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Annual Survey of State and Territorial Chronic Disease Prevention and Health Promotion Capacity and Organizational Development Needs—United States, 2023

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Abstract

Objective: The National Association of Chronic Disease Directors (NACDD) is a nonprofit organization that supports state and territorial chronic disease prevention and health promotion efforts through capacity building and technical assistance. Each year, NACDD surveys health department leaders who oversee chronic disease prevention and health promotion (hereafter, Chronic Disease Directors). We have previously used the annual survey results to inform strategic planning and resource allocation but have not historically published key findings in the peer-reviewed literature. In this paper, we report on NACDD's 2023 survey outcomes and place those findings into the broader public health policy context.

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Human participant compliance statement is not applicable for this study. This work derives from a member survey that elicits information at the organizational level.

Design: State Chronic Disease Directors completed a survey about their organizational capacity and development needs. Responses were summarized in aggregate and by jurisdiction size.

Results: State chronic disease units have varied staffing and responsibilities, but most address diabetes, cardiovascular diseases, and cancer screening and prevention. Chronic Disease Directors generally reported strong or improving capacity in most practice areas but ranked workforce development lower. Staffing increased slightly during 2023 compared with the 2020 baseline (median of 1.3 and 1.1 employees per 100 000 jurisdiction population, respectively). However, Chronic Disease Directors expressed ongoing concerns about turnover, hiring, and training of inexperienced staff, as well as about funding limitations and uncertainty. Looking forward to 2024, many Chronic Disease Directors expressed intentions to focus on supporting their workforce with training and development opportunities and addressing health equity.

Conclusions: During this period of pandemic recovery, turnover, hiring, and training—particularly of the many new public health staff—remain key areas of concern for many chronic disease units. Continued stabilization of public health funding and increased prioritization of organizational capacity development—particularly workforce development, chronic disease data systems, and tools for addressing health equity—could help ensure chronic disease units can better address current and emerging challenges in chronic disease prevention and health promotion.

Keywords

capacity building; chronic diseases; planning; public health leadership; workforce development

State and territorial health departments improve national health and safety by delivering essential public health services.[1,2] Although public health governance structures vary among jurisdictions, all have an organizational unit responsible for leading and managing chronic or noncommunicable disease prevention and health promotion activities (hereafter, “chronic disease unit”). Leaders of these units have various titles and roles and are collectively referred to in this paper as “Chronic Disease Directors.”

Chronic diseases—including heart disease, stroke, diabetes, and cancer—are leading causes of death and disability in the United States.[3] Chronic diseases have disparate impacts on racially and economically oppressed people and rural populations, primarily because of unjust differences in the environmental and social conditions that influence health.[4,5] Disruptions to health care and social systems during the pandemic exacerbated these longstanding health disparities,[6,7] underscoring the need to strengthen public health capacity.

The National Association of Chronic Disease Directors (NACDD) is a nonprofit organization that provides technical assistance and support for building public health operational, structural, and workforce resources that support effective evidence-based chronic disease prevention and health promotion services nationally. Its core membership includes the 59 state, territorial, and freely associated state health department Chronic Disease Directors and their staff. NACDD surveys Chronic Disease Directors annually to align capacity-building activities with evolving needs among partner jurisdictions. We have previously used the annual survey results to inform strategic planning and resource

allocation but have not historically published key findings in the peer-reviewed literature. This paper reports key results of NACDD's 2023 survey of chronic disease prevention and health promotion capacity and organizational development needs. We hope that increased transparency about the chronic disease prevention and health promotion capacity and needs will inform policy and funding decisions that will strengthen our national pursuit of health equity.

Survey Distribution and Analysis

NACDD's annual capacity and needs survey is designed to be completed by Chronic Disease Directors in approximately 15 minutes. It consists of a core set of closed- and open-ended questions addressing Chronic Disease Directors' self-reported demographic characteristics and a self-assessment of their jurisdictions' chronic disease prevention and health promotion capacity and organizational development needs. Additional variable survey questions related to emerging issues or current events may also be included. Participation is voluntary, and no compensation is offered. When appropriate, Chronic Disease Directors are asked to involve their teams in compiling their responses.

