LOCAL HEALTH DEPARTMENT CAPACITY FOR COMMUNITY ENGAGEMENT AND ITS IMPLICATIONS FOR DISASTER RESILIENCE

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Over the past decade, community engagement has become a central tenet of US federal doctrine on public health emergency preparedness. Little is known, however, about how the vision of a ready, aware, and involved populace has translated into local practice, or which conditions thus far have advanced community involvement in what is typically considered the province of government authorities and emergency professionals. In 2011-12, to help close that knowledge gap, investigators carried out semistructured qualitative interviews with practitioners ($N=25$) from 7 local health departments about which conditions have advanced or inhibited community engagement in public health emergency preparedness. Among the organizational factors identified as enabling local health departments' involvement of community residents and groups in emergency preparedness were a supportive agency leadership and culture, sufficient staffing and programmatic funding, interested and willing partners, and external triggers such as federal grants and disaster experiences that spotlighted the importance of community relationships to effective response. Facing budget and staff cuts, local health departments feel increasingly constrained in efforts to build trusted and lasting preparedness ties with community partners. At the same time, some progress in preparedness partnerships may be possible in the context of agency leadership, culture, and climate that affirms the value of collaboration with the community.

OVER THE PAST DECADE, community engagement has become a central tenet of federal doctrine on public health emergency preparedness. In 2010, the US Department of Health and Human Services (HHS) released the National Health Security Strategy (NHSS), which singled out "an informed, empowered, and resilient population" as essential to the US ability to withstand and recover from adversity.¹ In 2012, the NHSS implementation plan advocated a "whole community" approach to health security that fosters "community partnerships among individuals and their families; private-sector, nongovernmental, and academic organizations; and all forms of government (i.e., local, state, tribal, territorial, and federal)."^{2(p12)} The White House, the Department of Homeland Security (DHS), and

the Federal Emergency Management Agency (FEMA) similarly issued statements and guidance that acknowledge the public as a full partner with government in managing extreme events.³⁻⁵

Little is known, however, about how this vision of a ready, aware, and engaged population has translated into local practice, or which conditions thus far have advanced community involvement in what is typically considered the province of government authorities and emergency professionals. To help close that gap, we executed a 3-phase, mixed-methods examination of local health departments' organizational capacity to engage the public in public health emergency preparedness. Phase 2, which is reported here, involved semistructured qualitative interviews with

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practitioners about what organizational elements facilitate or impede local health departments' engagement of community partners in public health preparedness.

This inquiry into community engagement practice presents an opportunity to alert policymakers to concrete ways of strengthening community resilience, to guide local health department leaders in involving citizens and civil society more fully in the public health emergency preparedness enterprise, and to weigh in on broader scholarly discussions about public health system performance.⁶⁻⁸ This article reviews the study background, methods, and prevailing interview themes and then considers potential policy and practice implications of results.

STUDY BACKGROUND

Leveraging Community Contributions

Community engagement is a means to incorporate citizens and civil society into the larger government effort to manage health emergencies.⁹ Described in greater detail elsewhere,^{10,11} it is most readily conceived as a continuum of information flow between authorities and the people they serve: from pushing out education materials to the public (communication), to soliciting input from citizens to inform policy and practice (consultation), to engaging residents in a dialogue to characterize public policy issues and conceive solutions (collaboration).^{9,12} Interviewee descriptions of their own efforts to engage the community in public health emergency preparedness, as presented later, represent this entire continuum: preparing brochures for seniors on disaster readiness and their medications, conducting audience research on where diverse residents get trusted health risk information before and during disasters, enlisting volunteers in Medical Reserve Corps units and standing up neighbor-to-neighbor disaster assistance networks, and holding formal public deliberations about difficult decisions anticipated in a health emergency, such as how best to use scarce medical resources.

As manifest in these public health department activities, community engagement is advanced by federal grant guidance, national consensus statements on public health emergency preparedness, and core principles of public health practice. Thought leaders in and out of government have consistently asserted that the public health preparedness system includes individuals, communities, and businesses, and that government public health agencies are responsible for the system's overall integrity.^{1,13-15} Since September 11 and the anthrax letter attacks, and with federal grant support, state and local public health departments have assumed primary responsibility for preparing their jurisdictions to respond to disasters with significant health effects.^{16,17} Historically, federal public health emergency preparedness grant guidance prioritized risk communication, health information dissemination,

and incorporation of public input into preparedness and response plans.^{17,18} Current guidance further recommends convening coalitions with business, faith, and community-based organizations; integrating community input into problem-solving sessions; and enlisting volunteers in routine as well as emergency health and safety initiatives.¹⁹

