The Arizona Chronic Disease Plan

An Integrated Model For Promoting Healthy Communities

Arizona Department of Health Services

“Alone we
can do so little;
together we can
do so much.”

–Helen Keller

Arizona Department of Health Services

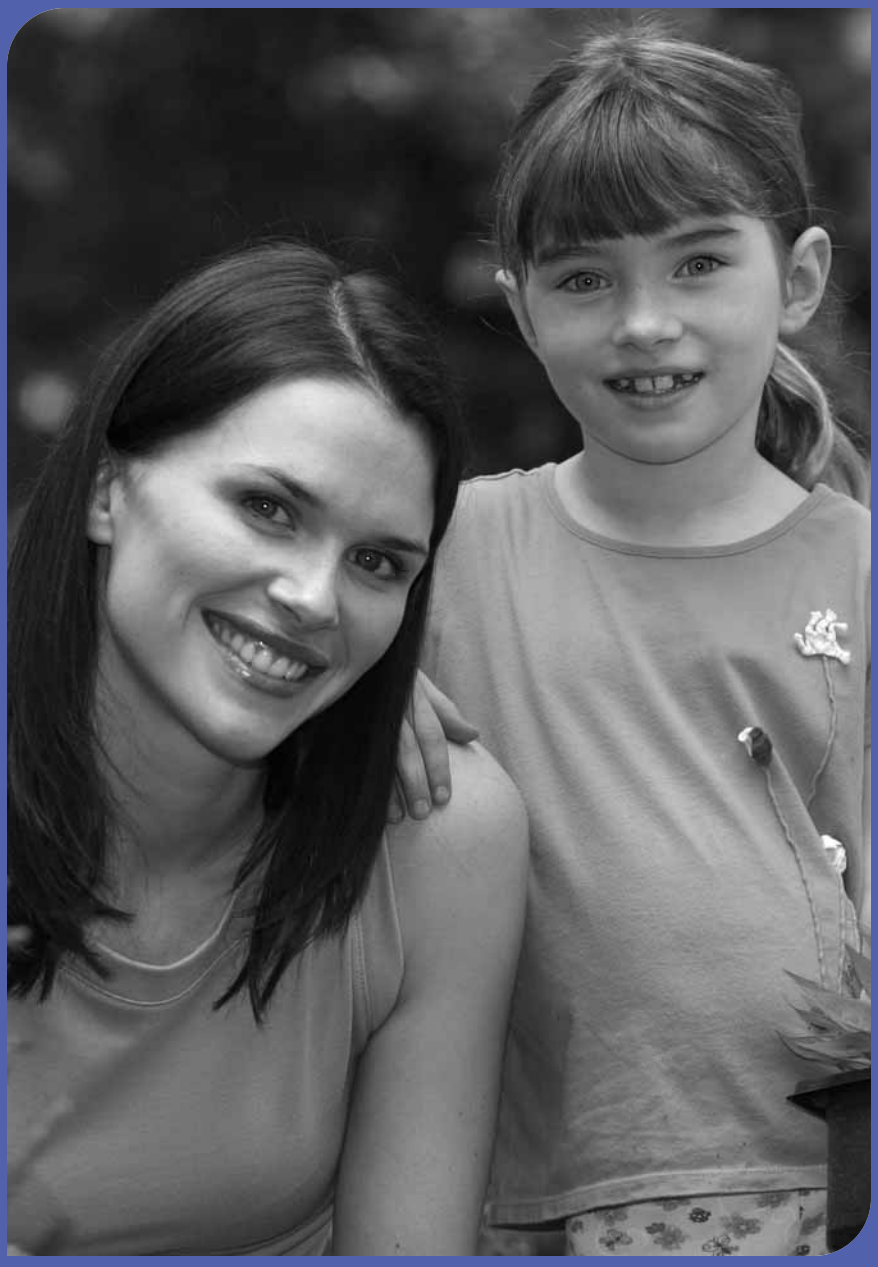
Dear Arizona Residents:

Chronic disease accounts for seven out of the 10 leading causes of death in Arizona and is the most common and preventable of all health problems. During the 20th Century, our citizens saw the focus of public health shift dramatically from the communicable diseases that were so prevalent during the early part of the century to chronic disease as the primary cause of mortality and morbidity. Diseases such as heart disease, cancer, lung disease, and stroke rank highest on the list as the four leading causes of death for Arizonans.

The Arizona Chronic Disease Plan: An Integrated Model for Promoting Healthy Communities is the culmination of a collaborative effort among members of the Chronic Disease Team who worked to combine the elements of six comprehensive disease-specific categorical plans into a cohesive and integrated model. It is an innovative and cutting-edge approach that promotes collective thinking and problem solving in addressing common elements of the disease-specific and primary risk factor categories. This plan represents the Arizona Department of Health Services' efforts to view chronic disease from a more comprehensive and integrated perspective.

The Arizona Chronic Disease Plan is not meant to be the final answer; rather it is a beginning in the department's ongoing commitment to reducing the impact of chronic disease in our state and, thereby, enhancing the quality of life for our citizens.

Susan Gerard
Director
Arizona Department of Health Services



Courtesy of Heard Museum

Acknowledgements

Chronic Disease Team

We would like to thank the members of the Chronic Disease Team for their dedication and commitment to the development of this plan. Their willingness to give of their time, energy, and expertise represents the true spirit of teamwork.

Trust Commission

We would like to thank the members of the Tobacco Revenue Use, Spending, and Tracking (TRUST) Commission for supporting the development of *The Arizona Chronic Disease Plan: An Integrated Model for Promoting Healthy Communities*.

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Consultants

Sincere gratitude to our technical consultants, Randy Kirkendall (Partnership for Prevention) and Tom Kean (Strategic Health Concepts) for their insight, direction, and support throughout the project.

Executive Summary

Chronic disease accounts for seven out of the 10 leading causes of death in the state of Arizona.[1] This plan is intended to provide state level agencies, communities, health care providers, funding agencies, organizations, policy and decision makers, and consumers direction and support in creating a system of care that proactively addresses the prevention, early detection and treatment of chronic disease in Arizona. It is hoped the framework presented will encourage the development of partnerships to promote a comprehensive and integrated approach to reducing mortality and morbidity due to chronic disease.

Vision for The Arizona Chronic Disease Plan:

An Integrated Model for Promoting Healthy Communities

1) The Arizona Chronic Disease (AzCD) Plan is a blueprint for developing a coordinated and integrated approach to chronic disease management in Arizona.
2) The AzCD Plan will be used as a vehicle for establishing partnerships with local communities and organizations to develop programs to address the burden of chronic disease.
3) The AzCD Plan will be used to establish funding priorities for a portion of the Arizona Tobacco Tax and Health Care Fund – Health Education Account. The funding priorities will address prevention and early detection of the four leading disease-related causes of death, i.e., heart disease, cancer, lung disease (chronic obstructive pulmonary disease or COPD), and stroke.
4) The AzCD Plan provides a framework for leveraging resources and exploring other funding streams.

Health Disparities

Despite the advances in medical technology impacting the early detection, diagnosis, and treatment of chronic disease, minority groups and other vulnerable populations still experience health care barriers and significantly higher rates of disease and mortality. Eliminating these disparities has become a priority for the health care system nationally and in Arizona.

How This Plan is Different

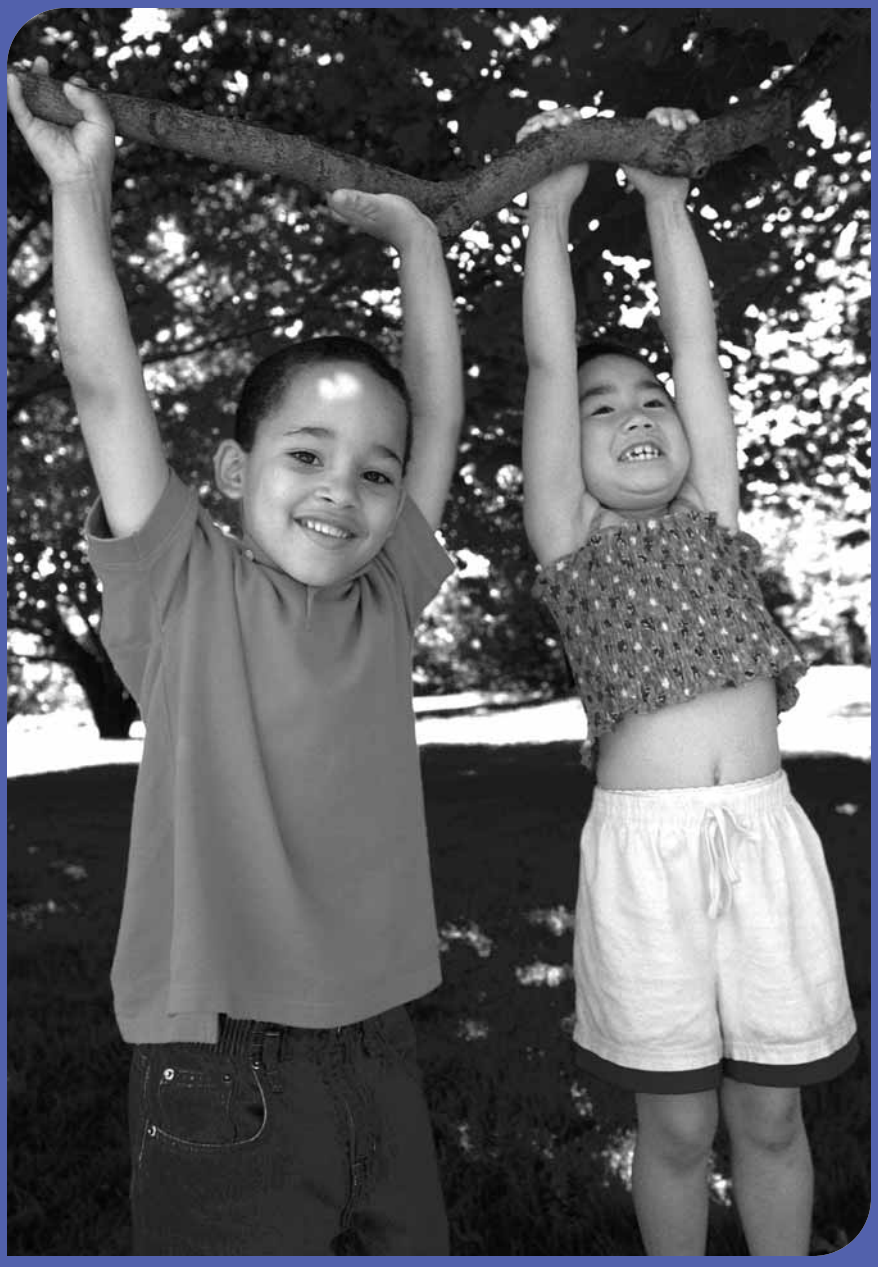
This plan is different than many other planning documents. The scope of the plan is very broad, encompassing several distinct disease categories: heart disease, cancer, lung disease (COPD and asthma), stroke, and diabetes and the risk factor categories of poor nutrition, physical inactivity, and use of commercial tobacco products (see definition of "tobacco" in glossary). Each of the disease-specific entities and risk factor categories has developed a comprehensive and integrated planning document that outlines evidenced-based objectives and strategies. The goal of the AzCD Plan is to effectively merge the many elements of the categorical plans into a coordinated, cohesive, and integrated model of the proposed system of care for the prevention and management of chronic disease in Arizona.

Healthy Lifestyles

This AzCD Plan supports the promotion of healthy lifestyles as primary prevention strategies in combating the key risk factors for chronic disease, i.e., poor nutrition, physical inactivity, and use of commercial tobacco products. The role of tobacco prevention and cessation programs is critical in the management of chronic disease. The burden of overweight and obesity contributes to premature death and disability, increased health care costs, lost productivity, and social issues. While not all chronic diseases are addressed in this plan, promoting a healthy lifestyle that includes good nutrition, physical activity and no use of commercial tobacco products will positively impact many chronic diseases not specifically included in the plan.

Summary

This plan represents the Arizona Department of Health Services' ongoing commitment to reducing the mortality and morbidity of chronic disease through collaboration among all stakeholders. It is hoped that the plan will encourage the development of partnerships among state agencies, policy and decision makers, communities, organizations, health care providers, and consumers to promote a comprehensive and integrated approach to improving the health of all Arizonans.



Introduction

Chronic disease accounts for seven out of the 10 leading causes of death in the state of Arizona.[1] Over the past several years, there has been an expansion of chronic disease programs within the Public Health Services Division of the Arizona Department of Health Services (ADHS).

Until recently, those chronic disease programs functioned independently without coordination among the various chronic disease initiatives, due in part to categorical funding requirements. With the expansion of chronic disease prevention, management, and control efforts, a need was identified to develop a more comprehensive and integrated approach.

There is neither funding to implement every strategy in the categorical plans, nor funding to support all of the initiatives addressed in this comprehensive plan. The reality is there are rarely sufficient financial resources to fully fund any plan. Many of the items in this comprehensive plan do not require funding, but a more effective coordination of state and community level efforts that are already in progress. ADHS is committed to dedicating human resources, time, and leadership to support implementation of the plan.

This plan is intended to provide state level agencies, communities, health care providers, funding agencies, organizations, policy and decision makers, and consumers direction and support in creating a system of care that proactively addresses the prevention, early detection and treatment of chronic disease in Arizona. It is hoped the framework presented will encourage the development of partnerships to promote a comprehensive and integrated approach to reducing mortality and morbidity due to chronic disease.

