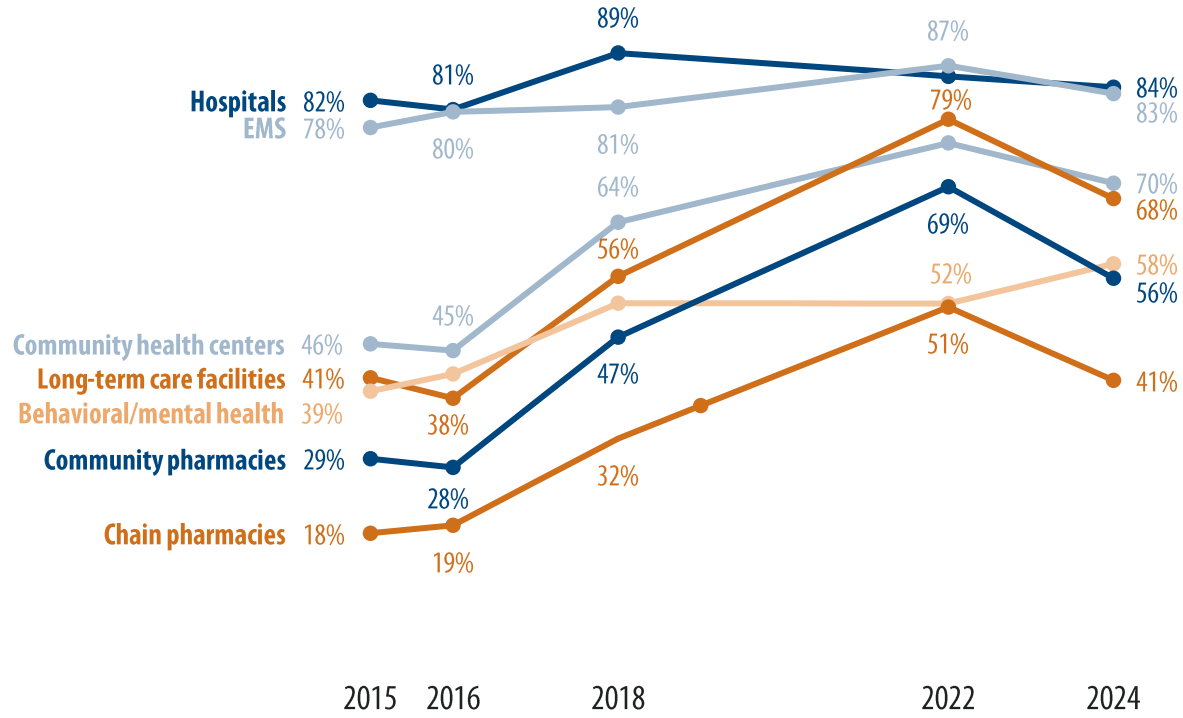
n=485–489

Local emergency management, local public safety, and K–12 schools were the most common community and government organizations with which LHDs had strong relationships (i.e., "good" or "excellent").

The least common organizations were colleges/universities and intelligence/security agencies, with approximately 20% of LHDs citing "fair" or "poor" connections. However, these were also the most common to not exist in the LHD's jurisdiction (not shown in the figure).

Strength of LHD partnership with *public health and healthcare* organizations for emergency preparedness planning activities, over time

Percent of LHDs *(selecting either "good" or "excellent")*



LHDs were more likely to report strong partnerships with public health and healthcare entities in 2024 than in 2015.

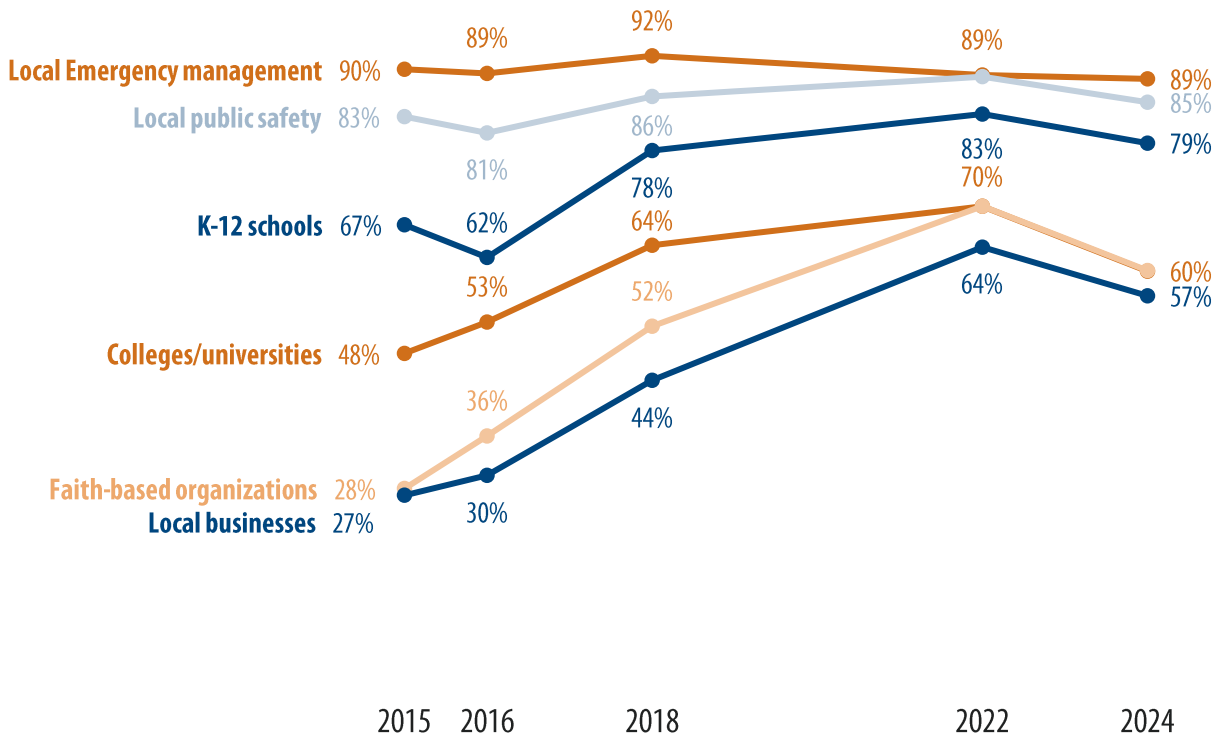
There was a peak in the proportion of LHDs with strong partnerships in 2022. However, between 2022 and 2024, the proportion decreased slightly—except for partnerships with behavioral/mental health organizations, which saw a slight increase.

Technical note
The proportions displayed exclude LHDs selecting "N/A" from the denominator.

n(2024)=387–489
n(2022)=297–365
n(2018)=273–386
n(2016)=315–432
n(2015)=332–336

Strength of LHD partnership with *community and government* organizations for emergency preparedness planning activities, over time

Percent of LHDs *(selecting either "good" or "excellent")*

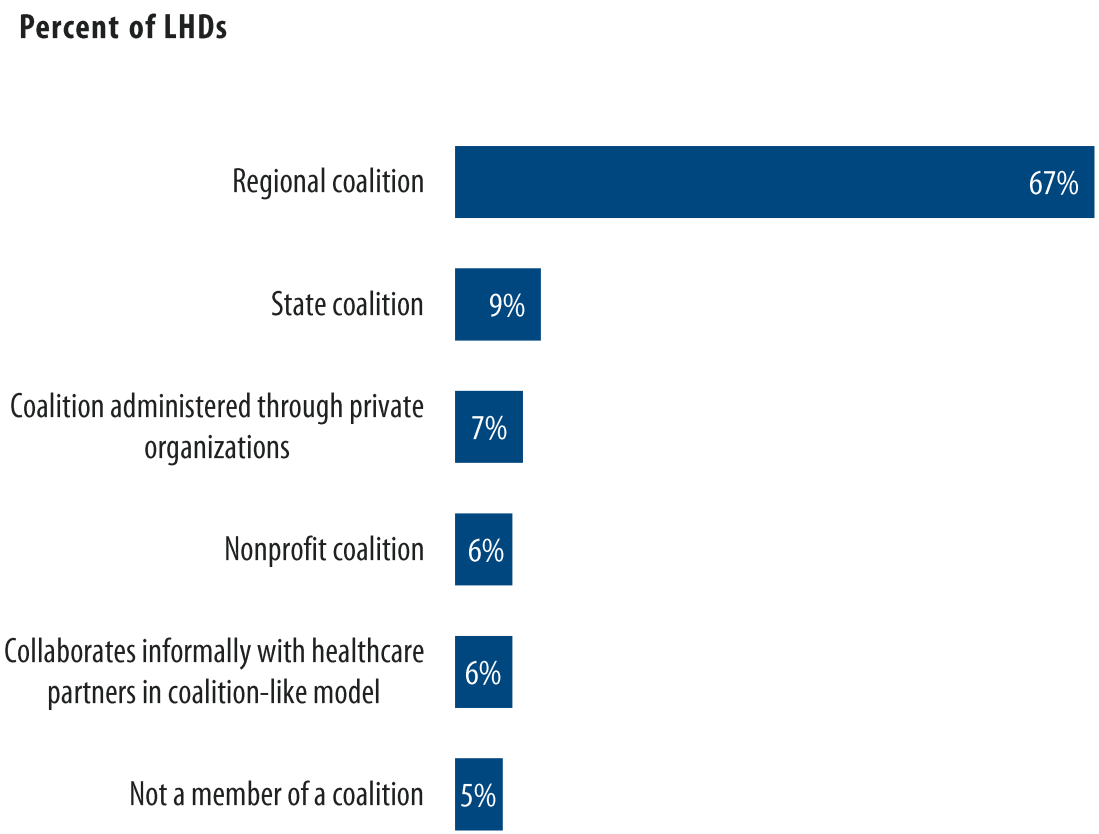


The strength of LHD partnerships with community and government entities have remained steady since 2018, except for partnerships with colleges/universities, faith-based organizations, and local businesses. For these three, LHDs were more likely to report strong partnerships between 2015 and 2022. The proportion reporting strong partnerships declined from 2022 to 2024.

