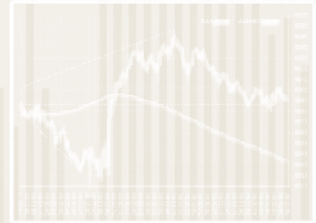
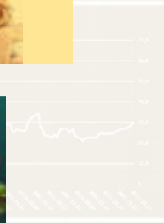


2013



National Profile OF LOCAL HEALTH DEPARTMENTS



NACCHO
National Association of County & City Health Officials



PROFILE

2013

National Profile OF LOCAL HEALTH DEPARTMENTS

January 2014

NACCHO

National Association of County & City Health Officials

The National Connection for Local Public Health



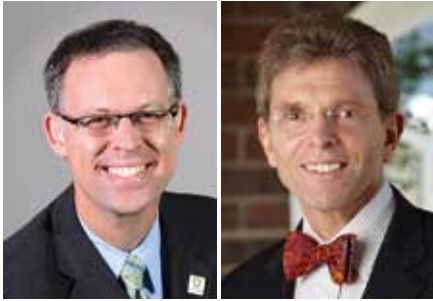
Acknowledgments

The 2013 National Profile of Local Health Departments study represented a collaborative effort by a diverse group in the public health community. The leadership and staff of the nation's local health departments (LHDs) served as critical partners and were the very foundation for the Profile study. State champions, representing state associations of county and city health officials and state health agencies, encouraged LHDs to complete the questionnaire and helped NACCHO achieve a high response rate.

The members of the Profile Workgroup provided key advice and assistance throughout all phases of the study. OmniStudio, Inc. designed the report, and Phyllis Jask completed the copyediting. NACCHO's Profile Team contributions included, in part, Nathalie Robin, who developed the Web-based interface; Giselle Plata, who coordinated study planning and follow-up; Carolyn Leep, who provided extensive knowledge and support; Jiali Ye, who analyzed data; and Sarah Newman, who collaborated to create the report. NACCHO's publications team and many other staff throughout NACCHO also provided essential assistance.

The Centers for Disease Control and Prevention and the Robert Wood Johnson Foundation supported the 2013 Profile study, and their guidance and sponsorship is gratefully appreciated.

Jan Wilhoit, Senior Project Management Specialist
2013 National Profile of Local Health Departments



For the past 24 years, NACCHO's National Profile of Local Health Department Study (Profile) has been one voice speaking about local health departments' people, resources, and activities nationwide. Government partners, researchers, philanthropies, community organizations, and NACCHO members, among the 2,800 LHDs, have benefited from analysis and interpretation of its data.

Anyone who has collected large amounts of data recognizes the time and energy needed to supply these data. NACCHO members, our partners, state associations of county and city health officials, the splendid Research and Evaluation Team at NACCHO, and our Profile workgroup are essential to the Profile's success.

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Quality and affordable medical care is important, but staying healthy depends even more on where we live, learn, work, and play. Local health departments exist to protect communities from unsafe food and water, disease outbreaks, costly preventable diseases, and other health threats.

Moving our nation toward a culture of health will require smart investments in public health and getting the highest value, most impactful outcomes from those investments. NACCHO's Profile study provides fundamental data to support research on public health systems, and we are grateful for the many dedicated local health department staff who participated in this survey.

Risa Lavizzo-Mourey, MD, MBA
President and CEO
Robert Wood Johnson Foundation



The Centers for Disease Control and Prevention is pleased to support NACCHO and its work on the National Profile of Local Health Departments. This 2013 Profile report is a valuable resource for all public health professionals, policymakers, federal agencies, researchers, and others to use to understand our nation's current local public health infrastructure.

The work of local health departments is critical in protecting the health of the community. I would like to commend NACCHO and the local health departments who provided these data, and their dedication and contribution to public health.

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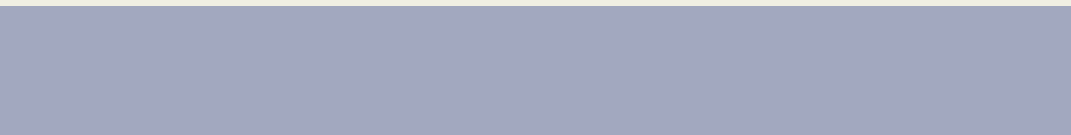
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CHAPTER 1

Introduction



The National Association of County and City Health Officials (NACCHO) conducted the first National Profile of Local Health Departments study in 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. Since then, NACCHO has conducted an additional six Profile studies, including in 2013. All Profile studies have been funded by the Centers for Disease Control and Prevention (CDC), and beginning in 2007, funding was also received from the Robert Wood Johnson Foundation (RWJF).

Purpose

The purpose of the 2013 National Profile of Local Health Departments (Profile) study was to develop a comprehensive and accurate description of LHD infrastructure and practice. Data from the Profile study are used by many people and organizations. 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.

Study Methodology

Study Population

Every Profile study has used 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 approximately 2,800 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. In those states, the state health agency chooses to respond to the Profile survey at either the regional or local level, but not at both levels.

NACCHO uses a database of LHDs based on previous Profile 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 2013 Profile study, a total of 2,532 LHDs were included in the study population. Hawaii and Rhode Island were excluded from the study because these state health departments operate on behalf of local public health and have no sub-state units.

Questionnaire Design

FIGURE 1.1 Questionnaire Topics 2013 Profile Study

Core (Core Only Response Rate = 78%)	Module 1 (Core + Module 1 Response Rate = 79%)	Module 2 (Core + Module 2 Response Rate = 82%)
Jurisdiction & Governance	Quality Improvement	Emergency Preparedness
Funding	Accreditation	Public Health Informatics
LHD Top Executive	Cross-Jurisdictional Sharing of Services	Access to Healthcare Services
Workforce	Human Resources Issues	Health Disparities
Activities	Partnerships and Collaboration	
Community Health Assessment and Planning	Practice-Based Research	
Guide to Community Preventive Services	Health Impact Assessments	
Policy-Making and Advocacy	County Health Rankings Report	
	Public Health Institute	
	Evaluation of Profile	

- The 2013 Profile study questionnaire included a set of core questions (Core) sent to all LHDs in the United States; additional supplemental questions were grouped into two modules.
- Many questions in the Core have been used in previous Profile studies and provide an ongoing dataset for comparative analysis; most new items were placed in modules.
- LHDs were randomly assigned to receive only the Core or the Core plus one of the two modules.

Sampling

All LHDs in the study population received the Core questionnaire. One of the two sets of supplemental questions or modules was included in the questionnaire for randomly selected LHDs. Stratified random sampling (without replacement) was used to assign LHDs to receive Core only or Core plus one of the two modules, 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 Distribution

The 2013 Profile questionnaire was piloted from October to November 2012. The final questionnaire was launched from January through March 2013, through 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. Paper copies were available upon request. Extensive efforts to encourage participants to complete the questionnaire included follow-up with non-respondents by NACCHO staff and a nationwide group of Profile study advocates, coupled with technical support offered through an e-mail address and telephone hotline.

- Overall, the 2013 Profile study had a response rate of 79 percent.
- With the exception of Massachusetts and Indiana, all states had a response rate of more than 60 percent.
- A total of 14 states and Washington, DC, had response rates of 100 percent.

Response Rates

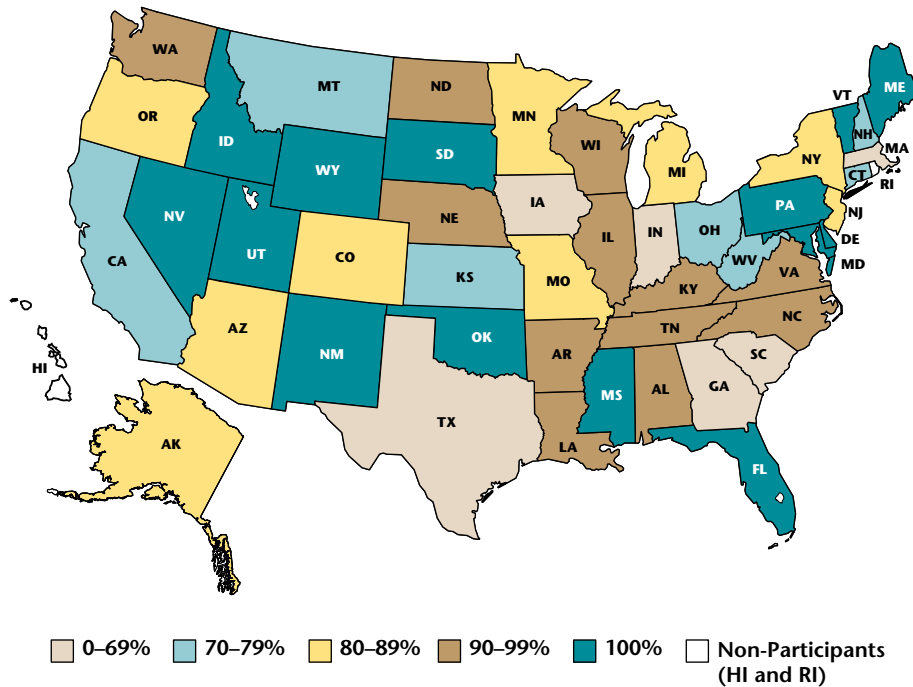
FIGURE 1.2 LHDs in Study Population, Number of Respondents, and Response Rates (by State)

State	Total Number of LHDs	Number of Respondents	Response Rate
All States	2,532	2,000	79%
Alabama	67	65	97%
Alaska	7	6	86%
Arizona	15	12	80%
Arkansas	75	74	99%
California	61	44	72%
Colorado	54	48	89%
Connecticut	74	52	70%
Delaware	2	2	100%
District of Columbia	1	1	100%
Florida	67	67	100%
Georgia	18	12	67%
Idaho	7	7	100%
Illinois	95	86	91%
Indiana	93	55	59%
Iowa	101	69	68%
Kansas	100	79	79%
Kentucky	57	54	95%
Louisiana	10	9	90%
Maine	10	10	100%
Maryland	24	24	100%
Massachusetts	329	132	40%
Michigan	45	40	89%
Minnesota	70	61	87%
Mississippi	9	9	100%
Missouri	115	95	83%
Montana	49	36	72%
Nebraska	21	19	90%
Nevada	4	4	100%
New Hampshire	4	3	75%
New Jersey	97	82	85%
New Mexico	6	6	100%
New York	58	47	81%
North Carolina	85	78	92%
North Dakota	28	27	96%
Ohio	124	93	75%
Oklahoma	70	70	100%
Oregon	34	30	88%

FIGURE 1.2 LHDs in Study Population, Number of Respondents, and Response Rates (by State)

State	Total Number of LHDs	Number of Respondents	Response Rate
Pennsylvania	16	16	100%
South Carolina	8	5	63%
South Dakota	8	8	100%
Tennessee	95	92	97%
Texas	65	44	68%
Utah	12	12	100%
Vermont	12	12	100%
Virginia	35	32	91%
Washington	35	32	91%
West Virginia	49	37	76%
Wisconsin	88	79	90%
Wyoming	23	23	100%

FIGURE 1.3 LHD Response Rates (by State)



- 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.

FIGURE 1.4 LHDs in Study Population, Number of Respondents, and Response Rates (by Population Served)

Size of Population Served	Total Number of LHDs	Number of Respondents	Response Rate
<25,000	1,040	745	72%
25,000–49,999	504	406	81%
50,000–99,999	402	329	82%
100,000–249,999	299	267	89%
250,000–499,999	150	125	83%
500,000–999,999	96	89	93%
1,000,000+	41	39	95%
Total	2,532	2,000	79%

Survey Weights and National Estimates

Unless otherwise stated, national statistics presented were computed using appropriate estimation weights. Estimation weights for the items from the core questionnaire were developed to account for dissimilar non-response by size of population served; estimation weights used to produce statistics from modules also accounted for sampling. By using estimation weights, the Profile study provides national estimates for all LHDs in the United States. Any 2008 or 2010 statistics included in this report were also weighted for non-response, but statistics may differ from previous years due to a special weight methodology. Special estimation weights were developed for some finance and workforce variables because the rate of item non-response is much higher in these two sections than in other sections of the Profile questionnaire. More details are provided in the finance and workforce chapters.

Study Limitations

The Profile study is a unique and comprehensive source of information on LHD finances, infrastructure, workforce, activities, and other important characteristics. There are several limitations, however, that 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 87 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; refer to Chapter 5 for details.

Comparisons with data from prior Profile studies are provided in some chapters, 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 significant differences.



Go to www.nacchoprofilestudy.org to access Chapter 1 of the 2013 National Profile of Local Health Departments, tables and figures from Chapter 1, and additional analyses based on 2013 Profile data.

CHAPTER 2

Jurisdiction, Governance, and Partnerships



Local health departments (LHDs) in the United States serve different jurisdiction types, with populations ranging from less than 1,000 to nearly 10 million. The governance of LHDs varies from state to state, and in some cases even within a state. LHDs also work closely with one another, through cross-jurisdictional sharing of services, and with other organizations in the community to provide local public health services.

- There are approximately 2,800 LHDs in the United States, but not every unit is included in the Profile study. LHDs operating under a centralized government structure may include multiple levels, for example, county units and multi-county regions or districts. The state health agency selects one level for inclusion in the Profile.
- 2,532 LHDs were included in the 2013 Profile study population.

- Only five percent of LHDs serve large jurisdictions of more than 500,000 people, yet they serve about half of the U.S. population (49%).
- Most LHDs (61%) are small, serving jurisdictions less than 50,000 people, and serving 10 percent of the U.S. population.

Populations and Jurisdictions Served by LHDs

FIGURE 2.1 Population Sizes Served by LHDs*

Size of Population Served	N	Percent
<10,000	437	17%
10,000–24,999	603	24%
25,000–49,999	504	20%
50,000–74,999	261	10%
75,000–99,999	141	6%
100,000–199,999	245	10%
200,000–499,999	204	8%
500,000–999,999	96	4%
1,000,000+	41	2%
Total	2,532	

Note: Due to rounding, percentages may not add up to 100 percent.

**Population data used for analyses are based on 2011 population estimates of the U.S. Census Bureau.*

FIGURE 2.2 LHD Jurisdictions (by Population Served)

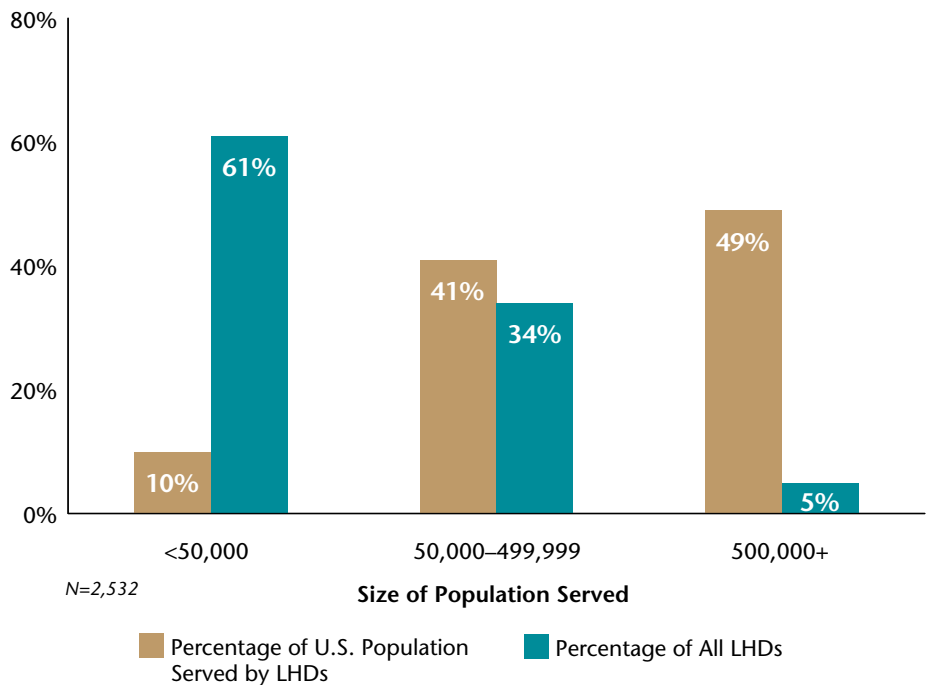
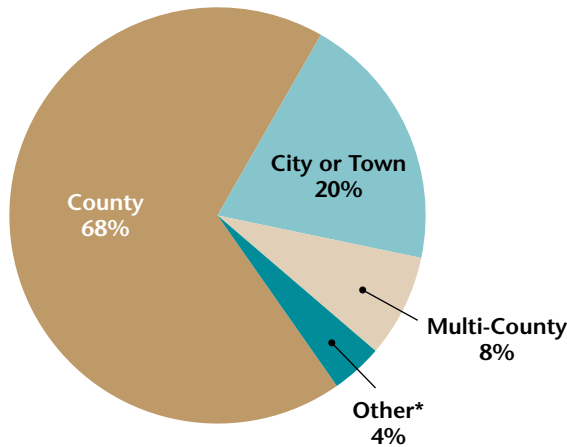


FIGURE 2.3 Geographic Jurisdictions Served by LHDs



N=2,532

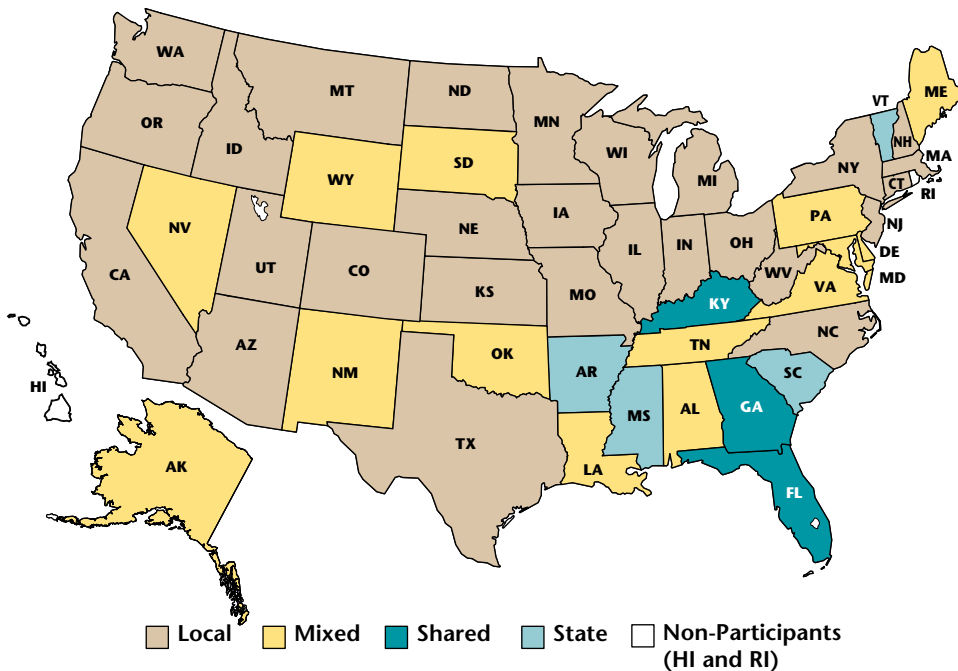
*"Other" category mostly includes LHDs serving multiple cities or towns.