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4) The AzCD Plan provides a framework for leveraging resources and exploring other funding streams.

ADHS Approach

Prevention and health promotion. ADHS believes in prevention and health promotion as the path to optimal health and wellness for all Arizonans. The 2005–2009 ADHS Strategic Plan includes specific strategies and objectives focusing on the prevention of chronic disease in Arizona through an integrated and comprehensive approach:

> The Department is working with health care providers, employees, and organizations to place greater emphasis on the importance of prevention and health promotion activities. By providing leadership and state-of-the-art health information to professionals and consumers alike, the Department can promote healthier lifestyles and reduce the incidence of chronic and degenerative diseases.[2]

Service delivery. ADHS believes in delivering services that are based on best practices and supported by evidence-based strategies.

Cultural responsiveness. ADHS believes all services and technical assistance should be provided in a manner that is responsive to cultural differences and values the importance of culture in the delivery of services to all segments of the population.

Reduction in health disparities. ADHS believes in order to reduce existing health disparities, a culturally responsive system of care should be developed and implemented among all levels of Arizona health care providers, which includes but is not limited to:

- Organizational self-assessment of cultural competence
- Integration of cultural and linguistic competence measures into existing quality improvement activities (See Appendix F for Culturally and Linguistically Appropriate Services Standards)
- Development/review of comprehensive written policies on cultural responsiveness
- Customer satisfaction surveys
- Solicitation of customer input relative to individual needs, beliefs, and behaviors
- Trainings and forums for providers and staff.

Despite the advances in medical technology impacting the early detection, diagnosis, and treatment of chronic disease, minority groups and other vulnerable populations still experience health care barriers and significantly higher rates of disease and mortality. Eliminating these disparities has become a priority for the health care system nationally and in Arizona.

> Current health data on Arizona residents shows marked differences in rates of disease and mortality among specific population groups. The Department is committed to addressing disparities in Arizona by increasing dialogue with communities, improving access to public health information, and working collaboratively on community action specifically targeted to improve health outcomes through prevention. The Department will also work to ensure that ***all*** Arizonans receive timely diagnosis and treatment of health conditions through expanded access to primary care.[3]

Native American population in Arizona. In addressing issues related to cultural competency and disparity, it is important to recognize that Arizona has one of the largest Native American populations in the country comprising approximately 5% of the state's population.[4]

There are 21 separate sovereign nations located on 24 Native American reservations throughout Arizona. This presents some distinct challenges in terms of geographic barriers, history, tradition, communication, and governmental structure. The element of sovereignty is a unique aspect of the Native American population, not shared by other minority groups, requiring additional accommodation to work successfully.

In addition to services, technical assistance is a critical need to improve health conditions on the reservations. Resources are significantly limited and capacity building or "nation building" is a critical need. Tribes prefer technical assistance be made available to them in a manner that allows them to customize the assistance based on the needs of the tribe.

Improved working relationships between the tribes and state agencies need to be established so tribes can be involved in future planning activities. Geographic barriers and efficient and expedient methods of communication present challenges in obtaining tribal input on planning activities at the state level. Soliciting input from Indian Health Service (IHS) or the Bureau of Indian Affairs (BIA) is one way used to obtain the Native American perspective in planning efforts; however, these agencies provide a federal perspective, which is not necessarily the local tribal perspective. While going directly to the tribes on the reservations is the only true source of obtaining tribal input, the Inter Tribal Council of Arizona (ITCA) presents an accessible and viable option for obtaining a tribal perspective.

Background

In July of 2002, the ADHS Office of Nutrition Services merged with some of the chronic disease prevention programs in ADHS to form a new office titled the Office of Chronic Disease Prevention and

Nutrition Services (OCDPNS). The chronic disease programs that merged included:

- Diabetes Prevention and Control
- Arthritis Control
- Well Woman Healthcheck Program (Breast and Cervical Cancer Early Detection and Diagnosis)

During the next year, funding was secured for planning grants in the areas of:

- Cardiovascular Risk Reduction
- Nutrition and Physical Activity
- Comprehensive Cancer Control

With the growing number of chronic disease programs in OCDPNS, its chronic disease prevention efforts expanded and work began on establishing comprehensive chronic disease programming and planning.

An additional motivating factor for the development of the comprehensive chronic disease plan was the need to establish direction and funding priorities for a portion of the Arizona Tobacco Tax and Health Care Fund – Health Education Account. Voter approval of Proposition 303 in 2002 increased the state tax on tobacco products and reenacted the Proposition 204 statute that established the Tobacco Tax and Health Care Fund – Health Education Account. As a voter approved initiative, a portion of the tobacco tax revenue (2%) was directed to the prevention and early detection of the four leading disease-related causes of death as periodically determined by the Centers for Disease Control and Prevention (CDC) or its successor agency.

Initially, the Chronic Disease Fund, which resides within ADHS, will address the following chronic diseases: heart disease, cancer, lung disease (COPD) and stroke. By statute, an external advisory commission (Tobacco Revenue Use Spending and Tracking Commission or TRUST) was established to oversee the Health Education Account. The 15-member, ADHS Director-appointed TRUST Commission serves in an advisory capacity to ADHS in providing oversight to the Tobacco Tax revenues, including the Proposition 303 Tobacco Tax-based chronic disease funds. Through internal and external stakeholder input, the decision was made to allocate these funds for screening and early detection programs, promoting healthy lifestyle programs, and development of a comprehensive chronic disease strategic plan.

As the public health agency that administers and manages the chronic disease funds, the need for a systems-level strategic plan that is both comprehensive and integrated is paramount. Having such a plan will ensure that chronic disease-related "baselines" are developed, actual needs are addressed, and funds are allocated in support of policy change and programmatic services.


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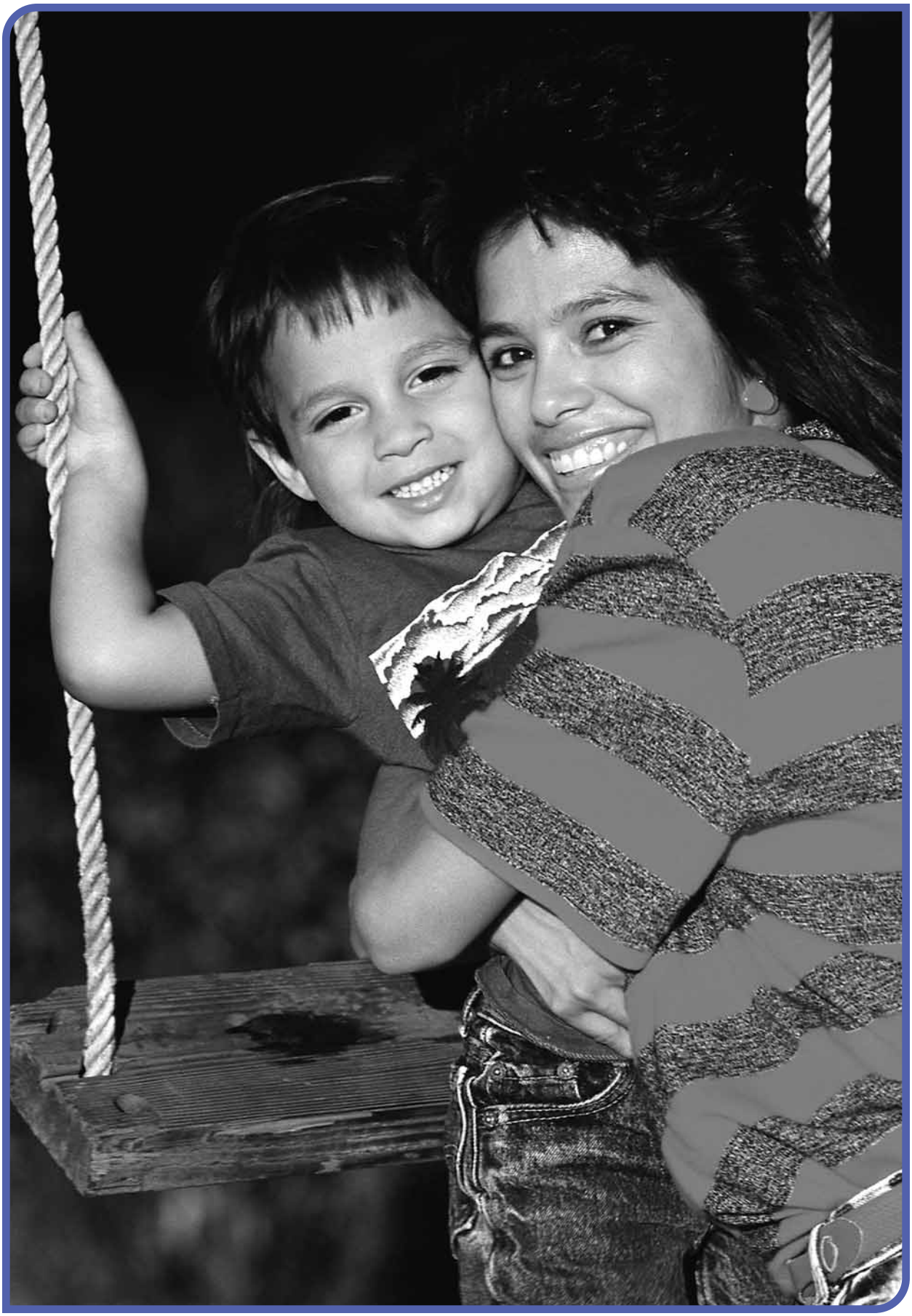


In the fall of 2003, the ADHS OCDPNS submitted a grant proposal to the Partnership for Prevention who had been designated by CDC to provide tailored technical assistance to selected states and metropolitan areas in developing comprehensive and integrated chronic disease prevention efforts. In January of 2004, ADHS was notified that Arizona was one of four sites out of 34 applicants to participate in the CDC project. During the planning process, the consultants facilitated on-site meetings of the Chronic Disease Team and provided direction and follow-up to the OCDPNS Office Chief and the AzCD Plan Manager during each of the on-site visits. In addition to the on-site meetings, the consultants were available for individual phone consultation, conference calls as needed, and review of written materials via email.

Chronic Disease Team

A Chronic Disease (CD) Team was established within ADHS to assist in the development and provide input on the AzCD Plan. Initially, the CD Team included the representatives from each of the categorical plans and appropriate administrative staff within OCDPNS and the Office of Tobacco Education and Prevention Program (TEPP). As the planning process progressed, other members were gradually added to the CD Team to broaden the scope of representation and/or provide needed input on relevant topic areas. Representatives from ADHS Nutrition Network, Social Marketing, Steps to a Healthier Arizona, Bureau of Public Health Statistics, Office of Health Systems Development, the Native American Liaison, and the coordinator from the Health Disparities Conference Committee, were added to the team as the planning process required their expertise. The technical assistance consultants facilitated the monthly CD Team meetings held from August 2004 to May 2005. The CD Team served as a steering committee providing direction and content information for the AzCD Plan. Decisions regarding common messaging, cross-cutting strategies, conflicting objectives, establishing priorities, and identifying gaps in the categorical objectives and strategies were all addressed through the CD Team. The CD Team also served as a review workgroup for all written materials pertaining to the AzCD Plan.

Definition of Chronic Disease

For the purposes of this document, chronic disease is defined as in the February 2003 revision of the Association of State and Territorial Chronic Disease Program Directors Bylaws:[5]

> Chronic disease is defined as an impairment or deviation from normal health having any of the following characteristics:
>
> - related to avoidable behavioral/environmental risk factors
> - is permanent
> - leaves residual disability
> - is caused by irreversible pathological alterations

- requires special training of the patient for rehabilitation
- may require a long period of supervision, observation, or care.

Comprehensive Approach

Miriam Webster Online defines the term comprehensive as "covering completely or broadly."[6] For the purpose of this plan, a comprehensive approach to chronic disease prevention and management is defined as addressing:

- The leading causes of death: heart disease, cancer, lung disease (COPD), and stroke
- Two of the most common and costly conditions: diabetes and asthma
- The major risk factors for chronic disease: physical inactivity, poor dietary habits, and use of commercial tobacco products
- The issues related to chronic disease management from a statewide perspective including: the general population, high-risk groups, and disparate populations
- The issues using a broad spectrum of intergenerational strategies implemented through a variety of intervention domains such as: schools, work sites, family and community, and the health care system.

Case for an Integrated Approach

The intent of integration is to strengthen program effectiveness and improve program impact thereby maximizing available resources. Achieving integration is a process whereby participants learn by sharing common strategies and goals, they can increase the overall impact and efficiency of their programs.

An integrated approach to chronic disease prevention provides opportunities for programs to work together to provide services more efficiently and effectively, promotes group problem solving and teamwork by collaboratively addressing common problems and issues, and supports a more synergistic style of intervention so the combined impact of all programs is enhanced.

