Embedding Disability Inclusion in Public Health:

Strategies to Strengthen Systems and Workforce Capacity

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To learn more about NACCHO's Health and Disability program activities, visit our program webpage at: https://www.naccho.org/programs/community-health/disability**.**

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Introduction

To advance the health of people with disabilities, local health departments (LHDs) must build internal capacity to ensure inclusive programs, policies, and services. People with disabilities make up more than 28% of the U.S. population and experience significant health disparities due to systemic barriers and exclusionary practices in healthcare access, economic stability, education, and community engagement (Mitra et al., 2022; CDC 2024). Despite the growing recognition of disability as a population with health disparities, public health systems still lack the workforce capacity and training needed to integrate disability-inclusive policies and practices to address the needs of people with disabilities.

The National Association of County and City Health Officials (NACCHO) Health and Disability program staff conducted a desk review to examine existing efforts to integrate disability inclusion into public health workforce development. The review also explored potential strategies for embedding disability expertise within local health departments and highlighted the need for sustained investment in workforce development. To complement the findings of the desk review, NACCHO staff conducted key informant interviews with public health professionals and disability inclusion experts. These discussions focused on identifying policy, systems and environmental strategies to increase workforce capacity and embed disability experts as a core public health practice.

Importantly, building disability-inclusive public health systems benefits not only people with disabilities but entire communities. When programs, services, and environments are designed to be accessible and inclusive, they create stronger systems that improve outcomes for everyone, for example, stronger emergency preparedness, broader access to health communication, and more resilient community infrastructures. By centering disability inclusion, local health departments strengthen their ability to serve diverse populations, reduce health disparities, and foster environments where all community members can thrive. This report presents a synthesis of findings from the desk review and interviews, offering actionable recommendations to embed disability expertise into public health systems and strengthen the workforce's capacity to address disability inclusion in a meaningful and sustainable way.

Methodology

Desk Review

NACCHO conducted a desk review of peer-reviewed articles, grey literature, national disability policies and existing public health workforce competencies. The objective was to synthesize existing research on disability inclusion in public health workforce development and highlight gaps in current practices. The search strategy focused on online U.S. public health materials published between 2014 and 2025 identified through public health journals, disability partner websites and national partner resources. The availability of peer-reviewed and grey literature may have excluded smaller or unpublished efforts and since disability inclusion in public health is an emerging and evolving field, some recent initiatives may not yet be reflected in the literature.

Key Informant Interviews

NACCHO's Health and Disability team and Evaluation team led seven interviews to explore policy, systems, and environmental changes that can help advance disability inclusion in public health practice. They sought to gather valuable insight on how public health departments can embed disability inclusion practices as a core public health practice and how to increase workforce capacity to engage in disability-inclusive public health initiatives.

Individuals from state-level programs, academic institutions, national nonprofits, and other disability partners were interviewed. They were chosen for their recognized expertise as disability and public health partners of NACCHO's Health and Disability team. Conducting up to seven interviews was designed to provide targeted insights from leaders in the field. While the findings from these interviews cannot be generalized to represent the experiences of all public health professionals or disability partners, they provide important context, illustrative examples, and real-world perspectives that complement and enrich the desk review findings. Interviews were conducted via Zoom, led by a member of the Evaluation team and a member of the Health and Disability team attended each interview. Each interview lasted approximately one hour. The interviews were recorded and transcribed by a third party.

A member of the evaluation team coded the interviews in Excel by identifying themes for each question. When appropriate, quotes from interviews were selected to illustrate the findings below. Quotes were slightly edited for clarity and brevity. However, the meaning or intent of the original statement was kept.

Summary of Findings

The desk review analyzed existing literature related to disability inclusion in public health and revealed gaps in public health workforce capacity that must be addressed. While "workforce capacity" is not yet clearly defined or systematically measured in relation to disability inclusion, it can be understood as the combination of staffing levels, training, expertise, and representation needed for local health departments to effectively and consistently integrate disability into programs, policies, and services.
Current literature points to the following gaps:

- Absence of clear guidance on incorporating disability competencies into the public health workforce development (Santoro et al., 2017).
- Inconsistent training across LHDs, leading to varying levels of understanding, accommodation, and implementation practices between jurisdictions (Havercamp et al., 2021).
- Insufficient disability data and utilization practices in public health planning tools like CHAs and CHIPs (Swenor et al., 2024; Breslin & Yee, 2024).
- Limited recognition and integration of disability in public health education and training (Sinclair, 2015).
- Lack of disability representation in health program planning, decision making and implementation and insights of people with lived experience interacting with public health systems and programs (Lee et al., 2023; Chandan, 2025).