The emphasis in public health emergency preparedness on community partners resonates with the broader historic shift among public health professionals toward working alongside—not independent of—community members and their top health concerns.²⁰⁻²⁶ It parallels, too, developments in the field of emergency management to adopt a more participatory and collaborative approach to reducing the impacts of natural and technological disasters.²⁷⁻³⁰ More broadly, the value now placed on the public's role in the public health emergency preparedness enterprise represents an additional chapter in a much longer, complex history, wherein US citizens are taking a more active role in shaping the public systems, policies, and programs that affect them—the subject of a large literature dispersed over many disciplines.³¹⁻³⁵

Enabling Health Agencies to Engage Their Partners

As public health emergency preparedness practitioners strive to develop an engagement capability and policymakers to foster its adoption, making explicit what is at stake could accelerate the desired collaborations: Why do community partnerships matter? And what are the prerequisites for their success? Arguably, community resilience (a strategic national aim) depends, in part, on quotidian local health department concerns, such as how many full-time employees (FTEs) are available to conduct outreach and build partnerships and whether agency IT support is sufficient to integrate social media into risk communication.

Helping make this link is the model for measuring public health system performance, developed by Handler et al⁶ and composed of the following elements:

- *Macro-Level Environment*: social, cultural, economic, and political forces that directly or indirectly influence the existence and functioning of the public health system;
- *Mission*: goals of the public health system and how they are operationalized;
- *Structural Capacity*: informational, organizational, physical, human, and fiscal resources that fuel public health practice;
- *Processes and Outputs*: modes of identifying and prioritizing population health issues as well as designing, executing, and evaluating interventions to address them; and
- *Outcomes*: short- and long-term changes in population health.

As noted by its authors, the framework can be applied to performance of the entire system, a specific public health organization, or an individual public health intervention. Our repurposed model for this study (Figure 1) focuses on

Figure 1. Community Engagement in the Context of Public Health Emergency Preparedness (PHEP) System Performance (adapted from Handler et al 2001).

the public health emergency preparedness mission—that is, “to prevent, protect against, quickly respond to, and recover from health emergencies.”^{13(p59)}

The model posits that increases in inputs such as health department staff, financing, and equipment lead to enhanced capacity to engage the community in the preparedness mission via outputs such as education and outreach, volunteer mobilization, and participatory planning. Such processes help improve population health outcomes, we propose, by fostering some of the “adaptive capacities”³⁶ or “core components”³⁷ theorized as underpinning collective resilience to disasters—that is, the ability to withstand, adapt to, recover from, and integrate lessons from an extreme event. They include communication (ie, a robust infrastructure to circulate information about health threats and protective behaviors), community competence (ie, the ability to act as a collective and cohesive unit that can define, address, and solve problems), and social capital (ie, social connectedness, reciprocal linkages, and a sense of community).^{36,37}

The robustness of the full model has yet to be explored empirically. This study represents, however, a first step in investigating the linkage between inputs and outputs: What structural capacity, from the practitioner’s perspective, enables the community engagement capability? As the findings reveal, staffing and financing are seen as structural precursors to success, but so, too, are organizational culture, agency leadership, and willing partners. Moreover, direct or vicarious experience of a disaster that spotlights the value of community collaborations to preparedness and response emerges as an important influence at the macro level.

Measuring Performance Relative to Structural Capacity

This study responds to the larger call for researchers to investigate more thoroughly the structural inputs that en-

able critical public health capabilities, in part to provide a better evidence base for policymakers and practitioners to make resource decisions. Noting the relative lack of research on public health system capacity and its measurement, one scholar has emphasized the need to evaluate public health performance *relative* to capacity: “How well did you do (process/performance), given what you had to work with (capacity)?”^{8(pp535-536)} This is especially true in the context of public health emergency preparedness performance, because the national dialogue and research agenda on core capabilities has inadvertently crowded out discussion of basic infrastructure requirements.

With the emergence of the public health emergency preparedness subfield have come robust debates about how to define, measure, and track improvements, especially given federal investments.^{15,38-40} Are we better prepared than we were? Where should we target future investments? To date, analytic first steps in answering these questions have been developing a clear vision of a prepared community, along with “actionable and measurable steps for attaining that vision.”^{40(p17)} Much needed effort has been expended to characterize those critical “functions,” “processes,” or “capabilities” that secure the population’s well-being in the face of potential threats.^{19,41} Community engagement has surfaced in most frameworks, as have surveillance and epidemiologic investigation, medical countermeasure dispensing, and mass patient care.^{15,40}