- Most LHDs (68%) are county-based, and eight percent serve multiple county jurisdictions.
- Twenty percent of LHDs serve cities or towns; most of these LHDs (91%) serve fewer than 100,000 people.
- Large cities are most often served by county health departments; only nine jurisdictions that serve more than 500,000 people are served by city health departments.

Government Authority over 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). 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 2.4 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

- Of the 2,532 LHDs included in the 2013 Profile study population, 1,943 are locally governed, 402 are units of the state health agency, and 187 have shared governance.
- In 27 states, all LHDs are locally governed.
- All LHDs in Florida, Georgia, and Kentucky, and some LHDs in Maryland and Wyoming, have shared governance.

- Seventy percent of all LHDs had a local board of health.
- Local boards of health are less common (33%) among LHDs serving large populations (1,000,000+).
- Local boards of health are more common (79%) among LHDs that are locally governed than LHDs with state or shared governance.
- Around half of LHDs with state (46%) or shared (52%) governance have a local board of health.

Local Boards of Health

FIGURE 2.5 LHDs with a Local Board of Health (by Population Served and Governance)

LHD Characteristics	Percentage of LHDs with Local Board of Health
All LHDs	70%
Size of Population Served	
<50,000	72%
50,000–499,999	70%
500,000–999,999	57%
1,000,000+	33%
Type of Governance	
State	46%
Local	79%
Shared	52%

n=1,974

- At least three quarters of local boards of health act in an advisory capacity (86%), set LHD policies and goals (79%), adopt public health regulations (76%), and approve LHD budgets (75%).
- Few local boards of health have authority to request a public health levy (37%) or impose taxes for public health (19%).

FIGURE 2.6 Local Boards of Health Functions*

Functions Performed by Local Boards of Health	Percentage of LHDs
Advise LHD or Elected Officials on Policies, Programs, and Budgets	86%
Set Policies, Goals, and Priorities that Guide the LHD	79%
Adopt Public Health Regulations	76%
Approve the LHD Budget	75%
Set and Impose Fees	71%
Hire or Fire Agency Head	65%
Request a Public Health Levy	37%
Impose Taxes for Public Health	19%
Other	2%

n=1,371

**Among LHDs with a local board of health.*

Cross-Jurisdictional Sharing of Services

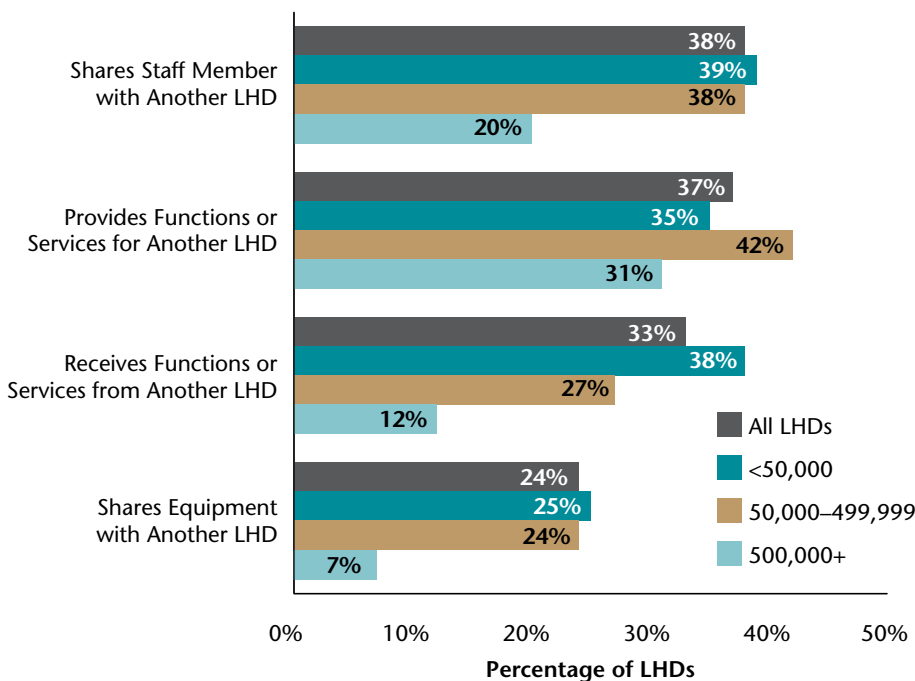
Cross-jurisdictional sharing of services is a term used to refer to the various means by which jurisdictions work together to provide public health services. LHDs across the country are looking to cross-jurisdictional sharing as a way to help them more efficiently and effectively deliver public health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

FIGURE 2.7 Cross-Jurisdictional Sharing of Resources among LHDs (by Population Served and Governance)

LHD Characteristics	Percentage of LHDs
All LHDs	54%
Size of Population Served	
<50,000	56%
50,000–499,999	53%
500,000+	35%
Type of Governance	
State	81%
Local	47%
Shared	51%

n=481

FIGURE 2.8 Types of Cross-Jurisdictional Sharing of Resources among LHDs (by Population Served)



n ranged from 451 to 467

- Approximately half of LHDs serving less than 500,000, and one-third (35%) of LHDs serving more than 500,000 people regularly shared resources, such as staff, equipment, or funding, with other LHDs.
- LHDs governed by a state authority shared resources most often (81%), compared with about half of LHDs with local (47%) or shared (51%) governance.
- In the past year, close to half (42%) of LHDs reported sharing resources to a greater extent than in the previous year, while only two percent reported sharing resources to a lesser extent.

- LHDs serving less than 50,000 people receive services most often (38%) from another LHD jurisdiction, compared to medium- (27%) and large-sized (12%) LHDs.
- Medium-sized LHDs, serving populations of 50,000 to 499,999, are more likely to provide services for another LHD jurisdiction (42%), than are small- (35%) or large-sized (31%) LHDs.
- LHDs serving more than 500,000 are the least likely of all LHDs to engage in cross-jurisdictional sharing of personnel, functions, services, and equipment.

- Cross-jurisdictional sharing by programmatic area occurs most frequently for emergency preparedness (35%), and epidemiology or surveillance (22%).
- Sharing resources to support any organizational function is less common (29%) than sharing resources to support any public health program (52%).

FIGURE 2.9 Cross-Jurisdictional Sharing of Resources among LHDs in Select Programmatic Areas and Organizational Functions

	Percentage of LHDs
Any Programmatic Area	52%
Emergency Preparedness	35%
Epidemiology or Surveillance	22%
Environmental Health Programs (Other than Inspection or Licensing)	21%
Inspection or Licensing	20%
Communicable Disease Screening or Treatment	18%
Maternal and Child Health Services	18%
Community Health Assessment	16%
Population-Based Primary Prevention Programs	13%
Chronic Disease Screening or Treatment	8%
Physician Clinical Services	6%
Any Organizational Function	29%
Health Officer/Medical Director	14%
Information Technology or Management	10%
Communications or Public Information	10%
Financial Management	9%
Human Resources	8%
Purchasing	7%

n ranged from 461 to 482

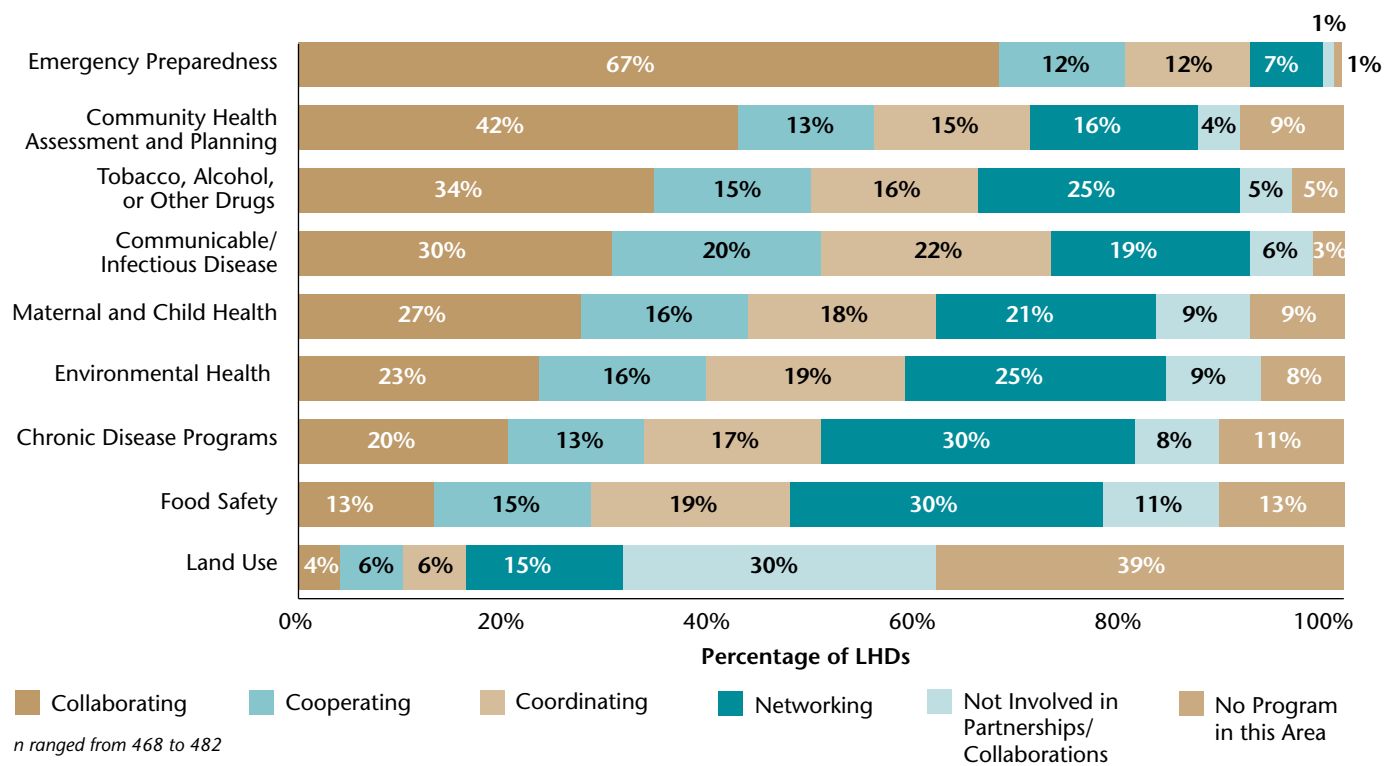


Go to www.nacchoprofilestudy.org to access Chapter 2 of the 2013 National Profile of Local Health Departments, tables and figures from Chapter 2, and additional analyses based on 2013 Profile data.

Partnerships within the Local Public Health System

LHDs serve as the backbone of the local public health system, which includes individuals and public and private entities that are engaged in activities that affect the public’s health. LHDs were asked to describe the ways in which they worked with other organizations in the community to accomplish goals in select programmatic areas in the past year, according to four types of relationships that increase in formality. The first and least formal—networking—includes exchanging ideas and information for mutual benefit, often via newsletter, meetings, conferences, or online. Coordinating involves exchanging information and altering activities for a formal purpose. Cooperating is exchanging information, altering activities, and sharing resources. The last and most formal way is collaborating, enhancing the capacity of the other partner for mutual benefit and a common purpose; collaborating also includes networking, coordinating, and cooperating.

FIGURE 2.10 Types of Partnerships among LHDs and Community Organizations (by Select Programmatic Area)



- More than three-quarters of LHDs reported some form of partnership in each of these areas except land use.
- The highest levels of partnership were reported for emergency preparedness, where approximately 80 percent of LHDs characterized their relationships as collaborating (67%) or cooperating (12%).
- LHDs also reported relatively high levels of more formal partnerships for community health assessment and planning, tobacco, alcohol, or other drugs, and communicable/infectious disease.
- LHDs most often reported less formal levels of partnership for environmental health, chronic disease programs, and food safety.

CHAPTER 3

Leadership



Local health department (LHD) top executives have many different titles across the United States: Director, Health Officer, Nurse Manager, Health Commissioner, and others. The top agency executive is defined as the highest ranking employee with administrative and managerial authority at the level of the LHD.

- The percentage of top agency executives working part-time decreased from 14 percent in 2005 to 10 percent in 2013.
- The number of female top executives has increased from 56 percent in 2005 to 60 percent in 2013.
- There has been little change in the percentages of top executives of color.

FIGURE 3.1 Characteristics of LHD Top Agency Executives (by Profile Study Year)

Characteristics	Percentage of LHD Top Executives	
	2005	2013
Part-Time Work Status	14%	10%
Female	56%	60%
Race Other than White*	8%	7%
Hispanic Ethnicity	1%	2%

n(2005) ranged from 2,202 to 2,257

n(2013) ranged from 1,946 to 1,966

**Respondents could report more than one race.*

- Twenty-five percent of LHD top executives are age 60 or older, compared with 16 percent in this age group in 2005.
- Most top executives are in their forties or fifties, although the percentage in this age group decreased from 85 percent in 2005 to 75 percent in 2013.

FIGURE 3.2 Age of LHD Top Agency Executives (by Profile Study Year)

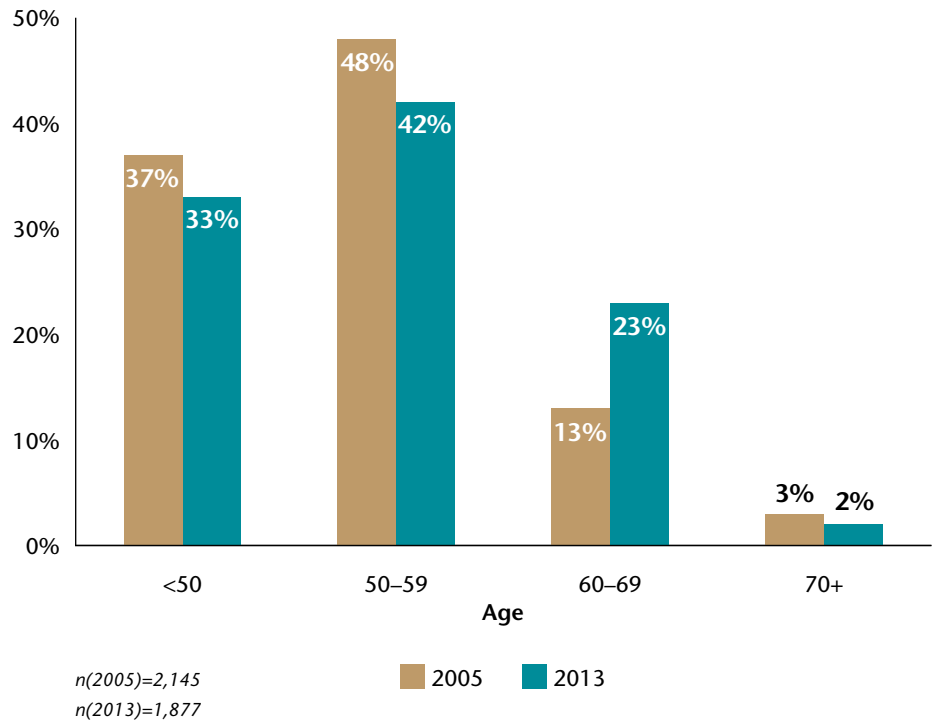


FIGURE 3.3 Education of LHD Top Agency Executives (by Highest Degree and Area)

Degree Types and Specialty Areas		All LHDs
Highest Degree		
Associate's		8%
Bachelor's		32%
Master's		45%
Doctoral		15%
Specialty Area		
Public Health ¹		22%
Nursing ²		32%
Medical ³		12%

n=1,889

¹ Public Health degree includes BSPH, MPH, DrPH, and PhD in Public Health.