Altogether these gaps highlight both the qualitative and quantitative aspects of workforce capacity. While there is not yet a standard benchmark for how many disability-trained staff or experts are needed within LHDs, defining workforce capacity could include several metrics. These may include the proportion of staff trained in disability competencies, the extent to which disability data is collected and applied in decision-making, and the level of engagement with disability communities in program planning. Future research and practice should aim to establish clearer definitions and measurable indicators of workforce capacity so that LHDs can track progress and identify the scale of investment required to close gaps in disability inclusion.

The key informant interviews highlighted the urgent need for intentional, system-level change to meaningfully include people with disabilities in public health. A major barrier is unstable funding, especially the limitations of short-term grants. Interviewees noted that without reliable funding, disability-inclusive initiatives are difficult to sustain. Many local programs, particularly in small or rural areas—struggle to qualify for grants due to population size or lack the staffing capacity to manage them. Sustainability requires not only continued investment from federal and state funders but also diversification of funding sources. This could include seeking support from private foundations and local businesses, as well as building partnerships with nonprofit organizations that share similar goals. Leveraging community resources and collaborating with cross-sector partners, such as disability advocacy groups, hospitals, or educational institutions, can also help local health departments secure non-governmental funding and expand the reach of disability-inclusive initiatives.

Despite these challenges, interviewees expressed strong commitment to advancing disability inclusion. They emphasized that public health continues to fall short in addressing the needs of one of the most underserved populations. Real progress requires not just programmatic fixes, but a broader cultural and structural shift—grounded in partnership, representation, and sustained investment.

Recommendations: Policies, Systems and Environmental Strategies

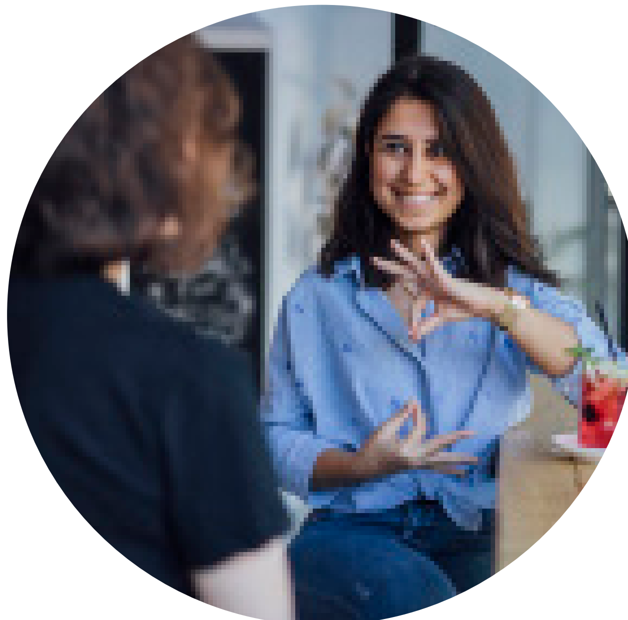
Build Disability Competencies into Public Health and Healthcare Education Programs

To prepare the public health workforce for roles in health departments, disability competencies should be prioritized in public health and healthcare education to establish a foundational understanding that supports both new and existing professionals in practicing disability-inclusive public health. To ensure this foundation, disability awareness and inclusion must be embedded as a core topic in the education and training of all current and future public health professionals. As one interviewee explained,

> *"It's not enough to have just continuing education for professionals that are already practicing—these trainings have to be embedded in education programs."*

Accrediting bodies like the Council on Education for Public Health (CEPH) play a critical role in this process. CEPH should require that disability inclusion is addressed as a topic in public health curricula before approving academic programs. By establishing disability as a standard part of the curriculum, CEPH can help ensure that future public health professionals are equipped with the knowledge and skills to support people with disabilities from the start of their careers.