Other benefits of addressing chronic disease with an integrated and collaborative approach are:

- Improved effectiveness in reaching shared target populations and organizations
- Ability to address common risk factors that are the same for many of the prominent chronic diseases: poor nutrition, physical inactivity, and use of commercial tobacco products
- Enhanced impact of common, consistent social marketing messages and strategies
- Opportunity for mutual problem solving and shared learning
- Coordination of similar intervention strategies that allows for improved coordination and effectiveness in developing interventions for common intervention sites such as schools, work sites, and communities

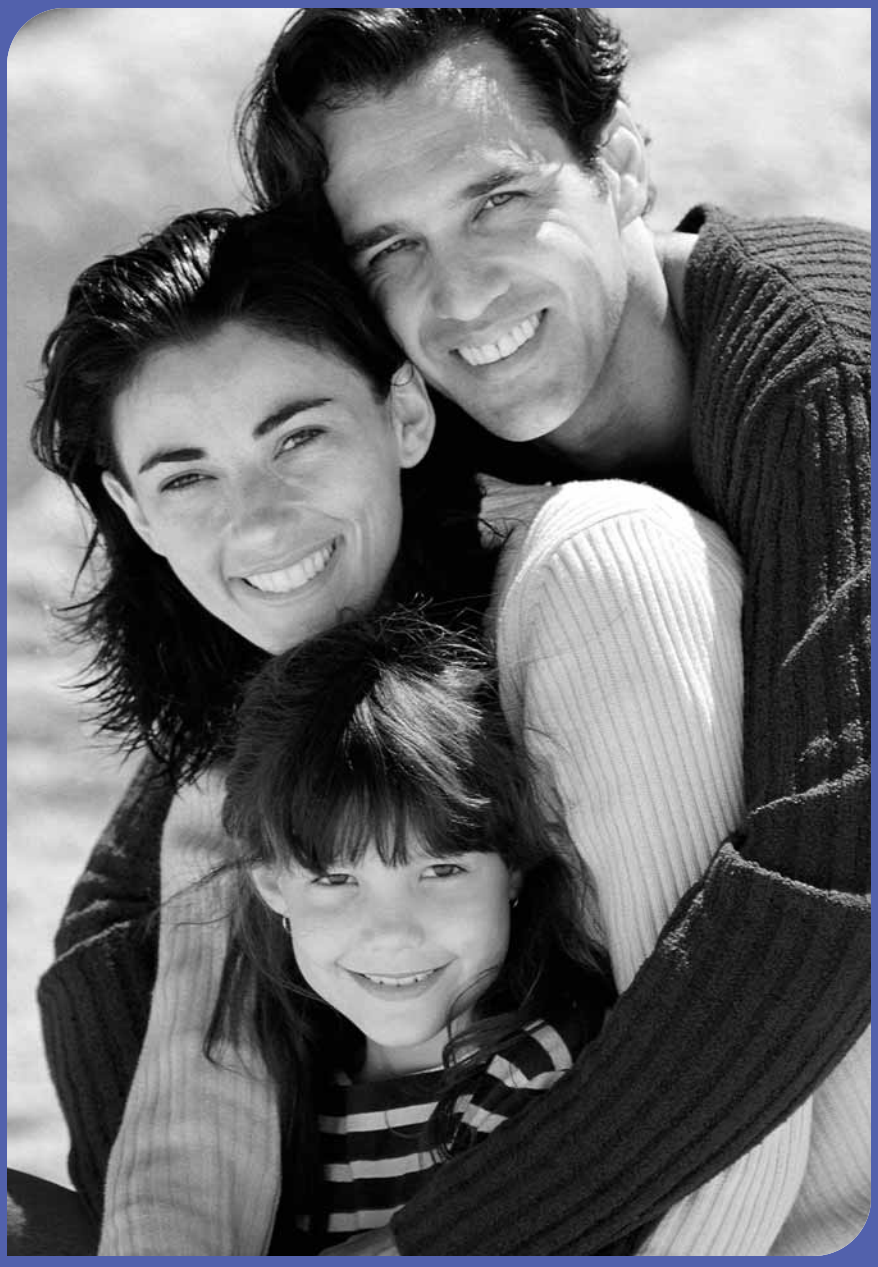
- Pooling of resources that maximize the efficiency and effectiveness of programs and allows for improved allocation of limited funding
- Enhanced data sharing
- Improved capacity for identifying and resolving gaps in service delivery when those issues are viewed from a multifaceted perspective
- Sharing of standards and best practices to eliminate duplication of effort and insuring consistency in standards of care
- Enhanced coordination with external partners that results in better communication across programs
- Coordination of provider education efforts
- Development of training tools for providers that facilitate the process for all concerned and avoids duplication of efforts
- Expanded impact of policy and environmental changes
- Clearly defined roles and responsibilities
- Overall greater impact and effectiveness of programs.

Timeframe for The Arizona Chronic Disease Plan

The initial cycle of the AzCD Plan will cover from 2005 through 2008. The projected timeframes for the categorical plans range from three years to five years as follows:

- Cardiovascular Disease Prevention Plan, 2005 – 2010
- Arizona Comprehensive Cancer Control Plan, 2005 – 2010
- Chronic Lung Disease Plan for the State of Arizona, 2005 – 2008
- Diabetes Prevention and Control Program Plan, 2005 – 2008
- Arizona Nutrition and Physical Activity Plan, 2005 – 2010
- Tobacco Education and Prevention Program Plan, 2005 – 2008

Given that strategies and priorities for the AzCD Plan were derived from the categorical plans, the CD Team decided that the overall timeframe for the AzCD Plan should be within the parameters of the categorical plans. The three-year timeframe for the AzCD Plan does not mean all objectives will be met within that period, rather the plan will be monitored, reassessed, and revised after the three years as needed.



The Plan

The Burden of Chronic Disease in Arizona

The 20th century saw major improvements in the quality of life for citizens in this country. The infant mortality rate dropped significantly and life expectancy increased by 30 years. The focus of public health also shifted dramatically from the communicable diseases that plagued the early part of this century to chronic disease as the primary causes of death and disability to our citizens.[7] Today, diseases such as heart disease, cancer, lung disease, and stroke are among the most common, costly and preventable causes of mortality and morbidity.[8] The aging of the baby-boomer generation, and the popularity of Arizona as a retirement state, place additional responsibilities on public health and the health care system to aggressively address chronic disease from a prevention perspective and utilize screening and early detection to reduce the burden of chronic disease.

Chronic disease accounts for seven out of the 10 leading causes of death in the state of Arizona.[1] They are the most prevalent, costly, and preventable of all health problems.

- In Arizona, heart disease and stroke were the first and fourth leading cause of death in 2003; 10,649 deaths were due to heart disease (24.9%) and 2,356 were due to stroke (5.5%).[1]
- Cancer is the second leading cause of death in Arizona, second only to heart disease. There were 9,451 deaths attributed to cancer in 2003 (22.1%).[1]
- Chronic Lower Respiratory Disease or Chronic Obstructive Pulmonary Disease (COPD) was the third leading cause of death in Arizona for 2003, accounting for 5.9% of deaths.[1]
- It was estimated that about 262,686 Arizonans had diabetes in 2002. The rate of diabetes-related hospital discharges increased from 133 per 100,000 population in 2000, to 147 per 100,000 population in 2002.[9]
- Asthma is one of the nation's most common and costly diseases, affecting 17 million Americans, including almost five million children. The prevalence for asthma among Arizona adults (persons 18 years of age or older) was approximately 13.9% in 2002.[10]
- "In 2002, more than half of the deaths in Arizona (54.8%) were from diseases for which overweight and obesity are known to increase risk, including

diseases of the heart (25.9%), malignant neoplasms (22.4%), and cerebrovascular disease (6.5%)."[11]

- "An estimated 65% of adults in the United States are overweight or obese."[12]
- In Arizona, 57.1% of adults are overweight or obese.[11]
- "The obesity rate among Arizona adults increased by 80% from 1990 to 2002."[11]
- "More than 60% of American adults do not get enough physical activity to provide health benefits and 26% are not active at all."[13]
- In 2003, prevalence data indicated that 21.2% of Arizonans did not engage in any physical activity.[14]
- "An estimated 45.8 million adults in the United States smoke cigarettes even though this single behavior will result in death or disability for half of all regular smokers."[15]
- Each year, approximately 440,000 people die due to tobacco-related diseases, which calculates to approximately 20% of all deaths in the United States.[16]
- "If current smoking patterns continue, 6.4 million people currently younger than 18 will die prematurely from a tobacco-related disease."[16]
- The 2002 prevalence rate for Arizona adults who smoke was 20%.[17]

The Need for an Arizona Chronic Disease Plan

Reviewing the objectives and strategies among the disease-specific entities, it becomes evident that there are many commonalities that overlap the disease categories such as common risk factors, service delivery methodologies, intervention sites, target populations, and need for common messages.

Between September 2004 and April 2005, seven focus groups were held in conjunction with the ***Chronic Disease Disparities in Arizona Conference*** (April 13–15, 2005) to discuss the issues related to chronic disease and minority populations throughout the state. Participants represented urban and rural communities, Asian, African American, Hispanic, Native American, White, and gay/lesbian/bisexual/transsexual populations.[18] Also, between November 2004 and March 2005, over 40 focus groups representing Arizonans 65 years of age and over were held by the Governor's Council on Aging to provide input for the Aging 2020 Plan.

Many common themes surfaced during the focus groups. The commonalities often identified the broader elements of the system of care and how responsive or unresponsive that system was to the needs of the individual groups. Common issues such as the need for a greater focus on prevention and early detection of chronic disease, culturally responsive health care and health education, strategies to address uninsured/underinsured, and access to care (primary and specialty) surfaced across the groups. The results of the touch point comparison of the disease entities as well as the results of the focus groups indicate a clear need for addressing these common elements through a coordinated, comprehensive, and integrated plan.

Health Disparities

There are distinct differences in the rates of mortality and morbidity for certain populations and racial and ethnic groups. While there are a number of common themes within the health-related issues for these groups, the solutions for these common issues may be different due to the varied needs, cultural diversity, and geographic locations relevant to the specific group(s). There may also be targeted issues that pertain only to certain populations.

In addition to the common issues, the chart to the right depicts examples of specific issues as identified by each group.

African American Community (Phoenix, AZ)

- Critical health issues: hypertension, diabetes, high cholesterol, prostate and breast cancer
- Sickness viewed as a sign of weakness
- Credibility is increased when information comes from person of same race and gender
- Males tend to not seek medical attention
- Wellness programs are well-received when connected to churches

Hispanic Communities (Yuma and South Tucson, AZ)

- Critical health issues: heart disease, diabetes, stroke, and hypertension
- Language barriers; lack of translation services in hospitals
- Immigrant status – legal v.s. non-legal
- In border communities, prefer to cross border to Mexico for health care
- Males tend to not seek health care
- Need for more lay health workers/promotoras

Rural Communities (Cottonwood area)

- Critical health issues: cardiovascular disease and cancer
- Geographic isolation; lack of transportation to providers
- Socio-economic disparities – includes very wealthy and very low income
- Underserved and high rate of uninsured
- Limited health resources

Native American Population (Native American Community Health Center (NACHC), Indian Health Service)

- Critical health issues: diabetes and obesity
- Native American provider for Native American clients is very important
- Cultural differences, language barriers
- Distance and transportation are challenges in access to services
- Cultural belief that discussing disease puts them at risk for transmission

Asian Community (Metro Phoenix, AZ)

- Critical health issues: hepatitis B/liver cancer, cardiovascular disease (hypertension, stroke, diabetes), cervical cancer, and tobacco
- Lack of general preventive health information
- Unaware that risk for breast cancer significantly increases for Asian women who have been in U.S. for 10 years or more
- Language barriers
- Medical interpreters needed
- Demographically dispersed
- Potential contradictions between Western medicine and Eastern medicine (homeopathic, acupuncture, etc.)

Age 65 Years and Over, Aging 2020 Forum

- Critical health issues: heart disease, cancer, cerebrovascular disease, chronic respiratory disease, and Alzheimer's disease
- Need for a single point of access to information and services
- Identify and disseminate models to learn about healthy aging
- A focus on prevention will require public education campaigns for lifelong education and healthy lifestyle education, active lifestyle programs, health information
- Increase use of computer and Internet based information (make programs less intimidating to older adults)
- Prioritize and educate about chronic diseases as they relate to high-risk populations

Gay/Lesbian/Bisexual/Transsexual (GLBT) (Wingspan – Tucson, AZ)

- Critical health issues: no cancer screening; health programs tied to HIV/STD screening
- Health movement does not exist unless focused on HIV
- Data is not collected specific to GLBT
- Lack of provider education about lesbian health
- Healthcare is the number one problem for transsexual community

Significant disparities exist between the health of the Native American and the general U.S. population. "Health gains among Indians have slowed or ceased altogether in recent years as disease patterns have changed. Injuries, chronic disease, and behavior-related diseases have emerged as new challenges. The new disease patterns are associated with consequences from poverty and cultural dislocation. Inadequate education, high rates of unemployment, and discrimination all contribute to unhealthy lifestyles and disparities in access to care."[19] Native Americans born today have a life expectancy of 72.9 years as compared with the life expectancy of 76.5 for all races in the U.S., an almost four year difference.[20] In Arizona, the disparity in life expectancy between Native Americans and all Arizonans is even more striking. In 2003, the average age at death from all causes in Arizona was 71.2 for all Arizonans compared with 54.7 for Native Americans, more than a 16 year difference.[21]

In April 2003, ADHS published a *Report of the Arizona Native American Primary Care Resources Workshop/Forum Series*,[22] which was a summary of work conducted during the summer of 2002 regarding the primary care resource needs of the Native American population in Arizona. Some of the key recommendations from that report are:

- Support and expand data sharing agreements and encourage collaboration among data holders to prevent fragmentation and improve data validity
- Encourage and support inter-tribal partnerships and collaboration
- Share information, resources, and technical assistance among all stakeholders
- Provide information and training to tribes regarding the available telemedicine options
- Encourage the design and implementation of programs that address access to care issues such as transportation, insurance applications procedures, and alternative medicine resources
- Explore available options for expanding traditional medicine programs
- Find innovative ways to address the health care provider workforce challenges.