Technical note
The proportions displayed exclude LHDs selecting "N/A" from the denominator.

n(2024)=387–489
n(2022)=297–365
n(2018)=273–386
n(2016)=315–432
n(2015)=332–336

LHD engagement in healthcare coalitions



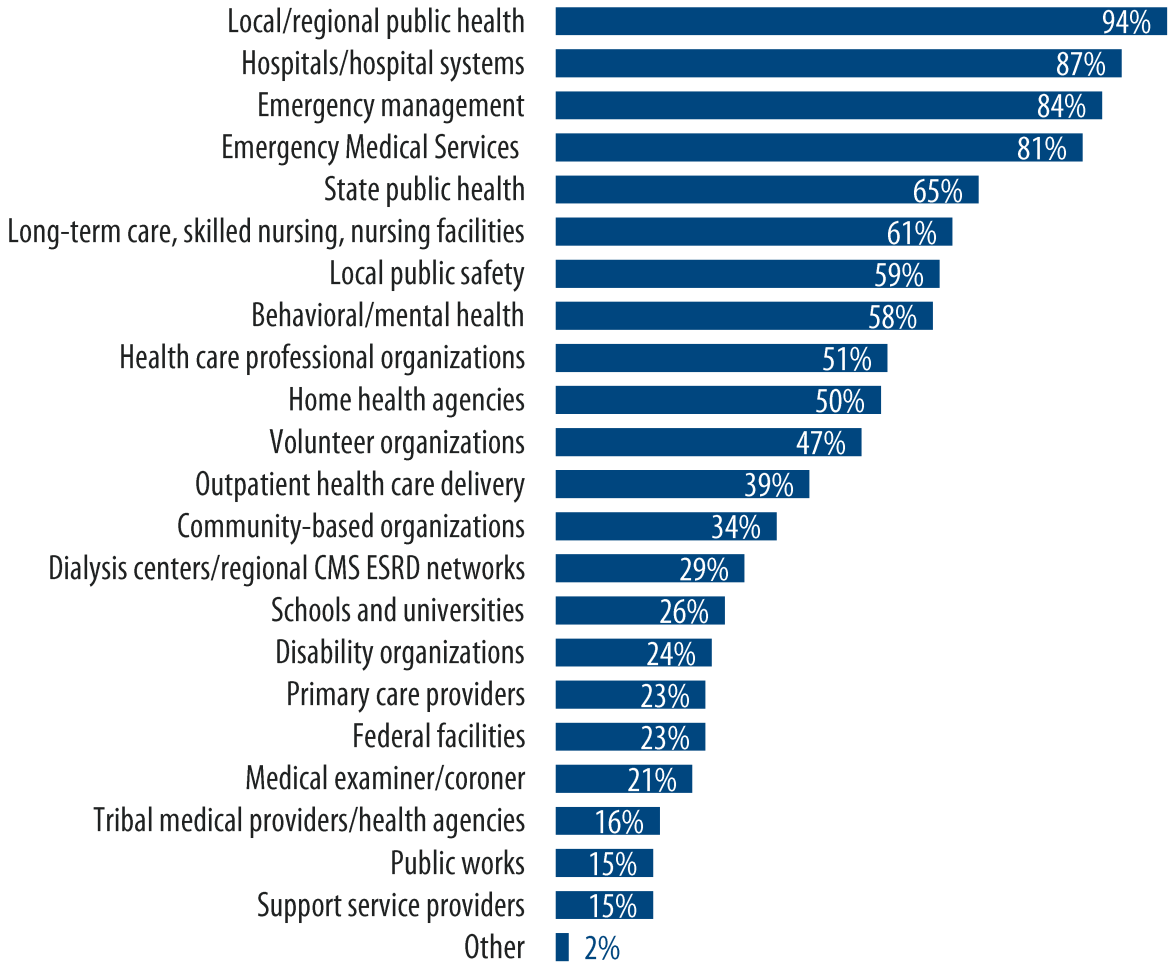
n=485

Most LHDs were engaged in regional healthcare coalitions to plan and implement preparedness activities. Less than 10% participated in either a state, private, or nonprofit coalition.

Although not shown in the figure, informal LHD collaborations with healthcare partners in a coalition-like model decreased by more than half between 2022 and 2024 (from 14% to 6%).

Groups represented in LHD-engaged healthcare coalitions

Percent of LHDs *(of those that engage in a coalition or coalition-like partner model)*



n=459

Most frequently, LHD-engaged healthcare coalitions included local/regional public health, hospitals/hospital systems, emergency management, and Emergency Medical Services (EMS) partners. Tribal medical providers/ health agencies, public works, and support service providers (e.g., clinical laboratories, pharmacies) were not typically engaged.

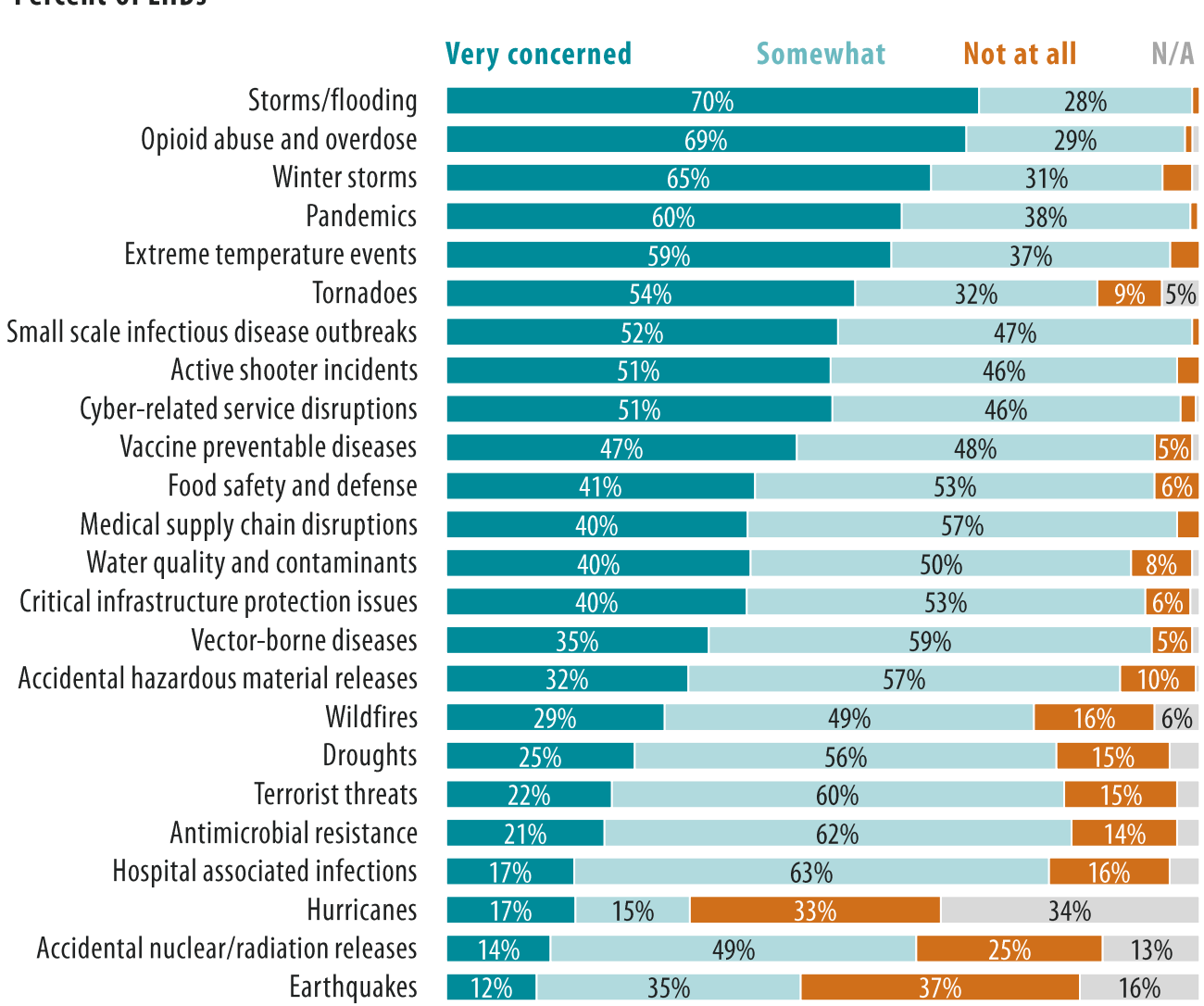
From 2022 to 2024, there was an approximate 10-percentage point decrease in LHD reports of engagement from health care professional organizations, community-based organizations, primary care providers, and schools/universities (not shown in the figure).