Several existing frameworks can guide the integration of disability inclusion. In health care education, the Core Competencies on Disability for Health Care Education , emphasize key areas such as disability identity, communication, health disparities, and accessibility within interprofessional team-based settings. In public health, the Core Competencies for Public Health Professionals and Including People with Disabilities: Public Health Workforce Competencies offers practical guidance for integrating disability into assessments and policy, aligning with accreditation standards.



Require Disability Inclusion Training in Local Public Health Department Workforce

Disability inclusion must be a core competency—not an optional skill—for public health professionals. As one interviewee shared, *"There's so much more provider training out there, and yet we still have people coming into these fields with no knowledge of disability."* Requiring Disability 101 training for all local public health staff is a critical first step. These training courses should be co-developed with disability-led organizations and people with lived experience, covering topics such as health disparities, cultural competency, and accessible service design with real-world examples. NACCHO's Health and Disability 101 provides an introduction to disability awareness and can serve as a practical starting point to build staff capacity in inclusive public health practices.

To sustain long-term change, disability inclusion must also be embedded in public health credentialing and licensure standards. While LHDs cannot directly influence certification policies, accreditation bodies, including those overseeing CHES/MCHES, RN/LPN, MPH, and MD credentials—should integrate disability-related content into exams and continuing education. Embedding these requirements into the structures that shape professional development will strengthen the capacity of LHDs to serve people with disabilities and uphold disability inclusion as a fundamental public health responsibility.

Integrate Disability Inclusion into Accreditation, Strategic Planning, and Workforce Standards

To create sustained change, LHDs should embed disability inclusion into accreditation, strategic planning, and workforce standards. LHDs can incorporate disability-related indicators into Community Health Assessments (CHAs) and Community Health Improvement Plans (CHIPs), which shape how local health and partners prioritize community health improvement strategies.

LHDs should partner with disability organizations and people with disabilities to guide what indicators and priorities are included in the CHA and CHIP. These partnerships ensure that plans reflect lived experiences and local disability needs. Evidence from a national study (Leslie et al., 2025) reinforces this connection. CHIPs were more likely to address disability when the CHA process included diverse partners, particularly when steering committees included disability organizations, when the local disability population was larger, and when community engagement was broad. One interviewee commented,

> *"Just talking about disability more and offering concrete examples during CHA/CHIP training makes a difference—like including goals to reduce transit wait times for medical appointments or offering disability etiquette training for providers."*

Accrediting bodies like the Public Health Accreditation Board (PHAB) can also influence public health practice by requiring demonstration of disability-inclusive practices in performance standards and workforce development plans, as part of reaccreditation reviews. Making this a standard component of CHA/CHIP guidance and accreditation criteria will help support disability as a fundamental part of public health systems.

Standardize and Utilize Disability Data Collection Across Public Health Systems

LHDs need to use standardized disability data to understand their whole community needs, monitor health disparities, improve service delivery and ensure people with disabilities are accurately represented.

"If you're not focusing on disability as a population, you're really missing a fourth of your population."

Using standardized tools like the American Community Survey (ACS) six-question set offers a practical approach to collecting meaningful disability data. An interviewee shared,

"To support consistency, I've been advocating for using the ACS six-question set, since it's already included in many familiar surveys like Census and BRFSS. If we added these questions to like our quit line intake, we'd know how many people with disabilities are using the service—and could even break it down by functional disability type."

LHDs can train staff on best practices for inclusive data collection and build awareness of why disability data matters. For example, staff can be trained to use standardized disability identifiers and to ensure surveys are available in plain language and multiple formats (e.g., screen reader–accessible, large print). Partnering with disability-led organizations can help set meaningful data priorities and ensure collection methods are accessible, culturally responsive, and grounded in lived experience.

Center People with Disabilities and Disability Organizations as Partners

Local health departments (LHDs) should prioritize sustained partnerships with disability-led and disability-serving organizations to inform public health initiatives with lived experience. Rather than building internal expertise from scratch, LHDs can leverage the existing knowledge of organizations such as Centers for Independent Living (CILs), University Centers for Excellence in Developmental Disabilities (UCEDDs), Special Olympics, and the National Association of Councils on Developmental Disabilities. For example, local Special Olympics chapters have helped jurisdictions launch inclusive community collaboratives, while UCEDDs offer opportunities for student placements, fellowships, and co-leadership models that build a pipeline of future leaders grounded in disability inclusion. Starting a local disability inclusion task force can bring together LHDs, disability-led organizations, state agencies, and academic partners to brainstorm inclusive strategies and guide implementation for public health initiatives. The National Council on Aging offers guidelines on fostering authentic engagement with people with disabilities. Equally important is establishing ongoing feedback with people who have lived experience and ensuring fair compensation for their expertise. One interviewee described how their department moved beyond passive engagement:

"We did a survey and realized no one—including us—was doing anything intentional. So, we organized an APHA panel and invited Special Olympics athletes to share what being healthy meant to them, what supported them, and what barriers they faced."