An email survey invitation was sent to Chronic Disease Directors at the end of October 2023, and responses were accepted in a Qualtrics-based survey through mid-January 2024. Fifty of 59 jurisdictions responded (85% response rate), representing 43 states (including the District of Columbia) and 7 U.S. territories or freely associated states. This response rate was comparable to rates during the previous 4 years (2019: 80%; 2020: 86%; 2021: 66%; 2022: 88%). Where available, comparisons are provided from surveys collected during prior years for historical context. Notably, alignment between the current survey and historical data is variable because the annual survey's format and purpose has been actively evolving over the past 5 years from a user experience survey to a more detailed needs assessment approach. For example, staffing numbers were unfortunately not collected prior to 2020, precluding comparison of workforce size from before the pandemic to the present day. We elected to use the earliest available staffing numbers from the 2020 survey. Thematic coding was employed by 2 independent coders for each open-ended question to systematically identify and categorize recurring patterns, themes, and concepts within the data. Initially, the coders familiarized themselves with the data by reviewing all responses. Subsequently, they conducted a content analysis to extract and quantify major themes. After coding, consensus was reached on the quantification of codes to ensure accuracy. This process helped to ensure that the themes were representative of the data. Data were analyzed in Microsoft Excel. Since the survey collected descriptive, self-reported data on organizational capacity and needs, statistical tests were not conducted, as the focus was on summarizing trends rather than testing hypotheses.

Respondent Characteristics

Respondents were asked to self-report their gender and racial or ethnic identities to understand the demographics of chronic disease leadership nationally. During 2023, most respondents identified as female (88%), and the rest (12%) identified as male. Over half of respondents identified as White (58%). Additional racial and ethnic identities represented

among directors included Asian or Asian American (16%), Black or African American (12%), Native Hawaiian or Pacific Islander (10%), Hispanic, Latinx, or Spanish origin (4%), and American Indian or Alaska Native (2%). One individual selected 2 race and ethnicity groups and is included in both selection percentages.

More than half (56%) of respondents had been incumbent in their roles for 3 years or less at the time of survey response. This percentage was higher than values reported for 0 to 3 years of incumbency in the previous 4 surveys (2019: 45%; 2020: 45%; 2021: 41%; 2022: 37%). Six percent of Chronic Disease Directors reported having served in this role for 4 to 5 years, 16% for 6 to 10 years, and 22% for more than 10 years.

Overall Organizational Capacity

NACDD structures organizational capacity building around the **ST**ate **A**ctivation and **R**esponse, or STAR framework.[8] The STAR framework consists of 6 distinct practice areas drawn from the literature on evidence-based public health practice and public health accreditation that enable a chronic disease unit to function optimally. Chronic Disease Directors were asked to self-assess their unit's current organizational capacity and perceptions of change in capacity over the past year for each practice area (Figure 1).

Most Chronic Disease Directors (92%) ranked their unit capacity to apply evidence-based practice as either a 3 or 4 on a scale of 1 to 4 (with 1 being lower and 4 being higher capacity). In contrast, only 30% ranked unit capacity for workforce development as either a 3 or 4. Results for all capacity areas can be seen in Figure 1a. Most Chronic Disease Directors felt unit capacity had increased or stayed the same across the 6 practice areas. However, some respondents felt they had experienced decreased capacity over the past year in the following areas: partnerships and relationships (2%), leadership (4%), management and administration (4%), and workforce development (6%; Figure 1b).

Program Areas

Chronic Disease Directors were asked to indicate program areas included in their units from a list of 47 established and emerging chronic disease program areas. Jurisdictions selected a median of 19 program areas (range: 2–34 program areas).