The needed spotlight on capabilities,⁴¹ however, has cast a long shadow on underlying resource needs. Early on, the point was argued that, lacking evidence to the contrary, structural capacity (eg, personnel, equipment, technology) is an insufficient indicator of the public health system’s ability to respond effectively to an emergency.^{38,39} But emerging research on public health system performance has begun to close the knowledge gap about the relationship among structural capacity, system performance, and

population health outcomes. Structural predictors of health department performance include larger staff, higher staff per population served, higher per capita public health spending, and greater community interaction.^{42,43} Evidence now also connects positive health outcomes with an increase in public health expenditures per capita, an increase in health department FTEs per capita, and enhanced local public health agency performance.^{44,45}

METHODS

This study is the second stage of a multiphase, mixed-methods investigation of local health departments' organizational capacity to engage the community in public health preparedness. Conducted in 2010, the first phase was a secondary analysis of 2005 and 2008 national health department survey data from the National Association of County and City Health Officials (NACCHO). In that study, 3 local health department staff positions—emergency preparedness coordinator, public information specialist, and health educator—emerged as strong predictors of community engagement in public health emergency preparedness.⁴⁶ In 2011-12, we carried out practitioner interviews (reported here) to explore further the infrastructure that enables community engagement in public health emergency preparedness. Phase 2 findings have informed phase 3, a national survey of local health departments (under way at this writing) focused on public health emergency preparedness community engagement capacity, activities, and resource needs.

In phase 2, we interviewed 25 practitioners from 7 local health departments, including regional pairings between “high performers” and “high aspirers” in emergency preparedness community engagement. *High-performing* health departments were selected based on their leadership in developing best practice materials on community engagement for other agencies; *high-aspiring* health departments were selected based on recommendations by key informants in the region about peer agencies that were motivated but not yet successful in this arena. We selected local health departments with different performance levels to discern more readily the organizational elements that either enabled or constrained agencies from engaging with community partners. Informant health departments came from 3 distinct regions—the US northeast, northwest, and southwest—and represented small-to-large and rural-to-urban health departments. This purposive sampling was intended to reflect the highly variegated US public health system.⁴² A total of 8 local health departments were approached and agreed to participate; 1 eventually did not respond to follow-up scheduling requests.

Interviewees included health department leaders, emergency preparedness coordinators, public information officers, community health educators, and other public health workers with public health emergency preparedness and/or

community engagement responsibilities. Typically 45 minutes long, interviews were conducted individually over the phone or in person, with the exception of 1 health department that opted for a facilitated 2-hour group conversation to expedite data collection and benefit internal discussions. During the interviews, the research team posed standard open-ended questions aimed at discerning the health department's perspective on the public's role in public health emergency preparedness, concrete examples of how local health departments engage community partners in their jurisdiction's emergency preparedness, barriers and facilitators of community engagement in emergency preparedness, and federal support that health departments see as facilitating their work in this arena.

We prepared a summary report for each interview synthesizing handwritten notes and audiotaped exchanges. Because of time and budget constraints, interviews were not transcribed or coded via computer. Over the course of data collection, the team met periodically to discuss interviewee responses, trends, and implications. Categories, themes, and subthemes were produced iteratively, with a priori themes embedded in the interview protocol and others induced from individual reports and comparison across them.⁴⁷ Structural elements seen to influence community engagement in public health emergency preparedness were variously framed by subjects as being present, absent, or in scarce supply at their respective health departments. Interviewee quotes included in the results below have been edited to improve clarity.

WHAT ENABLES COMMUNITY ENGAGEMENT

Among the factors informants identified as key to health department success in emergency engagement for public health preparedness were supportive agency leadership and culture, sufficient staffing and programmatic funding, interested and willing partners, and external triggers such as federal grants and disaster experiences that spotlighted the importance of community ties to effective response.

1. External Triggers that Motivate Local Health Departments and the Community to Engage

- *A rupture in routine thinking due to a disaster helps to catalyze community engagement in public health emergency preparedness.*

Key informants from every health department we examined recounted specific disasters and outbreaks that drove home the need for their agencies to collaborate more effectively with the larger community. As other researchers have observed, a window of opportunity opens in the wake of a disaster: Through direct or vicarious experience of a major crisis, decision makers become more amenable to policies that could avert a comparable shock in the future.⁴⁸

Individuals who have just undergone a disaster respond positively to personal preparedness messages given their greater salience.⁴⁹

In the case of these respondents, the value of working with community partners and the public at large became more apparent through firsthand, and even secondhand, disaster experience. One local health department, far from Hurricane Katrina's immediate effects, witnessed the disproportionate impact of New Orleans flooding on poor minorities; as result, the staff recommitted themselves to partnering with community-based groups that serve vulnerable populations to keep this safety net intact during emergencies, to disseminate health risk and emergency information more readily to marginalized groups, and to ensure that emergency planning reflects the interests of those most at risk.