Preparedness Planning Capacity

This chapter includes the following:

- Level of concern and preparedness about public health threats and hazards
- Populations addressed in preparedness planning activities
- Administrative preparedness mechanisms in place
- Barriers to administrative preparedness
- Existence of community recovery plans
- Existence of local stockpiles
- Use of inventory management systems (IMS)

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



n=484–489

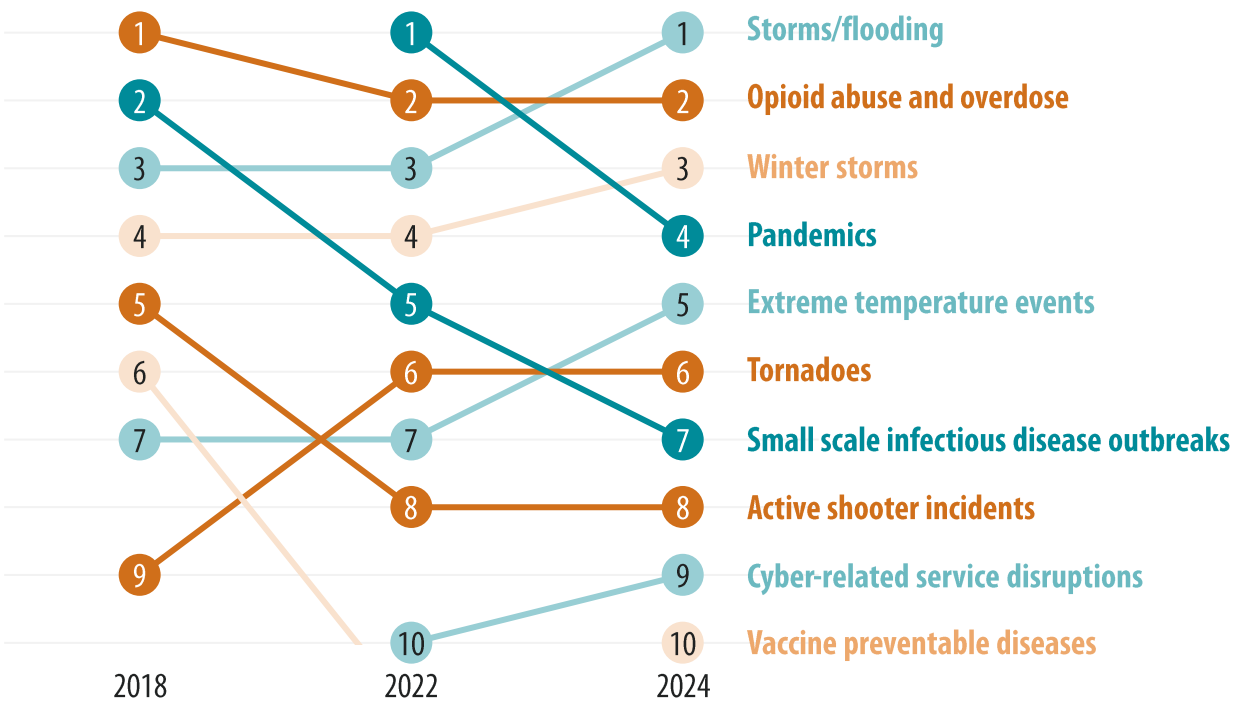
More than 65% of LHDs reported being very concerned about storms/flooding, opioid use, and winter storms.

More than one-third of LHDs were not at all concerned about earthquakes and hurricanes.

Although not shown in the figure, the proportion of LHDs that reported being very concerned about pandemics fell from 83% in 2022 to 60% in 2024, coinciding with a 22-percentage point rise in reports of being somewhat concerned about this same threat.

Ranking of proportion of LHDs reporting being very concerned about the impact of threats or hazards in community, over time

Rank order of threats/hazards



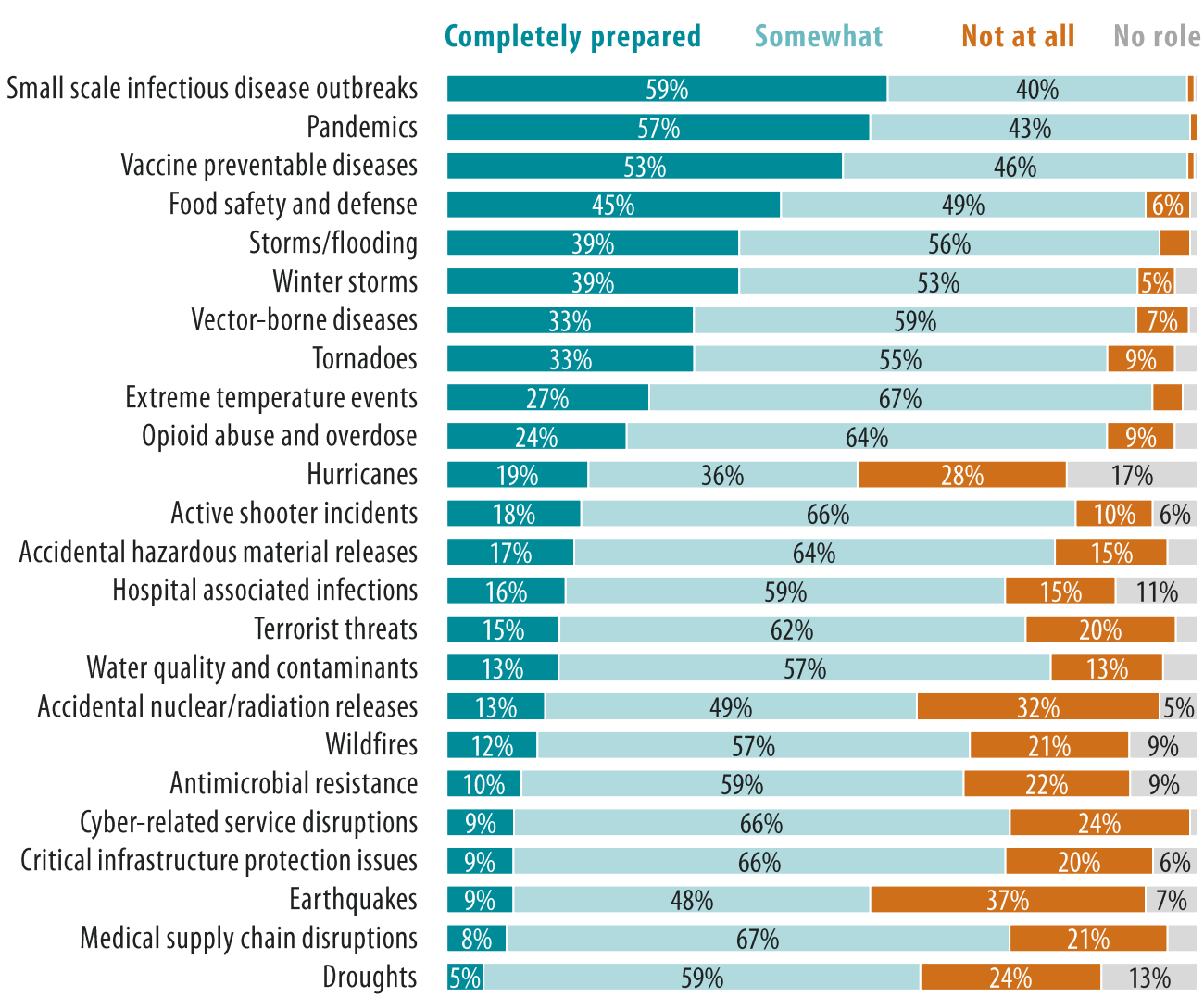
The threats about which LHDs are very concerned have varied over time. Notably, more LHDs reported concern about weather-related threats (storms/flooding, extreme temperature events, tornadoes) from 2018 to 2024. On the other hand, fewer LHDs were concerned about small scale infectious disease outbreaks and active shooter incidents in 2024 than in prior years.

Technical note
The ranking indicates the highest to lowest proportion of LHDs reporting "very concerned." Threats that did not rank in the top 10 in 2024 are not displayed in earlier years.

n(2024)=484–488
n(2022)=360–364
n(2018)=372–386

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

Percent of LHDs *(of those identifying threat as a concern)*



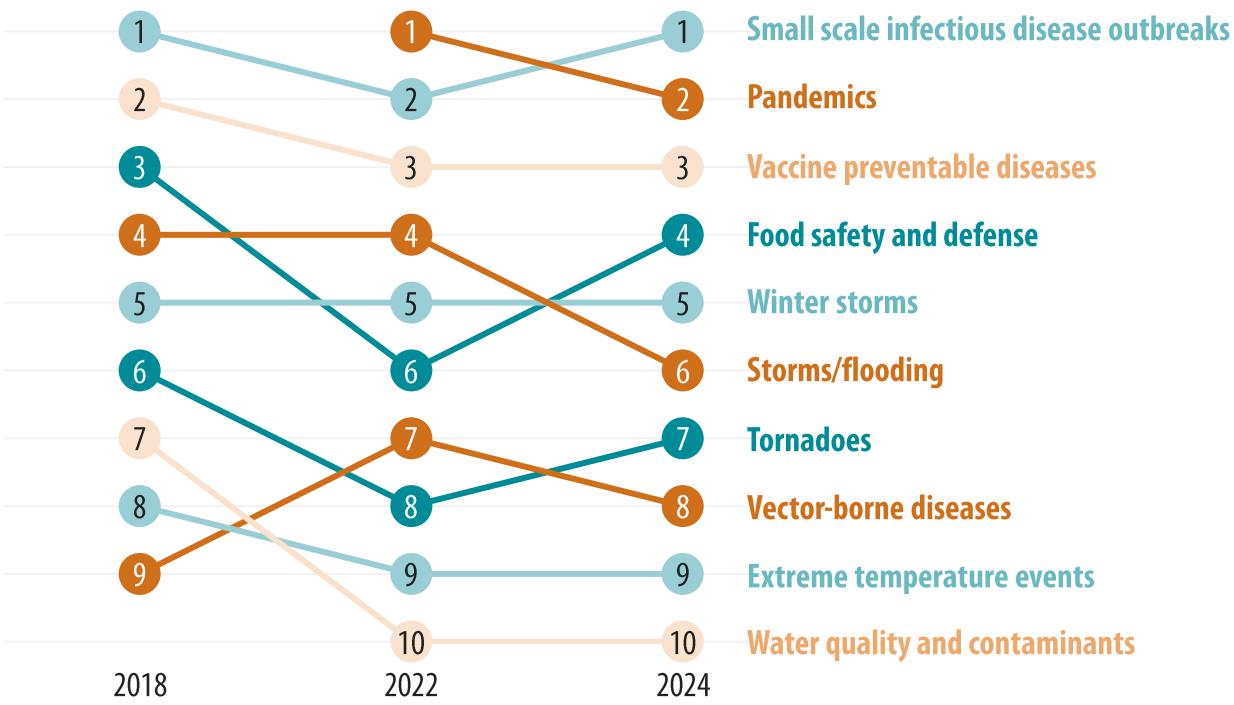
n=325–488

LHDs were at least somewhat prepared to address most threats or hazards identified as facing their community. In particular, more than half of LHDs reported being completely prepared to respond to small scale infectious disease outbreaks, pandemics, and vaccine preventable diseases.