As another shared, CILs are a critical connector:

"They know the community, they have deep relationships, and they'll link you to individuals, family members, direct support professionals—just start by showing up to a CIL event."

These partnerships not only strengthen inclusion efforts today but also lay the groundwork for system changes rooted in community expertise.

Foster a Cultural Shift Toward Disability Inclusion in Public Health Practice

"It's a cultural change. We keep trying to solve it at the programmatic level. But what the disability community is saying is, 'No, we need a societal change.'"

This shift begins with small, scalable practices that demonstrate impact and build buy-in. For example, one local health department revised their emergency evacuation plan after identifying gaps in supporting electricity-dependent individuals through data-sharing with emergency management. This kind of local coordination can drive broader systems change centered on disability needs. Free training modules, inclusive communication updates, and peer learning collaboratives are other low-cost, high-impact strategies to build early momentum and readiness.

Interviewees stated that system-level policy changes can be challenging for public health in federally or state-funded positions with limited advocacy capacity, but policy can also include internal protocols, agency priorities, or funding requirements, not just legislation. Adding disability demographic fields to CHAs, for example, is a systems-level action that centers people with disabilities as a health disparity population. Public health must also reexamine how disability is conceptualized and measured within its own frameworks. One interviewee emphasized,

“Public health still thinks good work means reducing disability or treating it away overall—it's built into our metrics like disability-adjusted life years. We don’t treat disability as a demographic like race or gender, so it’s a constant fight to include disability identifiers in standardized ways.”

Shifting this mindset is necessary to build a public health culture rooted in the social model of disability —one that addresses accessibility barriers and systemic participation gaps rather than viewing disability solely as a condition to be treated or minimized.

Develop An Inclusive Public Health Environment

Building an inclusive public health environment requires more than ADA compliance—it takes intentional changes in communication, staffing, infrastructure, and leadership. Interviewees emphasized that access goes beyond providing information or services; it means ensuring that health messaging and access to services are understandable and designed for all. This includes using plain language, universal design, and disability-informed messaging across all communications. As one interviewee noted,

"It's easy to forget that plain language applies to everything—not just one document, but emails, websites, and all communication."

Interviewees also highlighted the importance of hiring dedicated disability inclusion staff—ideally people with lived experience—to coordinate efforts, build capacity, and serve as liaisons across programs. As one interviewee put it, "Without full-time staff, inclusion work falls through the cracks." Leadership buy-in is equally important to inform funding and workforce development decisions for disability inclusion work. One interviewee shared,

"It can be challenging to get training systematized unless you have full support from the state health department."

Inclusion must also extend to physical environments and programming. One state partnership with Centers for Independent Living and ADA-trained staff supported health departments in conducting 'walk-move audits'—bringing staff and community members together to move through public health spaces and identify barriers in real time.

"We look at what it means to arrive by bus or by car and experience the space together… It brings the work to life and helps staff understand what accessibility really means," one interviewee shared.

Ultimately, inclusive public health practice begins with rethinking communication, staffing, infrastructure, and leadership to ensure accessibility is actively built into every aspect of the public health environment.

Conclusion

Addressing gaps in disability inclusion within public health requires coordinated action across all levels of the public health system. Local health departments play a pivotal role in leading this work by embedding disability as a core part of public health function. This includes integrating disability competencies into CHAs and CHIPs, strategic planning, communications, accreditation efforts, and workforce development. To sustain progress, LHDs need greater investment in disability-specific staff roles, ongoing training for current and future professionals, meaningful partnerships with disability-led organizations, and improved approaches to disability data collection. These recommendations are grounded in both research and the expertise of national and state disability and public health leaders. By committing to inclusive systems and centering people with disabilities in planning and decision-making, LHDs can build more equitable, responsive, and trusted public health programs that serve their entire communities.

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