² Nursing degree includes ASN, AND, BSN, BAN, MN, MSN, DNP, and PhD in Nursing.

³ Medical degree includes MD, DO, DDS, and DVM.

- Sixty percent of LHD top executives have earned a master's or doctoral degree.
- Less than one-third of LHD top executives have earned a degree in public health (22%), nursing (32%), or medical (12%) areas.

FIGURE 3.4 Mean Tenure of LHD Top Agency Executives (by Population Served and Governance)

LHD Characteristics	Mean Tenure* (Years)
All LHDs	8.7
Size of Population Served	
<25,000	9.2
25,000–49,999	9.4
50,000–99,999	8.5
100,000–499,999	7.8
500,000+	6.4
Type of Governance	
State	7.9
Local	9.2
Shared	6.5

n=1,930

*From April 2013.

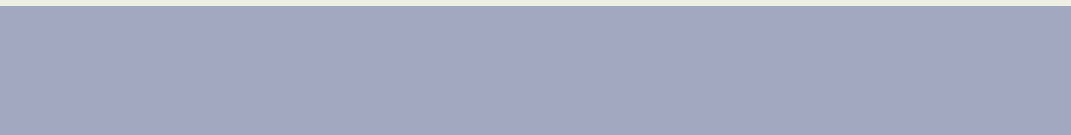
- LHD top executives have been in their positions for an average of 8.7 years.
- Top executives at LHDs serving smaller populations have been in their position longer, on average, than top executives at LHDs serving larger populations.
- Top executives at locally governed LHDs have been in their position longer, on average, than other top executives.



Go to www.nacchoprofilestudy.org to access Chapter 3 of the 2013 National Profile of Local Health Departments, tables and figures from Chapter 3, and additional analyses based on 2013 Profile data.

CHAPTER 4

Workforce

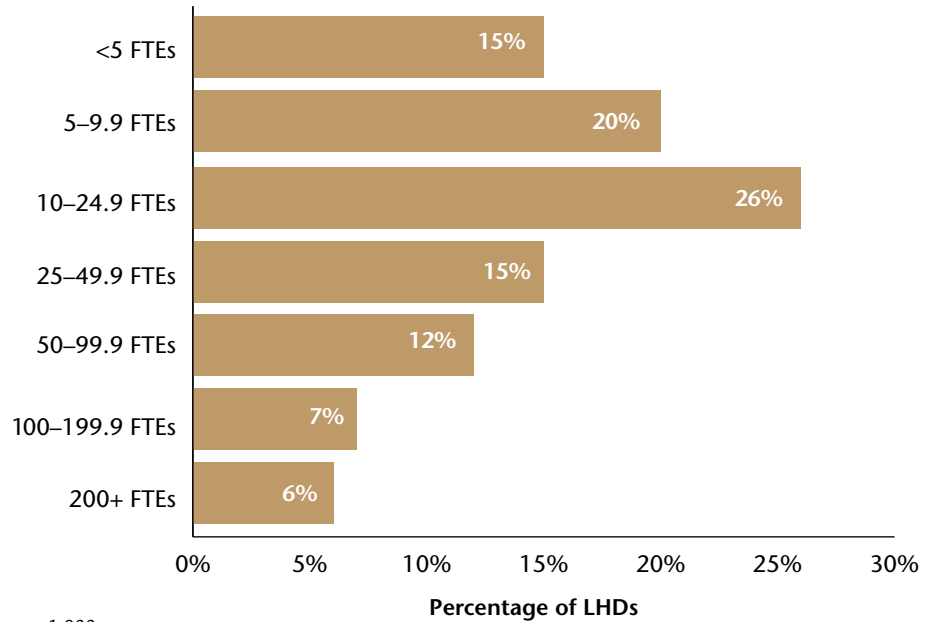


Local health department (LHD) employees are a major component of the public health workforce and play a vital role in protecting and improving the health of the communities they serve. The number, full-time equivalents (FTEs), and occupations of LHD employees vary by size of population served and by the programs and services provided by LHDs. Findings from the 2013 Profile make another major contribution in describing, and thus understanding, the make-up of the LHD workforce.

- Almost all LHDs (88%) employ fewer than 100 FTEs.
- Fifteen percent of LHDs employ fewer than five FTEs, and six percent employ 200 or more FTEs.

Number of LHD Employees

FIGURE 4.1 Number of FTEs Employed by LHDs



n=1,922

Note: Due to rounding, percentages do not add to 100 percent.

- The median number of staff employed by LHDs (employees or FTEs) varies by almost two orders of magnitude between LHDs serving the smallest and largest jurisdictions.
- Since 2010, the median number of employees and FTEs has decreased in LHDs serving jurisdiction population categories of 25,000 or more.
- Staffing decreases were greatest among LHDs serving large populations, with median numbers of employees and FTEs decreasing by more than 10 percent for LHDs serving 500,000 people or more.

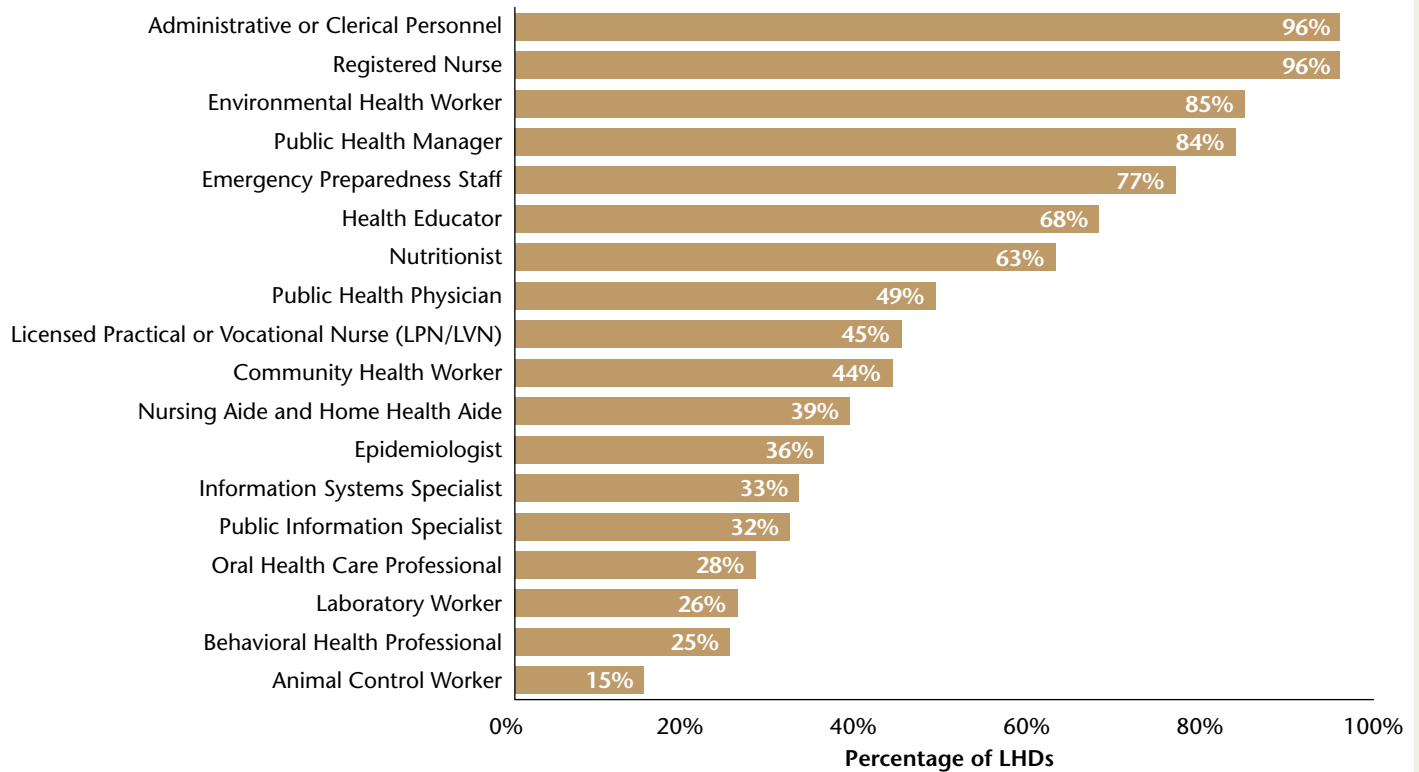
FIGURE 4.2 Median Number of Employees and FTEs at LHDs (by Profile Study Year and Population Served)

	Median Number of Employees		Median Number of FTEs	
	2010	2013	2010	2013
All LHDs	20	20	17	17
Size of Population Served				
<10,000	6	6	4	4
10,000-24,999	12	12	9	9
25,000-49,999	19	18	16	15
50,000-99,999	35	33	30	28
100,000-249,999	77	69	67	64
250,000-499,999	155	135	134	130
500,000-999,999	323	269	300	251
1,000,000+	531	470	530	453

n ranged from 1,922 to 2,033

Occupations Employed by LHDs

FIGURE 4.3 Select Occupations of LHD Employees



n ranged from 1,460 to 1,935 based on occupation

- More than 75 percent of LHDs employ administrative or clerical personnel (96%), registered nurses (96%), environmental health workers (85%), public health managers (84%), and emergency preparedness staff (77%).
- More than one third of LHDs employ staff in three new occupations added to the 2013 Profile questionnaire: Licensed practical or vocational nurses (LPN/LVN) (45%), community health workers (44%), and nursing and home health aides (39%).

Use caution when comparing 2013 Profile estimates of the percentage of LHDs that employ specific occupations to estimates from previous Profile studies. An unusually large amount of missing data makes the 2013 estimates more uncertain than those from other Profile studies.

FIGURE 4.4 Median Number of LHD FTEs in Select Occupations (by Population Served)

	All LHDs	Size of Population Served							
		<10,000	10,000–24,999	25,000–49,999	50,000–99,999	100,000–249,999	250,000–499,999	500,000–999,999	1,000,000+
Median Number of FTEs in All Staff Positions	17	4	9	15	28	64	130	251	453
Median FTEs in Select Occupations									
Administrative or Clerical Personnel	4	1	2.5	4	6.79	14	28.25	48.5	101.5
Registered Nurse	4	1	2.75	4	6	12	19	34.5	44.45
Environmental Health Worker	2	0.1	1	1.8	3	7	14	25	34
Public Health Manager	1	0.7	1	1	2	2	4	14	17
Emergency Preparedness Staff	0.74	0	0.2	0.5	1	1	2	4	5
Health Educator	0.9	0	0	0.55	1	1.71	3	5	9.9
Nutritionist	0.5	0	0	0.6	1	3	5	8.5	20.9
Public Health Physician	0	0	0	0	0	0.25	1	1.7	3
Community Health Worker	0	0	0	0	0	0.5	2	6	20
Epidemiologist	0	0	0	0	0	0	1	2	6
Information Systems Specialist	0	0	0	0	0	0	1	2	4.5
Laboratory Worker	0	0	0	0	0	0	0	2	10
Licensed Practical or Vocational Nurse (LPN/LVN)	0	0	0	0	0	0	0	2	3
Public Information Specialist	0	0	0	0	0	0	0	1	1
Behavioral Health Professional	0	0	0	0	0	0	0	1	0
Oral Health Care Professional	0	0	0	0	0	0	0	0	1

n ranged from 1,282 to 1,922 based on occupation

- LHDs that serve small populations typically employ staff in a relatively small number of occupations, including administrative or clerical personnel, registered nurses, environmental health workers, public health managers, and emergency preparedness staff.
- LHDs that serve medium-sized populations also typically employ staff in occupations such as health educators, nutritionists, physicians, and community health workers.
- Only LHDs that serve populations of 500,000 or more people typically employ staff in occupations such as licensed practical or vocational nurses (LPN/LVN), public information specialists, oral health care professionals, laboratory workers, or behavioral health professionals.

FIGURE 4.5 Estimated Size of LHD Workforce for All Staff and Select Occupations (by Profile Study Year)

	2008		2013	
	Estimated Workforce Size	95% Confidence Interval	Estimated Workforce Size	95% Confidence Interval
All Staff Positions				
Total Employees	190,000	160,000–219,000	162,000	139,000–185,000
Total FTEs	166,000	141,000–191,000	146,000	124,000–168,000
Select Occupations (FTEs)				
Administrative or Clerical Personnel	38,400	32,300–44,400	35,000	29,200–40,800
Registered Nurse	32,900	29,800–36,000	27,700	22,600–32,900
Environmental Health Worker	15,300	12,900–17,600	13,300	11,100–15,400
Public Health Manager	9,500	8,400–10,600	10,100	8,300–12,000
Community Health Worker	N/A	N/A	6,700	5,100–8,300
Nursing Aide and Home Health Aide	N/A	N/A	5,400	3,700–71,000
Health Educator	4,400	3,900–4,900	5,100	3,900–6,400
Nutritionist	4,200	3,700–4,700	5,000	4,400–5,600
Behavioral Health Professional	7,400	5,300–9,400	4,000	2,800–5,300
Licensed Practical or Vocational Nurse (LPN/LVN)	N/A	N/A	3,200	2,200–4,200
Emergency Preparedness Staff	N/A	N/A	2,900	2,300–3,400
Oral Health Care Professional	N/A	N/A	2,600	1,800–3,500
Public Health Physician	2,100	1,700–2,600	2,100	1,400–2,700
Information Systems Specialist	2,100	1,300–2,800	2,100	1,200–2,900
Laboratory Worker	N/A	N/A	2,000	1,400–2,500
Epidemiologist	1,300	920–1,600	1,800	780–2,900
Animal Control Worker	N/A	N/A	1,200	840–1,500
Public Information Specialist	440	370–500	550	470–630

n ranged from 1,282 to 1,942 based on occupation

Note: Numbers do not add to totals because listed occupational categories were not exhaustive of all LHD occupations.

N/A: Occupation not included in the 2008 Profile questionnaire.

- The estimated overall LHD workforce in FTEs decreased by approximately 12 percent from 2008 to 2013 (166,000 to 146,000).
- The estimated total employment of registered nurses by LHDs decreased by approximately 5,000 FTEs between 2008 and 2013; the estimated total employment of environmental health workers by LHDs decreased by approximately 2,000 FTEs between 2008 and 2013.
- Between 2008 and 2013, the estimated total FTEs employed by LHDs increased among epidemiologists, public information specialists, nutritionists, health educators, and public health managers.
- Between 2008 and 2013, the estimated total FTEs by LHDs decreased among behavioral health professionals, registered nurses, environmental health workers, and administrative or clerical personnel.

- Administrative or clerical personnel and registered nurses make up the largest percentage of the LHD workforce, totaling 24 percent and 19 percent of the workforce respectively.
- More than half of the LHD workforce is composed of administrative or clerical personnel, registered nurses, and environmental health workers.
- The addition of six new occupations to the 2013 Profile questionnaire reduced the percentage of the LHD workforce that is not categorized by occupation to 10 percent.

FIGURE 4.6 LHD Workforce Composition (by Select Occupation)

Occupation	Percentage of Total FTEs
Administrative or Clerical Personnel	24%
Registered Nurse	19%
Other Profile Occupation Categories*	15%
Not Categorized	10%
Environmental Health Worker	9%
Public Health Manager	7%
Community Health Worker	5%
Nursing Aide and Home Health Aide	4%
Health Educator	3%
Nutritionist	3%

n ranged from 1,282 to 1,942 based on occupation

**Ten occupations with less than three percent of LHD workforce.*

Note: Due to rounding, percentages do not add to 100 percent.

Technical Notes

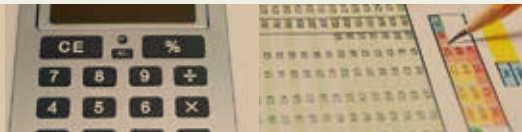
In order to minimize data loss, special statistical weights were developed to calculate the estimated size of the LHD workforce. Each estimate was developed using all valid data available, regardless of missing information in other occupations, total employees, and total FTEs. In addition to missing data, the great variety in the number of staff employed by LHDs results in high variance, as reflected by the large confidence intervals reported (Figure 4.5).



Go to www.nacchoprofilestudy.org to access Chapter 4 of the 2013 National Profile of Local Health Departments, tables and figures from Chapter 4, and additional analyses based on 2013 Profile data.

CHAPTER 5

Finance

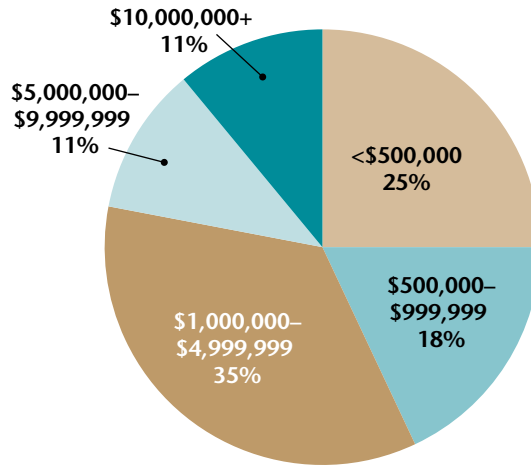


Examining local health department (LHD) financing emphasizes the diversity in LHD size and scope. Average total annual expenditures range from less than \$800,000 among LHDs that serve populations of less than 25,000 people to more than \$128 million among LHDs serving the largest populations. Exploring LHD revenue sources also demonstrates the varied ways states and local communities have chosen to fund local public health activities and services. Levels of reserve funds, which can help protect agencies from fluctuations in revenues, provide a measure of LHD resilience to economic stresses.