Approximately one-quarter of LHDs were not at all prepared to respond to hurricanes, cyber-related service disruptions, or droughts. Meanwhile, approximately one-third reported this same status for accidental nuclear/radiation releases and earthquakes.

Ranking of proportion of LHDs reporting being completely prepared to respond to threats or hazards identified as facing community, over time

Rank order of threats/hazards



The top five threats to which LHDs felt completely prepared to respond have remained about the same over time, with only slight variations since 2018. Most notably, more LHDs reported feeling prepared to address food safety and defense—which moved from rank six in 2022 to four in 2024—while fewer LHDs were prepared to address storms/flooding—which moved from rank four to six during the same timeframe.

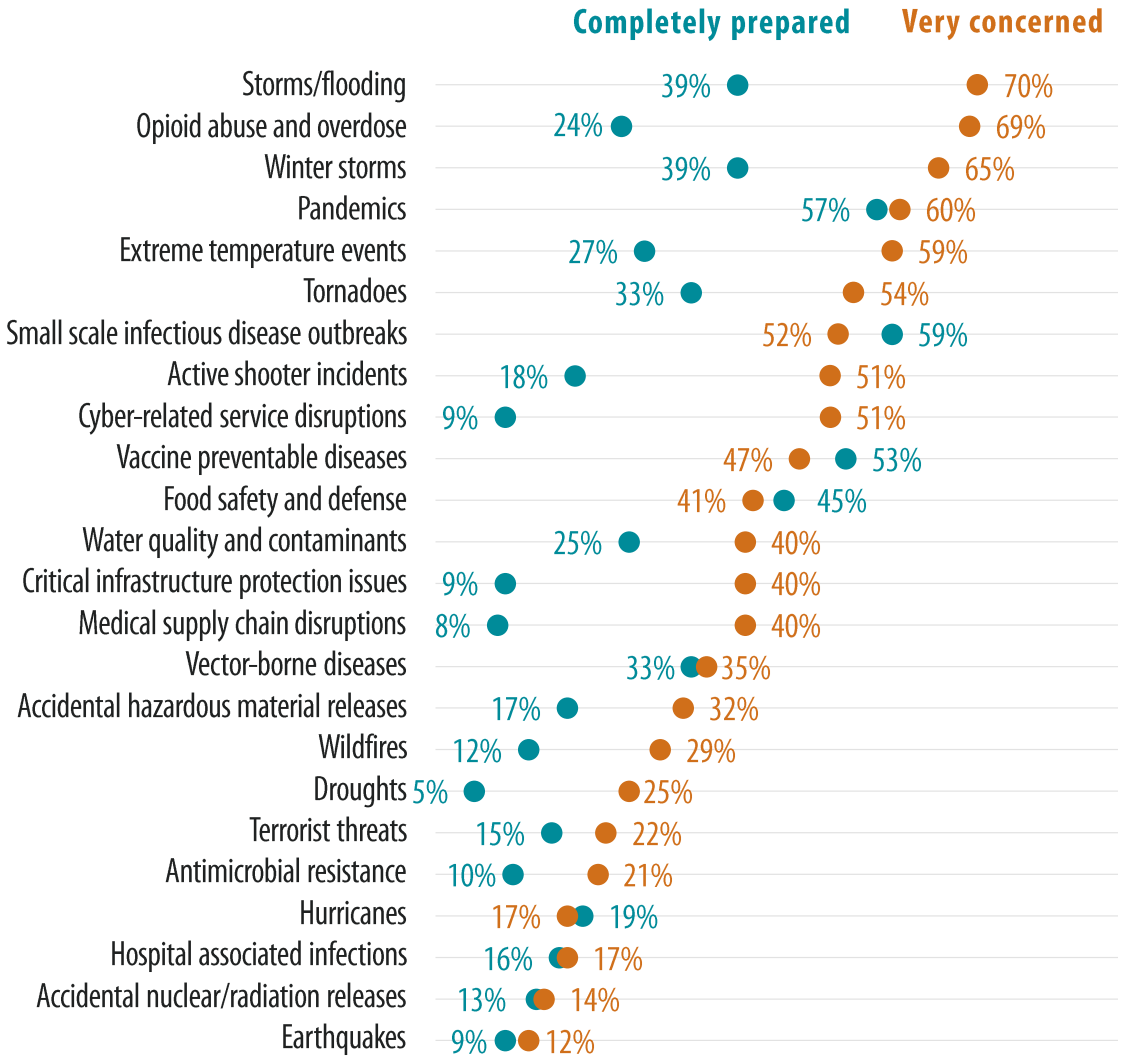
Technical notes

The ranking indicates the highest to lowest proportion of LHDs reporting "very concerned." In 2018 and 2022, the response option was "very prepared" and in 2024, this changed to "completely prepared." Threats that did not rank in the top 10 in 2024 are not displayed in earlier years.

n(2024)=325–487
n(2022)=236–362
n(2018)=372–386

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

Percent of LHDs



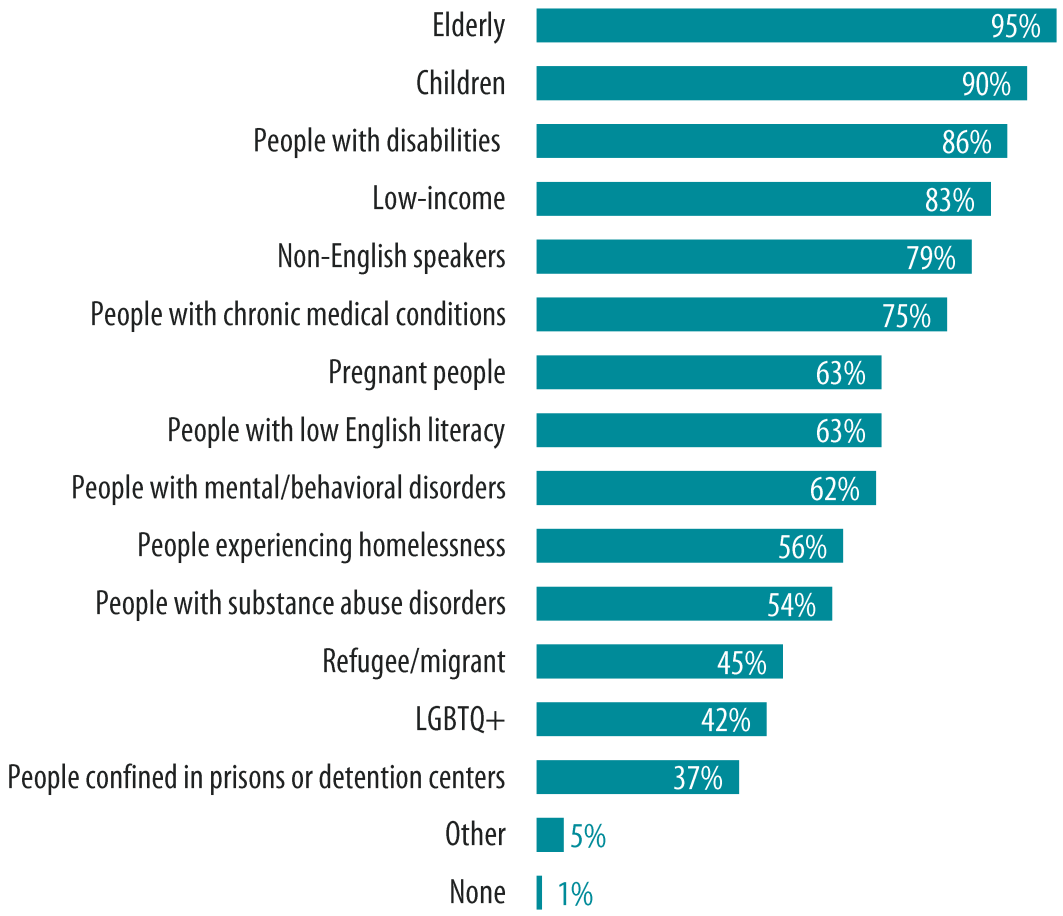
n=325–489

LHDs reported feeling much more concerned than prepared to respond to several threats, including opioid use, cyber-related service disruptions, active shooter incidents, extreme temperature events, medical supply chain disruptions, storms/flooding, and critical infrastructure issues.

LHDs felt more prepared than concerned about small-scale infectious diseases, vaccine preventable diseases, food safety and defense, and hurricanes.

At-risk/vulnerable populations addressed in preparedness planning efforts

Percent of LHDs



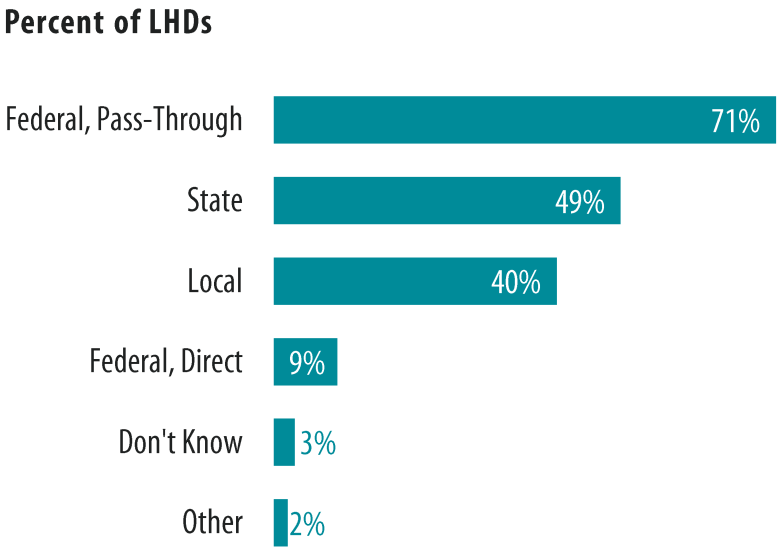
n=482

More than four in five LHDs reported addressing a variety of at-risk groups in their preparedness planning efforts, including older adults, children, people with disabilities, and low-income populations.