The Cost of Not Taking Action

Americans are living longer due to advances in science and medical technology and improvements in living conditions. Life expectancy has increased from 59 years of age in 1950, to 77 years of age today. The percentage of the population over age 65 years has significantly increased and will continue to rise. Since 1900, the number of people in America age 65 years or older has increased from three million to nearly 35 million and this number is expected to double to 70 million in the next 30 years. Because health care needs of older adults are usually greater than younger adults, medical costs can be expected to increase with the growing numbers of adults over age 65 years.[23]

The growing number of adults over the age of 65 years, the cost of improvements in medical technology, and inflation have all contributed to the

rising costs of health care. If current trends continue, by 2011, we can expect to be spending over 2.8 trillion dollars nationally on health care. With a public health focus that emphasizes prevention as a priority, we can become a healthier society and enjoy five to seven additional years of healthy life if we improve access to quality health care, emphasize healthy lifestyles, and focus on reaching the greatest number of people at the lowest cost through effective policies and strategies.[24]

Chronic disease is *not* an inevitable result of the aging process. In many cases, chronic disease is the result of preventable, behavioral practices that, over time, significantly increase an individual's risk for any one of a number of chronic diseases. Evidence indicates that individuals will take control of their behavior and their health when presented with education and support.[25]

While it is difficult to predict the cost of Arizona's not taking action, there is ample national and state-specific evidence regarding the cost and impact of the primary risk factors for chronic disease (i.e., poor dietary habits, physical inactivity, and use of commercial tobacco products).

Estimated cost of poor dietary habits.

- "Among children and adolescents, annual hospital costs related to obesity were $127 million during 1997–1999...up from $35 million during 1979–1981." [26]
- "In 2000, the total cost of obesity in the United States was estimated to be $117 billion, of which $61 billion was for direct medical costs and $56 billion was for indirect costs." [26]
- "Each year, over $33 billion in medical costs and $9 billion in lost productivity due to heart disease, cancer, stroke, and diabetes are attributed to diet." [26]

Estimated cost of physical inactivity.

- Blue Cross Blue Shield of Minnesota did a study calculating the dollars required to treat the results of inactivity for its members.

  "Using a 'cost of illness' approach to medical expenses for particular diseases, the study found that heart disease was the most expensive result of a sedentary lifestyle, costing $35.3 million in 2000. In that year, nearly 12% of depression and anxiety and 31% of colon cancer, heart disease, osteoporosis and stroke cases were due to physical inactivity. This translates to $83.6 million, or $56 per member." [27]
- "In 2000, health care costs associated with physical inactivity were more than $76 billion." [26]

Estimated cost of commercial tobacco use.

- "Direct medical expenditures attributed to smoking total more than $75 billion per year. In addition, smoking costs an estimated $80 billion per year in lost productivity." [28]
- "About 14% of all Medicaid expenditures are for smoking-related illnesses." [7]
- "Even if current tobacco use stopped, the residual burden of use among past users would cause disease for decades to come." [29]

By making healthier choices, individuals can reduce their risk for chronic disease. CDC estimates that with as little as a 10% weight loss, an overweight person can reduce their lifetime medical costs by as much as $2,200–$5,300, and if 10% of adults would begin a walking program, $5.6 billion dollars in heart disease costs could be saved.[26] Additionally, smokers who stop smoking reduce the potential medical costs associated with cardiovascular disease by approximately $47 the first year and $853 during the following seven years.[16]

How This Plan is Different

This plan is different from many other planning documents. The scope of the plan is very broad, encompassing several distinct disease categories: heart disease, cancer, lung disease (COPD), stroke, and diabetes, and the risk factor categories of poor nutrition, physical inactivity, and use of commercial tobacco products. Each of the disease-specific entities has developed a comprehensive and integrated planning document that outlines evidenced-based objectives and strategies particular to the disease category. The risk factor categories of poor nutrition, physical inactivity, and commercial tobacco use have likewise developed planning documents that identify the key strategies for improving healthy lifestyle behaviors and reducing risk for chronic disease. The categorical plans were developed by bringing together appropriate agency and community partners, utilizing best practice standards and guidelines, and conducting assessment of state and community needs.

Each categorical plan presents a statewide guideline for reducing the impact of chronic disease in Arizona from a disease-specific and/or risk factor perspective and will continue to function in that capacity. The goal of the AzCD Plan is to enhance the impact of these categorical plans by identifying common, cross-cutting objectives and strategies. The intent in identifying these overlapping areas is to maximize the effectiveness of implementing cross-cutting strategies to achieve a synergistic effect. In other words, by working together, the effectiveness of each plan is enhanced and the overall results are potentially greater than what each plan is able to accomplish individually. The elements of systems coordination, collaboration, and integration are critical to the success of this new approach to chronic disease management and prevention.

The overall planning process for the AzCD Plan was unique in that it did not follow the typical strategic planning format of needs assessment, internal/external review, SWOT analysis, establishment of goals and objectives. These aspects of a typical planning process were accomplished in the development of the individual categorical plans. The goal of the AzCD Plan was to effectively merge the many elements of the categorical plans into a coordinated, cohesive, and integrated model of the proposed system of care for the prevention and management of chronic disease in Arizona.

In the development of the AzCD Plan, a number of matrices were used to visually represent those commonalities across the categorical plans. Common areas were identified in service delivery methodologies, risk factors, target populations, common messages, and intervention sites. (See Appendix A.) These matrices were also useful in identifying contradicting areas and/or gaps in strategies. An important aspect of this analysis was to ensure that the common messages were consistent and that overlapping strategies were not in conflict.

We recognize that the AzCD Plan does not include all chronic diseases. However, it does address the current four leading causes of mortality: heart disease, cancer, lung disease, and stroke, and diabetes and asthma, which are among the most common and costly chronic diseases. Diabetes, in addition to being a disease category, is also a significant risk factor for cardiovascular disease. In addition to the disease-specific categories mentioned above, the plan also includes the primary risk factors of commercial tobacco use, poor nutrition, and physical inactivity that impact the above disease categories and many other chronic diseases. Promoting a healthy lifestyle that includes good nutrition, physical activity and no commercial tobacco use will also positively impact many chronic diseases not specifically addressed in the plan.

It is anticipated that additional disease categories will be added to the AzCD Plan over time and that priorities will be revised to reflect current trends, advances in science and technology, and changes in the needs of the population. This plan represents ADHS' efforts to approach chronic disease from a more comprehensive and integrated perspective. It is an innovative approach that is reflected in national public health programs. The plan is an initial phase in the Department's long-term commitment to reducing the impact of chronic disease in Arizona. It is meant to be a guide for encouraging collaboration among state agencies and community stakeholders in working together to combat the most common disease-related causes of mortality and morbidity in Arizona.

Purpose of the Plan

Create a paradigm shift. The AzCD Plan shifts the focus of chronic disease management and control from the more traditional disease-specific emphasis to a more comprehensive and integrated risk factor approach. It reflects a paradigm shift in how we think about chronic disease and what methodologies are used in reducing the overall impact of these diseases in our society.

Provide direction. The plan provides a clear direction for addressing the issues of chronic disease prevention and early detection in Arizona. Key cross-cutting strategies will be identified in the primary risk factor areas and in the disease-specific priority areas.

Set funding priorities. The plan identifies initial funding priorities, specifically for the Proposition 303 Tobacco Tax chronic disease fund. The plan provides direction for the allocation of these funds over the next three-year period. Per Arizona Revised Statutes, these funds are to be used "for the prevention and early detection of the four leading disease-related causes of death in this state, as periodically determined by the Centers for Disease Control and Prevention, or its successor agency. Initially, these are cancer, heart disease, stroke and pulmonary disease." (Statutory reference – Appendix B.)

Ensure ongoing assessment and evaluation. The plan provides a consistent vehicle for ongoing assessment of chronic disease programs and a system for evaluating the effectiveness of strategies designed to reduce the burden of chronic disease. It includes a plan for periodic review that consists of evaluation and revision of established priorities, timeframes, and strategies.

How to Use This Document

The objectives and strategies in the AzCD Plan are not meant to be mandates, but rather a guide to assist communities and organizations in implementing strategies locally. Examples of current projects and community initiatives are described. Suggestions and opportunities are provided for communities and organizations to become involved in systems change at the local level to the extent that is feasible based on their current resources. Communities are encouraged to select small projects or segments of larger projects to implement.

Description of Categorical Plans

There are six programs plans involved in the development of the AzCD Plan:

1. Arizona Cardiovascular Disease Prevention Plan
2. The Arizona Comprehensive Cancer Control Plan
3. Lung Disease Plan for the State of Arizona
4. Diabetes Prevention and Control Program Plan
5. Arizona Nutrition and Physical Activity Plan
6. Tobacco Education and Prevention Program Plan

Each program has developed a plan using widely accepted national standards and evidenced-based strategies. The categorical plans were developed using a variety of methodologies and formats due to many factors such as availability of resources and timeframes, and requirements of specific grants and funding streams. A conscious decision was made not to require any specific structure or format in the development of the individual plans, but rather allow the workgroups and subcommittees to develop the individual plans based on identified needs.

Arizona Cardiovascular Disease Prevention Plan. The goal of the Arizona Cardiovascular Disease (CVD) Prevention Plan is to create an

integrated and comprehensive state action plan to increase the cardiovascular health of all Arizonans and decrease the burden of heart disease and cerebrovascular disease. The CVD Prevention Plan will establish a community partnership in order to share existing data and ideas. Through this partnership it will be possible to assess the status of CVD in Arizona in relation to health education, health status and policy. The plan focuses on secondary prevention for those individuals who have been diagnosed with some form of CVD. The prevention and education strategies are aimed at decreasing the risk of a second CVD event such as a stroke or a heart attack. It also focuses on reducing the disability associated with CVD.

The emphasis of the CVD Prevention Plan is secondary prevention. Categories for the secondary prevention objectives and strategies are primarily intervention targets and/or sites such as: individual interventions, community, education, health care system (hospitals, providers, first responders), work site, policy and environmental changes, health marketing, disparities, and surveillance.

Arizona Comprehensive Cancer Control Plan. The goal of the Arizona Comprehensive Cancer Control (CCC) Plan is to reduce the overall burden of cancer through the prevention, early detection, and effective treatment of cancer, and improving the quality of life of those living with cancer through a statewide system of care. According to the CDC, CCC is "an integrated and coordinated approach to reduce the incidence, morbidity, and mortality of cancer through prevention, early detection, treatment, rehabilitation, and palliation." [29] CCC is a process achieved through a partnership of public and private stakeholders who hold the common mission of reducing the overall burden of cancer. ADHS, in conjunction with partners, has developed a statewide comprehensive cancer control plan. Partners include: American Cancer Society, the University of Arizona's Arizona Cancer Center and College of Public Health, Arizona Health Care Cost Containment System, American College of Surgeons, Arizona Oncology Nursing Society, Phoenix Indian Medical Center, Translational Genomics Research Institute (TGen), and many more organizations.

Chronic Lung Disease Plan for the State of Arizona. The Chronic Lung Disease Plan for the State of Arizona has two components: a plan addressing chronic obstructive pulmonary disease (COPD) and a plan addressing asthma. The overall goals of the COPD Plan are to reduce the proportion of adults in Arizona whose activity is limited due to chronic lung disease and reduce deaths from COPD among Arizona adults.

The primary goals for the Asthma Plan are to reduce asthma deaths in Arizona, asthma-related hospitalizations and emergency department visits,

and the number of asthma-related missed school and workdays.

ADHS initiated the development of these plans with the intent of setting priorities by formulating objectives and suggesting strategies to address chronic obstructive pulmonary disease and asthma as serious public health issues in Arizona.

The Chronic Lung Disease Plan for the State of Arizona (both COPD and Asthma) used a combination of disease specific and system intervention strategies. The COPD categories for the objectives and strategies included: epidemiology and research, treatment and management, consumer education and quality of life, prevention, disparity, collaborative efforts, advocacy, and public awareness. Asthma incorporated most of the above categories as well, except that prevention was changed to secondary prevention and school childcare issues was added to the list of objectives.

Diabetes Prevention and Control Program Plan. The goal of the Diabetes Prevention and Control Program Plan is to reduce the burden of diabetes in the state of Arizona. Much of this burden can be prevented with early detection, improved delivery of care, and better education on diabetes self-management. The program is committed to providing communities statewide with technical assistance and support resources to address the quality of life for people living with diabetes. The Diabetes Program provides continuing education to health care professionals and lay health workers on primary and secondary prevention, the most recent standards of care and best practices, health systems improvements through on-site chart audits, staff training and evaluation, and training of community health workers in diabetes self-management skills. The population they serve is culturally diverse and usually lacks access to care. The plan targets at-risk populations, persons living with diabetes, and their families.