LHD Total Annual Expenditures

- More than half of all LHDs (53%) spend between \$500,000 and \$5 million per year; one-quarter of all LHDs spend less than \$500,000 per year.
- On average, LHDs spend just over \$7.2 million per year, or a median of almost \$1.3 million per year.
- 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 5.1 Total Annual LHD Expenditures



n=1,516

FIGURE 5.2 Mean and Quartiles of Total Annual LHD Expenditures (by Population Served)

Size of Population Served	Mean	25th Percentile	50th Percentile (Median)	75th Percentile
All LHDs	\$7,220,000	\$496,000	\$1,290,000	\$4,180,000
<25,000	\$799,000	\$228,000	\$459,000	\$954,000
25,000-49,999	\$1,780,000	\$670,000	\$1,180,000	\$2,180,000
50,000-99,999	\$3,350,000	\$1,390,000	\$2,570,000	\$4,310,000
100,000-249,999	\$6,990,000	\$3,610,000	\$5,910,000	\$8,520,000
250,000-499,999	\$14,500,000	\$7,290,000	\$11,100,000	\$17,000,000
500,000-999,999	\$59,400,000	\$14,200,000	\$28,100,000	\$48,400,000
1,000,000+	\$128,000,000	\$30,000,000	\$60,500,000	\$97,200,000

n=1,516

LHD Per Capita Expenditures and Revenues

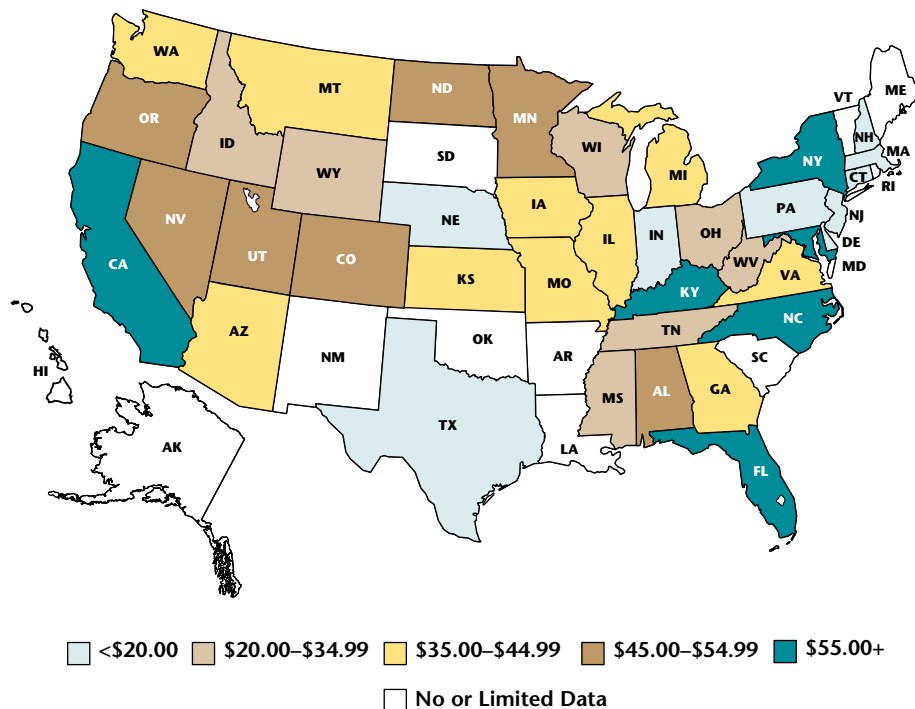
FIGURE 5.3 Median and Mean Annual Per Capita LHD Expenditures and Revenues (by Population Served and Governance)

LHD Characteristics	Expenditures		Revenues	
	Median	Mean	Median	Mean
All LHDs	\$39	\$57	\$39	\$58
Size of Population Served				
<25,000	\$43	\$67	\$46	\$69
25,000–49,999	\$33	\$50	\$37	\$52
50,000–99,999	\$37	\$48	\$38	\$47
100,000–249,999	\$36	\$45	\$38	\$45
250,000–499,999	\$32	\$43	\$31	\$39
500,000–999,999	\$40	\$78	\$40	\$82
1,000,000+	\$32	\$48	\$32	\$48
Type of Governance				
State	\$35	\$44	\$36	\$48
Local	\$37	\$54	\$37	\$55
Shared	\$67	\$89	\$67	\$89

n(Expenditures)=1,516
n(Revenues)=1,346

- Median and mean annual per capita expenditures were similar to annual per capita revenues across LHDs.
- On average, LHDs serving the smallest populations (fewer than 25,000 people) have higher per capita revenues and expenditures than LHDs serving larger populations.
- LHDs with a shared governance structure receive and spend almost twice as much on average as LHDs with exclusively local or state governance.

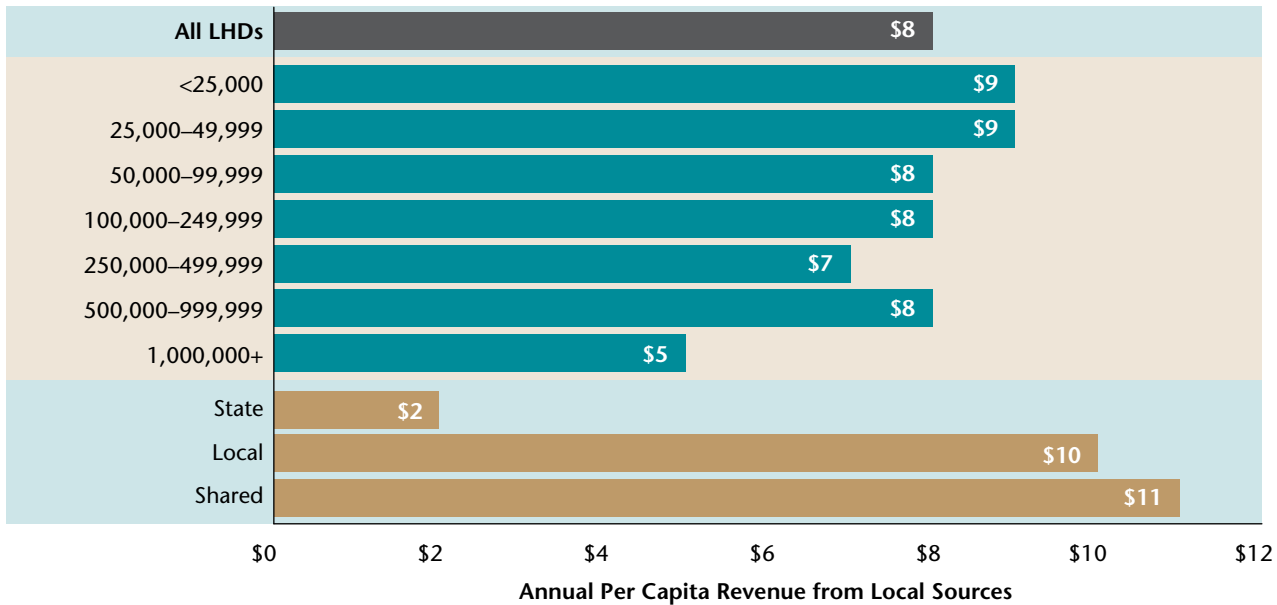
FIGURE 5.4 Median Annual Per Capita LHD Expenditures (by State)



- LHD median annual per capita expenditures vary greatly by state, with LHDs in Indiana, New Jersey, Massachusetts, and Connecticut spending less than \$15 per person, and LHDs in New York and Maryland spending more than \$100 per person.
- Median per capita LHD expenditures was less than \$20 in nine states, \$20 to \$35 in seven states, \$35 to \$45 in 10 states, \$45 to \$55 in seven states, and more than \$55 in six states.

LHD Revenue Sources

FIGURE 5.5 Median Annual Per Capita Revenues from Local Sources (by Population Served and Governance)



n=1,549

- Nationwide, LHDs receive a median of \$8 per person from local government sources; with medians ranging from \$7 to \$9 per person for population categories with fewer than one million people.
- LHDs serving populations of one million or more receive a median of \$5 per person from local government sources.
- On average, state-governed LHDs receive only \$2 per person from local sources, whereas locally governed LHDs receive \$10 per person and LHDs with a shared governance structure receive \$11 per person.
- Median per capita revenue from local sources varies by state, with LHDs in Nebraska, Alabama, and Arkansas receiving less than \$2 per person from local sources, and LHDs in North Carolina receiving more than \$20 per person.

FIGURE 5.6 Median Annual Per Capita LHD Revenues from Local Sources (by State)

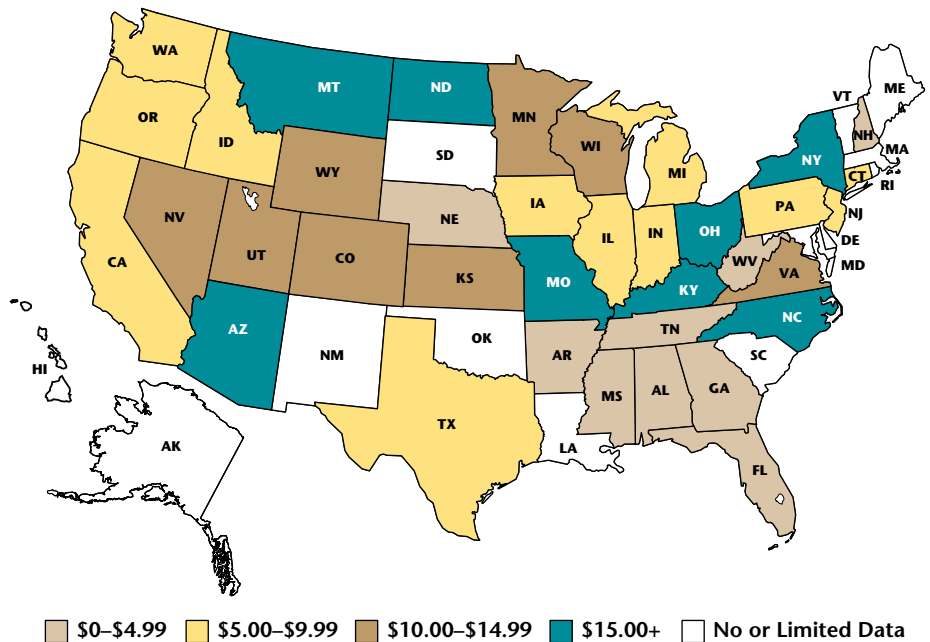
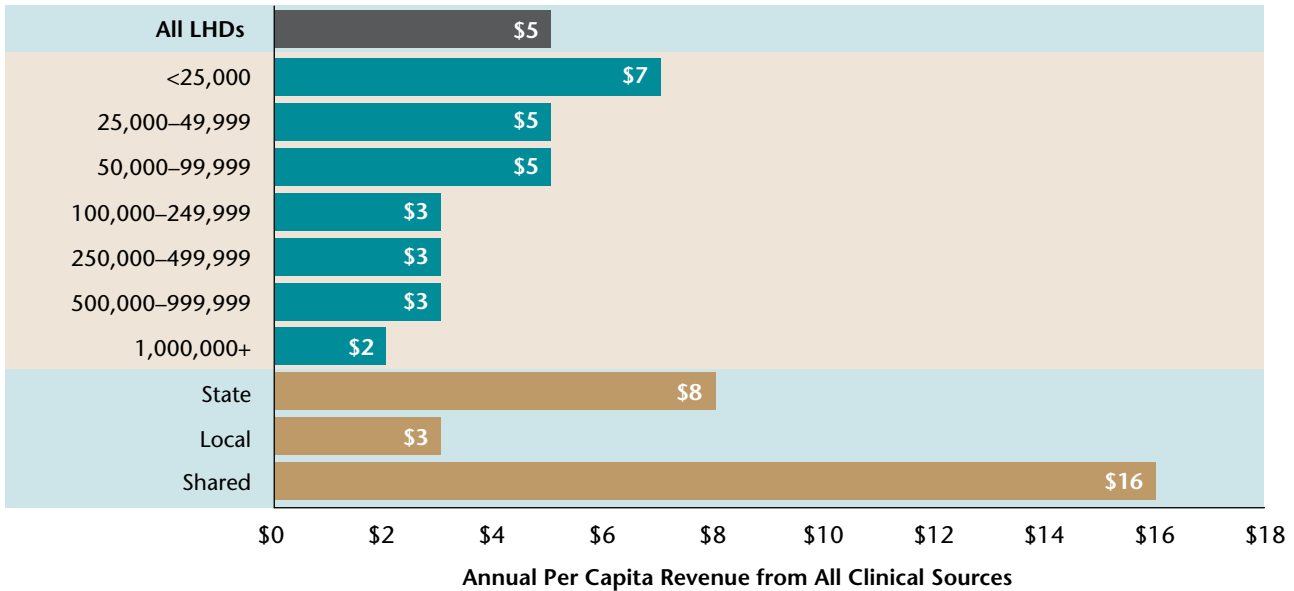
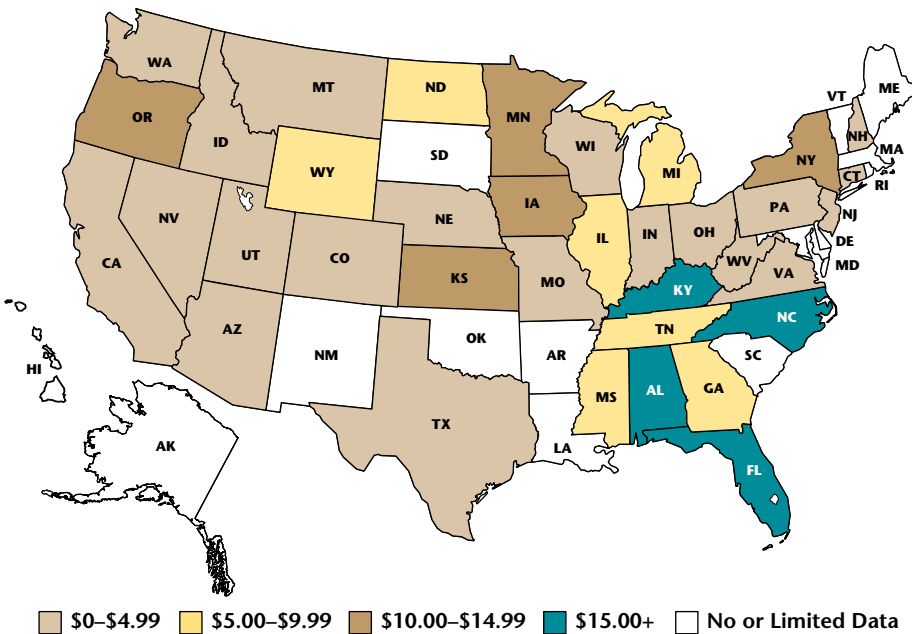


FIGURE 5.7 Median Annual Per Capita Revenues from All Clinical Sources (by Population Served and Governance)



n=1,364

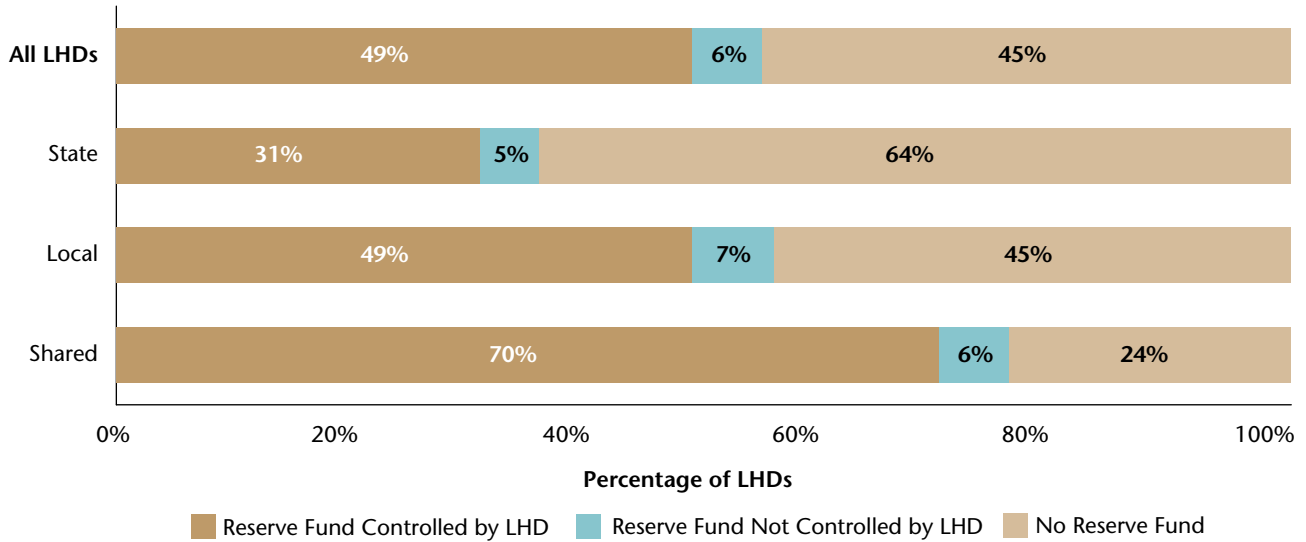
FIGURE 5.8 Median Annual Per Capita LHD Revenues from All Clinical Sources (by State)



- Nationwide, LHDs receive a median of \$5 per person from clinical sources (including Medicare, Medicaid, private insurance, and patient personal fees).
- On average, LHDs serving smaller populations receive more per person from clinical sources than LHDs serving larger populations.
- Median revenues from clinical sources for LHDs with a shared governance structure are \$16 per person; median revenues for state-governed LHDs (\$8 per person) and locally governed LHDs (\$3 per person) are lower.
- Median per capita revenue from clinical sources varies by state; medians are less than \$5 per person in 20 states and more than \$15 per person in four states.