The 2009 H1N1 influenza pandemic, too, was a watershed in self-reflection and altered local health departments' practice. To get out vital information and improve vaccine access in diverse communities, one agency decided to work with city ministers to improve outbreak management plans, produce culturally appropriate messages, and secure familiar places such as local churches for vaccination clinics. H1N1 led another health department to realize limits to its communication performance; absence of a local radio or TV station forced staff to become more deliberate in reaching residents, especially vulnerable groups. A staff member surveyed vaccination clinics, homeless clinics, social clubs, and other community groups to learn where people get their health-related information so that the local health department could redirect their outreach efforts.

These same events, too, brought community members and leaders to local health departments' figurative doorstep, seeking both information and ways to take meaningful action. A health department in one jurisdiction that had received numerous Katrina evacuees also experienced a surge in volunteer interest, prompting them and emergency management partners to rethink their system for incorporating volunteers. In another jurisdiction, Katrina prompted self-awareness among some faith- and community-based organizations of their potential role in preparedness, although it was not their everyday mission; as a result, the local health department found these groups more willing to partner on subsequent preparedness initiatives.

- *Federal public health emergency preparedness priorities and granting processes play a key role in the community engagement activities of local health departments.*

Informants universally singled out the federal government as a driver behind local efforts to involve the community in public health emergency preparedness and as a patron from whom local health departments would welcome additional political, financial, and technical support. A clear federal vision communicated to state and local political authorities on why and how to engage the com-

munity in preparedness and response would greatly ease the struggle that front-line local health department practitioners now feel in advancing this objective. To align local practice with US government statements on resilience and "whole community," subjects argued, federal preparedness grants should provide more realistic funding levels, thus enabling local health departments to deliver current deliverables focused on community collaboration. Better integration among CDC, HHS, and DHS grants was also desired, so that the objective is genuine *community* preparedness, not "siloed" programs.

Other federal grant changes believed to enable health department community engagement are sustained multi-year preparedness funding, a longer time horizon for deliverables, expectations that are mindful of local limitations, and appropriate metrics: Ensuring a robust safety net for vulnerable populations in disaster and instilling household preparedness among at-risk communities are long-term ventures that rely on intangibles such as social trust. Agencies that serve large, socioeconomically diverse populations with a heavy public health burden also felt that additional funds were necessary to engage community partners in their jurisdictions. To sustain preparedness as a priority among all local health department practitioners and to leverage community ties that other public health sectors already enjoy, a few informants suggested that all federal grants to local health departments designate a small proportion for preparedness work.

Informants were eager for more technical guidance (discussed later) and easily accessible training from the federal government on how to implement a community engagement vision. Opinions varied, however, on how prescriptive operational advice should be. One informant strongly advocated a more "standardized" pathway for local health departments to engage community partners; simply leaving health departments to feel their own way to a vague objective would be frustrating and divert scarce resources. Others, however, wanted flexibility to set priorities based on individual contexts (eg, "We have international border issues, not a nuclear power plant"), in accord with community preferences (eg, when responding to grants, "We have to tell the community 'this' is what is important" rather than act on the community's own priority), and cognizant of local limitations (eg, "Great [federal] ideas do not necessarily trickle down").

2. Organizational Culture that Validates and Prioritizes Community Collaboration

- *Buy-in by top agency leaders encourages the department and the community to engage.*

Interviews with every queried local health department cited endorsement by agency leaders as a major influence on whether or not community engagement in public health emergency preparedness could succeed. When influential

top health department leaders viewed community collaboration in preparedness as an important public health endeavor, staff members were able to devote more time and attention to this objective. Supportive executives were measured in terms of their own belief in community partnerships, dedication to finding resources for engagement activities, willingness to open up health department business to public input, commitment to securing influential contacts for engagement staff, and an investment of scarce personal time, including off-hours, for specific initiatives. For 2 health departments, lack of executive support for preparedness overall stifled staff efforts to work closely with the community around disaster issues.

One health agency broadened its community preparedness efforts to include public deliberations on how best to use scarce medical resources in a health emergency. According to informants, “hands on” involvement of local health department leaders in the public meetings, as well as behind-the-scenes administrative support, was critical to the initiative’s success. Direct, visible participation by top management in the event, convened on the weekend, communicated that the agency valued the time and input of community members. Top leaders took pains to create a safe environment for the public to ask questions, helping to build trust. One informant from another local health department who doubted his agency’s ability to formalize this deliberative approach cited the lack of a leader willing to “give up control” as well as little flexibility in letting community advisors help set department priorities.

