National Association of Chronic Disease Directors
Competencies for Chronic Disease Practitioners
October 2016

This document contains the revised Competencies supported by the National Association for Chronic Disease Directors (NACDD). It is for Chronic Disease practitioners, partners in chronic disease prevention and health promotion, and interested others in promotion, planning and policy.

Each of the seven competencies areas contains specific sub-competencies to guide professional development and career progression. It also includes a separate table highlighting the added sub-competencies per area relative to ensuring equity.

NACDD is currently constructing a complete guide and toolkit for enhancing competencies of chronic disease practitioners at every level. In addition to producing the guide for practitioners, NACDD will apply these Competencies to every professional development initiative it undertakes or supports, beginning with the 2017 Chronic Disease Academy.

NACDD thanks the Professional Development Committee and the Board of Directors for support in finalizing the revised competencies.

COMPETENCY AREA 1: BUILD SUPPORT

Chronic disease practitioners establish strong working relationships with stakeholders, including other programs, government agencies and nongovernmental lay and professional groups to build support for chronic disease prevention and control.

1. Establish and maintain linkages and/or partnerships with key stakeholders (including other programs, government agencies and nongovernmental lay, and professional groups) to build support for chronic disease prevention and control.
2. Use effective collaboration strategies to build meaningful partnerships.
3. Listen to others in an unbiased manner, respect points of view of others, and promote the expression of diverse opinions and perspectives.
4. Interact effectively with other major sectors and key stakeholders (including the healthcare industry, transportation, parks and recreation, education and private sector).
5. Facilitate integration between chronic disease programs and other state health- related programs (e.g., surveillance, oral health, maternal and child health, Medicaid, state employee health insurance, emergency service providers and planners).
6. Communicate effectively in writing for professional and lay audiences.
7. Communicate effectively verbally for professional and lay audiences.
8. Prepare and present the business case for chronic disease prevention effectively (e.g. ROI, Reimbursement Models and related language, communicating public health impact in non-public health terms).
9. Facilitate use of coalitions as effective change agents for chronic disease prevention and control.
10. Advocate for chronic disease programs and resources.
11. Work collaboratively with partners on data collection and interpretation.
12. Use the media, social media, advanced technologies, community networks and public relations concepts to communicate information.
13. Lead and participate in groups to address emerging chronic disease issues.
14. Facilitate group interactions, verbal exchange, roundtable discussions to support informed decision making.
15. Develop enough social capital and political savvy to navigate the appropriate organizational systems quickly.
16. Participate in national work groups to facilitate effective implementation of chronic disease programs.
17. Identify and describe the roles of the key stakeholders on a national level.

18. Develop and support partnerships among public, nonprofit and private entities to provide a comprehensive infrastructure to increase awareness, drive action, and ensure accountability in efforts to end health disparities and achieve health equity across the lifespan.

COMPETENCY AREA 2: DESIGN AND EVALUATE PROGRAMS

Chronic disease practitioners develop and implement evidence-based interventions and conduct evaluation to ensure on-going feedback and program effectiveness.

1. Use program evaluation findings to improve program performance.
2. Identify and use public health data as a tool to develop and prioritize interventions or policies for chronic disease.
3. Select appropriate program and intervention activities.
4. Develop evaluation plans for chronic disease programs and activities.
5. Apply principles of cultural appropriateness to program design.
6. Apply cost-effectiveness, cost-benefit, and cost- utility analyses as appropriate.
7. Identify a data analysis agenda for state chronic disease programs.
8. Identify program-specific content areas.
9. Apply and use scientifically sound evaluation techniques.
10. Present accurate demographic, statistical, programmatic, and scientific information effectively for professional and lay audiences.
11. Use and apply economic evaluation techniques.
12. Incorporate GeoMapping techniques into data analysis.
13. Report and communicate data effectively (visually and verbally).
14. Understand how to invest in community-based participatory research and evaluation of community- originated intervention strategies in order to build capacity at the local level for ending health disparities.
15. Develop skills to expand and transfer knowledge generated by research and evaluation for decision- making about policies, programs, and grant-making related to health disparities and health equity.

COMPETENCY AREA 3: INFLUENCE POLICIES AND SYSTEMS CHANGE

Chronic disease practitioners implement strategies to change the health related policies of private organizations or governmental entities capable of affecting the health of targeted populations.

1. Assess the impact of public policies, laws, and regulations on chronic disease prevention and control.
2. Use health economics concepts and language to present chronic disease programs in a convincing manner to appropriate audiences.
3. Use policy as a tool in advancing chronic disease and control.
4. Build advocacy for policy and systems change.
5. Articulate relative risks of disease effectively.
6. Explain systems thinking and principles of systems change through ROI, payment reform and care coordination models.
7. Describe the historical development, structure, and interaction of public health and health care systems.
8. Identify local government structures. Demonstrate skill in engaging local government, health discussions, planning, etc.
9. Clearly articulate the impact of social determinants of health policies on health (include non-traditional partners such as housing, transportation and community design for example).
10. Ensure the availability of data of all racial populations and transferring knowledge related to racial, ethnic and underserved populations.