Reserve Funds in LHDs

FIGURE 5.9 LHD Reserve Fund Status (by Governance)

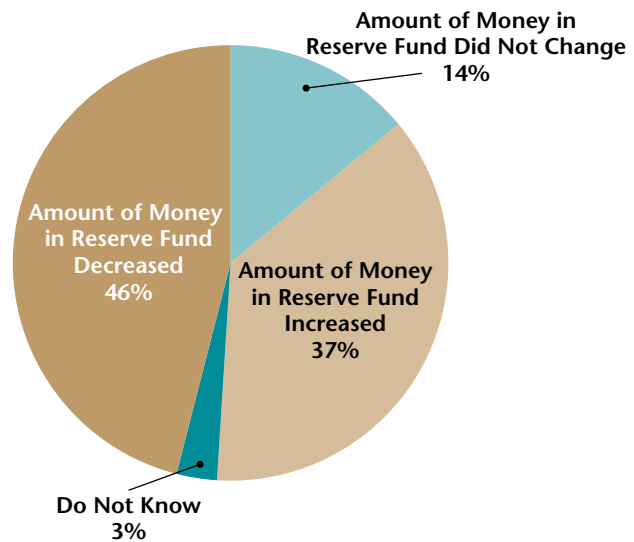


n=1,659

- Almost half of all LHDs have a reserve fund that is controlled by the LHD (49%), few (6%) have a reserve fund not controlled by the LHD, and 45 percent of LHDs do not have a reserve fund.
- LHDs with a shared governance structure are more likely to have a reserve fund controlled by the LHD (70%) than are locally governed LHDs (49%) or state-governed LHDs (31%).

- Almost half of all LHDs with a reserve fund experienced a decrease in the amount of money in their reserve funds (46%) in their most recently completed fiscal year. Conversely, 37 percent experienced an increase in the amount of money in their reserve funds.

FIGURE 5.10 Net Change in LHD Reserve Fund*



n=921

*Based on LHDs with a reserve fund.

Data Limitations

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 2013 Profile lead to a greater degree of approximation than was necessary for other chapters of this report.

Several centralized states (Oklahoma, Vermont, and South Dakota) do not provide any financial data for their local health units, so national estimates omit these states completely. In some other states (Alaska, Arkansas, Delaware, Louisiana, Massachusetts, Maine, New Mexico, and South Carolina) data are very incomplete, so reliable state-level estimates cannot be developed for certain financial measures. For Figures 5.4, 5.6, and 5.8 state estimates were not computed using estimation weights to account for non-response. Data for the District of Columbia were not included in the analysis because its status as both a local and state health department results in extreme values relative to other LHDs.

Like previous Profile surveys, the 2013 Profile collected data on revenue from state and federal sources. Examination of these data indicated that many LHDs erroneously reported federal funds they received through their state health agency (federal pass-through funding) as direct federal funding. Consequently, NACCHO cannot report reliable statistics based on those data.

In addition, LHD fiscal years do not all operate on the same cycle. LHDs reported financial data from different periods, making comparisons across LHDs difficult.

Lastly, 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.



Go to www.nacchoprofilestudy.org to access Chapter 5 of the 2013 National Profile of Local Health Departments, tables and figures from Chapter 5, and additional analyses based on 2013 Profile data.

CHAPTER 6

Programs and Services



Local health departments (LHDs) are involved in various activities that contribute to the goal of creating and maintaining healthy environments and communities. The 2013 Profile questionnaire listed 87 different public health programs and services, only seven of which are provided by more than three-quarters of all LHDs nationwide. The types of services provided in a particular jurisdiction depend on numerous factors, including state laws, community needs and priorities, funding, and availability of public health-related services from other agencies in the community.

- Four of the top 10 services that LHDs provided directly were immunizations and tuberculosis screening or treatment.
- LHDs most often provide lab services and HIV/AIDS screening through contracts, but few LHDs overall are involved in these services.
- Findings from previous Profile studies are included when trends were observed.
- All statistics presented reflect services provided directly by LHDs (with the exception of Figure 6.2).

- Nearly all LHDs, regardless of jurisdiction size, provide immunization services to adults and children.

Programs and Services Provided by LHDs

FIGURE 6.1 Ten Programs and Services Provided Directly and Most Frequently by LHDs

Rank	Program or Service	Percentage of LHDs
1	Communicable/Infectious Disease Surveillance	91%
2	Adult Immunization Provision	90%
3	Child Immunization Provision	90%
4	Tuberculosis Screening	83%
5	Environmental Health Surveillance	78%
6	Food Service Establishments Inspection	78%
7	Tuberculosis Treatment	76%
8	Food Safety Education	72%
9	Population-Based Nutrition Services	69%
10	Schools/Daycare Center Inspection	69%

n ranged from 1,949 to 1,975

FIGURE 6.2 Ten Programs and Services Provided Most Frequently via Contracts

Rank	Program or Service	Percentage of LHDs
1	Lab Services	11%
2	HIV/AIDS Screening	8%
3	Lead Inspection Regulation	7%
4	STD Screening	7%
5	HIV/AIDS Treatment	6%
6	STD Treatment	6%
7	Cancer Screening	6%
8	Population-Based Tobacco Prevention Services	6%
9	Tuberculosis Treatment	5%
10	Tuberculosis Screening	5%

n ranged from 1,929 to 1,971

Immunization Services

FIGURE 6.3 LHDs Providing Adult and Childhood Immunization Services (by Population Served)

Immunization Category	All LHDs	Size of Population Served				
		<25,000	25,000–49,999	50,000–99,999	100,000–499,999	500,000+
Adult	90%	87%	92%	94%	93%	92%
Child	90%	85%	92%	93%	92%	95%

n ranged from 1,963 to 1,975

Screening and Treatment for Diseases and Conditions

FIGURE 6.4 LHDs Providing Select Screening and Treatment for Diseases and Conditions (by Profile Study Year and Population Served)

	Profile Study Year		2013				
	2005	2013	Size of Population Served				
	All LHDs	All LHDs	<25,000	25,000–49,999	50,000–99,999	100,000–499,999	500,000+
Communicable Disease							
Tuberculosis Screening	82%	83%	75%	85%	87%	92%	92%
Tuberculosis Treatment	71%	76%	67%	77%	78%	87%	91%
STD Screening	60%	64%	55%	59%	67%	81%	92%
STD Treatment	56%	60%	50%	56%	62%	78%	87%
HIV/AIDS Screening	58%	61%	47%	56%	68%	82%	94%
HIV/AIDS Treatment	21%	24%	19%	20%	25%	34%	41%
Non-Communicable Disease or Condition							
Blood Lead Screening	63%	61%	57%	64%	64%	65%	62%
High Blood Pressure Screening	69%	57%	62%	57%	58%	49%	50%
Diabetes Screening	48%	36%	35%	34%	40%	37%	42%
Cancer Screening	42%	36%	30%	34%	42%	44%	44%
Cardiovascular Disease Screening	34%	27%	23%	26%	32%	29%	39%

n ranged from 1,915 to 1,971

- Since 2005, screenings for non-communicable diseases or conditions has decreased in all areas.
- LHDs that serve larger populations are more likely to provide screening services for communicable diseases than are LHDs that serve smaller populations.

Maternal and Child Health Services

FIGURE 6.5 LHDs Providing Select Maternal and Child Health Services (by Population Served)

Maternal and Child Health Services	All LHDs	Size of Population Served				
		<25,000	25,000–49,999	50,000–99,999	100,000–499,999	500,000+
WIC	65%	58%	65%	68%	76%	77%
Maternal Child Health Home Visits	60%	53%	57%	66%	68%	78%
Family Planning	54%	50%	55%	57%	61%	63%
EPSDT (Early Periodic Screening, Diagnosis, and Treatment)	36%	36%	37%	37%	37%	38%
Well Child Clinic	32%	29%	31%	36%	35%	33%
Prenatal Care	27%	20%	27%	34%	32%	35%
Obstetrical Care	8%	5%	8%	9%	14%	18%

n ranged from 1,929 to 1,971

- Many LHDs provide services to support the health of mothers and children, including Women, Infants, and Children (WIC) services (65%), maternal and child health home visits (60%), and family planning (54%).
- Few LHDs provide direct clinical services to mothers and children, such as obstetrical care (8%), prenatal care (27%), and well child clinics (32%).

Other Health Services

FIGURE 6.6 LHDs Providing Select Other Health Services (by Population Served)

Other Health Services	All LHDs	Size of Population Served				
		<25,000	25,000–49,999	50,000–99,999	100,000–499,999	500,000+
Oral Health	24%	14%	20%	29%	40%	50%
Home Healthcare	21%	28%	19%	20%	13%	10%
Comprehensive Primary Care	11%	7%	9%	16%	15%	20%
Behavioral/Mental Health Services	10%	7%	8%	12%	14%	25%
Substance Abuse Services	7%	4%	6%	9%	10%	20%

n ranged from 1,940 to 1,949

- Few LHDs provide health services, such as oral health (24%) and home healthcare (21%).
- LHDs that serve larger populations are more likely to provide these other health services than are LHDs that serve smaller populations, with the exception of home healthcare.

Epidemiology and Surveillance Services

- Almost all LHDs (91%) provide communicable/infectious disease surveillance, and most provide environmental health surveillance (78%) and maternal and child health (61%) surveillance.
- LHDs that serve larger populations are more likely to provide surveillance services than are LHDs that serve smaller populations.

FIGURE 6.7 LHDs Providing Select Epidemiology and Surveillance Services (by Population Served)

Epidemiology and Surveillance Services	All LHDs	Size of Population Served				
		<25,000	25,000–49,999	50,000–99,999	100,000–499,999	500,000+
Communicable/Infectious Disease	91%	86%	93%	93%	96%	96%
Environmental Health	78%	69%	84%	84%	88%	82%
Maternal and Child Health	61%	53%	62%	66%	71%	78%
Syndromic Surveillance	47%	38%	42%	49%	63%	81%
Chronic Disease	44%	37%	40%	49%	54%	62%
Behavioral Risk Factors	36%	28%	36%	44%	44%	55%
Injury Surveillance	27%	21%	24%	30%	34%	48%

n ranged from 1,910 to 1,975

Population-Based Primary Prevention Services

FIGURE 6.8 LHDs Providing Select Population-Based Primary Prevention Services (by Population Served)

Primary Prevention Services	All LHDs	Size of Population Served				
		<25,000	25,000–49,999	50,000–99,999	100,000–499,999	500,000+
Nutrition	69%	60%	68%	72%	83%	86%
Tobacco	68%	60%	72%	72%	77%	80%
Physical Activity	52%	44%	53%	57%	61%	68%
Chronic Disease Programs	50%	42%	48%	54%	60%	72%
Unintended Pregnancy	49%	42%	50%	50%	56%	69%
Injury	38%	35%	37%	39%	43%	50%
Substance Abuse	24%	19%	27%	29%	28%	30%
Violence	21%	16%	21%	21%	27%	38%
Mental Illness	12%	9%	12%	13%	18%	17%

n ranged from 1,910 to 1,959

- Most LHDs provide population-based primary prevention services focused on nutrition (69%) and tobacco use (68%).
- LHDs are less likely to be involved in population-based primary prevention for substance abuse (24%), violence (21%), or mental illness (12%).

Environmental Health Services

FIGURE 6.9 LHDs Providing Select Environmental Health Services (by Population Served)

Environmental Health Services	All LHDs	Size of Population Served				
		<25,000	25,000–49,999	50,000–99,999	100,000–499,999	500,000+
Food Safety Education	72%	63%	76%	83%	79%	78%
Vector Control	48%	39%	51%	55%	57%	62%
Groundwater Protection	40%	31%	40%	44%	57%	53%
Surface Water Protection	33%	25%	34%	37%	43%	46%
Indoor Air Quality	31%	27%	29%	35%	34%	45%
Pollution Prevention	22%	14%	20%	26%	29%	44%
Hazmat Response	17%	13%	13%	19%	25%	32%
Collection of Unused Pharmaceuticals	16%	15%	21%	16%	16%	15%
Air Pollution	16%	12%	14%	19%	19%	32%
Hazardous Waste Disposal	15%	13%	12%	15%	19%	29%
Land Use Planning	14%	11%	13%	20%	17%	17%
Radiation Control	13%	10%	11%	14%	17%	20%
Noise Pollution	12%	10%	12%	14%	14%	21%

n ranged from 1,910 to 1,954

- Seventy-two percent of LHDs provide food safety education.
- The three least common environmental health services provided by LHDs are noise pollution (12%), radiation control services (13%), and land use planning services (14%).

- LHDs are most likely to provide regulation, inspection, or licensing services to food service establishments (78%), schools/daycares (69%), public swimming pools (68%), and septic systems (66%).
- Few LHDs provide regulation, inspection, or licensing of milk processing (12%) or cosmetology businesses (12%).
- While most regulation, inspection, or licensing services are more likely to be provided by LHDs serving larger populations, the regulation, inspection, or licensing of hotel/motels and of cosmetology businesses are more likely to be provided by LHDs serving mid-sized populations.

Regulation, Inspection, or Licensing Services

FIGURE 6.10 LHDs Providing Select Regulation, Inspection, or Licensing Services (by Population Served)

Regulation, Inspection, or Licensing Services	All LHDs	Size of Population Served				
		<25,000	25,000–49,999	50,000–99,999	100,000–499,999	500,000+
Food Service Establishments	78%	69%	80%	86%	89%	79%
Schools/Daycares	69%	62%	71%	75%	77%	68%
Public Swimming Pools	68%	56%	68%	78%	83%	83%
Septic Systems	66%	60%	66%	72%	77%	67%
Smoke-Free Ordinances	59%	50%	61%	64%	69%	70%
Private Drinking Water	56%	51%	54%	59%	65%	58%
Body Art	55%	43%	61%	67%	65%	56%
Hotels/Motels	50%	44%	53%	59%	53%	41%
Lead Inspection	49%	37%	53%	56%	58%	66%
Children’s Camps	48%	39%	52%	56%	58%	53%
Campgrounds & RVs	40%	29%	40%	49%	56%	40%
Public Drinking Water	33%	27%	29%	38%	43%	48%
Food Processing	32%	31%	33%	36%	30%	37%
Health-Related Facilities	31%	26%	34%	38%	32%	38%
Solid Waste Disposal Sites	28%	24%	25%	30%	35%	38%
Mobile Homes	28%	21%	29%	36%	34%	29%
Solid Waste Haulers	28%	26%	27%	27%	31%	30%
Housing Inspections	26%	24%	28%	29%	24%	29%
Tobacco Retailers	25%	22%	27%	26%	26%	34%
Milk Processing	12%	12%	9%	14%	12%	20%
Cosmetology Businesses	12%	10%	13%	18%	12%	8%

n ranged from 1,904 to 1,962

Other Public Health Services

FIGURE 6.11 LHDs Providing Select Other Public Health Services (by Population Served)

Other Public Health Services	All LHDs	Size of Population Served				
		<25,000	25,000–49,999	50,000–99,999	100,000–499,999	500,000+
Vital Records	54%	45%	56%	57%	65%	69%
Outreach and Enrollment for Medical Insurance	42%	37%	40%	47%	49%	56%
School Health	36%	34%	37%	36%	36%	44%
Laboratory	27%	20%	23%	26%	38%	66%
School-Based Clinics	27%	31%	25%	24%	20%	27%
Asthma Prevention or Management	19%	13%	16%	21%	26%	44%
Animal Control	15%	11%	16%	23%	15%	15%
Veterinarian Public Health	13%	9%	13%	15%	19%	24%
Correctional Health	11%	11%	9%	11%	12%	20%
Occupational Safety and Health	10%	7%	11%	10%	10%	16%
Medical Examiner's Office	4%	2%	2%	2%	8%	11%
Emergency Medical Services	3%	2%	1%	3%	5%	17%

n ranged from 1,930 to 1,951

- LHDs sometimes provide various other public health-related services, such as vital records services (54%), outreach and enrollment for medical insurance (42%), and school health activities (36%).
- Few LHDs provide emergency medical services (3%) or have a medical examiner's office (4%).



Go to www.nacchoprofilestudy.org to access Chapter 6 of the 2013 National Profile of Local Health Departments, tables and figures from Chapter 6, and additional analyses based on 2013 Profile data.