- *When community engagement is seen as a professional duty, its strategic importance is elevated.*

Organizational culture and climate figured in each local health department’s narrative about what facilitated or inhibited community inclusion in public health emergency preparedness. Professional commitment to working with the community was seen to fuel efforts, in some cases, despite limited leadership support. Such commitment was expressed as part of a larger ethos that public health work was public service, requiring strong community ties and interest in diverse perspectives. One practitioner cited her strong belief that collaborations enhance public health work in general, something learned through years working in parent-child health and her experience that good vaccination rates were impossible without public support. Labor-intensive public deliberations, in particular, were seen as possible only when practitioners believed they needed to speak to people other than themselves when wrestling with preparedness policy dilemmas.

For community engagement in emergency preparedness to be successful, explained informants, organizational support had to be “multi-tiered, from top to bottom” and engrained across all departments, not just the preparedness division. One practitioner, lacking such a work environment, nonetheless pressed on, casting herself as a “cham-

pion” of community preparedness. In the same predicament at another health department, practitioners reinforced each other’s dedication to community engagement in emergency preparedness and actively cultivated innovation in getting it done. Commenting on health departments where public involvement in emergency preparedness is not a priority, informants explained that peers assumed “it isn’t my job” or did not yet appreciate the value of partnerships.

Nonetheless, larger forces were seen to impinge on a supportive organizational culture, for good and for ill. One health department attributed their success to a regional culture that valued community involvement in government affairs, something manifest in a local executive’s efforts to fund such local health department activities. Informants from high-performing and high-aspiring health departments both noted that other preparedness demands and deliverables (eg, mass dispensing planning) weighed heavily on them, despite their commitment to community engagement. During the 2009 H1N1 flu pandemic, one local health department felt torn between the equally important goals of community outreach and mass vaccination clinics. Singling out community engagement in a strategic plan, suggested one informant, increased the likelihood that efforts would remain a priority even when the funding landscape changed.

3. Material Resources that Procure Time, Place, and People for Interaction

- *Engaging community partners in public health preparedness is staff-intensive work.*

Interviewees repeatedly cited having dedicated and skilled personnel who have the time for outreach and collaboration as a top facilitator in local health departments for successful engagement of the community in public health emergency preparedness. As one informant put it, community involvement requires “more warm bodies out there.” Having sufficient staff was seen as fundamental to a range of preparedness objectives: developing an overall strategy for community engagement in emergency preparedness, cultivating organizational ties with community- and faith-based organizations, doing broad public outreach and education, developing trusting relationships with vulnerable populations, mobilizing volunteer resources, and incorporating citizen input into preparedness policymaking.

Underscoring the importance of labor power, informants described strategies to cobble together a community engagement workforce for preparedness. Constrained by limited staff, one local health department collaborated with the emergency management agency for public outreach. Another health department, unable to sustain a preparedness network of community connections on its own, tapped into the mayor’s neighborhood liaison office. Hampered by inflexible hiring processes, a third turned to a contractor,

risking the loss of that person's knowledge once the contract expired. In thinking about what would help cover the staffing gap, interviewees floated creative ideas (not yet realized) such as cross-training employees with community ties (eg, WIC program) to be preparedness ambassadors and building up a core health educator pool to interact regularly with the public on all public health issues, including preparedness.

Informants lamented recent staff cutbacks in terms of curtailed community work: "We can only go out once every 2 weeks instead of 3 times a week." "There are some difficulties reaching population groups... [who don't watch] ... the English media, and how do you find those persons when the people you have are already multi-tasking as it is?" "We have to do more with less." One informant wistfully considered what was possible if she only had "1 more person" for health fairs.

Conversations about staffing levels readily shifted to discussions of time. Being available to the community often meant working overtime and afterhours: training sessions in the evenings, health fairs on weekends, and public deliberation exercises on weekends. Too, making contacts, nurturing relationships, and building up credibility was time-consuming work. Such activities take time, health department interviewees argued, because they involve human interactions and because they must be performed continuously; otherwise trusting social ties erode. The human element is critical, noted one informant, much in the same way that people prefer to reach a person rather than a prerecorded message when they call the local health department with a health question.

- *Preparedness training sessions, tweets, grants, and giveaways cost money and bring people to the table.*

One of the most strongly emphasized themes during the interviews was that sustained funding was necessary for community engagement in public health emergency preparedness, and those funds were not available. Even high performers noted a financial struggle and said they were "limping along." Interviewees spoke of patchwork budgets to underwrite community involvement using whatever sources were available (eg, PHEP, Urban Area Security Initiative, and City Readiness Initiative grants; United Way dollars; NACCHO Advanced Practice Center funds; city and county support; H1N1 response funds). Informants also recounted an ebb and flow of engagement depending on external funding: dissolution of the local health department or county's neighborhood association preparedness pilot when federal dollars dropped; a public policy deliberation exercise that was made possible through supplemental pandemic planning funds; stoppage, once H1N1 response monies were gone, of an internal workgroup to coordinate community outreach across health department divisions.