Although not shown in the figure, there were a few notable variations among LHDs of different sizes. Medium and large LHDs were more likely to address people experiencing homelessness, low English literacy populations, and immigrants in preparedness planning, compared to small LHDs.

In addition, 42% of LHDs offer specific training for working with at-risk populations during public health emergencies (not shown in the figure).

Funding sources for preparedness related activities



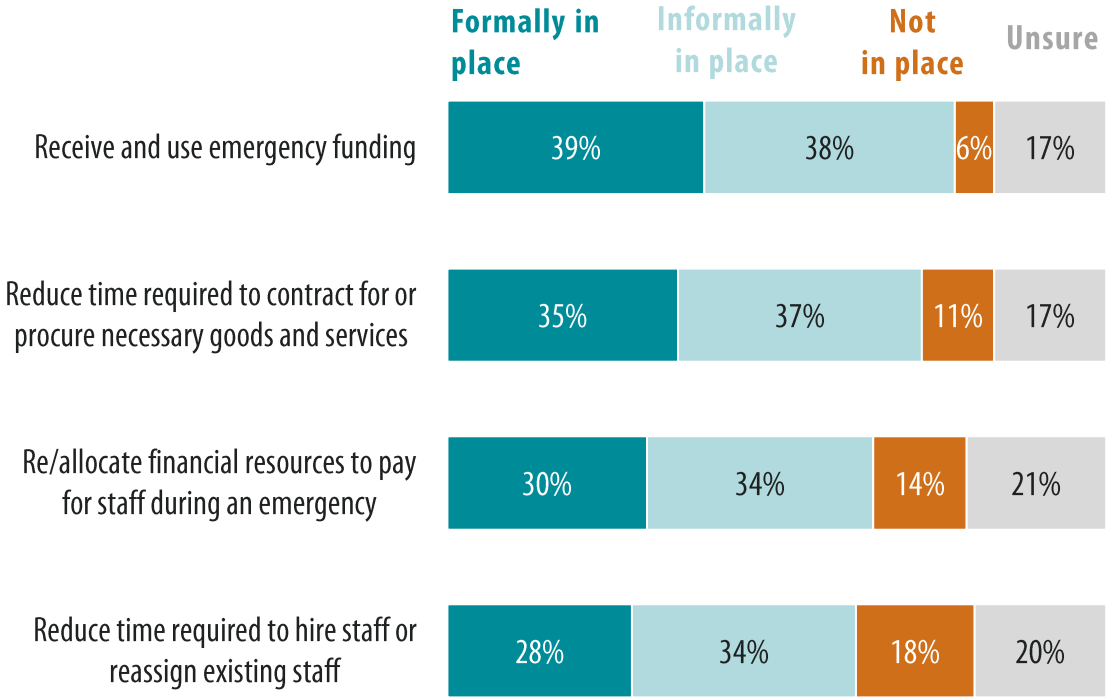
Seven in 10 LHDs receive preparedness funding from federal pass-through mechanisms, and nearly half from state sources. Very few LHDs reported receiving funding directly from the federal government.

Although not shown in the figure, small and medium LHDs tended to report more state and local sources, compared to large LHDs. Over 9 in 10 large LHDs received federal pass-through funding for preparedness related activities.

n=482

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

Percent of LHDs



The majority of LHDs have expedited mechanisms in place to address administrative preparedness needs during a public health emergency, with slightly more using an informal than a formal process—with the exception of receiving and using emergency funds.

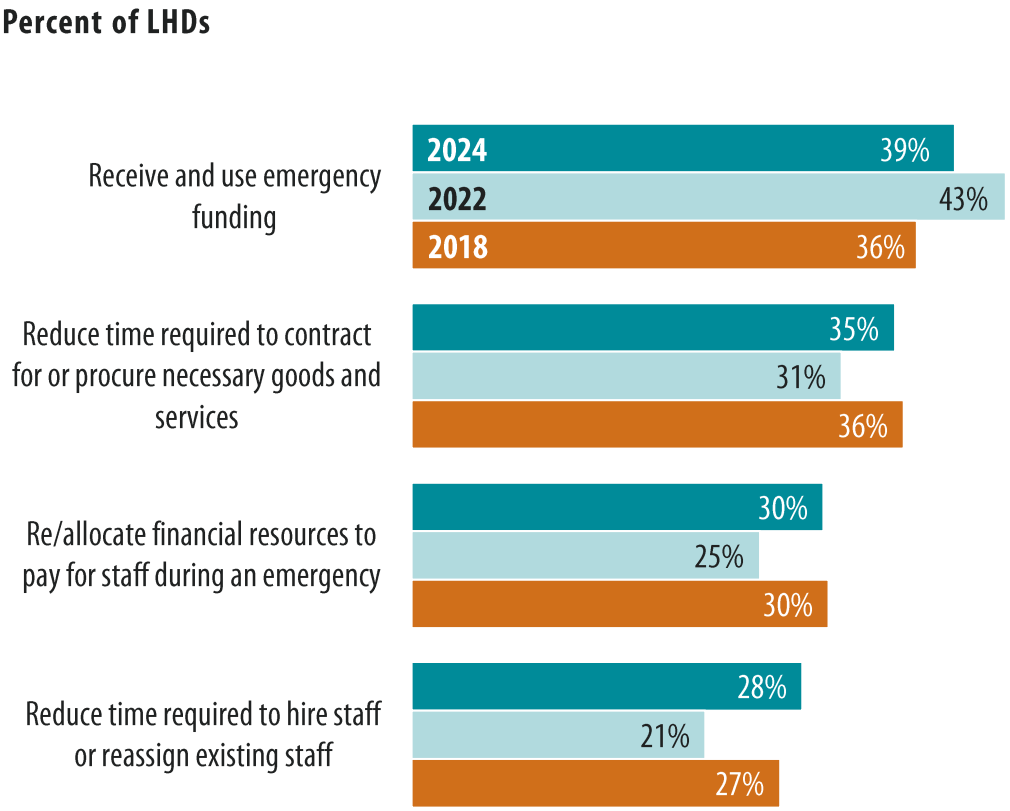
Notably, almost 20% of LHDs were unsure about whether there were expedited mechanisms in place across the administrative preparedness categories assessed.

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

n=477–478

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

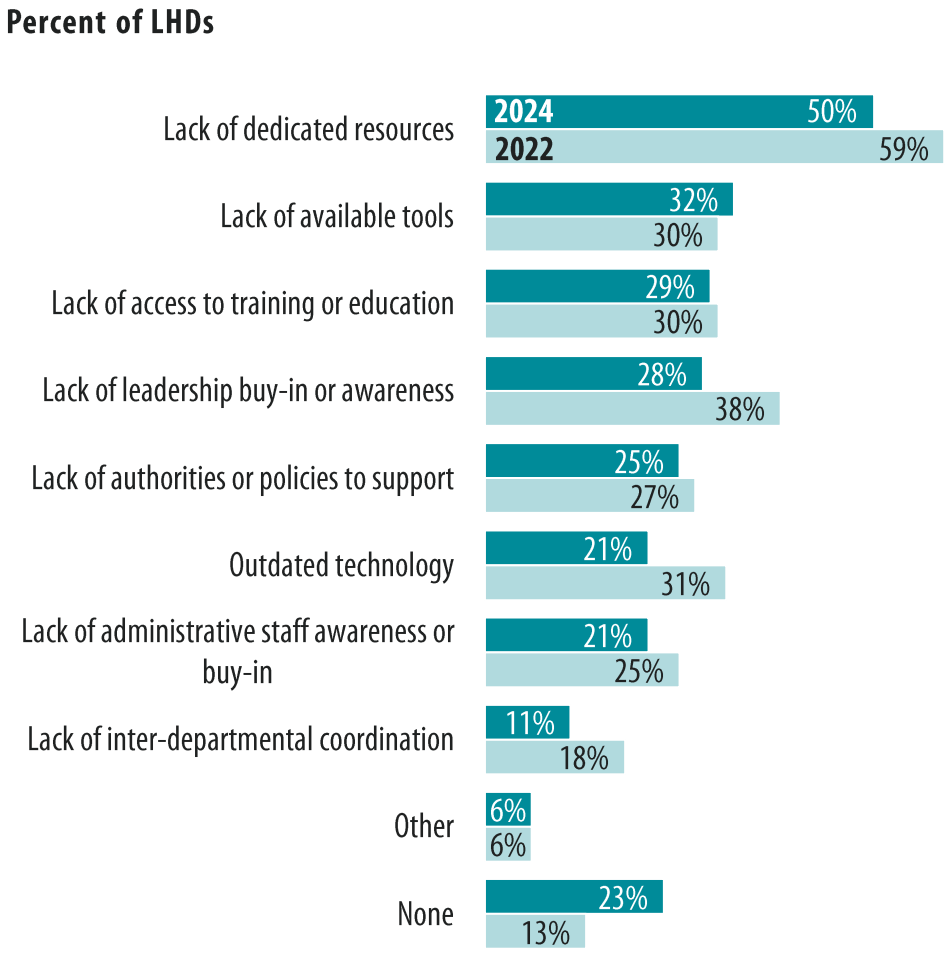
Formal mechanisms in place to address administrative preparedness activities during a declared emergency, over time