The Diabetes Prevention and Control Program Plan components include: identifying and reducing health disparities in the Hispanic and Native American populations, establishing linkages to promote wellness and physical activity, as well as measurement procedures to track program success, reducing the number of new cases and end-stage renal disease related to diabetes, and decreasing the number of persons with diabetes that receive lower extremity amputations.

The Diabetes Prevention and Control Program Plan used the Ten Essential Public Health Services as the framework for developing strategies. There were three subcommittees who worked on developing the strategies: Surveillance, Education, and Advocacy. Each of the strategies were then linked to the appropriate Essential Public Health Service.

Arizona Nutrition and Physical Activity Plan. The goals of the Arizona Nutrition and Physical Activity (NUPA) Plan are to reduce the burden of chronic disease and obesity in Arizona

through nutrition and physical activity efforts. The purpose of the plan is to provide guidelines for schools, health care providers, communities, and work sites to address overweight and obesity in Arizona. It also represents an opportunity to develop policies and modify our environments in ways that will ultimately help Arizona residents lead healthier lives. The plan provides Arizona with a wide range of public health opportunities with objectives and strategies for action. The development of this plan demonstrates that working together to address the burden of chronic disease and obesity are the first steps towards combating this problem in Arizona.

The Arizona Nutrition and Physical Activity Plan, developed by the NUPA Program, used intervention sites as the focus for their workgroups. Originally there were seven workgroups consisting of Family and Community, Schools, Physical Environment, Health Care, Special Needs and Work Site. In the final version of the plan, health care was incorporated into the family and community section and the special needs objectives, strategies, and action steps were incorporated into all of the above sections of the plan.

Tobacco Education and Prevention Program Plan. The goal of the Tobacco Education and Prevention Program (TEPP) Plan is to reduce disease, disability, and death related to tobacco use by: preventing the initiation of commercial tobacco use among young people; promoting quitting among young people and adults, specifically those identified who have high prevalence of commercial tobacco use; eliminating nonsmokers' exposure to environmental tobacco smoke; identifying and eliminating the disparities related to commercial tobacco use and its effects among different population groups.[29] The core elements of the plan, as found in most comprehensive tobacco control programs, include preventing the initiation of tobacco use among youth and young adults, promoting smoking cessation, and reducing exposure to secondhand smoke.

The TEPP Plan was developed primarily as an internal operational plan. Objectives and strategies focused on intervention sites and/or types of intervention necessary to reduce the burden of commercial tobacco use, i.e., community programs, chronic disease programs, health care, school, enforcement, statewide programs, counter-marketing, cessation programs, surveillance and evaluation, and administration and management. Although the plan was developed primarily by internal staff, an external advisory committee provided input and feedback in the development of the objectives and strategies.

Integration

Healthy Lifestyles

"Tobacco use is the single most preventable cause of death and disease in our society." [30] The role of tobacco prevention and cessation programs is critical in the management of chronic disease. The burden of overweight and obesity manifests itself in "premature death and disability, in health care costs, in lost productivity, and in social stigmatization." [31] If allowed to continue, overweight and obesity may cause as much disease and death as tobacco use.[32]

This AzCD Plan supports the promotion of healthy lifestyles as primary prevention strategies in combating the key risk factors for chronic disease, i.e., poor nutrition, physical inactivity, and use of commercial tobacco products. A healthy lifestyle includes: maintaining healthy weight, following healthy eating guidelines, engaging in regular physical activity, and no use of commercial tobacco products.

Healthy weight. Body Mass Index (BMI) is used to determine whether or not a person is overweight. It is calculated by "dividing a person's weight (in kilograms) by his or her height (in meters, squared). BMI can also be calculated by multiplying weight (in pounds) by 705, then dividing by height (in inches) twice." [33]

Healthy weight for adults is defined as: BMI >18.5 < 24.9.

- BMI standard for "overweight" is defined as BMI > 25.0 – 29.9.
- BMI standard for "obese" is defined as a BMI ≥ 30.0. [14]

Healthy weight for children is defined as a BMI for age from the 5th percentile to the 85th percentile.

- "Underweight" is defined as BMI-for-age < 5th percentile.
- "At risk/overweight" is BMI for age between the 85th – 95th percentile.
- "Obese" is defined as BMI-for-age > 95th percentile.[34]

Healthy eating. Healthy eating is defined as (complete definition in Appendix C.):

- Making smart choices from every food group

- Finding your balance between food and physical activity
- Getting the most nutrition out of your calories.

A healthy eating plan is one that:

- Emphasizes fruits, vegetables, whole grains, and fat-free or low-fat milk and milk products
- Includes lean meats, poultry, fish, beans, eggs, and nuts
- Is low in saturated fats, transfats, cholesterol, salt (sodium), and added sugars
- Promotes indigenous foods grown as close to the consumer as possible.

Physical activity. Physical activity is defined as:[35]

- 30 to 60 minutes of moderate activity most days of the week for the average adult
- 60 minutes of moderate to vigorous activity most days of the week for children.

Tobacco-free.

- Do not use commercial tobacco products of any kind.
- If you use commercial tobacco products, stop as soon as possible.

Priorities for Chronic Disease Prevention

Selection of priorities. In the selection of priorities for the AzCD Plan, the categorical plans were asked to identify 5–10 priorities. Criteria for establishing plan priorities included:

- Ability to make a difference
- Needs, gaps, health disparities
- Feasibility
  - ► Community action
  - ► State action
- Systems change, provides sustainability
- Measurable, outcome driven
- Catalyst for change
- Cross-cutting strategies, integrated approach
- Reach/impact; return on investment
- Evidenced-based, standards, guidelines
- Resources: financial, human resources, community assets, stakeholder engagement.

The matrix in Appendix D lists all of the priorities submitted by the categorical plans. These priorities were later re-configured within the context of the framework established by the CD Team as described on the following page.

Priorities

Once the priorities were identified from the categorical plans, they were placed under the appropriate intervention level of the framework (Individual choice, Health care provider responsibility, Systems support) and divided into integrated and disease-specific priorities. Some of the disease-specific priorities appear in more than one intervention level as appropriate. The designation of integrated and disease-specific perspectives acknowledges both the common areas of overlap as well as the unique aspects of each disease category.

I. Individual Priorities
(Consumer Education)

A. Promote healthy lifestyles as primary prevention for chronic disease.

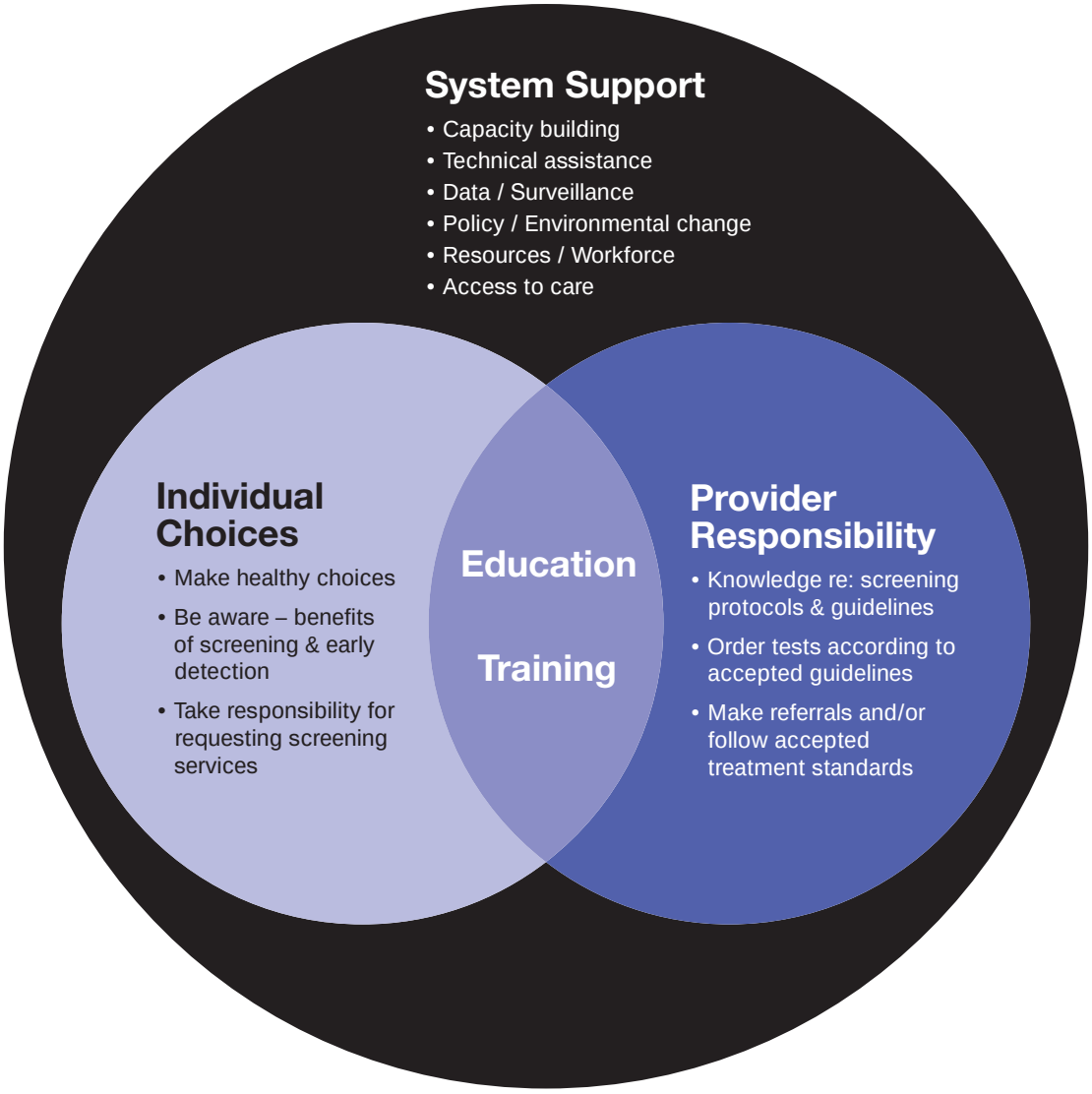
Integrated:

- Saturate communities with consistent, culturally sensitive and intergenerational messages regarding healthy lifestyles

Framework

The CD Team reviewed the selected priorities from the categorical plans. The integrated priorities for the plan were identified as the common overlapping areas from the categorical plans in three functional areas:

1. **Individual choice (consumer education)**
2. **Health care provider responsibility (provider education and training)**
3. **System support**



The AzCD Plan Envisions...

AN INDIVIDUAL WHO...

- Eats a healthy diet
- Maintains a healthy weight
- Engages in regular physical activity
- Abstains from or quits using commercial tobacco products of any kind
- Participates in chronic disease early detection and screening
- Actively requests referral for appropriate screening procedures from health care provider
- Complies with recommended treatment and follow-up to screening procedures
- Takes responsibility for partnering with the health care provider in making decisions about personal health screening, diagnosis, treatment, and follow-up.

A HEALTH CARE PROVIDER WHO...

- Counsels patients regarding healthy lifestyle behaviors
- Orders appropriate screening tests based on standards of care for chronic disease
- Utilizes current advances in screening technology and screening protocols
- Provides information on all appropriate options for treatment and/or follow-up for patient consideration
- Makes appropriate arrangements for treatment and/or follow-up
- Monitors patient compliance with recommended treatment and/or follow-up.

A SUPPORTIVE SYSTEM THAT...

- Creates a process for collecting accurate and timely data for surveillance and evaluation purposes
- Promotes policy and environmental changes to support individual healthy lifestyle choices and provider involvement in the prevention and early detection of chronic disease
- Provides technical assistance to facilitate “capacity building” and sustainability in local communities
- Provides access to affordable, quality health care for all residents
- Promotes collaboration of advocacy groups for resolution of common cross-cutting issues
- Strives to eliminate disparities in mortality and morbidity due to chronic disease.

Disease-Specific:

Cardiovascular

- Increase the number of those diagnosed with heart and cerebrovascular disease who participate in cardiac rehabilitation and other formal, multidisciplinary approaches to secondary prevention of the heart and cerebrovascular disease

Cancer

- Reduce the risks for developing cancer among all Arizonans by promoting and engaging in healthy behaviors

Lung

- Promote healthy living practices that provide the most effective method of preventing COPD (tobacco abstinence, periodic health checks, and avoidance of unhealthy work environments)

Lung

- Improve self-management knowledge and behavior in people with COPD, their families and other caregivers

B. Inform, educate, and empower consumers regarding benefits of early detection and the availability of screening resources.

Integrated:

- Implement health marketing campaigns regarding the benefits of and options for early detection of chronic disease
- Develop and implement a health marketing campaign to encourage consumers to become actively involved as partners with their health care provider in initiating referrals for screening services

Disease-Specific:

Cardiovascular

- Increase the number of people who are aware and can recognize the signs and symptoms of a stroke and know the next step that needs to be taken

Cardiovascular

- Increase the number of people who are aware and can recognize the signs and symptoms of a heart attack or myocardial infarction

Cardiovascular

- Increase the number of women who are aware of the symptoms of a heart attack, which are very different from the signs of a heart attack for men

Cancer

- Promote, increase, and optimize the appropriate utilization of high-quality cancer screening and follow-up services

Cancer

- Increase the proportion of women aged 40 and over who have received a mammogram and clinical breast exam within the past year to 70% by 2010

Cancer

- For adults aged 50 and over, increase the proportion of the population who has been screened for colorectal cancer using colonoscopy, sigmoidoscopy, or fecal occult blood test to 50% by 2010

Lung

- Improve early detection and diagnosis of COPD

C. Link people to needed personal health services by developing and disseminating a comprehensive list of resources regarding screening, early detection and treatment services.