Chronic disease units included a diversity of program areas, most commonly diabetes (100% of 49 respondents; 1 respondent skipped this question), heart disease and stroke (92%), tobacco (76%), nutrition (64%), and physical activity (64%). Some units also indicated responsibilities for breast and cervical cancer screening and early detection (60%), colorectal cancer screening (58%), cancer registry (52%), Alzheimer's disease (50%), asthma (40%), and oral health (30%). Many jurisdictions participated in 1 or more national programs or funding opportunities, most commonly Comprehensive Cancer Control (80%), Preventive Health and Health Services Block Grant (50%), WISEWOMAN (46%), BOLD (42%), and Healthy Communities (40%). Most indicated that they use public health tools and approaches such as evaluation (66%), policy and systems change (66%), community-clinical linkages (65%), epidemiology and surveillance (60%), and self-management education or self-efficacy approaches (60%).

Two-thirds (66%) of chronic disease units included health equity, social determinants of health (SDOH), and social justice in their program area selections.

Staffing

Chronic disease units varied in size, with a median of 25 full-time employees (range: 2–200). Nearly half (46%) also reported having 1 or more part-time employees (median: 0, range: 0–45 part-time employees). When standardized by jurisdiction population,[9–16] chronic disease units had a median of 1.3 employees (full- or part-time) per 100 000 population (range: 0.2–102.2) compared with 1.1 employees per 100 000 population (range: 0.1–61) during 2020.

Chronic disease units in smaller jurisdictions (less than 1 million residents) had a median staffing of 8.9 employees per 100 000 population compared with 1.5 employees per 100 000 people in medium-sized jurisdictions (1–5 million residents) and 0.5 employees per 100 000 people in larger jurisdictions (>5 million residents).

Of the 45 jurisdictions that responded to both the 2020 and 2023 surveys, 67% reported having more chronic disease unit staff during 2023 compared with 2020 (Figure 2). The median increase in staffing between 2020 and 2023 was 5 employees (range: −30 to +59). Notably, actual chronic disease capabilities were lower than reported staffing during 2020 because more than a quarter (26%) of chronic disease staff were either partially or fully assigned to COVID-19 response duties at that time.

Health Equity

In the 2023 survey, additional questions about efforts and barriers to addressing health equity in chronic disease units were asked. On average, respondents ranked their unit's focus on increasing health equity as 8.1 on a scale of 1 (not a focus) to 10 (extremely focused). More than half (52%) of chronic disease units had a designated staff member or a team responsible for leading health equity initiatives. Most respondents (86%) agreed or strongly agreed that their units had a clear understanding of SDOH, and nearly all had also partially (42%) or fully (56%) integrated SDOH into strategic planning and program development.

Lack of funding (60%) and insufficient data (44%) were the most frequently selected barriers to addressing health equity, and in parallel, the most frequently selected resources needed to effectively address health equity were funding (80%) and data and analytics tools (68%).

Challenges, Successes, and Focus Areas

Respondents were given the opportunity to provide free text descriptions of their units' notable challenges and successes during the past year and to identify their areas of focus for 2024. Staffing and funding were the most mentioned challenges. Of the 35 respondents who answered this question, challenges related to funding and resources were cited by 77% of respondents. Specific concerns related to insufficient funding, loss of funding, and constraints in how funds were spent or disbursed that prevented use for their most pressing

needs, such as hiring. A similar percentage (75%) mentioned difficulties with staffing. Specific concerns included loss of trained staff to retirement and departures, difficulties with hiring owing to the complexity of governmental processes and competition with private sector salaries and benefits, presence of many inexperienced staff who required training and development, and understaffing because of insufficient resources to match workload.

Thirty-one respondents noted successes they had celebrated in the past year. These were more varied in topic than the challenges and included successfully obtaining new funding, accomplishing specific programmatic goals, making organizational changes in hiring, salaries, and unit structure, addressing or improving culture or employee well-being, forging collaborations and partnerships, and obtaining support for policy changes. Several respondents specifically mentioned being fully staffed or hiring multiple new employees as successes for 2023.