In 2024, more LHDs reported having formal mechanisms in place to address administrative preparedness activities than in 2022—returning to 2018 proportions. However, this trend is flipped for the proportion of LHDs receiving and using emergency funding, with fewer LHDs reporting formal mechanisms for this activity in 2018 and 2024, compared to 2022.

n(2024)=477–478
n(2022)=338–339
n(2018)=372–375

Barriers to administrative preparedness



n(2024)=453
n(2022)=328

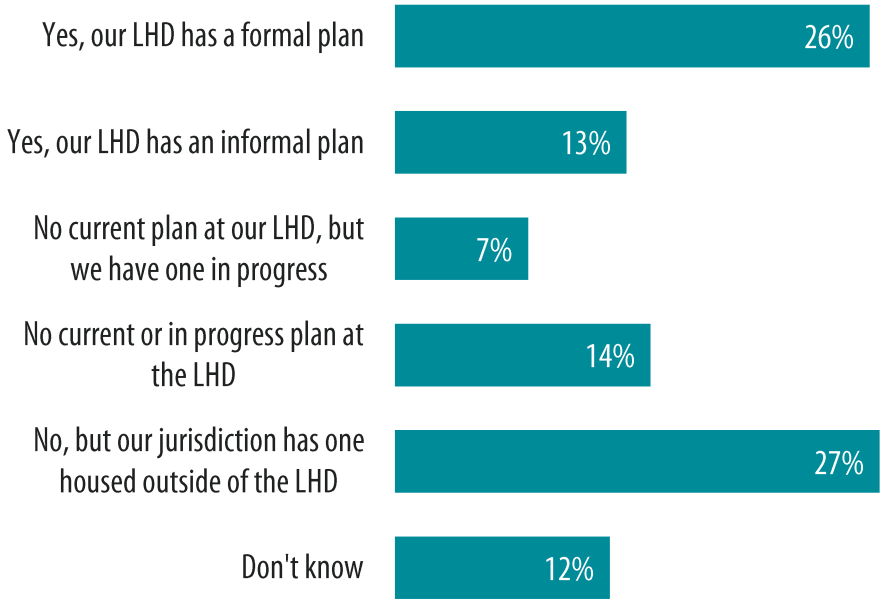
In both 2022 and 2024, most LHDs reported that a lack of dedicated resources was a barrier to administrative preparedness.

Although 77% of LHDs reported having at least one barrier to administrative preparedness in 2024, this is a notable decrease from 87% in 2022. In particular, the proportion of LHDs citing either a lack of dedicated resources, lack of leadership buy-in or awareness, or outdated technology as a barrier decreased nearly 10 percentage points over the two years.

Although not shown in the figure, most LHDs reported that best practices and templates would be useful resources to further strengthen administrative preparedness efforts. In addition, one-third of LHDs would find checklists, advocacy, and trainings helpful.

Existence of community recovery plans within local jurisdictions

Percent of LHDs



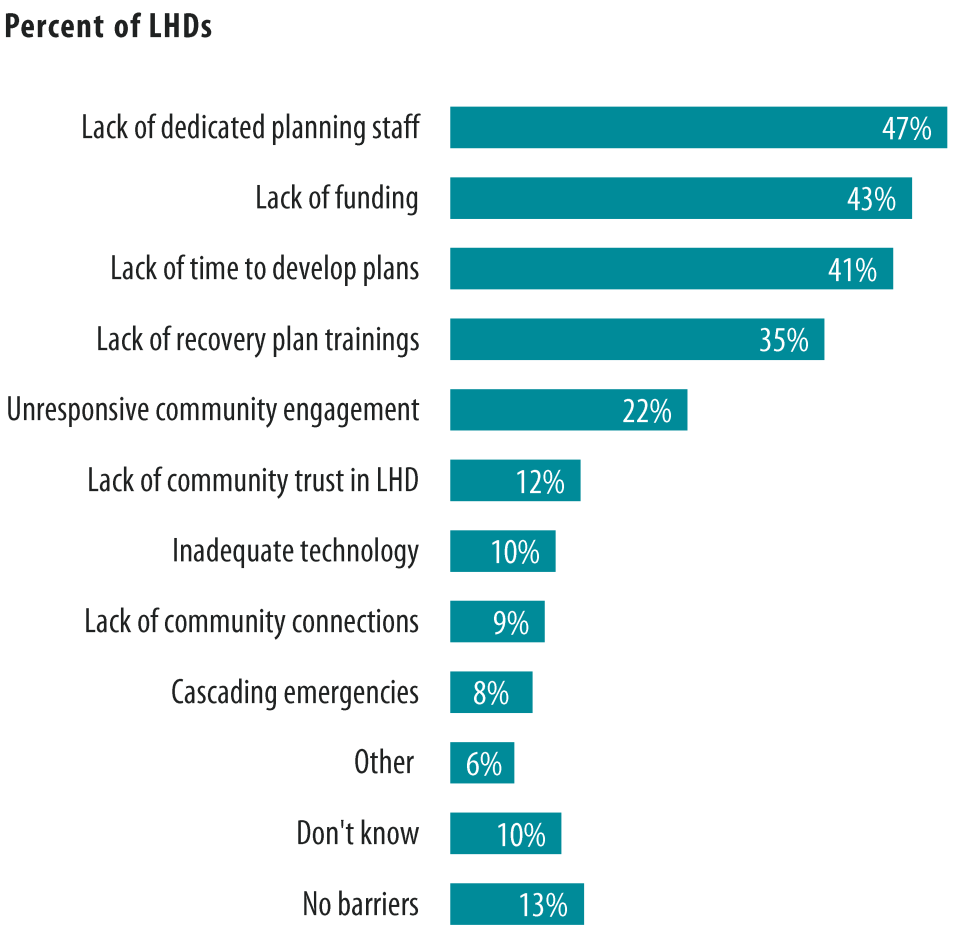
Most LHD jurisdictions have a community recovery plan in place. Most often, these are managed by the LHD—with 39% of LHDs indicating they have either a formal (i.e., official written plan established prior to an emergency) or informal plan and another 27% indicating there is a plan outside the LHD's management.

Although not shown in the figure, large LHDs were approximately twice as likely to report their jurisdiction's community recovery plan is housed outside of the LHD, compared to small and medium LHDs.

n=477

Community recovery is the ability to collaborate with community partners to plan and advocate for the rebuilding of public health, medical, and mental/behavioral health systems to at least a level of functioning comparable to the pre-incident levels.

Barriers to community recovery planning

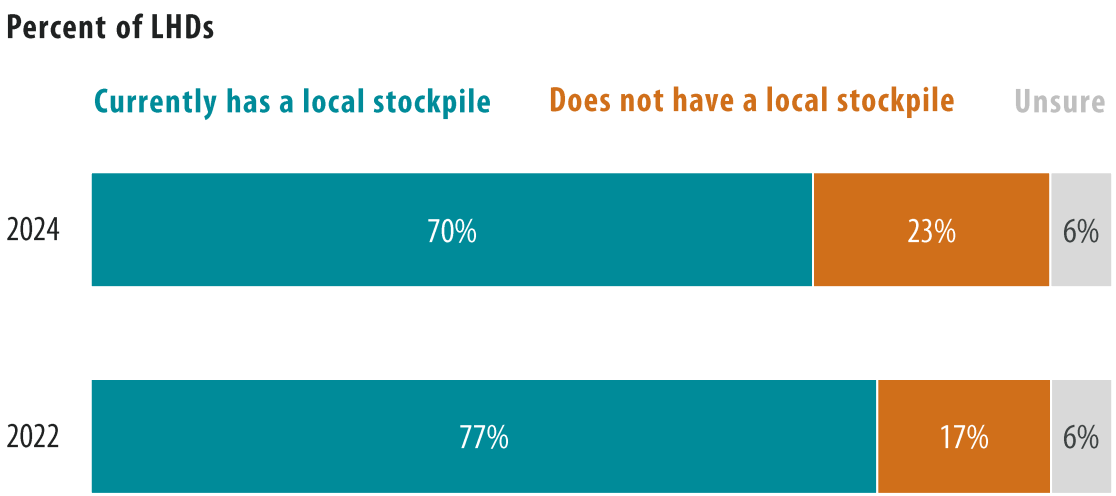


n=472

A lack of dedicated planning staff, funding, and time to develop recovery plans were the most common barriers to community recovery planning.

Although not shown in the figure, at least 50% of LHDs reported that recovery plan templates and/or checklists would be useful when working on community recovery planning. Though trainings and best practices were also seen as helpful, LHDs reported that they would rather have tangible tools that can be tailored for their own agency.