Integrated:

- Develop database of screening/early detection resources

- Provide multi-media access for screening/early detection resource database

Disease-Specific:

Cancer

- By 2008, increase access to quality information and patient navigation sites across the state and identify barriers to access

Cancer

- Educate the public regarding the importance and relevance of participating in clinical trials

Lung

- Improve self-management knowledge and behavior in people with COPD, their families and other caregivers

II. Health Care Provider Priorities *(Provider Training)*

A. Promote screening for chronic disease according to established guidelines.

Integrated:

- Develop and disseminate adult early, periodic, screening, diagnosis, and treatment guidelines for chronic disease

Disease-Specific:

Cancer

- Promote, increase, and optimize the appropriate utilization of high-quality cancer screening and follow-up services

Cancer

- Increase the proportion of women aged 40 and over who have received a mammogram and clinical breast exam within the past year to 70% by 2010

Cancer

- For adults aged 50 and over, increase the proportion of the population who have been screened for colorectal cancer using colonoscopy, sigmoidoscopy, or fecal occult blood test to 50% by 2010

Lungs

- Improve early detection and diagnosis of COPD

B. Assure competent public and personal health care by educating providers regarding benefits of screening and screening benchmarks.

Integrated:

- Train physicians on appropriate screening and referral protocols for chronic disease
- Encourage public health systems to develop effective health communication and education strategies for providers
- Increase number of health care systems that incorporate basic skills intervention trainings as professional development for staff and service providers
- Increase provider education and training offered to medical students regarding disparities

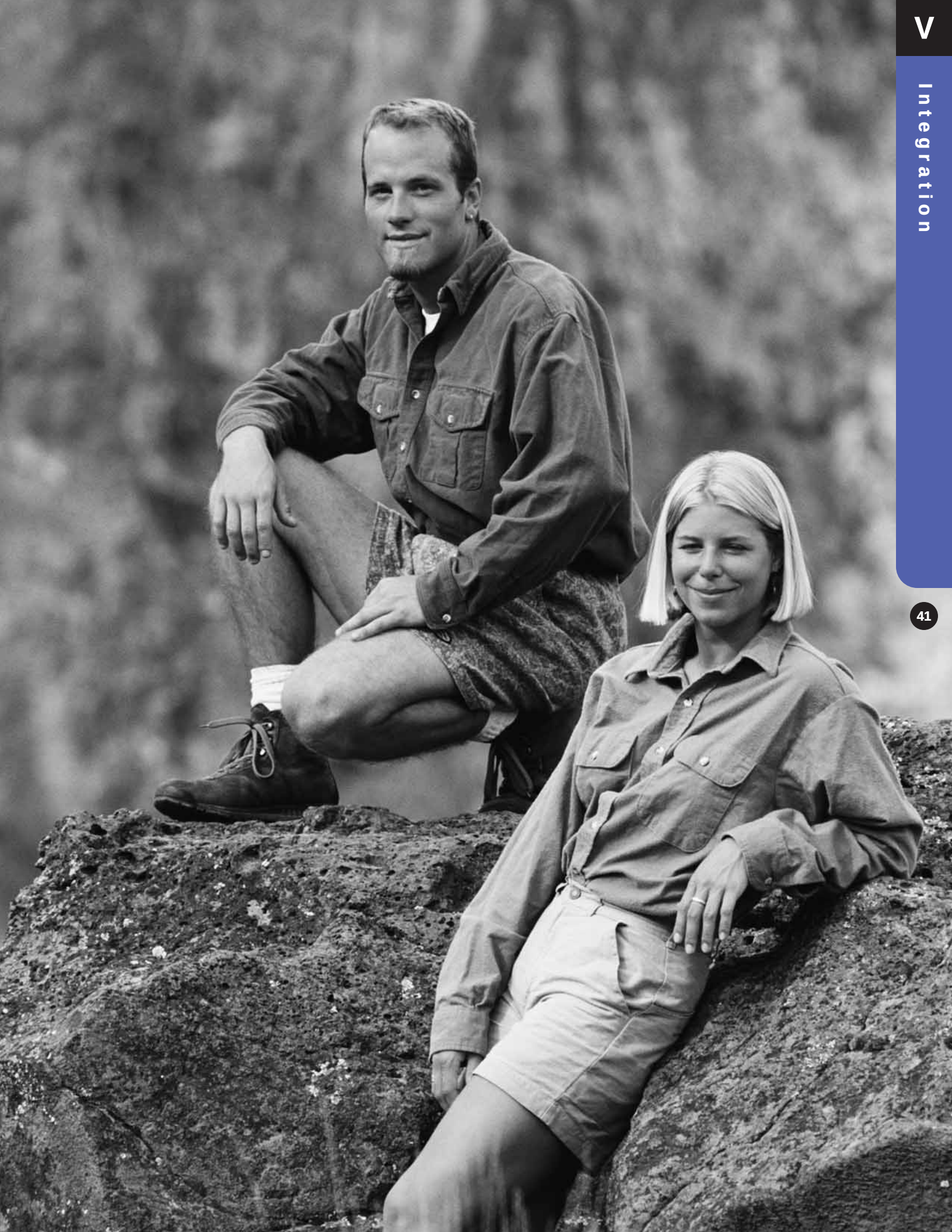
Disease-Specific:

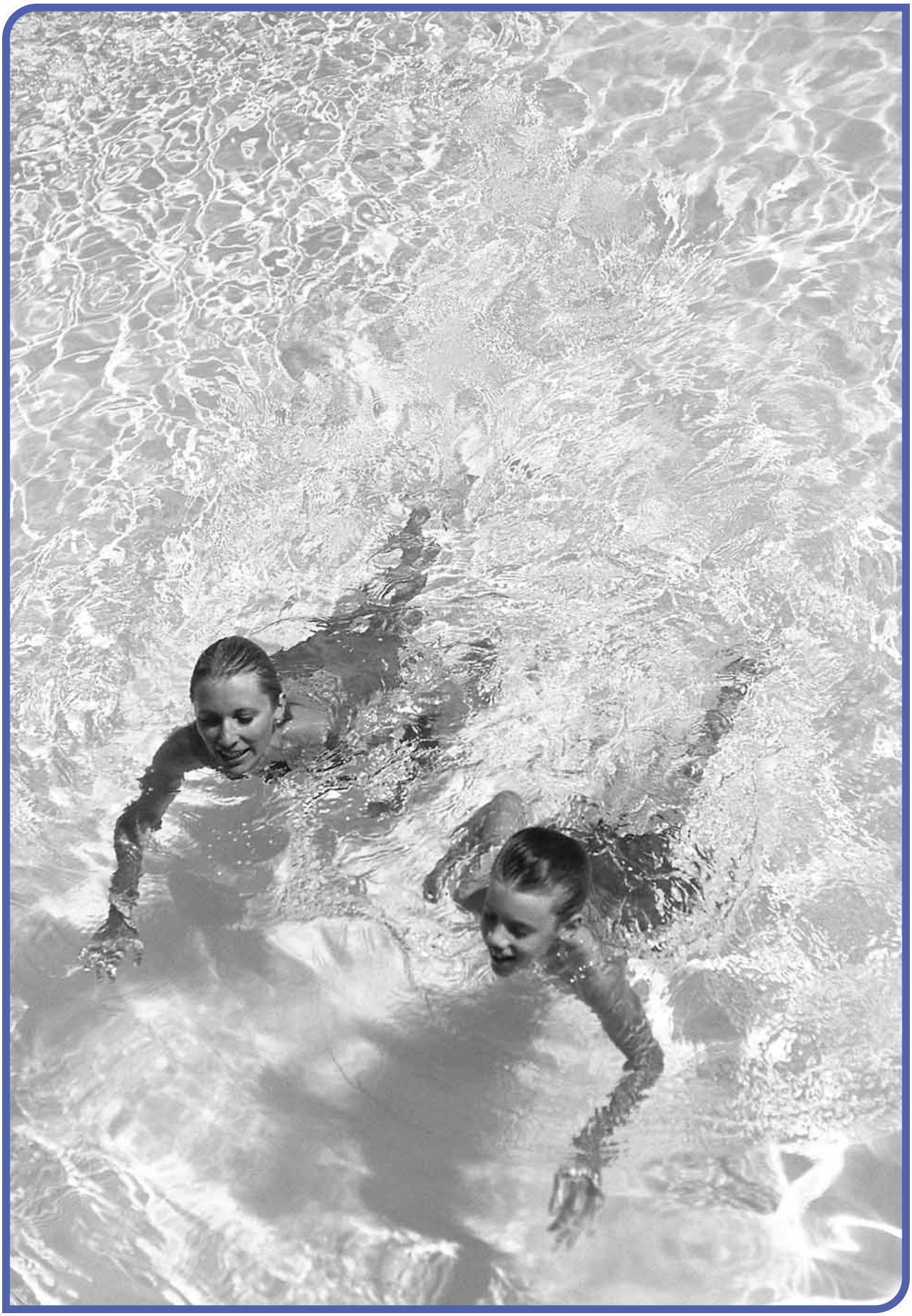
Cancer

- Promote, increase, and optimize the appropriate utilization of high-quality cancer screening and follow-up services

Cancer

- Increase the proportion of women aged 40 and over who have received a mammogram and clinical breast exam within the past year to 70% by 2010





Cancer

- For adults aged 50 and over, increase the proportion of the population who has been screened for colorectal cancer using colonoscopy, sigmoidoscopy, or fecal occult blood test to 50% by 2010

Lung

- Improve early detection and diagnosis of COPD

Lung

- Increase awareness of the medical community, public health officials and the general public that COPD is a serious public health problem in Arizona

C. Educate providers regarding appropriate referrals based on screening outcomes.

Integrated:

- Train physicians on appropriate referral protocols for chronic disease

Disease-Specific:

Cardiovascular

- Increase the number of people that are being referred to the appropriate professionals to receive medical nutrition therapy and a formal exercise prescription to treat high cholesterol and high blood pressure

Cardiovascular

- Increase the number of those diagnosed with heart and cerebrovascular disease who participate in cardiac rehabilitation and other formal, multidisciplinary approaches to secondary prevention of the heart and cerebrovascular disease

Cancer

- Educate the public regarding the importance and relevance of participating in clinical trials

Cancer

- Promote, increase, and optimize the appropriate utilization of high-quality cancer screening and follow-up services

Lung

- Educate health care providers to manage patients with COPD to increase longevity and quality of life and reduce exacerbation of the disease

Lung

- Promote better care for patients with COPD in Arizona according to established guidelines

III. System Support Priorities

A. Improve data and surveillance systems.

Integrated:

- Expand existing data collection to include more specific ethnicity, socioeconomic, geographic, and linguistic information
- Ensure adequate resources to develop and maintain surveillance data systems

Disease-Specific:

Cardiovascular

- Increase the number of hospitals participating in the American Heart Association's program "Get With The Guidelines"

Cancer

- Create database inventory or clearinghouse for cancer researchers in the state

Lung

- Establish a surveillance system to accurately track the mortality and morbidity of COPD in Arizona and also measure the impact on the economy of the state

B. Develop policies and environmental changes to support community and individual health efforts.

Integrated:

- Work with policymakers to encourage screening and diagnostic services as benefits in existing health plans
- Partner with governmental regulatory agencies to manage environmental and occupational risk factors

Disease-Specific:

Cardiovascular

- Implement protocols whereby a paramedic/EMT unit may bypass a hospital in order to transport a stroke victim to a primary stroke center, thereby increasing their chance for survival

Cancer

- Increase access to appropriate and effective cancer diagnosis and treatment services

Cancer

- Increase support for health care providers and payers in directing those affected by cancer to quality of life services

Lung

- Advocate and support policies to reduce the prevalence of commercial tobacco use and secondhand smoke exposure among Arizonans

Lung

- Support research into COPD etiology and clinical management, as well as health care policies and outcomes particularly as the activities relate to state issues

C. Support plans and actions that support the development of community infrastructure.

Integrated:

- Encourage planners, developers, and policymakers to design healthy communities
- Work with architect and engineer educators regarding the inclusion of healthy environmental design in curriculum
- Provide technical assistance to communities in terms of capacity building
- Create multiple mechanisms for community health care agencies to exchange information to solidify a universal message/program

D. Promote access to quality personal and population-based health services.

Integrated:

- Promote access to and provide economic support for convenient health care, prevention, and early detection services
  - ► Improve access to screening services for the four leading causes of death: heart disease, cancer, lung disease (COPD), and stroke
  - ► Provide financial support for screening services (four leading causes of death)
  - ► Increase access to telemedicine sites around Arizona
- Improve provider accessibility and availability
- Set measurable clinical standards based on scientifically valid guidelines

Disease-Specific:

Cardiovascular

- Increase the number of hospitals participating in the American Heart Associations program "Get With The Guidelines"

Cardiovascular

- Increase the number of primary stroke centers in AZ from six to 15

Cardiovascular

- Increase the number of automated external defibrillators in the public, beginning where people congregate in large numbers and where EMS availability may be delayed