Of the 29 respondents who elaborated on focus areas for the coming year, more than half (55%) highlighted staffing and workforce development, and slightly more than a quarter (27%) were prioritizing efforts to further health equity work in their jurisdictions. Other focus areas mentioned included strengthening cross-sectoral partnerships and collaboration, managing change, increasing workforce well-being and culture, and advancing public health policy.

Discussion

Chronic Disease Directors generally reported strong or improving capacity in key practice areas, including evidence-based practice, leadership, and management and administration. However, they ranked themselves lower in workforce development, underscoring the need to develop structures at the organizational level to support and sustain a systematic approach to workforce development. Despite signs that the number of chronic disease staff may be returning to pre-pandemic levels in many jurisdictions, turnover, hiring, and training remain key areas of concern for many chronic disease units.

The challenges that Chronic Disease Directors shared related to staffing and workforce development are consistent with a recent report that noted a stabilization of the public health workforce at near pre-pandemic levels, with continuing concerns broadly about stagnation in public health funding, hiring process inefficiencies, and difficulty with attracting, training, and retaining employees.[17] Although our data suggest that chronic disease staffing may be stabilizing in many jurisdictions, raw head counts do not capture the underlying staffing shortages and churn experienced by public health departments throughout the pandemic and continuing into this recovery phase. Multiple studies have documented that public health staffing has been insufficient to deliver foundational services even prior to 2020, particularly in chronic disease and injury prevention.[17–19] Furthermore, turnover escalated during 2017 to 2021, with nearly half of all state and local health department employees leaving during this period.[20] During 2021, about a quarter of chronic disease staff indicated intention to leave within the next year due to insufficient pay, work overload and burnout, and poor organizational culture.[21]

Chronic Disease Directors also expressed concerns about resource and funding instability, inflexibility, and uncertainty affecting their ability to staff and manage their programs and effectively advance health equity. Throughout the pandemic, the federal government provided more than $800 billion to state governments for economic relief and maintenance of essential community functions, with a limited portion of these funds designated for the public health workforce.[22] Although flexible funding that targets public health workforce development through the American Rescue Plan and Public Health Infrastructure Grant has provided needed help to public health departments with recruiting, retaining, and retraining staff, it is unclear how recipients will leverage those investments and whether longer-term funding increases will sustain their efforts.[23] Notably, chronic diseases and injury prevention are one of the areas with the smallest shares of planned hired/retentions under this funding (3% of planned hired/retentions), second only to maternal, child, and family health (2%).[23]

Chronic Disease Directors ranked their units lower in their workforce development capacity compared with other areas, and many planned to focus on workforce training and support as a key priority during 2024. The Centers for Disease Control and Prevention's National Center for Chronic Disease Prevention and Health Promotion funding through the National Organization for Chronic Disease Prevention and Health Promotion (DP-23-0009) may help address these immediate needs. As an award recipient, NACDD stewards this funding to meet chronic disease units where they are to build and strengthen organizational capacity and capabilities of the chronic disease workforce. Addressing lower capacity in the workforce development practice area by employing a strategic and systematic approach to staff learning and professional development may be part of the antidote to the numerous challenges facing Chronic Disease Directors relatedto turnover, hiring, and training of inexperienced staff.

NACDD offers a rapid cycle organizational development model for improving effectiveness and efficiency in state health department chronic disease prevention and health promotion practices (aligned with the STAR Program framework[8] used for assessing capacity in this survey). NACDD works with Chronic Disease Directors and their teams to build a shared understanding of organizational capacity, including systematic approaches to workforce development. Participating state teams then create solutions tailored to their contexts, including establishing processes to facilitate and meaningfully recognize on-the-job training, building training toolkits related to health equity, and establishing processes to support employee growth through customized stretch assignments. If expanded, this promising capacity-building approach would help address the need for expanded organizational capacity and workforce development.

Although many Chronic Disease Directors reported stable or improving capacity in key practice areas and workforce these gains coexist with significant challenges in staffing and funding. The complexity of public health practice means that improvements in certain capacities can coexist with persistent barriers related to funding and staffing shortages.