Existence of stockpiles within local jurisdictions



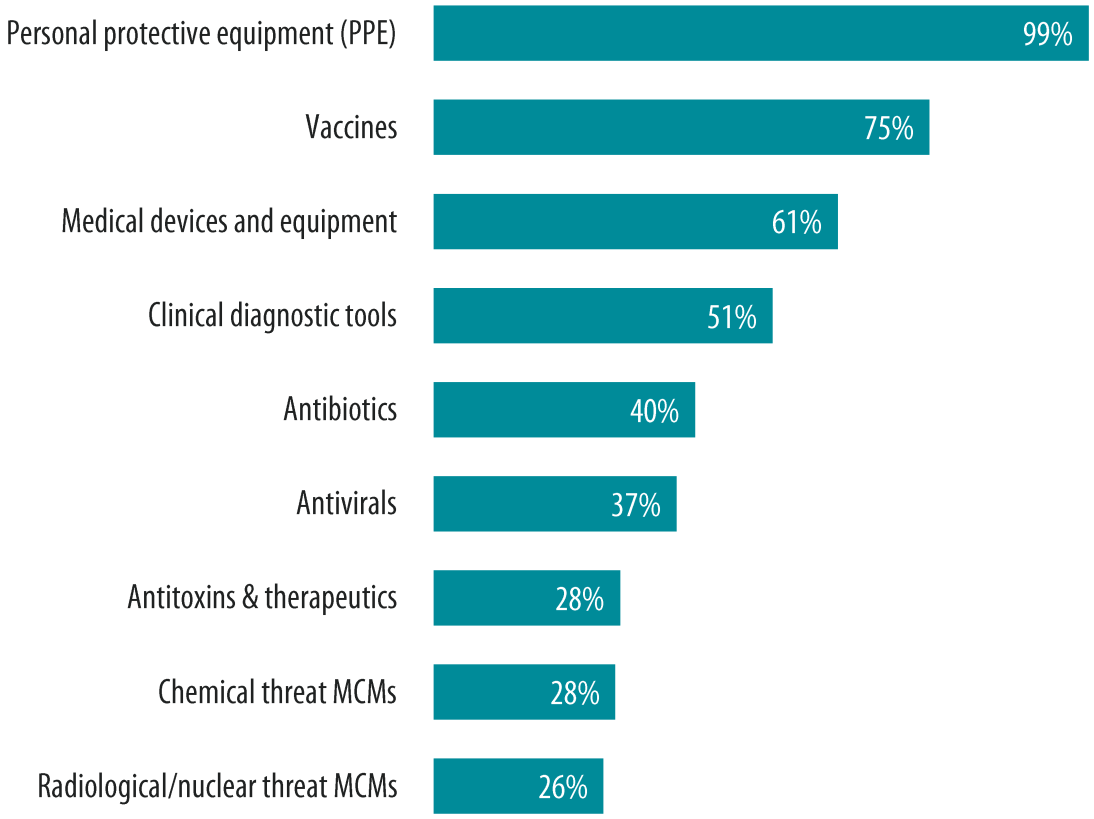
Seven in 10 LHDs indicated currently having local stockpile in 2024, which is a slight decrease from 2022. Although not shown in the figure, the existence of a local stockpile was more common in larger jurisdictions.

The top barrier to having a local stockpile was storage, but funds and maintenance were also major challenges (not shown in the figure).

n(2024)=489
n(2022)=341

Supplies available within local stockpile

Percent of LHDs *(of those currently with a local stockpile)*

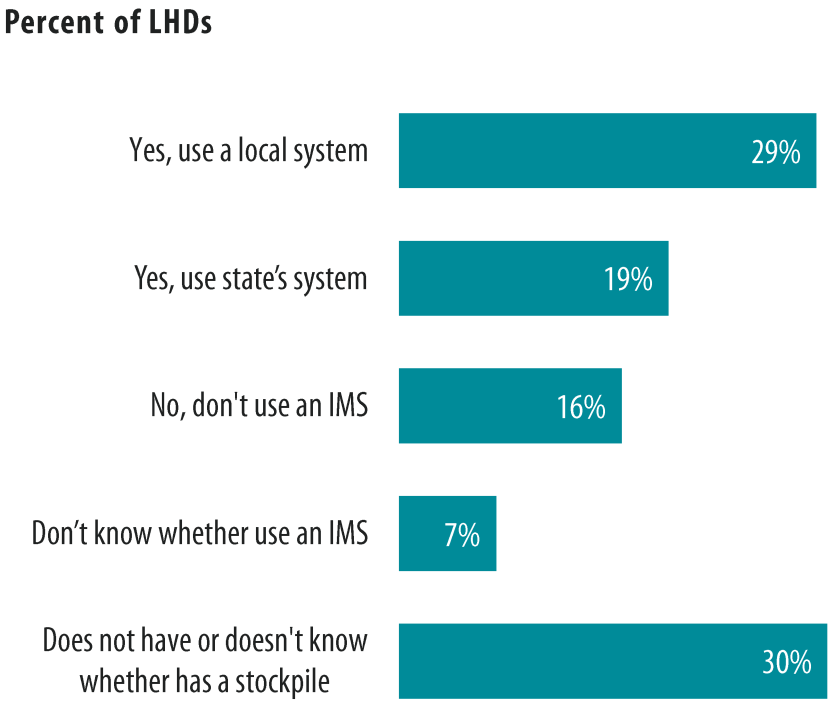


n=339–347

Most LHDs with a local stockpile reported that it included personal protective equipment (PPE), vaccines, medical devices and equipment, and clinical diagnostic tools.

Although not shown in the figure, LHDs did not know the number of days of supplies available for many supply categories. When they did know, it was typically seven or more days, across supply categories—except for antitoxins and chemical threat medical countermeasures (MCMs), of which less than two days was the most reported supply available.

Use of inventory management system for jurisdiction's stockpile



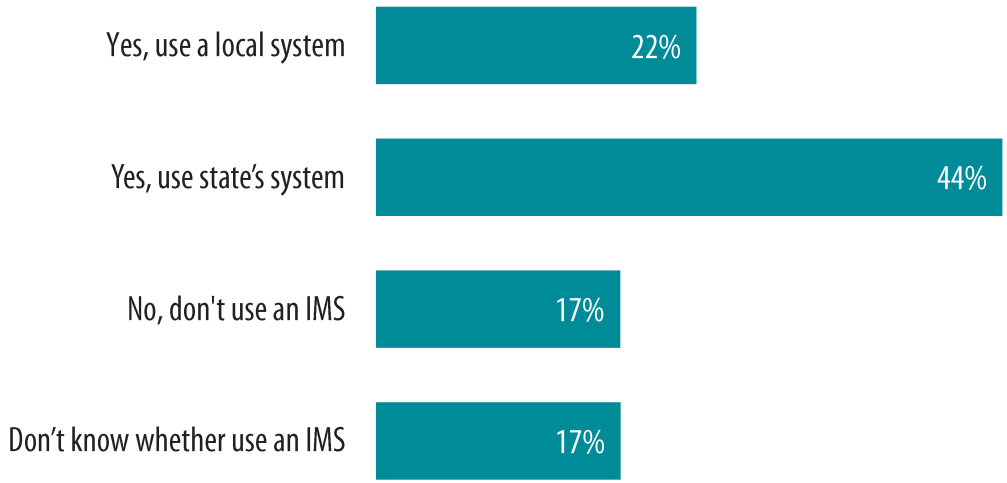
n=487

For their jurisdiction's stockpile, nearly half of LHDs use an inventory management system (IMS), with use of a local system being more common than a state system.

Although not shown in the figure, large LHDs are more likely to use a local IMS for their stockpiles, compared to medium and small LHDs. Meanwhile, medium and small are more likely to use a state IMS, compared to large LHDs.

Use of inventory management system for tracking of federal government assets

Percent of LHDs



For tracking federal government assets, two in three LHDs use either a local or state IMS; 17% don't use an IMS, and another 17% don't know if they use one. Notably, a state IMS is more commonly used for tracking federal assets than for a jurisdiction's stockpile.

Although not shown in the figure, large LHDs are more likely to use a local IMS for tracking, compared to medium and small LHDs. Meanwhile, medium and small are more likely to use a state IMS, compared to large LHDs.

n=484

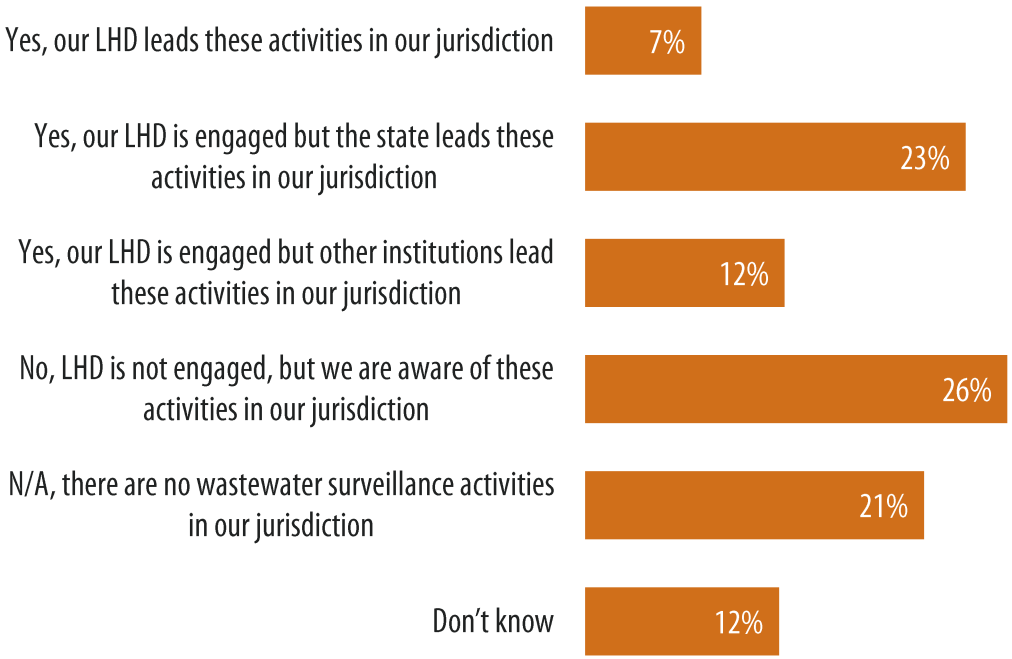
Preparedness & Response Activities

This chapter includes the following:

- Engagement in wastewater monitoring
- Activities conducted during the past year
- Changes in LHD participation in activities in the past three years