Cardiovascular

- Increase the number of people that are being referred to the appropriate professionals to receive medical nutrition therapy and a formal exercise prescription to treat high cholesterol and high blood pressure

Cancer

- Increase access to appropriate and effective cancer diagnosis and treatment services

Cancer

- Increase the proportion of women aged 40 and over who have received a mammogram and clinical breast exam within the past year to 70% by 2010

Cancer

- For adults aged 50 and over, increase the proportion of the population who has been screened for colorectal cancer using colonoscopy, sigmoidoscopy, or fecal occult blood test to 50% by 2010

Cancer

- Educate the public regarding the importance and relevance of participating in clinical trials

Cancer

- Increase access to the comprehensive management of acute, chronic, and delayed effects of cancer and its treatments

Cancer

- By 2007, utilize telemedicine to increase access to state of the art diagnosis and treatment techniques and expertise as well as second opinions and resources

Cancer

- Increase support for health care providers and payers in directing those affected by cancer to quality of life services

Cancer

- Promote participation in cancer clinical trials in Arizona, specifically among underserved populations

Lung

- Increase awareness of the medical community, public health officials and the general public that COPD is a serious public health problem in Arizona

Lung

- Improve access to pulmonary rehab programs for Arizonans with COPD to prevent premature morbidity and mortality

E. Mobilize community partnerships and promote collaboration of advocacy groups.

Integrated:

- Encourage advocates for chronic disease entities to work together
- Create multiple mechanisms for community health care agencies to exchange information to solidify a universal message/program

Disease-Specific:

Cardiovascular

- Support a capacity building conference, promoting collaboration among existing agencies in order to disseminate information about current and developing screening methods and tools by 2010

F. Monitor health status to identify and strive to reduce disparities.

Integrated:

- Ensure that all Arizonans receive quality screening, diagnostic, and treatment services

Disease-Specific:

Cancer

- Reduce cancer disparities among Arizonans

Cancer

- By Fall 2005, create a health disparities work group that will research and identify current barriers to care as well as draft strategies to reduce inequalities in cancer care

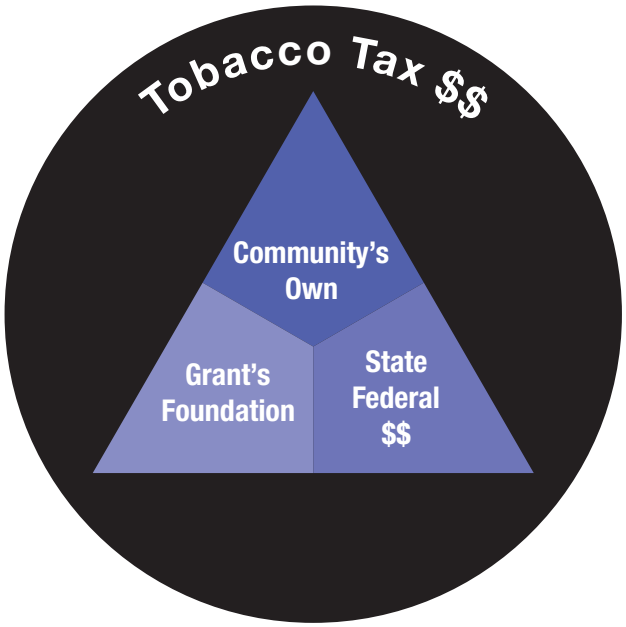
Funding Priorities

One of the motivating reasons for developing the AzCD Plan was to provide direction and set funding priorities for the Proposition 303 Tobacco Tax funds. These funds give Arizona a unique opportunity to design a funding stream which not only supports the prevention and early detection of the four leading causes of death, but does it in an innovative manner which simultaneously promotes the integration of resources where commonalities exist and disease specific initiatives where they are most needed.

The unique aspects of this funding allows the TRUST to design a system to reduce the impact of chronic disease and, as such, is a major strength of this funding source. Example A, below, shows a more traditional model where funding streams have tended to be very targeted, which has limited the ability to integrate program efforts. Example B, also below, demonstrates an integrated model for customizing a system of care to address multiple priorities through combined funding streams.

EXAMPLE A — Community Resources Traditional Model Targeted Resources

EXAMPLE B — Community Resources Integrated Model Transcends Targeted Resources



Implementing an Integrated Approach

For the purposes of this plan, an integrated approach to the management of chronic disease requires, at a minimum, addressing one integration priority in each of the three areas (Individual, Health Care Provider, and System) across at least two or more disease/risk factor related categories. This can be accomplished by initiating two or more new categorical areas simultaneously or by adding a new categorical area to existing services or resources.

In other words...

1) Program chooses one or more integration priorities in each of the three areas:

- Individual
- Health Care Provider
- System

2) For each of the integration priorities, the program must cut across two or more categorical areas, i.e., disease/risk factor related.

Add a new categorical interest area to existing services / resources

OR

Promote two or more new categorical areas simultaneously

This approach is based on addressing chronic disease issues from multiple levels of integration interventions including the individual, the provider, and finally the system of care, and linking those intervention modalities to more than one disease/risk factor specific categorical area. It combines the integrated perspective with the targeted approach to achieve a more comprehensive and coordinated model.

As pictured on the next page, to implement an integrated model, programs would select one integration priority from each outer circle and link those to two or more of the inner circle disease and/or risk factor specific categories.

State Level Action

ADHS has many health care initiatives currently in operation including: programs involving border health, children with special health care needs, minority health and disparities, medically underserved areas, tobacco education and prevention, chronic disease, older adults, linkages with local health departments, and primary care. For a list of related ADHS programs and services, see Appendix E.

Community Level Action

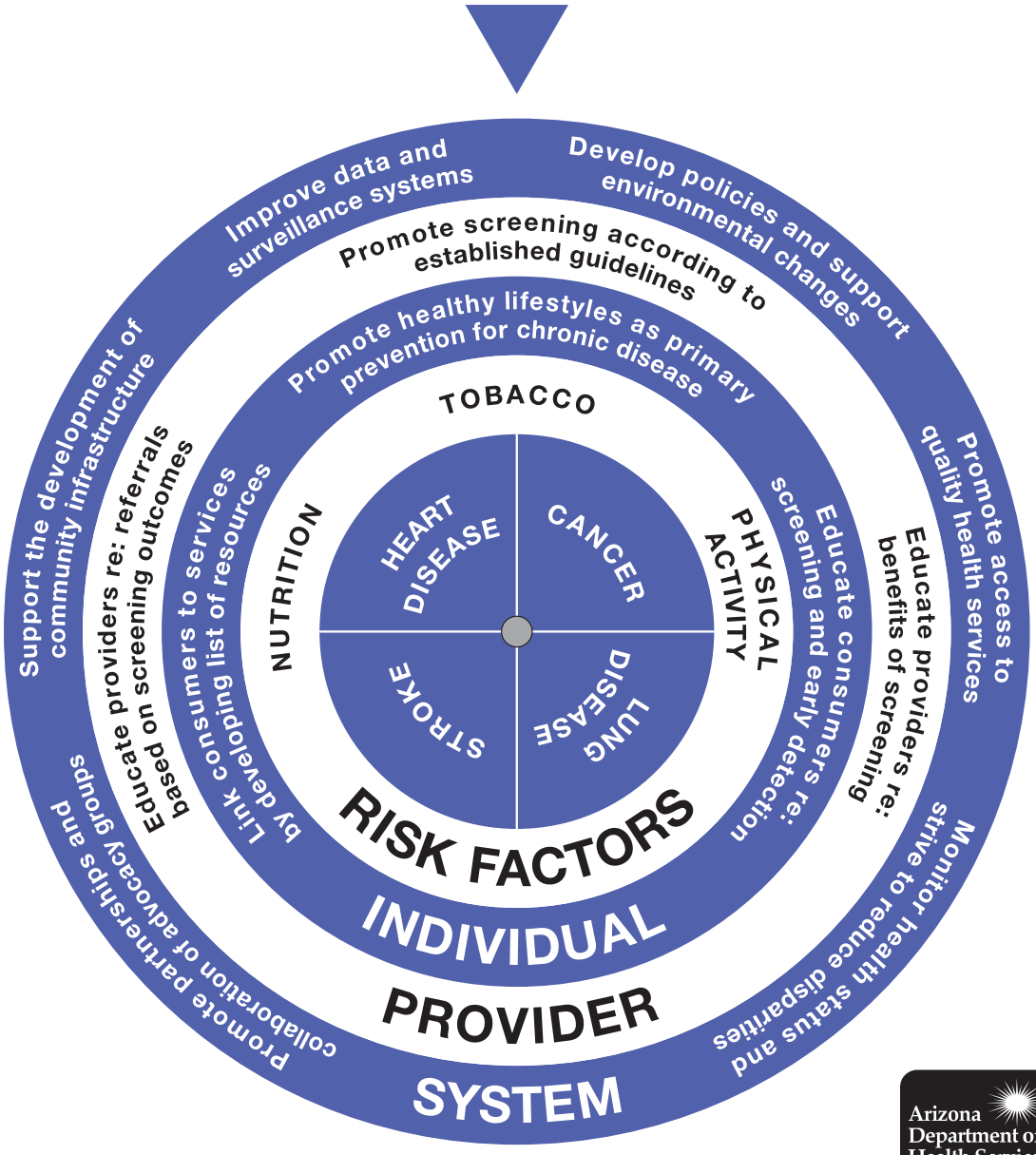
There are also a number of communities who have developed model integrated systems for promoting the "healthy community" concept. The following are examples of some of those programs:

Steps to a Healthier Arizona

The Steps to a Healthier US five-year cooperative agreement program funds states, cities, and tribal entities to implement chronic disease prevention efforts focused on reducing the burden of diabetes, overweight, obesity, and asthma and addressing three related risk factors: physical inactivity, poor nutrition, and commercial tobacco use.

Integration Wheel

Line up selected disease, risk factor and strategy for each level of intervention (individual, provider, system) with the arrow. Use the resulting framework to develop an operational plan with specific action steps, timelines and responsible individuals.



Arizona Department of Health Services

There are several border communities in Arizona – Cochise County, Santa Cruz County, Yuma County, and the Tohono O'odham Nation – participating in this model of reducing chronic disease disparities. Special action groups in each community, consisting of providers, families, community organizations, and schools, form partnerships to address chronic disease issues in their communities. For more information on the Steps program, see *http://www.healthierus.gov*

Healthy Avondale

Healthy Avondale is based on the statewide Healthy Arizona 2010 initiative. The Healthy Avondale program has been in existence since October 2003 and is a partnership with ADHS, local businesses, schools, health care providers, community and faith-based organizations, and others. The program promotes participation in four primary areas: healthy lifestyle choices, healthy eating, physical activity, and early detection and screening. The intent of the program is to involve the entire community and build a place where all residents can live a healthier life. For more information on the Healthy Avondale program, see *http://www.avondale.org*

Evaluation

Ongoing assessment and revision of the AzCD Plan

Over the next three years, the AzCD Plan will be monitored on an ongoing basis through various methods with revisions made as needed. Outlined below are some of the assessment strategies that will be implemented.

Annual review. There will be a review of the AzCD Plan on an annual basis based on several sources of input. An evaluation survey form will be included in the document. Users of the plan will be asked to complete the form and submit their comments and feedback regarding the priorities, strategies, and integrated model proposed in the plan.

Quarterly meetings of the CD Team. The CD Team will meet at a minimum on a quarterly basis to:

- Present updates on the status of the implementation of the categorical plans
- Document new integrated community initiatives
- Track data from categorical plans
- Provide ongoing CD Team assessment and feedback of the AzCD Plan

Contract performance measures and deliverables. Contracts issued under the Proposition 303 funding will be monitored to track outcomes, performance measures and deliverables.

State level integration initiatives. New integrated chronic disease organizational initiatives within ADHS will be documented.

Summary

This plan represents ADHS' ongoing commitment to reducing the mortality and morbidity of chronic disease through collaboration among all stakeholders. It is hoped that the AzCD Plan will encourage the development of partnerships among state agencies, policy and decision makers, communities, organizations, health care providers, and consumers to promote a comprehensive and integrated approach to improving the health of all Arizonans.