It is important to note several potential limitations to these survey-based findings. The reliance on self-reported data from Chronic Disease Directors may introduce bias or inaccuracies in assessing the true organizational capacity and development needs of their

units. Additionally, while the response rate was 85%, the findings may not fully represent the experiences of all state and territorial chronic disease units, particularly those that did not participate, potentially limiting the generalizability of the results.

Conclusions

Looking into 2024, many Chronic Disease Directors expressed intentions to focus on supporting their workforce with training and development opportunities and addressing health equity and SDOH. In the short term, general funding for public health workforce development and focal investments in community health workers,[24] health equity,[25] and data modernization (as part of the previously mentioned infrastructure grants and other grant mechanisms) are presently available in many states to support those intentions. However, as of this writing, both community health worker and health equity funds are slated to end in 2024 without a specific federal funding mechanism for continuing that work.

Many state and territorial health departments may be unable to maintain programs and operations established to respond to urgent concerns without more flexible and predictable funding that can be applied to long-term projects, including improvements in recruitment and hiring systems and sustainable workforce development.[26] Government organizational structures and requirements often create lags in hiring and resource distribution[27] that can limit the utility of time-limited funds for ensuring continuity of services and filling existing workforce gaps. This situation can lead to harmful cyclical hiring and laying off of workers due to gaps in funding. For example, during December 2023, health departments across the country began applying new funding to hiring and retaining an estimated 6000 public health workers,[23] while, at the same time, more than 350 public health staff were laid off in Washington state as a result of the exhaustion of COVID-19 funding.[28] Similar to the mass layoffs of temporary public health contractors as the acute pandemic response wound down,[29] an additional wave of departures may still loom as remaining COVID-19 response funds dry up.

Although the acute crisis is over, the pandemic left new challenges in its wake—including long COVID, a substantial health debt[30], a fragile health care system, and widened health disparities. Continued stabilization of public health funding and increased prioritization of organizational capacity development—particularly workforce development, chronic disease data systems, and tools for addressing health equity—could ensure chronic disease units have the skilled workers and resources needed to address both current and emerging challenges in chronic disease prevention and health promotion.

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Implications for Policy & Practice

- Despite certain commonalities, such as addressing diabetes, heart disease and stroke, and cancer, state and territorial chronic disease units have varied staffing and responsibilities, highlighting the need for and importance of crosscutting capacity, regardless of the specific disease topic.
- Chronic Disease Directors generally report strong or improving capacity in key practice areas, including evidence-based practice, leadership, and management and administration. However, they ranked themselves lower in workforce development, underscoring the need to develop structures at the organizational level to support and sustain a systematic approach to workforce development.
- During this period of pandemic recovery, turnover, hiring, and training—particularly of the many new public health staff—remain key areas of concern for many chronic disease units.
- Although these results suggest signs of stabilization in chronic disease units and their workforces, the tendency for public health funding to follow a boom-bust cycle could jeopardize efforts to address health equity and the additional chronic disease health debt accrued during pandemic disruptions.