Engagement in wastewater monitoring

Percent of LHDs

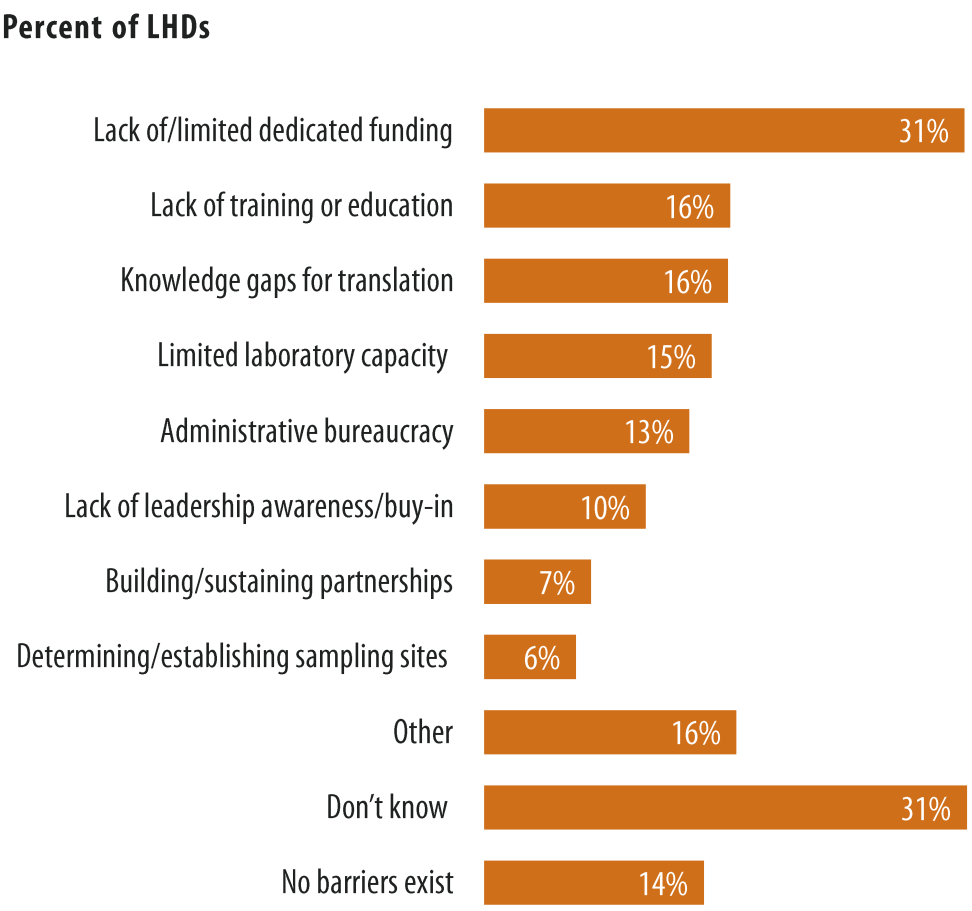


More than two in five LHDs are engaged in wastewater monitoring, with most of these activities being led at the state level. Another 47% of LHDs are not engaged in these activities, though some reported they do exist in their jurisdiction.

n=487

Wastewater monitoring (i.e., wastewater surveillance) is the strategic sampling and testing of wastewater and analysis and interpretation of the collected data (such as presence or concentration of pathogens, physical-chemical measures) to better understand disease within a community.

Barriers to wastewater monitoring



n=473

A lack of dedicated funding was the most common barrier to wastewater monitoring. However, nearly one-third of LHDs didn't know what barriers existed related to this work.

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

Percent of LHDs

	Planning	Training	Drills/ exercises	Regular coordination	Outreach	Real-event responses	No activities
Infectious disease	64%	53%	33%	48%	34%	38%	6%
Community preparedness	59%	39%	36%	42%	39%	20%	7%
Emergency risk communications	59%	41%	42%	37%	24%	24%	9%
Weather-related events	62%	36%	33%	41%	32%	38%	10%
Medical countermeasure dispensing	68%	52%	43%	39%	22%	22%	11%
Other at-risk populations	52%	31%	24%	39%	46%	21%	13%
Environmental health	56%	34%	17%	35%	25%	30%	15%
Healthcare preparedness	60%	43%	39%	49%	22%	20%	15%
Non-pharmaceutical interventions	56%	29%	18%	28%	16%	25%	22%
Disaster sheltering	53%	34%	21%	37%	17%	19%	24%
Bio-surveillance	51%	26%	19%	32%	18%	19%	25%
Disaster behavioral/mental health	51%	36%	12%	29%	20%	9%	26%
Volunteer management	46%	33%	32%	27%	24%	19%	28%
Cybersecurity	38%	42%	17%	18%	6%	10%	31%
Mass fatality	51%	26%	23%	25%	5%	4%	32%
CBRN events	52%	36%	24%	24%	6%	2%	32%
Long-term recovery	44%	17%	8%	23%	14%	14%	36%
People experiencing homelessness	26%	10%	5%	26%	36%	17%	37%
Critical infrastructure protection	38%	19%	12%	25%	10%	14%	40%
Terrorist threats	38%	19%	10%	15%	3%	1%	52%
Climate change/adaptation	34%	19%	8%	18%	14%	9%	53%

n=475–483

LHDs prioritized planning activities for medical countermeasure dispensing, infectious disease, weather-related events, and healthcare preparedness. Training also focused on some of these areas (i.e., infectious disease and medical countermeasure dispensing).

Although not shown in the table, smaller LHDs were more likely to report no activities than larger LHDs—except for long-term recovery.

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

Percent of LHDs *(No change not displayed)*

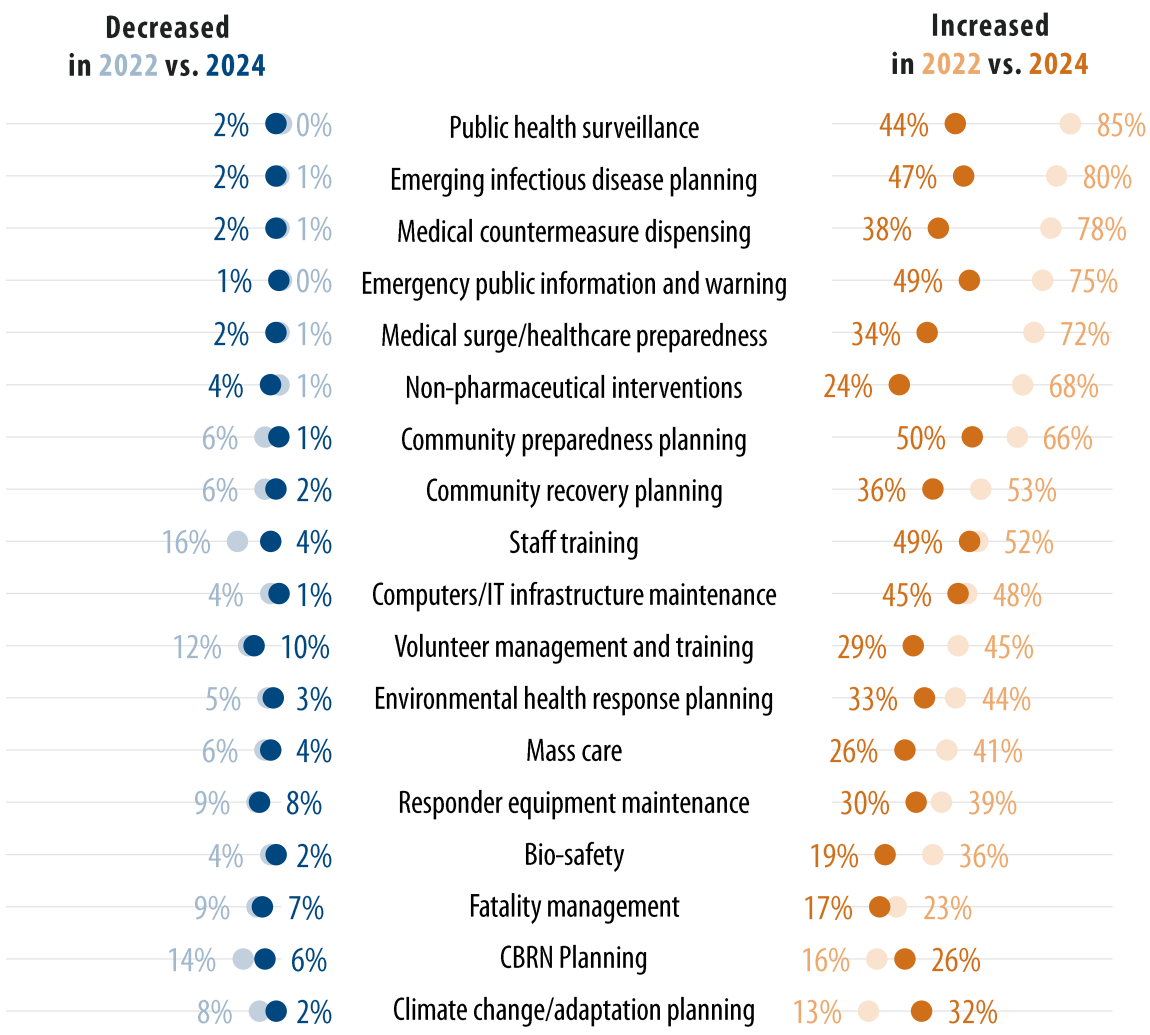
n=377–477

More than 40% of LHDs indicated that their participation increased in community preparedness planning, emergency public information and warning, staff training, emerging infectious disease planning, IT infrastructure maintenance, and public health surveillance.

Notably, LHDs were unsure about how their participation in bio-safety changed in the past three years.

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

Percent of LHDs *(No change not displayed)*



n(2024)=377–477 n(2022)=277–344

LHDs were much less likely to have increased their participation in several preparedness activities in 2024 than in 2022 (i.e., public health surveillance, medical countermeasure dispensing, and non-pharmaceutical interventions).

In contrast, LHDs were more likely to have increased participation in planning for chemical, biological, radiological, and nuclear (CBRN) activities and the health impacts of extreme weather events in 2024 than in 2022.

Notably, the proportion of LHDs increasing engagement in staff training and computers/IT infrastructure maintenance remained about the same between 2022 and 2024.

NACCHO
National Association of County & City Health Officials

PUBLIC HEALTH PREPAREDNESS

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

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