"Staff and funding" was a common, terse answer as to what kept local health departments from advancing work in

this arena, and informants detailed myriad activities and items, all with a price tag, to help build better connections with and prepare the public. For outreach and education, such programmatic support made possible the "giveaways" (eg, hand sanitizers, emergency backpacks) and the free training sessions that hooked the public's interest in preparedness. Surveys, informant interviews, focus groups, translation services, and ethnic newspaper inserts—at a cost—were seen to improve health communicators' preparedness and response messaging to diverse audiences. Informants from one local health department contemplated what further reach into the community was possible via social media, if only they had sufficient IT expertise and infrastructure—unlikely in the current economy.

A community engagement budget was also seen as enabling community-based organization ties and readiness. Having decided to "stop spending money on ourselves," one health department provided mini-grants to community-based organizations, targeting those who serve vulnerable populations. Incentives helped to activate the organization's interest in preparedness and support continuity of operations planning so the agencies could still serve clients in an emergency. Moreover, the community-based organizations were better poised to raise client and employee awareness about preparedness and to circulate the health department's critical information to clients in an emergency. Not as far along, a smaller local health department spoke of needing funds first to map out at-risk populations and the community-based organizations serving them. At a minimum, argued some informants, health departments need funds to entice partners to the table, help communicate the value of the relationship, and give under-resourced groups the means to act. Once relationships are well established, suggested some informants, finances could drop in importance.

Formal processes to solicit citizen input into preparedness policy decisions, in particular, were judged as valuable and resource-intensive. Among the expenses seen as necessary were: a central meeting space easily accessible to residents, including those without cars; a convenient time for people who could not take time off from work; compensation to draw diverse attendees and recognize the value of their time; and expertise in exercise design, recruitment, and facilitation. Given investments of staff, money, and agency credibility, explained experienced practitioners, citizen deliberations of policy dilemmas (eg, how to use scarce medical resources in a disaster) are best done well and sparingly. Unfortunately, noted an informant, they are a "luxury" for most and only possible at their health department because of a one-time convergence of external funds and enough internal staff.

- *Social skills and technical expertise improve local health departments' performance in community engagement for public health emergency preparedness.*

Having the right staff and the right methods figured in most narratives about what enabled community engagement in emergency preparedness. Given the interpersonal nature of such work, people skilled at communication and social interaction are best suited for “putting a face” on the health department, explained informants. Interpersonal skills are needed, noted an informant, especially when a health department commits itself to soliciting public input on key policy decisions. Such an exercise requires “intimacy” between the agency and the community, something more likely with staff who can “share ideas, hear concerns, respond to concepts, feel the pulse of a room, know the people in there are a collective but they’re actually individuals, understand general themes and thought processes, and really at the end of the day, . . . it increases the feeling of transparency and the feeling of trust. . . .”

Demographically and culturally diverse personnel, too, were seen to help a local health department connect better with different publics and avoid, as one person put it, “group think.” Several informants reiterated the need for culturally competent approaches to engage community- and faith-based organizations and residents around preparedness and response. One person described the health department’s challenge in addressing some Muslims’ concerns about porcine gelatin (something not allowed due to a connection to pork) contained in H1N1 vaccine, given differences across mosques and religious teaching. Another noted having to find a good way to overcome the hesitancy among some Native Americans to discuss preparedness because of the belief that speaking of disaster could cause it to happen.

Many informants strongly desired more technical advice on how to “do” community engagement, whether in the form of model practices shared among health departments or federal guidance distributed among public health emergency preparedness grantees. Of particular interest was guidance on methods that were not resource-intensive and applicable in large, diverse urban centers. The least familiar method, public policy deliberations, was seen to present special hurdles. Two agencies who were novices before conducting such an exercise with outside experts felt that peers could benefit from guidance on when the method is most useful, templates to steer through the process, and evaluation tools to gauge effectiveness. More broadly, one practitioner said that more scientific research was needed on community resilience and concrete interventions to help strengthen it.