CHAPTER 7

Emergency Preparedness and Response

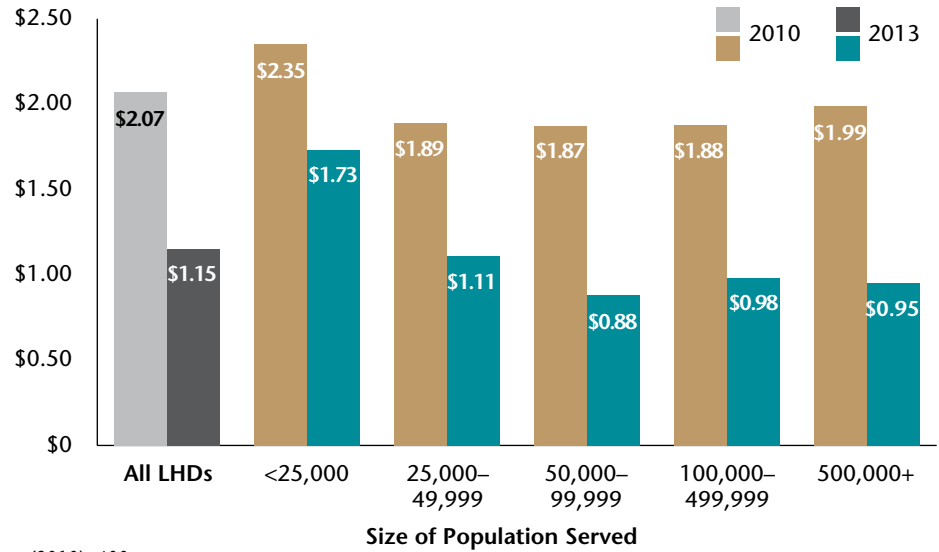


Responding to a broad range of disasters and public health emergencies is an essential service of local health departments (LHDs). LHDs play a key role in preventing and responding to disease outbreaks, environmental hazards, and natural disasters. Understanding LHD capacity and experience with responding to these events can be important in predicting the quality of their response to future emergencies.

- Revenue for LHD preparedness activities decreased from a median of \$2.07 per person in 2010 to \$1.15 per person in 2013.
- LHDs that serve a jurisdiction of more than 50,000 received approximately half the median revenue per person in 2013 compared to 2010.

Funding for Emergency Preparedness

FIGURE 7.1 Median Per Capita Revenue for LHD Preparedness Activities (by Profile Study Year and Population Served)*



n(2010)=400
n(2013)=377
*For most recently completed fiscal year.

Emergency Preparedness Activities

FIGURE 7.2 LHD Participation in Select Emergency Preparedness Activities (by Population Served and Governance)

Emergency Preparedness Activity	All LHDs	Size of Population Served			Type of Governance		
		<50,000	50,000–499,999	500,000+	State	Local	Shared
Developed or Updated a Written Emergency Plan	87%	84%	90%	95%	70%	91%	96%
Provided Emergency Preparedness Training to Staff	84%	81%	88%	97%	78%	85%	96%
Participated in Tabletop Exercises or Drills	76%	69%	86%	100%	50%	82%	93%
Assessed Emergency Preparedness Competencies of Staff	66%	64%	69%	76%	47%	70%	90%
Participated in Functional Exercises or Drills	66%	58%	76%	90%	52%	68%	83%
Reviewed Relevant Legal Authorities	47%	44%	51%	68%	20%	53%	66%
Participated in Full-Scale Exercises or Drills	38%	30%	48%	68%	37%	37%	53%

n=498

- Most LHDs have developed or updated a written emergency plan (87%) or provided emergency preparedness training to staff (84%).
- LHDs that serve larger populations are more likely to participate in emergency preparedness activities, compared to LHDs that serve smaller populations; for example, all LHDs that serve more than 500,000 people have participated in tabletop exercises or drills, and almost all (97%) have provided emergency preparedness training to staff.
- LHDs with shared governance are more likely to participate in emergency preparedness activities than are LHDs governed exclusively by state or local authorities.

LHD Response to All-Hazards Events and Participation in Drills or Exercises

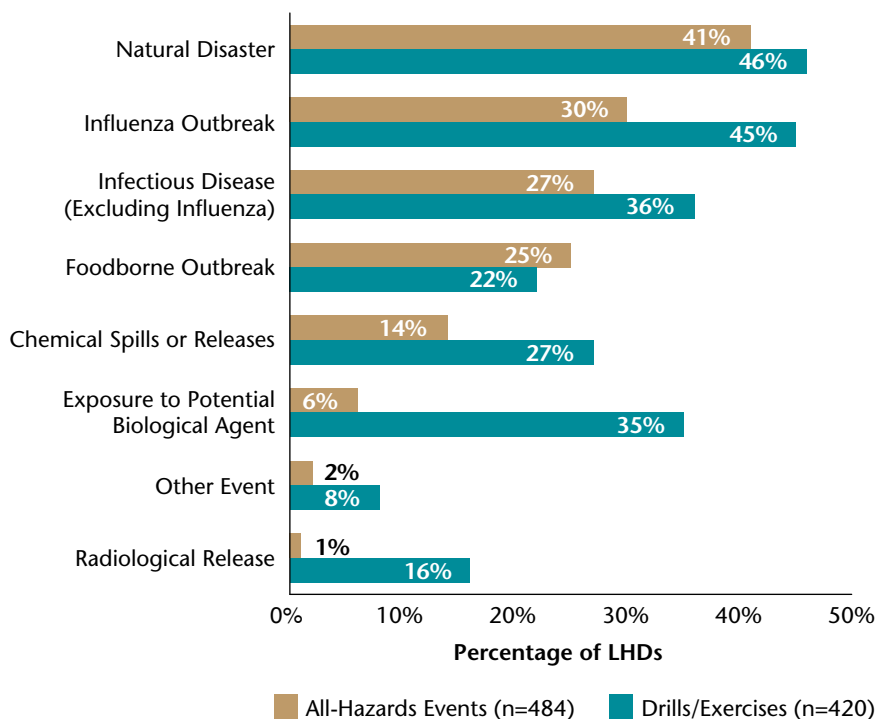
FIGURE 7.3 LHD Response to All-Hazards Events or Participation in Drills or Exercises (by Population Served and Governance)*

LHD Characteristics	Percentage of LHDs	
	All-Hazards Events	Drills/Exercises
All LHDs	55%	93%
Size of Population Served		
<25,000	41%	91%
25,000–49,999	54%	94%
50,000–99,999	58%	90%
100,000–499,999	76%	96%
500,000+	79%	100%
Type of Governance		
State	39%	83%
Local	56%	95%
Shared	88%	100%

*Since September 2010. n=495 n=496

- Since September 2010, more than half of all LHDs (55%) have responded to at least one all-hazards event, and almost all (93%) have participated in an emergency response drill or exercise.
- LHDs that serve larger populations are more likely to have responded to an all-hazard event than are LHDs that serve smaller populations.
- LHDs that are governed by a shared state and local structure are more likely to have responded to an all-hazard event (88%) or participated in an emergency response drill or exercise (100%) than are LHDs governed exclusively by state or local authorities.

FIGURE 7.4 LHD Response to a Specific All-Hazards Event or Participation in a Drill or Exercise*

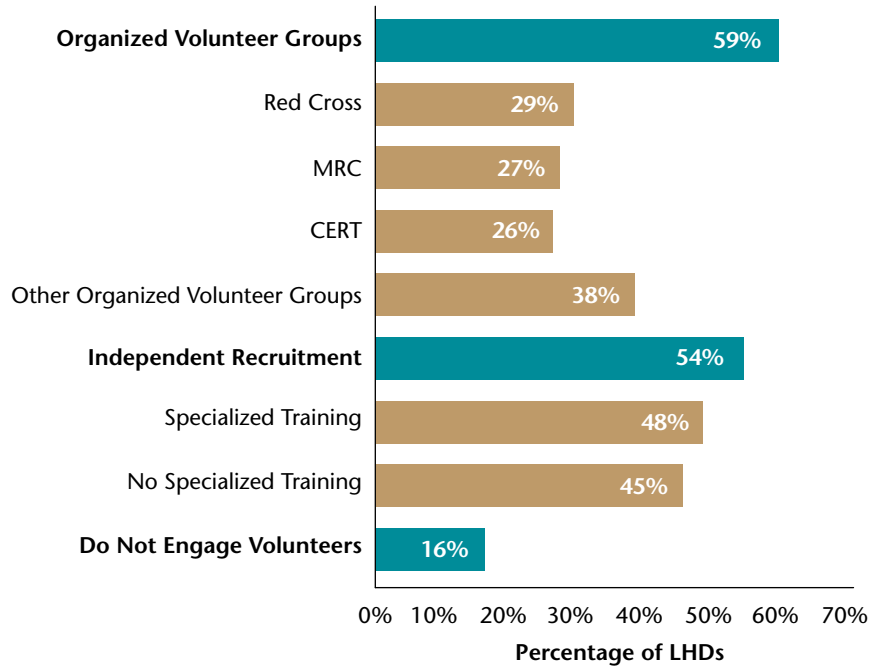


- Natural disasters are the most common all-hazards event LHDs have responded to since September 2010 (41%), followed by an influenza outbreak (30%) and an outbreak of other infectious diseases (27%).
- Similarly, LHDs are most likely to have participated in natural disaster drills/exercises (46%) since September 2010, followed by drills/exercises for an influenza outbreak (45%) and an outbreak of other infectious diseases (36%).
- LHDs also prepare for rare events; for example, few LHDs (6%) have responded to an exposure to a potential biological agent since September 2010, but 35 percent of LHDs have participated in drills/exercises to prepare for such an event.

Use of Volunteers for Emergency and Response Preparedness

- More than half of LHDs (59%) used organized groups as a source of volunteers, including the Red Cross (29%), the Medical Reserve Corps (MRC) (27%), and the Community Emergency Response Team (CERT) (26%).
- Fifty-four percent of LHDs independently recruited volunteers, both volunteers with specialized training (48%) and without specialized training (45%).

FIGURE 7.5 Sources of LHD Volunteers Used for Preparedness Activities



n=496



Go to www.nacchoprofilestudy.org to access Chapter 7 of the 2013 National Profile of Local Health Departments, tables and figures from Chapter 7, and additional analyses based on 2013 Profile data.

CHAPTER 8

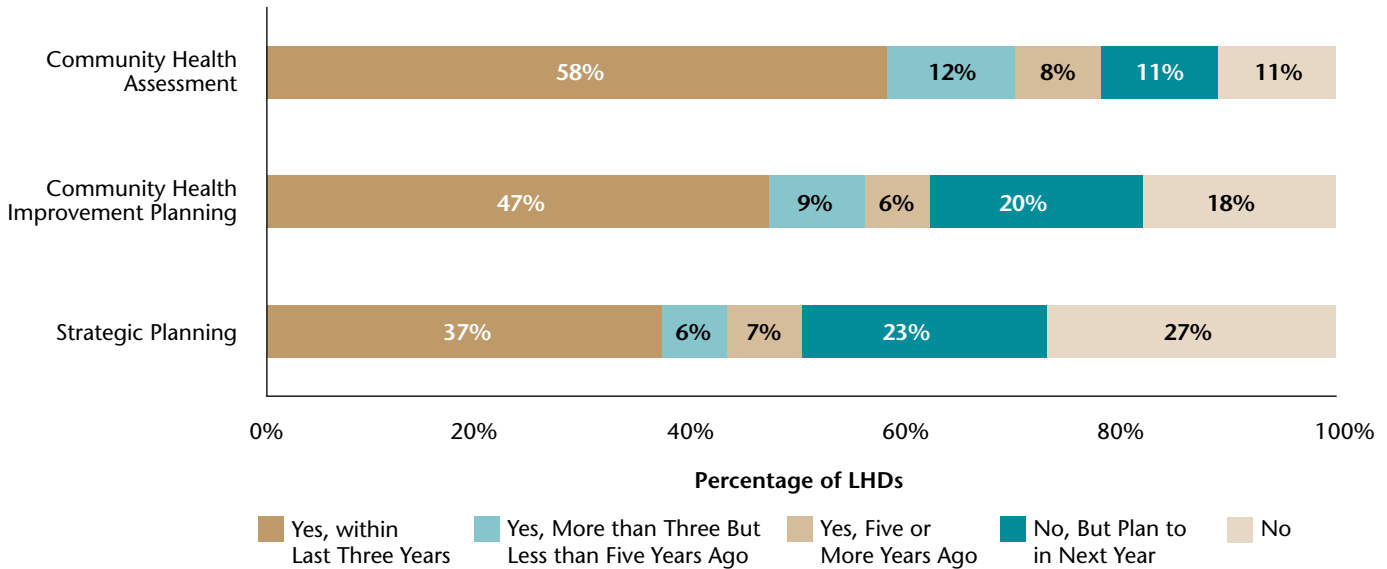
Assessment, Planning, and Improvement



Community health assessment (CHA), community health improvement planning (CHIP), and agency strategic planning (SP) are processes that help local health departments (LHDs) assess their community's health and well-being, identify the unique health needs of their communities, and define specific action steps toward meeting established goals. Quality improvement (QI) is the formal, systematic approach applied to LHD processes in order to achieve measurable improvements in programs and services. CHA, CHIP, internal SP, and QI are all requirements for achieving voluntary accreditation under standards set by the Public Health Accreditation Board (PHAB).

Community Health Assessment, Community Health Improvement Planning, and Strategic Planning

FIGURE 8.1 LHD Participation in Community Health Assessment, Community Health Improvement Planning, and Strategic Planning



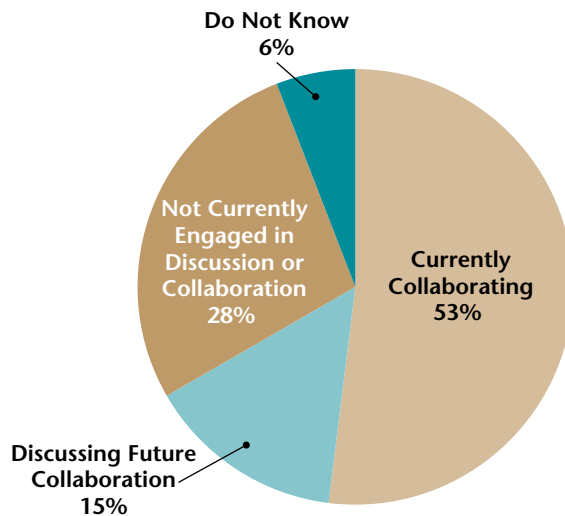
n ranged from 1,959 to 1,964

- Most LHDs have completed a CHA (70%) or a CHIP (56%) within the past five years for their jurisdiction; less than half of LHDs (43%) have completed an agency-wide SP within the past five years.
- Of the LHDs that have completed a CHA, CHIP, or SP at some time, most have reported doing one within the last three years.
- During 2013, 23 percent of LHDs expected to complete an SP and 20 percent expected to complete a CHIP.

Community Health Needs Assessment in the Affordable Care Act

The Patient Protection and Affordable Care Act (ACA) requires that non-profit hospitals conduct and report on a Community Health Needs Assessment (CHNA) every three years to maintain their tax-exempt status. The ACA also requires that a CHNA takes into account input from stakeholders that represent the broad interests of the community served by the hospital facility, including those with special knowledge or expertise in public health. Depending on their capacity, LHDs may play an important role in this process and can be vital to developing the CHNA.

FIGURE 8.2 Collaboration between LHDs and Non-Profit Hospitals on Community Health Assessments



n=1,958

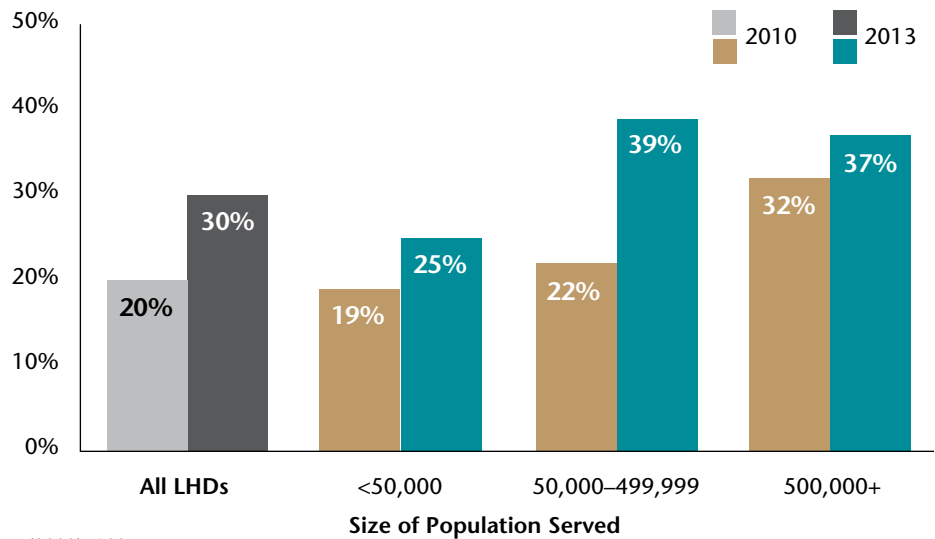
Note: Due to rounding, percentages do not add up to 100 percent.