COMPETENCY AREA 4: LEAD STRATEGICALLY

Chronic disease practitioners articulate health needs and strategic vision, serve as a catalyst for change and demonstrate program accomplishments to ensure continued funding and support within their scope of practice.

1. Demonstrate critical thinking.
2. Leverage resources.
3. Apply effective problem-solving processes and methods.
4. Provide leadership to create key values and shared vision.
5. Create a culture of ethical standards within organizations and communities.
6. Educate decision makers on budget initiatives based on priorities..

7. Translate policy into organizational plans, structures and programs.
8. Respond with flexibility to changing needs.
9. Facilitate integration and coordination across chronic disease programs.
10. Create and/or identify policy agenda to align goals and measures for chronic disease programs.
11. Generate, share, and accept new ideas and incorporate them.
12. Oversee the development and implementation of a statewide chronic disease plan that incorporates named goals, measures of success, and actions to align goals and measures.
13. Identify individual and organizational responsibilities within the context of the Essential Public Health Services and core functions.
14. Demonstrate ability to build capacity at all levels of decision making to promote community solutions for ending health disparities.
15. Demonstrate ability to improve coordination, collaboration, and opportunities for soliciting community input on funding priorities and involvement in research and services.
16. Demonstrate ability to invest in young people to prepare them to be future leaders and practitioners to end health disparities.

COMPETENCY AREA 5: MANAGE PEOPLE

Chronic disease practitioners oversee and support the optimal performance and growth of program staff as well as themselves.

1. Recruit and retain a diverse chronic disease workforce (culture, age, gender, race, etc.).
2. Manage a team of professional staff effectively.
3. Support professional and personal development for chronic disease program staff.
4. Recruit and mentor a diversely-skilled interdisciplinary team.
5. Motivate individuals and teams to achieve goals.
6. Implement processes so that staff from multiple programs can identify underlying common goals and outcomes.
7. Negotiate budgets and contract requirements/objectives with both funders and contractors.
8. Promote team and organizational learning and collaboration.
9. Practice effective time management.
10. Mediate and resolve conflicts effectively.

11. Conduct performance appraisals and give guidance/feedback to staff regularly.
12. Balance multiple tasks.
13. Match staff skills to tasks.
14. Navigate relevant fiscal systems effectively.
15. Prioritize work responsibilities of self and staff.
16. Employ effective interviewing and questioning strategies.
17. Effectively manage meetings and conferences.
18. Demonstrate ability to develop and support the health workforce and related industry workforces to promote the availability of cultural and linguistic services, program development, etc.
19. Demonstrate ability to increase diversity and competency of health workforce and related industries through recruitment, retention and training of racially, ethnically, and culturally diverse individuals and through leadership action by healthcare organizations and systems.

COMPETENCY AREA 6: MANAGE PROGRAMS AND RESOURCES

Chronic disease practitioners ensure the consistent administrative, financial, and staff support necessary to sustain successful implementation of planned activities and build opportunities.

1. Manage chronic disease programs within budget constraints.
2. Set program goals and objectives of chronic disease programs.
3. Monitor chronic disease program performance.
4. Apply strategies to transition from planning to implementation.
5. Navigate cooperative agreements with the CDC.
6. Balance needs, requirements, partnerships, work load, etc. for multiple projects/programs.
7. Assess an organization implementation readiness, capacity and effectiveness.
8. Identify and assess potential funding opportunities.
9. Develop and justify a line-item budget that aligns with program activities.
10. Provide technical assistance to partners, subcontractors and others as needed.

11. Prepare proposals for funding from a variety of sources.
12. Conduct internal and external needs and assets assessments to inform program planning.
13. Adhere to public health laws, regulations, and policies related to chronic disease prevention and control.
14. Apply organizational theory to professional practice.
15. Apply current techniques in decision analysis and planning for chronic disease.
16. Understand basic principles and concepts of information system design and collaborate with others to develop a plan to collect and use data.
17. Conduct regular and purposeful site visits with grantees.
18. Develop and manage budgets that cross multiple award and funding cycles.
19. Apply project management principles.
20. Apply economic principles and concepts to program management.
21. Develop a diverse funding portfolio: federal and state, foundations, hospital community benefit and university-obtained grant dollars.
22. Demonstrate ability to implement strategies to promote health equity and investing the resources to that end.
23. Demonstrate ability to apply a health equity lens to the development, execution and evaluation of programs.