4. Community Partners Who Welcome the Chance to Team Up

- *Shared and reasonable expectations concerning the preparedness role of community organizations and residents lay a good foundation.*

Recognizing the self-interests and day-to-day realities of community partners, argued some informants, puts local health departments in a better position to promote pre-

paredness as a shared concern. As interviewees recounted, emergency professionals are becoming increasingly aware of the role that faith- and community-based organizations can play in preparedness and response at the same time that some groups without a formal disaster mission are starting to embrace it. Many spoke of the multiplying effect of working with community groups and of leveraging ties with trusted intermediaries to reach out broadly across the population and deeply into vulnerable communities. Organizations that have a health mission (eg, Federally Qualified Health Centers, faith-based nurses), operate in culturally and linguistically diverse communities, and serve seniors and the disabled were among the many partners with whom health departments sought preparedness ties.

Good working relationships between local health departments and community groups, several interviewees explained, require reasonable expectations on both sides. It is “tricky” sometimes, noted an informant, because some community-based organizations (in this case, those serving the Latino community) are “so tapped out.” Unless the federal government provides public health emergency preparedness funding for community partners to work *with* the health department, asserted one interviewee, it is unreasonable for the health department to engage them in emergency preparations: “There needs to be a two-way street.” At the same time, noted another interviewee, the ultimate goal should be to develop an organization’s “internal capacity”—that is, to have the institution *and* its clients internalize preparedness objectives so that the health department’s continued support would be unnecessary.

On the topic of personal preparedness, informants also spoke of the need for local health departments to be sensitive to the urgent demands many residents faced daily, which curtailed their ability to plan for low-probability events. “We can’t assign the same role to everyone,” explained an interviewee who argued that more expectations should be placed on economically secure English speakers, thus freeing responders to focus on the people more at risk. Another interviewee felt that the recession stymied preparedness efforts of the health department and the larger community: “[T]he stress of the whole economy is holding everything back.” Encouraging people with neither the individual- or neighborhood-level resources to undertake basic preparedness, she continued, was hard to do.

- *Good faith efforts and face-to-face exchanges help preserve precious community ties.*

Creating and nurturing relationships, practitioners repeatedly expressed, with faith- and community-based organizations, local opinion leaders, and diverse subpopulations is a long-term endeavor. If a local health department wants residents and the groups that represent and serve them to join the preparedness enterprise, then it must regularly interact with them and in culturally sensitive ways: “It’s the relationship and that you show up and that you

know them and that you embrace them.” “Residents need to see us,” stated an outreach worker; moreover, “being there in person constantly, consistently, regularly” was how the health department could better connect with communities who distrusted authorities.

Apart from face-time, explained interviewees, community partners often require other evidence of the agency’s commitment to them, such as “follow up” and “follow through.” This can be as simple as getting back to people with answers in a timely manner. In the case of a local health department that is soliciting the involvement of community-based organizations and businesses in Strategic National Stockpile dispensing, an agency needs to “make good” on any promises it gives. When sharing key preparedness policy decisions, health department leaders should offer proof that residents have been heard and that their input will be integrated into real outcomes: “The public is very sensitive but also very aware of when agencies are blowing smoke, if you will, if they [the agencies] are not interested and just are ... checking boxes.”

Informants admitted challenges in maintaining public faith in local health departments and interest in preparedness. Focused on executing “tasks” to meet “grant deliverables,” some informants felt that they had little time to commit to relationship-building and that this work was not sufficiently valued in a “bean-counting” environment. Experienced at working with community-based organizations, one interviewee found the work “hard to prioritize”: what meetings with which groups should she go to? A “big health department with a lot of resources” still struggled with the time it took to establish good ties. In comparison, a smaller rural health department noted its advantage: Their community was tighter and already believed that they needed to be self-sufficient in the immediate aftermath of a disaster.

STUDY LIMITATIONS

Because we relied on summary reports, a key study limitation is potential investigator recording bias.⁴⁷ When preparing the manuscript, however, the team invited respondents to review and comment on categories and themes, thus enhancing the validity of how their remarks were selected, sorted, and framed.⁴⁷ We did not discern any significant differences in responses between high-aspiring and high-performing local health departments about the structural elements seen to influence community engagement. A larger sample size and a recruitment strategy that assigned health departments to different performance categories according to objective criteria would present greater opportunity for rigorous comparison between groups and for more in-depth understanding of those structural features having the most significance for effective community engagement in public health emergency preparedness.

IMPLICATIONS FOR POLICY AND PRACTICE

Study observations are drawn from a small purposive sample, limiting the extent to which more general inferences and recommendations can be made. With that caveat, the investigators draw in the broader literature to analyze the results and offer the following assessment of what research subjects’ remarks could imply for policy and practice.