- Slightly more than half of all LHDs (53%) are currently collaborating with non-profit hospitals on a CHA, and an additional 15 percent are discussing future collaboration.
- Less than one-third of LHDs (28%) are not engaged in any discussion or collaboration with non-profit hospitals on a CHA.

LHD Accreditation by Public Health Accreditation Board

- In 2013, 30 percent of all LHDs had completed the PHAB requirements for accreditation, namely completing a CHA, CHIP, and SP within the past five years.
- More LHDs completed the PHAB requirements in 2013 compared to 2010, regardless of jurisdiction size.
- In 2013, LHDs that serve populations of 50,000 to 499,999 people were most likely to have completed the PHAB requirements (39%), followed by LHDs serving jurisdictions of more than 500,000 people (37%).

FIGURE 8.3 LHDs that Completed Three PHAB Prerequisites (by Profile Study Year and Population Served)*

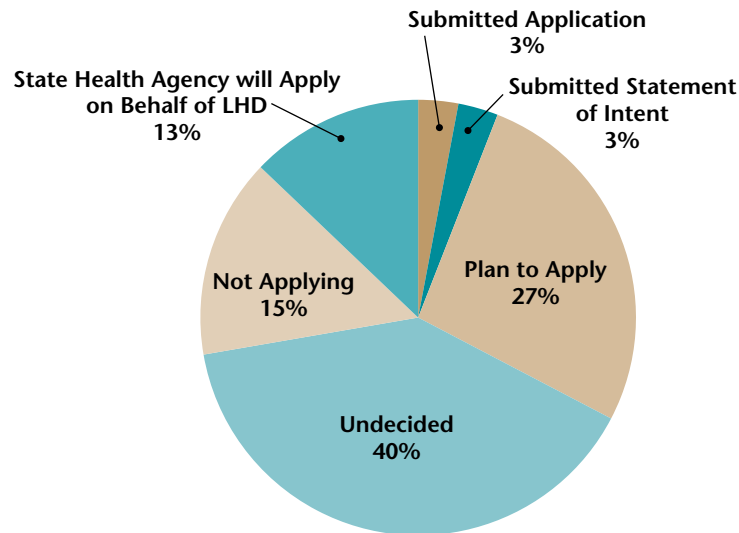


n(2010)=519
n(2013)=1,939

*PHAB prerequisites are completion of a community health assessment (CHA), community health improvement plan (CHIP), and agency-wide strategic plan (SP) within the past five years.

- Although 27 percent of LHDs plan to apply for PHAB's accreditation program, only three percent had submitted a statement of intent and only three percent had submitted an application in early 2013.
- Fifteen percent of LHDs have decided not to apply for PHAB's accreditation program.
- Almost half of LHDs (40%) have not decided whether to apply for PHAB's accreditation program.

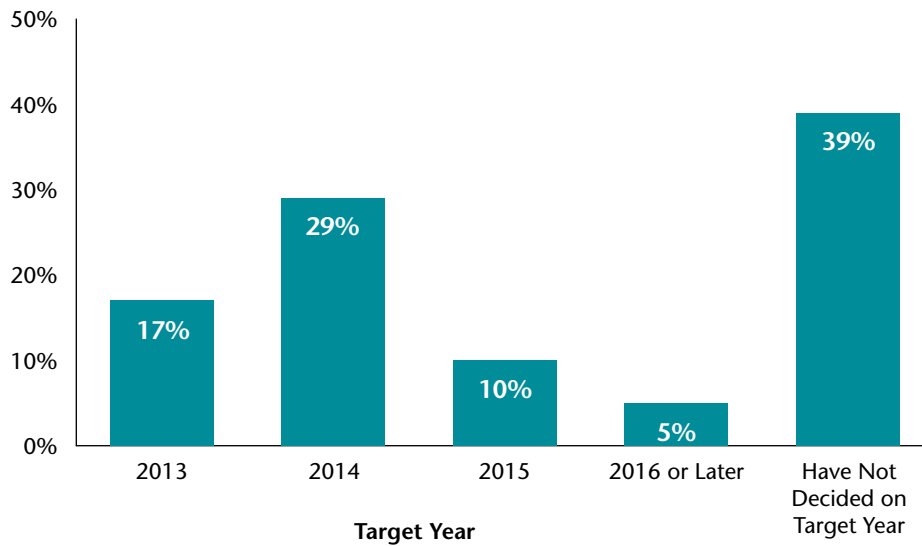
FIGURE 8.4 LHD Level of Engagement with PHAB's Accreditation Program



n=448

Note: Due to rounding, percentages do not add up to 100 percent.

FIGURE 8.5 Target Year for LHD to Submit Statement of Intent for PHAB Accreditation*



n=128

*Of LHDs that intend to apply for accreditation.

- Almost half of LHDs (46%) that intend to apply for accreditation plan to submit a statement of intent for PHAB accreditation by 2014.
- Although 27 percent of LHDs plan to apply for PHAB accreditation, 39 percent of these LHDs have not decided on a target year for submitting a statement of intent.

FIGURE 8.6 LHD Application Status with PHAB Accreditation Program (by Population Served and Governance)

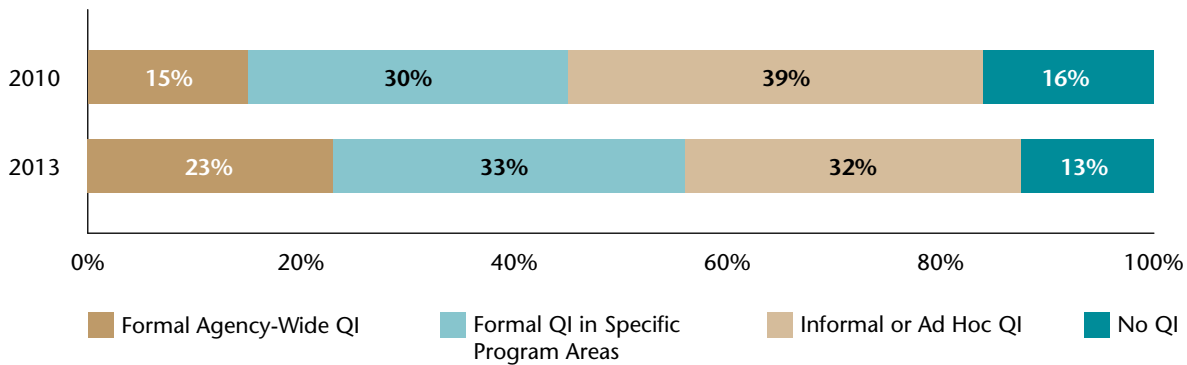
Application Status with PHAB Accreditation Program	All LHDs	Size of Population Served			Type of Governance		
		<50,000	50,000–499,999	500,000+	State	Local	Shared
Submitted Application	3%	0%	6%	15%	2%	3%	3%
Submitted Statement of Intent	3%	0%	7%	0%	3%	3%	1%
Plan to Apply	27%	22%	32%	40%	21%	27%	33%
Undecided	40%	48%	29%	19%	22%	48%	20%
Not Applying	15%	17%	13%	5%	7%	19%	9%
State Health Agency will Apply on Behalf of LHD	13%	12%	13%	20%	45%	0%	34%

n=448

- More LHDs that serve smaller jurisdictions are undecided about whether to apply for PHAB’s accreditation program and are not applying for accreditation, compared to LHDs that serve larger populations.
- LHDs that are locally governed are more likely to be undecided about whether to apply for PHAB’s accreditation program and are not applying for accreditation, compared to LHDs governed by a state agency or shared structure.
- Almost half of LHDs governed by a state agency (45%) and more than one-third of LHDs governed by a shared state and local structure (34%) reported that a state health agency will apply for accreditation on their behalf.

Quality Improvement

FIGURE 8.7 LHD Level of QI Implementation (by Profile Study Year)



n(2010)=522
n(2013)=477

- In 2013, more than half of LHDs (56%) have formal QI programs, most often in specific program areas.
- More LHDs have formal agency-wide QI programs in 2013 (23%) compared to 2010 (15%).
- Fewer LHDs in 2013 have an informal or ad hoc QI program (32%) compared to LHDs in 2010 (39%), and fewer have no QI program (13%) compared to LHDs in 2010 (16%).

Evidence Base for Public Health Practice

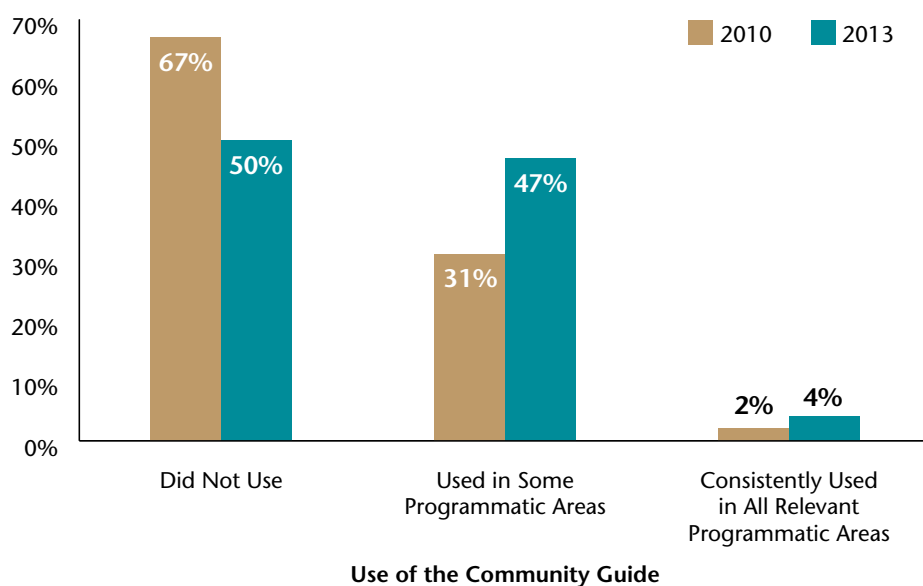
LHDs both apply and contribute to the evidence base for effective public health practices. Using policies and practices that are based on the best available evidence helps ensure that LHD resources are used effectively. The Guide to Community Preventive Services (Community Guide) is a free resource designed to help identify evidence-based programs, practices, and policies to improve health and prevent disease, injury, and disability in the community. LHDs contribute to the evidence base by participating in public health research in many different ways, from identifying important research questions to collecting or reporting data for a research study.

FIGURE 8.8 LHD Use of the Community Guide (by Population Served)

Use of the Community Guide	All LHDs	Size of Population Served				
		<25,000	25,000–49,999	50,000–99,999	100,000–499,999	500,000+
Did Not Use the Community Guide	38%	49%	38%	34%	26%	12%
Used the Community Guide in Some Programmatic Areas	36%	25%	37%	40%	50%	59%
Consistently Used the Community Guide in All Relevant Programmatic Areas	3%	2%	3%	3%	4%	7%
Do Not Know Extent of Use of the Community Guide within LHD	23%	25%	23%	22%	19%	21%

n=1,954

- Almost 40 percent of all LHDs (and 66% of LHDs that serve large populations) report using the Community Guide.
- Only three percent of all LHDs (and 7% of LHDs that serve large populations) report using the Community Guide in all relevant programmatic areas.

FIGURE 8.9 LHD Use of the Community Guide (by Profile Study Year)*

n(2010)=350

n(2013)=1,510

*LHDs reporting "do not know" are treated as missing for this analysis.

- LHD use of the Community Guide increased from approximately one-third of all LHDs in 2010 to one-half of LHDs in 2013.
- Although more LHDs had used the Community Guide in 2013 compared to 2010, few LHDs (4%) reported using it in all relevant programmatic areas in 2013.

FIGURE 8.10 Select Research Activities of LHDs*

Research Activity	Percentage of LHDs
Any Research Activities Below	56%
Collecting, Exchanging, or Reporting Data for a Study	36%
Applying Research Findings to Practices within Own Organization	27%
Disseminating Research Findings to Key Stakeholders	25%
Analyzing and Interpreting Study Data and Findings	24%
Identifying Research Topics and Questions that are Relevant to Public Health Practice	20%
Helping Other Organizations Apply Research Findings to Practice	13%
Recruiting Study Sites or Study Participants	12%
Developing or Refining Research Plans or Protocols for Public Health Studies	9%

n=463

*Within past two years.

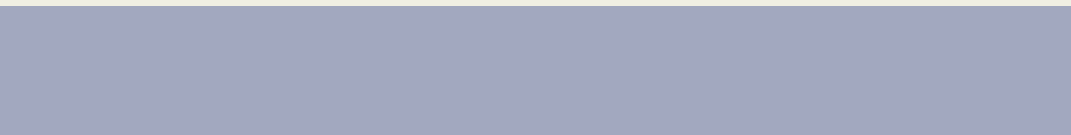
- More than half of all LHDs (56%) have been involved in a research activity within the past two years.
- The most common research activities conducted by LHDs within the past two years are collecting, exchanging, or reporting data for a study (36%) and applying research findings to practices within their organization (27%).
- Few LHDs (9%) develop or refine research plans or protocols for public health studies.



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CHAPTER 9

Public Health Policy



Policy development is one of the three core functions of public health and is becoming an increasingly important tool in protecting and improving the public's health. Because local health departments (LHDs) have in-depth knowledge of health-related issues in their communities, they play a vital role in educating others about policies and strategies to address these health-related issues. Together with community partners and elected officials, LHDs work to advance laws, regulations, policies, and practices to improve health and health equity in their communities.

LHD Policy and Advocacy Activities

- Most LHDs (87%) have been involved in a policymaking activity.
- More LHDs have been involved in a policymaking activity at the local level (81%) than the state (58%) or federal level (15%).
- LHDs most frequently communicate with policymakers (79%) and participate on public health-related boards or advisory panels (65%).

FIGURE 9.1 Select Policymaking Activities of LHDs (by Level of Government)

Policymaking Activities	Level of Government			
	At Any Level of Government	Local	State	Federal
Any Policymaking Activities	87%	81%	58%	15%
Communicated with Legislators, Regulatory Officials, or Other Policymakers*	79%	69%	49%	12%
Participated on a Board or Advisory Panel Responsible for Public Health Policy	65%	54%	29%	4%
Prepared Issue Briefs for Policymakers	55%	50%	21%	3%
Gave Public Testimony to Policymakers	51%	44%	21%	2%
Provided Technical Assistance to Legislative, Regulatory, or Advocacy Group*	50%	44%	24%	3%

n ranged from 1,921 to 1,945

*Regarding proposed legislation, regulations, or ordinances.

- Most LHDs (90%) have been involved in some policy or advocacy area in the past two years.
- LHDs are most likely to have participated in policy or advocacy activities related to the use of tobacco, alcohol, or other drugs (65%), emergency preparedness and response (58%), and obesity/chronic disease (48%).

FIGURE 9.2 LHD Involvement in Select Policy or Advocacy Areas*

Policy or Advocacy Areas	All LHDs
Any Policy or Advocacy Areas	90%
Tobacco, Alcohol, or Other Drugs	65%
Emergency Preparedness and Response	58%
Obesity/Chronic Disease	48%
Food Safety	43%
Waste, Water, or Sanitation	34%
Animal Control or Rabies	31%
Funding for Access to Healthcare	28%
Oral Health	25%
Injury or Violence Prevention	20%

n=1,936

*In past two years.

FIGURE 9.3: LHD Involvement in Policy or Advocacy Activities Focused on Tobacco, Alcohol, or Other Drugs*

Policy or Advocacy Activities Focused on Tobacco, Alcohol, or Other Drugs	All LHDs
Smoke-Free Indoor Air	52%
Reducing Sale of Tobacco to Minors	38%
Smoke-Free Outdoor Air	35%
Reducing Exposure to Alcohol or Tobacco Advertising	20%
Reducing Alcohol or Drug Impaired Driving	13%
Raising Cigarette Taxes	13%
Other	6%
Diverting Certain Drug Offenders into Treatment	5%
Raising Alcohol Taxes	3%

n=1,936

**In past two years.*

- More than half of all LHDs (52%) have been involved in smoke-free indoor air policy or advocacy activities in the past two years.
- LHDs are less likely to be involved in policy activities related to alcohol or other drugs, such as diverting certain drug offenders into treatment (5%) or raising alcohol taxes (3%).

FIGURE 9.4: LHD Involvement in Policy or Advocacy Activities Focused on Obesity or Chronic Disease*

Policy or Advocacy Activities Focused on Obesity or Chronic Disease	All LHDs
School or Child Care Policies that Encourage Physical Activities	35%
School or Child Care Policies that Reduce Availability of Unhealthy Foods	34%
Community Level Urban Design and Land Use Policies to Encourage Physical Activity	26%
Increasing Retail Availability of Fruits and Vegetables	25%
Expanding Access to Recreational Facilities	23%
Active Transportation Options	16%
Nutritional Labeling	8%
Other	4%
Limiting Fast Food Outlets	1%

n=1,936

**In past two years.*

- Approximately one-third of LHDs have been involved in school or child care policies that encourage physical activity (35%) or reduce the availability of unhealthy foods (34%) in the past two years.
- Few LHDs are involved in advocating for nutritional labeling (8%) or limiting fast food outlets (1%).