COMPETENCY AREA 7: USE PUBLIC HEALTH SCIENCE

Chronic disease practitioners gather, analyze, interpret and disseminate data and research findings to define needs, identify priorities and measure change.

1. Discuss the underlying causes and management of chronic diseases, including behavioral, medical, genetic, environmental and social factors using applied ethical principles.
2. Describe socioeconomic and behavioral determinants of health disparities.
3. Develop and adapt approaches to problems that take into account differences among populations.
4. Apply ethical principles to the collection, maintenance, use, and dissemination of data and information.
5. Recognize and apply current relevant scientific evidence.
6. Monitor and analyze chronic disease epidemiology and surveillance data to identify burden, trends and outcomes.

7. Articulate key chronic disease issues.
8. Identify relevant and appropriate data and information sources for chronic disease (GIS, electronic health records and other emerging methodologies).
9. Identify the factors that influence the delivery and use of public health programs and services.
10. Define and interpret non-traditional data to address chronic disease prevention and control (e.g. transportation data, electronic health records and cigarette sales).
11. Explain relevant inferences from quantitative and qualitative data.
12. Select and use appropriate data collection methods and maintain current standards of data collection.
13. Discuss issues of data integrity and comparability.
14. Know and apply the Chronic Disease Indicators.
15. Guide the translation of research into chronic disease programs and activities.
16. Discuss quantitative evaluation.
17. Discuss qualitative evaluation.
18. Implement social marketing strategies.
19. Maintain up-to-date knowledge on the development of genetic advances and technologies relevant to chronic diseases.
20. Explain basic clinical terms and etiology for chronic diseases.
21. Demonstrate a commitment to social justice and health equity.
22. Integrate principles of social justice into public health practice and promotion.
23. Demonstrate cultural sensitivity towards underserved populations.

Equity and Chronic Disease Competencies: At-a-Glance Guide

	Competency Area	Health Equity Related Sub-competency
1	**BUILD SUPPORT:** Chronic disease practitioners establish strong working relationships with stakeholders, including other programs, government agencies and nongovernmental lay and professional groups to build support for chronic disease prevention.	Develop and support partnerships among public, nonprofit and private entities to provide a comprehensive infrastructure to increase awareness, drive action, and ensure accountability in efforts to and health disparities and achieve health equity across the lifespan.
2	**DESIGN AND EVALUATE PROGRAMS:** Chronic disease practitioners develop and implement evidence-based interventions and conduct evaluation to ensure ongoing feedback and program effectiveness.	Understanding how to invest in community-based participatory research and evaluation of community-originated intervention strategies in order to build capacity at the local level for ending health disparities.
		Develop skills to expand and transfer knowledge generated by research and evaluation for decision-making about policies, programs, and grant-making related disparities and health equity.
3	**INFLUENCE POLICIES AND SYSTEMS CHANGE:** Chronic disease practitioners implement strategies to change the health-related policies of private organizations or governmental entities capable of affecting the health of targeted populations	Clearly articulate the impact of social determinants of health policies on health (include non-traditional partners such as housing, transportation, and community design for example).
		Ensure the availability of data of all racial populations and transferring knowledge related to racial, ethnic and underserved populations.

4	**LEAD STRATEGICALLY:** Chronic disease practitioners articulate health needs and strategic vision, serve as a catalyst for change, and demonstrate program accomplishments to ensure continued funding and support within their scope of practice.	Demonstrate ability to build capacity at all levels of decision-making to promote community solutions for ending health disparities.
		Demonstrate ability to improve coordination, collaboration, and opportunities for soliciting community input on funding priorities and involvement in research and services.
		Demonstrate ability to invest in young people to prepare them to be future leaders and practitioners to end health disparities.
5	**MANAGE PEOPLE:** Chronic disease practitioners oversee and support the optimal performance and growth of program staff as well as themselves.	Demonstrate ability to develop and support the health workforce and related industry workforces to promote the availability of cultural and linguistic services, program development, etc.
		Demonstrate ability to increase diversity and competency of health workforce and related industries through recruitment, retention and training of racially, ethnically, and culturally diverse individuals and through leadership action by healthcare organization and systems.
6	**MANAGE PROGRAMS AND RESOURCES:** Chronic disease practitioners ensure the consistent administrative, financial, and staff support necessary to sustain successful implementation of planned activities and build opportunities.	Demonstrate ability to implement strategies to promote health equity and investing the resources to that end.
		Demonstrate ability to apply a health equity lens to the development, execution and evaluation of programs.

7	**USE PUBLIC HEALTH SCIENCE:** Chronic disease practitioners gather, analyze, interpret and disseminate data and research findings to define needs, identify priorities, and measure change.	Demonstrate a commitment to social justice and health equity.
		Integrate principles of social justice into public health practice and promotion.
		Demonstrate cultural sensitivity towards underserved populations.