Make Long-term Investments in Community Engagement

Informants make a compelling case that community engagement in preparedness requires resources, with human capital arguably being the most important. From the perspective of local practitioners, a top priority for federal policymakers is to allocate preparedness funding for local health department staff to work more closely with community partners. Grant funding levels and timeframes should be in keeping with the priority that current doctrine places on community engagement and the practical realities of how long it takes to nurture social relationships.

The suggestion by health departments that steadily applied human resources are essential to involving community partners in preparedness complements what is known more generally about community-based health partnerships. Initiatives that have dedicated personnel to reach out into the community, sustain member relationships, and foster cohesion are better able to achieve their objectives.^{23,24,50-54} Social relationships essential to participatory public health research are similarly dependent on people and time.²³ Problems arise, however, when funder expectations about programmatic timeframes are at odds with the extended periods practitioners typically need to establish robust ties in the community.²³

It may be reasonable, for now, that preparedness funding for community engagement is less than optimal while the country recovers from the recession. As the government’s finances begin to improve, however, preparedness budget lines should genuinely reflect the priority of community engagement. Meanwhile, in the current economic context, an important short-term preparedness investment by the federal government is development and dissemination to local health departments of more technical guidance on how to design and implement a community engagement strategy—namely, one that is less resource-intensive and suited to large diverse populations.

Promote Collaboration When Budgets Are Tight

Given today’s constrained agency budgets, informants’ experience that finances are not the exclusive enabler of community engagement in public health emergency

preparedness is heartening. Intangibles like agency leadership and culture also matter. To advance community engagement, then, federal leaders can use the bully pulpit forcefully and consistently to validate the community's role in preparedness as well as state and local practitioners' work with partners. Doing so in the aftermath of a disaster can capitalize on that window of opportunity when routine thinking is disrupted. Health department leaders, too, can strive to provide steady encouragement that motivates emergency preparedness staff working with the community. Workforce training that reinforces the significance of community engagement to public health performance can also help promote a professional ethic affirming collaboration with the public.

Local health department observations that leadership helps facilitate community involvement in emergency preparedness match what is known about community health coalitions. Strong evidence suggests a link between effective collaborations to enhance population health and leadership that inspires vision, commitment, resources, inclusion, and action.^{24,50,51} An evaluation of 39 partnerships in which local health departments were central showed that health agencies who worked well with community groups had strong, dedicated leaders who used inclusive planning processes, creative financing measures, flexible organizational arrangements, and communication skills to promote collaborations.⁵²

Theoretical and empirical studies also suggest that organizational elements such as climate, values, mission, and preferences influence performance of the public health system.^{8,55} An institutional milieu that promotes shared expectations, communication and collaboration, and innovation,⁵⁵ and in which the workforce feels empowered by management,⁵⁶ has a positive effect on performance. Emerging literature also suggests that health department institutional culture plays a significant role in community health outcomes such as childhood immunization rates.⁵⁷

Practice Face-Time and Follow-up

Face-time and follow-up are a kind of social currency that local health departments are now using and that they should consider investing more in public health emergency preparedness partnerships. As noted by some informants, a financial exchange has been important for some health departments to establish good working relationships with community-based organizations and to build up the internal capacity of these organizations to weather emergencies and continue to serve clients. At the same time, interviewees underscored the importance of acting in good faith, being visible, and sustaining personal contact to maintain strong relationships. Effective community engagement, it would seem, means spending more time in the field than the office and interacting socially more than maintaining a partner call list.

Other research into health department emergency planners' relationships with faith- and community-based organizations has similarly revealed the premium that these groups place on "staff time, communication, respect, trust, and governance," more so than funding and supplies.^{58(p2305)} Given the intense staff time required to foster collaboration, some analysts have even recommended that public health departments consider forming fewer, more strategic connections with community partners in a context of scarce resources (though opinions differ on this approach).^{58,59}

CONCLUSIONS

Conversations with practitioners about factors that inhibit or facilitate their involvement of community partners in the emergency preparedness enterprise reveal a mix of sobering and hopeful conclusions. Local health departments' performance in readying communities for health emergencies involves knowing which critical functions to carry out *and* having sufficient structural capacity to do so. At the very same time in which community engagement has emerged as a central tenet of US preparedness, local health departments face reduced budgets and staff with which to reach residents; even one of the most accomplished of partnering health departments sees itself "limping along." Yet, finances are not considered the exclusive enabler to working alongside the community on disaster issues. Agency leadership, vision, culture, and climate also help fuel collaboration. Some room may exist, even in an era of austere budgets, for government decision makers at all levels to leverage modest changes and integrate citizens, faith- and community-based organizations, and businesses more fully into public health preparedness. Once the country emerges from the recession, policymakers and practitioners can then enact the more comprehensive investments that study informants recommend.

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