New Local Public Health Ordinances or Regulations

FIGURE 9.5 Local Public Health Ordinances or Regulations Adopted in LHD Jurisdiction* (by Population Served and Governance)

Public Health Ordinances or Regulations	All LHDs	Size of Population Served			Type of Governance		
		<50,000	50,000–499,999	500,000+	State	Local	Shared
Any Ordinances/Regulations	35%	28%	44%	62%	29%	36%	47%
Tobacco, Alcohol, or Other Drugs	21%	17%	26%	45%	23%	19%	37%
Environment	15%	12%	19%	30%	6%	18%	12%
Other	13%	10%	18%	32%	9%	14%	18%

n=1,949
*In past two years.

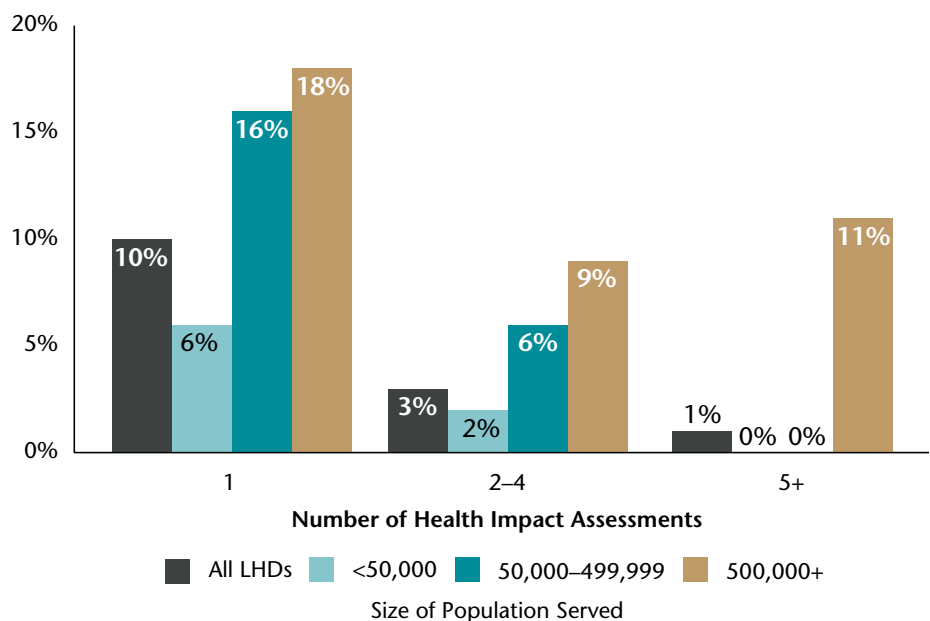
- Thirty-five percent of all LHDs have had a new public health ordinance or regulation adopted in their jurisdiction in the past two years.
- LHDs that serve a population of more than 500,000 people are more likely to have had a new public health ordinance or regulation adopted in their jurisdiction (62%) compared to LHDs that serve a population of fewer than 50,000 people (28%).
- LHDs with a shared governance structure are more likely to have had a new public health ordinance or regulation adopted in their jurisdiction (47%) compared to LHDs with local (36%) or state (29%) governance.

- Fourteen percent of all LHDs have been involved in one or more health impact assessments in the past two years.
- LHDs that serve a population of more than 500,000 people are more likely to have participated in one or more health impact assessments in the past two years (38%) compared to LHDs that serve between 50,000 and 499,999 people (22%) and LHDs that serve fewer than 50,000 people (8%).

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Health Impact Assessments

FIGURE 9.6 Number of Health Impact Assessments in Which LHDs Participated* (by Population Served)



n=462
*In past two years.

Addressing Health Disparities

FIGURE 9.7 LHD Activities to Address Health Disparities*

Activities to Address Health Disparities	Percentage of LHDs
Any Activities	84%
Describing Health Disparities in Jurisdiction Using Data	57%
Supporting Community Efforts to Change the Causes of Health Disparities	54%
Training Workforce on Health Disparities and Their Causes	48%
Offering Staff Training in Cultural/Linguistic Competency	47%
Educating Elected or Appointed Officials about Health Disparities and Their Causes	44%
Prioritizing Resources and Programs Specifically for the Reduction in Health Disparities	34%
Recruiting Workforce from Communities Adversely Impacted by Health Disparities	18%
Taking Public Policy Positions on Health Disparities	16%
Conducting Original Research that Links Health Disparities to Differences in Social or Environmental Conditions	11%

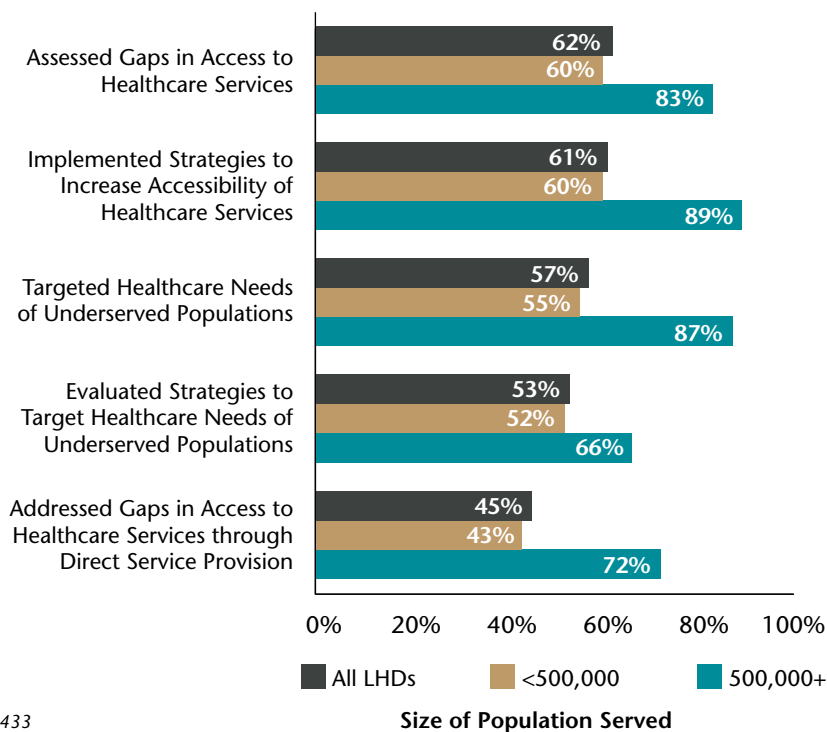
n=484

*In past two years.

- Eighty-four percent of LHDs have been involved in an activity to address health disparities in the past two years.
- More than half of all LHDs have described health disparities in their jurisdiction using data (57%) and supported community efforts to change the causes of health disparities (54%).
- Few LHDs have conducted original research linking health disparities to differences in social or environmental conditions (11%), taken public policy positions on health disparities (16%), or recruited workforce from communities adversely impacted by health disparities (18%).

Addressing Access to Healthcare Services

FIGURE 9.8 LHD Activities to Ensure Access to Healthcare Services (by Population Served)

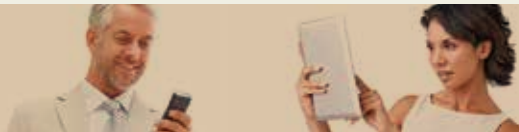


n=433

- Most LHDs were actively involved in ensuring access to healthcare services by addressing gaps in access (62%) or implementing strategies to increase accessibility of services (61%).
- LHDs serving larger populations were more likely to engage in activities to promote access to healthcare services than were LHDs serving smaller populations.
- Forty-five percent of all LHDs (and 72% of LHDs serving populations larger than 500,000) address gaps in access to healthcare through direct service provision.

CHAPTER 10

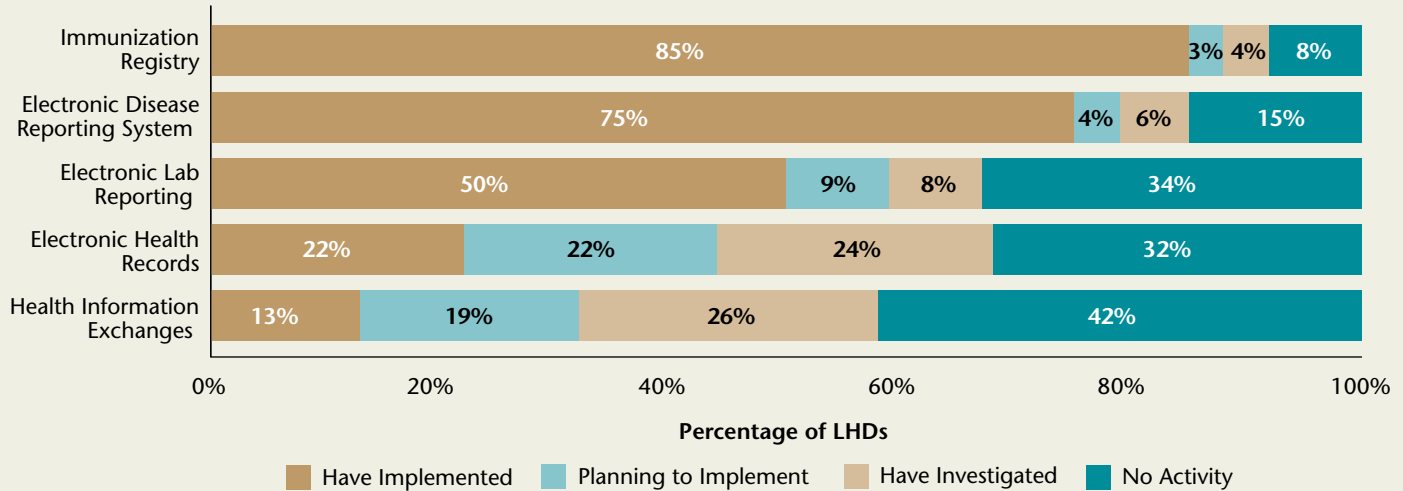
Information Technology



Local health departments (LHDs) in the United States use various information technology systems, such as immunization registries, reporting systems, and electronic syndromic surveillance systems. LHDs also use information technology to enhance their communication channels and mobile technology tools, including smartphones and electronic tablets.

Information Technology Systems

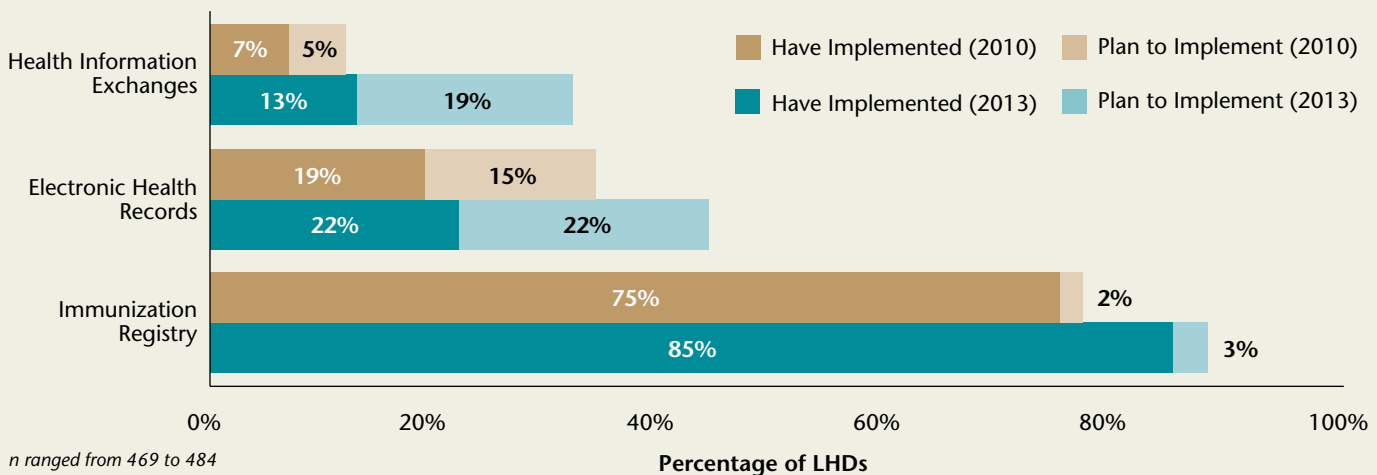
FIGURE 10.1 LHD Level of Activity in Information Technology Areas



n=469
 Note: Due to rounding, percentages do not add to 100 percent.

- The most common information technology systems implemented by LHDs are immunization registries and electronic disease reporting systems, implemented by 85 percent and 75 percent of LHDs respectively.
- Relatively few LHDs have implemented electronic health records (22%) or health information exchanges (13%), although nearly half of LHDs are planning to implement or have investigated implementing each of these systems.

FIGURE 10.2 LHD Implementation in Information Technology Areas (by Profile Study Year)



n ranged from 469 to 484

- The percent of LHDs that have implemented or plan to implement health information exchanges, electronic health records, and immunization registries has increased from 2010 to 2013.
- Although 15 percent of LHDs reported in 2010 that they planned to implement electronic health records, the percent of LHDs reporting they have implemented electronic health records increased only three percent between 2010 and 2013.

Syndromic Surveillance Systems

FIGURE 10.3 LHD Use of Electronic Syndromic Surveillance Systems (by Population Served and Governance)*

LHD Characteristics	Percentage of LHDs
All LHDs	62%
Size of Population Served	
<50,000	57%
50,000–499,999	69%
500,000+	82%
Type of Governance	
State	60%
Local	63%
Shared	65%

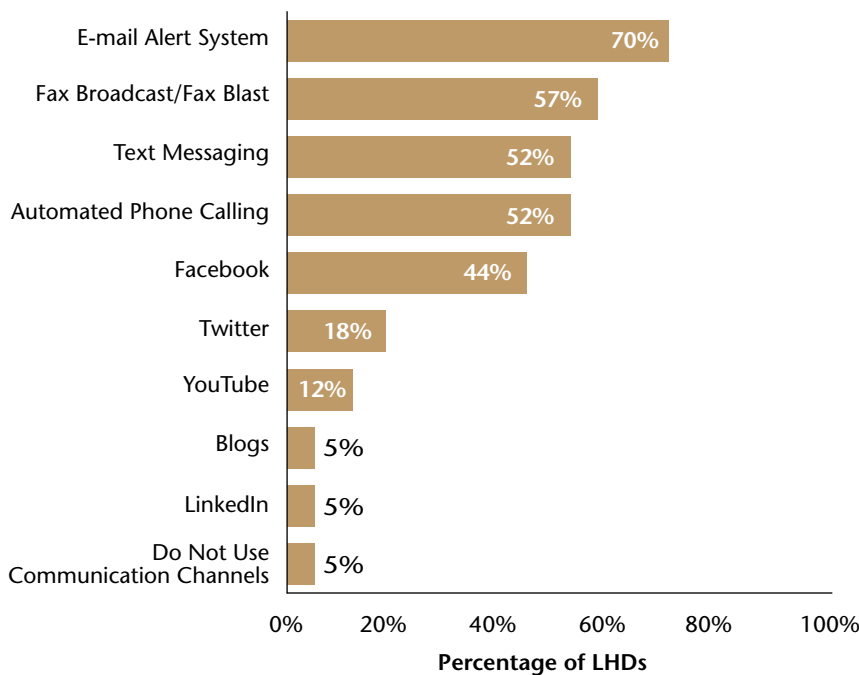
n=482

*Includes electronic syndromic surveillance system developed by LHD or another entity.

- Sixty-two percent of all LHDs have used an electronic syndromic surveillance system.
- LHDs that serve a population of more than 500,000 people are more likely to have used an electronic syndromic surveillance system (82%) compared to LHDs that serve a population of fewer than 50,000 people (57%).
- Approximately the same percent of LHDs have used an electronic syndromic surveillance system regardless of LHD governance structure.

Communication Channels

FIGURE 10.4 LHD Use of Communication Channels



n=475

- LHDs rely heavily on traditional channels for communication, such as e-mail alert systems (70%), broadcast fax (57%), and automated phone calling (52%).
- More than half of LHDs (52%) use text messaging for communication.
- Facebook is the most commonly used social media communication channel (used by 44% of LHDs), followed by Twitter (18%) and YouTube (12%).

Mobile Technology Tools

FIGURE 10.5 LHD Use of Mobile Technology Tools (by Population Served and Governance)

Mobile Technology Tools	All LHDs	Size of Population Served			Type of Governance		
		<50,000	50,000–499,999	500,000+	State	Local	Shared
Smartphones	91%	86%	97%	98%	88%	91%	93%
Electronic Tablets	48%	40%	55%	75%	18%	55%	55%

n=419

- Almost all LHDs (91%) have used smartphones, whereas approximately half (48%) have used electronic tablets.
- LHDs that serve a population of more than 500,000 people are more likely to have used smartphones (98%) and electronic tablets (75%) compared to LHDs that serve fewer than 50,000 people (86% use smartphones, 40% use tablets).
- Fewer LHDs with state governance (18%) use electronic tablets than do LHDs with local or shared governance (each at 55%).



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About NACCHO

NACCHO is the national organization representing local health departments. NACCHO supports efforts that protect and improve the health of all people and all communities by promoting national policy, developing resources and programs, seeking health equity, and supporting effective local public health practice and systems.

Funding for this project was provided by the Centers for Disease Control and Prevention (under cooperative agreements 5U38HM000449-05 and 1U38OT000172-01) and the Robert Wood Johnson Foundation® in Princeton, New Jersey. The contents of this document are solely the responsibility of NACCHO and do not necessarily represent the official views of the sponsors.

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