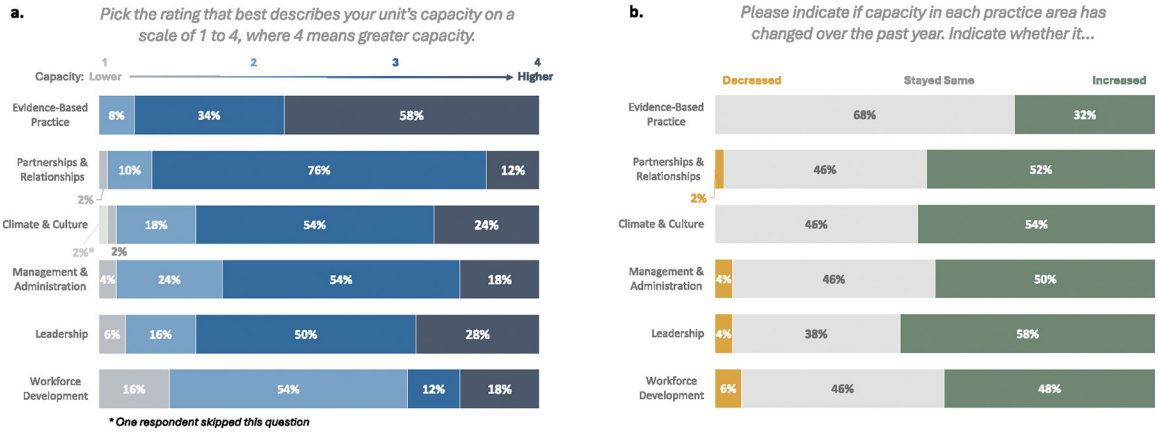

FIGURE 1.

State and Territorial Chronic Disease Prevention and Health Promotion Capacity (N = 50)—the United States, 2023.

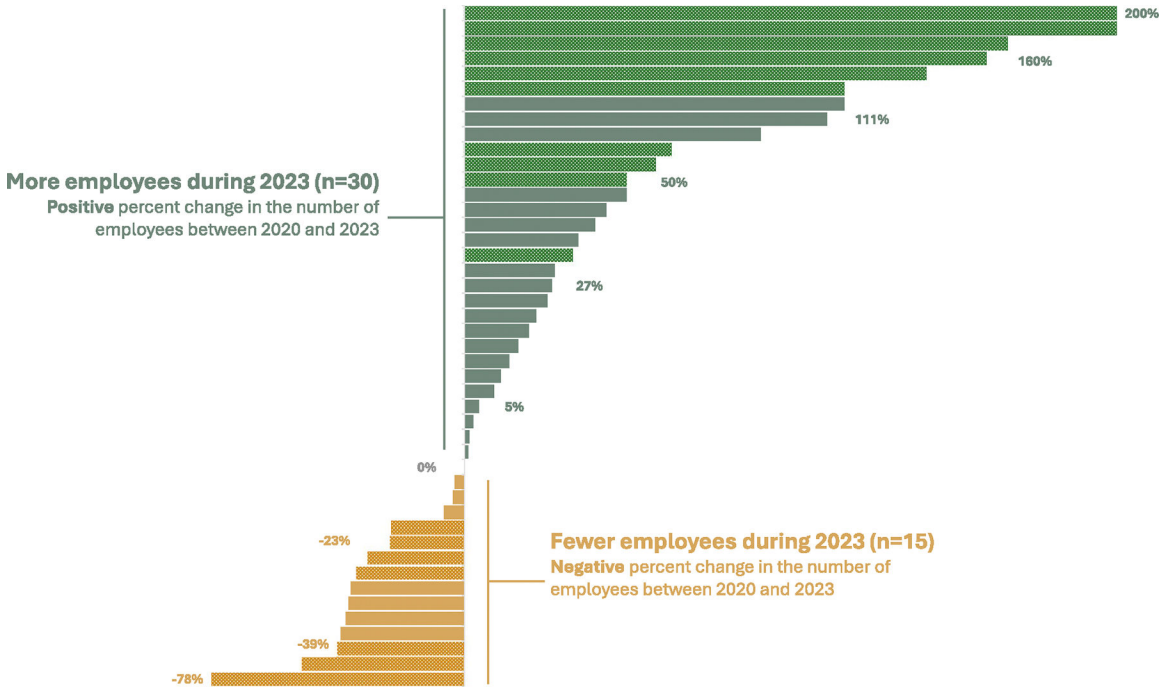

FIGURE 2.

Percent Change in Number of Chronic Disease Unit Employees During 2020 Versus 2023, by Jurisdiction (N = 45*)—the United States. *One jurisdiction reported no change in staffing and five jurisdictions were excluded due to nonresponse in either 2020 or 2023. Patterned bars indicate jurisdictions that had 20 or fewer employees during 2020, such that a relatively small change in the number of employees will result in a relatively large percent change.