Appendix A:
Sample Matrices

SERVICE DELIVERY

PROGRAM CATEGORY	HEART	STROKE	CANCER	LUNG	DIABETES	NUTRITION/ PHYSICAL ACTIVITY	TOBACCO
SCREENING & DETECTION	X	X	X	X			X
SECONDARY PREVENTION	X	X		X	X		
DIAGNOSIS & TREATMENT	X	X	X	X			X
MASS MEDIA / HEALTH MARKETING	X	X	X	X	X	X	X
POLICY / ENVIRONMENTAL CHANGE	X	X	X	X	X	X	X
ADVOCACY	X	X	X		X		X
HEALTH EDUCATION (CONSUMER)	X	X	X	X	X	X	X
PROVIDER EDUCATION	X	X	X	X	X	X	X
INFRASTRUCTURE / DATA SURVEILLANCE	X	X	X	X	X	X	X
ACCESS TO CARE	X	X	X	X	X		X
RESEARCH			X	X			X
FINANCIAL / INSURANCE ISSUES			X	X			X
QUALITY OF CARE	X	X	X	X	X	X	X
COLLABORATION	X	X	X	X	X	X	X
FUNDING / GRANTS	X	X	X		X		
TOBACCO CONTROL	X	X	X	X			X
CULTURAL COMPETENCY / SENSITIVITY					X		X

INTERVENTION SITES

PROGRAM CATEGORY	HEART	STROKE	CANCER	LUNG	DIABETES	NUTRITION/ PHYSICAL ACTIVITY	TOBACCO
SCHOOLS			X	X		X	X
WORK SITES	X	X	X	X		X	X
COMMUNITY & FAMILY	X	X	X	X	X	X	X
HEALTH CARE SYSTEM	X	X	X	X	X	X	X

MESSAGES

PROGRAM CATEGORY	HEART	STROKE	CANCER
PREVENTION & EARLY DETECTION	• Cholesterol screening • BP screening • Work site health screenings	• Cholesterol screening • BP screening • Work site health screenings–Stroke Check	• Sun protection • Colon cancer screening • Breast cancer screening • Cervical cancer screening • Prostate cancer screening
NUTRITION	• 5 A Day • AZ Nutrition Network • BMI	• 5 A Day • AZ Nutrition Network • BMI	• 5 A Day • Fiber • Kilocalories • Low-fat
PHYSICAL ACTIVITY	• P.L.A.Y. • W.E.L.L. • Work site programs • Physical education in schools	• P.L.A.Y. • W.E.L.L. • Work site programs • Physical education in schools	• Moderate activity: 30–60 minute/day 5 days per week
ALCOHOL			• Abstain or moderate intake
TOBACCO	• Smoking cessation • Smoke-free environments	• Smoking cessation • Smoke-free environments	• Smoking prevention, cessation, & second-hand smoke • “Quit line” for AZ

PROGRAM CATEGORY			
LUNG	**DIABETES**	**NUTRITION / PHYSICAL ACTIVITY**	**TOBACCO**
• Periodic health checks • Avoid unhealthy work environments	• ABCs of Diabetes • Decrease: Hb-A-1C level BP Cholesterol • Foot exams • Eye exams	• Culturally sensitive & intergenerational media messages re: preventive screening, healthy weight & physical activity	
	• Achieve & maintain healthy weight	• Healthy eating; healthy lifestyles • Encourage work site breast-feeding policy • BMI • 5 A Day • Portion Control	• BMI
	• P.L.A.Y.	• Physical activity; healthy lifestyles	
	• Abstain		
• Tobacco abstinence	• Reduce / abstain		• "Go Cold Turkey" • Cessation for Diabetics • "Inhale Life"; "Be Tobacco Free" • Native American "Breathe Tradition, Respect Tobacco" • Spanish language– "Respire Vive" • African & Asian – "Ashes to Ashes – be tobacco free"

ANALYSIS OF CATEGORICAL PLAN OBJECTIVES (sample)

ANALYSIS OF OBJECTIVES (sample)

PREVENTION & EARLY DETECTION

CARDIOVASCULAR	CANCER	LUNG (COPD)
• Increase numbers of Arizonans who know their cholesterol numbers	• Routine oral cancer screening	• Reduce exposure to environmental and occupational risk factors
• Increase numbers of Arizonans who know their BP numbers	• Skin self exams	• Improve early detection & diagnosis of COPD
• Increase numbers of physicians who follow guidelines for cholesterol screening & treatment	• Increase numbers of Arizonans who use effective sun protection	• Promote healthy living practices
• Increase numbers of physicians who follow guidelines for BP screening & treatment	• Promote use of American Cancer Society guidelines	• Reduce exposure to environmental & occupational risk factors
• Increase numbers of physicians & EMTs who follow triage guidelines for stroke	• Develop consistent screening guidelines for colon cancer	• Develop practical & feasible list of indicators for spirometry
• Follow “Barbershop Hypertension Screening Program” re: identifying hypertension in African Americans	• Consistent standards for all populations	• Encourage PCPs to perform office spirometry for all patients who report smoking or have symptoms of COPD
	• Screening tool for lung cancer	• Develop consensus for severity assessment criteria
	• Increase to 70% women 40 yrs+ who had breast exam & mammogram within past year	
	• Prostate cancer screening for high-risk groups	
	• Adults 50+, increase colorectal screening to 50%	
	• Women 18yrs+, increase pap test to 95%	
	• Total body screening for skin cancer	

ANALYSIS OF CATEGORICAL PLAN OBJECTIVES (sample)

DIABETES	NUTRITION / PHYSICAL ACTIVITY	TOBACCO
• The Diabetes Prevention and Control Program is mandated to lead diabetes-related secondary and tertiary prevention	• Saturate communities with culturally sensitive & intergenerational messages re: preventive screening, healthy weight & physical activity • Streamline and focus obesity prevention efforts in AZ	• Fund early detection screenings of COPD, • Increase number of health care professionals who provide intervention messages and encourage cessation to clients • Promote Public Health Cessation Standards through health care provider trainings

Courtesy of Heard Museum

Appendix B:
Arizona Revised Statutes
Title 36 Public Health and Safety
Chapter 6 Public Health Control
Article 8 Tobacco Tax Funds

36-770. Tobacco products tax fund

(Caution: 1998 Prop. 105 applies)

A. The tobacco products tax fund is established consisting of revenues deposited in the fund pursuant to section 42-3251.01 and interest earned on those monies. The Arizona health care cost containment system administration shall administer the fund.

B. Forty-two cents of each dollar in the fund shall be deposited in the proposition 204 protection account established by section 36-778.

C. Five cents of each dollar in the fund shall be deposited in the health research fund established by section 36-275.

D. Twenty-seven cents of each dollar in the fund shall be deposited in the medically needy account established by section 36-774.

E. Twenty cents of each dollar in the fund shall be deposited in the emergency health services account established by section 36-776.

F. Four cents of each dollar in the fund shall be deposited in the health care adjustment account established by section 36-777.

G. Two cents of each dollar in the fund shall be deposited in the health education account established by section 36-772.

H. Except as provided in section 36-776, monies in the fund:

1. Are continuously appropriated.
2. Do not revert to the state general fund.
3. Are exempt from the provisions of section 35-190 relating to lapsing of appropriations.

36-771. Tobacco tax and health care fund

A. The tobacco tax and health care fund is established. The fund consists of all revenues deposited in the fund pursuant to sections 42-3252 and 42-3302 and interest earned on those monies. On notice from the department, the state treasurer shall invest and divest monies in the fund and in all accounts in the fund as provided by section 35-313, and monies earned from investment shall be credited to the fund.

B. The fund shall be deposited in four separate accounts and shall be administered pursuant to the provisions of and for the purposes prescribed by this article.

C. Except as provided by subsection F of this section, the fund and its accounts are not subject to appropriation. Expenditures from each account are not subject to additional approval, notwithstanding any statutory provision to the contrary.

D. Monies in the fund and its accounts:

1. Do not revert to the state general fund under any circumstances.

2. Are exempt from the provisions of section 35-190 relating to lapsing of appropriations.

E. Monies in the fund:

1. Shall be spent only for purposes that are authorized by this article.

2. Shall not be used for expenditures on capital construction projects, lobbying activities involving elected officials or political campaigns for individuals or any ballot proposal.

F. Notwithstanding any other provision of this section, the legislature may appropriate monies from the fund to the department of revenue for the reasonable administration and enforcement costs of the department in administering the levy of taxes that are dedicated to the fund pursuant to section 42-3252. The appropriation shall be applied before monies are deposited in the fund accounts. Any unused monies at the end of the fiscal year revert to the fund.

36-772. Health education account; audit; reports

(Caution: 1998 Prop. 105 applies)

A. In addition to the monies deposited pursuant to section 36-770, twenty-three cents of each dollar in the tobacco tax and health care fund shall be deposited in the health education account for programs for the prevention and reduction of tobacco use, through public health education programs, including community based education, cessation, evaluation and other programs to discourage tobacco use among the general population as well as minors and culturally diverse populations.

B. The department of health services shall administer the account.

C. Except as provided in subsection D of this section, monies that are deposited in the health education account:

1. Shall be used to supplement monies that are appropriated by the legislature for health education purposes and shall not be used to supplant those appropriated monies.

2. Shall be spent for the following purposes:

(a) Contracts with county health departments, qualifying community health centers as defined in section 36-2907.06, Indian tribes, accredited schools, nonprofit organizations, community colleges and universities for education programs related to preventing and reducing tobacco use.

(b) Administrative expenditures related to implementing and operating a program developed pursuant to subdivision (a) to award and oversee contracts for education programs including obtaining expert services to assist in evaluating requests for proposals and responses to those requests.

(c) Department of health services expenditures for developing and delivering education programs that are designed to prevent or reduce tobacco use including radio, television or print media costs. When contracting for the development and production of original advertising materials, the department shall require advertising, production and editorial firms to use their best efforts to employ or contract with residents of this state to manage, produce and edit the original advertising. The department shall report annually by December 1 to the governor, the president of the senate and the speaker of the house of representatives regarding instances when the department did not employ or contract with residents of this state, including the reasons for failing to do so.

(d) The evaluations required by subsection F of this section.

D. The department of health services shall use monies deposited in the account pursuant to section 36-770 for the prevention and early detection of the four leading disease related causes of death in this state, as periodically determined by the centers for disease control and prevention, or its successor agency. Initially, these are cancer, heart disease, stroke and pulmonary disease. The monies shall only be used to supplement monies that are appropriated by the

legislature and shall not be used to supplant those appropriated monies.

E. Monies from the health education account shall not be spent for lobbying activities involving elected officials or political campaigns for individuals or any ballot measure.

F. The department of health services shall evaluate the programs established pursuant to subsection C, paragraph 2 of this section and shall biennially submit a written report of its findings to the governor, the president of the senate and the speaker of the house of representatives. The department of health services shall provide a copy of each report to the secretary of state and the director of the Arizona state library, archives and public records. The department of health services shall submit its first report on or before November 15, 2004. The first report shall include data beginning in fiscal year 2001-2002

36-773. Health research account

A. Five cents of each dollar in the tobacco tax and health care fund shall be deposited in the health research account for research on preventing and treating tobacco-related disease and addiction.

B. The Arizona disease control research commission shall administer the account.

C. Monies that are deposited in the health research account shall only be used to supplement monies that are appropriated by the legislature for health research purposes and shall not be used to supplant those appropriated monies.

36-774. Medically needy account; definition

A. Seventy cents of each dollar in the tobacco tax and health care fund shall be deposited in the medically needy account to provide health care services to persons who are determined to be eligible for services pursuant to section 36-2901.01 or 36-2901.04 as provided by the Arizona health care cost containment system pursuant to chapter 29, article 1 of this title or any expansion of that program or any substantially equivalent or expanded successor program established by the legislature providing health care services to persons who cannot afford those services and for whom there would otherwise be no coverage. These services shall include preventive care and the treatment of catastrophic illness or injury, as provided by the Arizona health care cost containment system.

B. The Arizona health care cost containment system administration or any successor shall administer the account.

C. Monies that are deposited in the medically needy account:

1. Shall only be used to supplement monies that are appropriated by the legislature for the purpose of providing levels of service that are established pursuant to chapter 29, article 1 of this title to eligible persons as defined in section 36-2901 or any expansion of those levels of service, or for any successor program established by the legislature providing levels of service that are substantially equivalent to, or expanding, those provided pursuant to chapter 29, article 1 of this title to eligible persons.

2. Shall not be used to supplant monies that are appropriated by the legislature for the purpose of providing levels of service established pursuant to chapter 29, article 1 of this title.

D. For purposes of this section, "levels of service" means the provider payment methodology, eligibility criteria and covered services established pursuant to chapter 29, article 1 of this title in effect on July 1, 1993.

36-775. Adjustment account

A. Two cents of each dollar in the tobacco tax and health care fund shall be deposited in the adjustment account for transfer of appropriate amounts to the corrections fund established by section 41-1641 to compensate for decreases in the corrections fund resulting from lower tobacco tax revenues available under section 42-3104 as a result of the levy of luxury taxes that are dedicated to the tobacco tax and health care fund pursuant to section 42-3252. Any monies in the adjustment account in excess of the amount needed for the adjustment revert to the tobacco tax and health care fund for distribution in equal proportions to the accounts described under sections 36-772, 36-773 and 36-774.

B. The department of revenue shall administer the adjustment account.

36-776. Emergency health services account

(Caution: 1998 Prop. 105 applies)

A. The emergency health services account is established consisting of monies deposited pursuant to section 36-770. The Arizona health care cost containment system administration shall administer the account. The administration shall use account monies solely for the reimbursement of uncompensated care, primary care services and trauma center readiness costs.

B. Monies in the account are subject to legislative appropriation. Any monies remaining unexpended and unencumbered on June 30 of each year in the account revert to the proposition 204 protection account established by section 36-778.

36-777. Health care adjustment account

(Caution: 1998 Prop. 105 applies)

A. The health care adjustment account is established consisting of monies deposited pursuant to section 36-770. The department of revenue shall administer the account.

B. The department of revenue shall transfer appropriate amounts of account monies to the health education account established by section 36-772, the health research account established by section 36-773 and the medically needy account established by section 36-774 to compensate for decreases in these accounts due to lower tobacco tax revenues available under section 36-771 as a result of the levy of luxury taxes that are dedicated to the tobacco products tax fund pursuant to section 42-3251.01.

C. Any monies in the account in excess of the amount needed for the adjustments prescribed in this section revert to the tobacco products tax fund for distribution in equal amounts to the accounts described in section 36-770, subsections B, C, D and E.

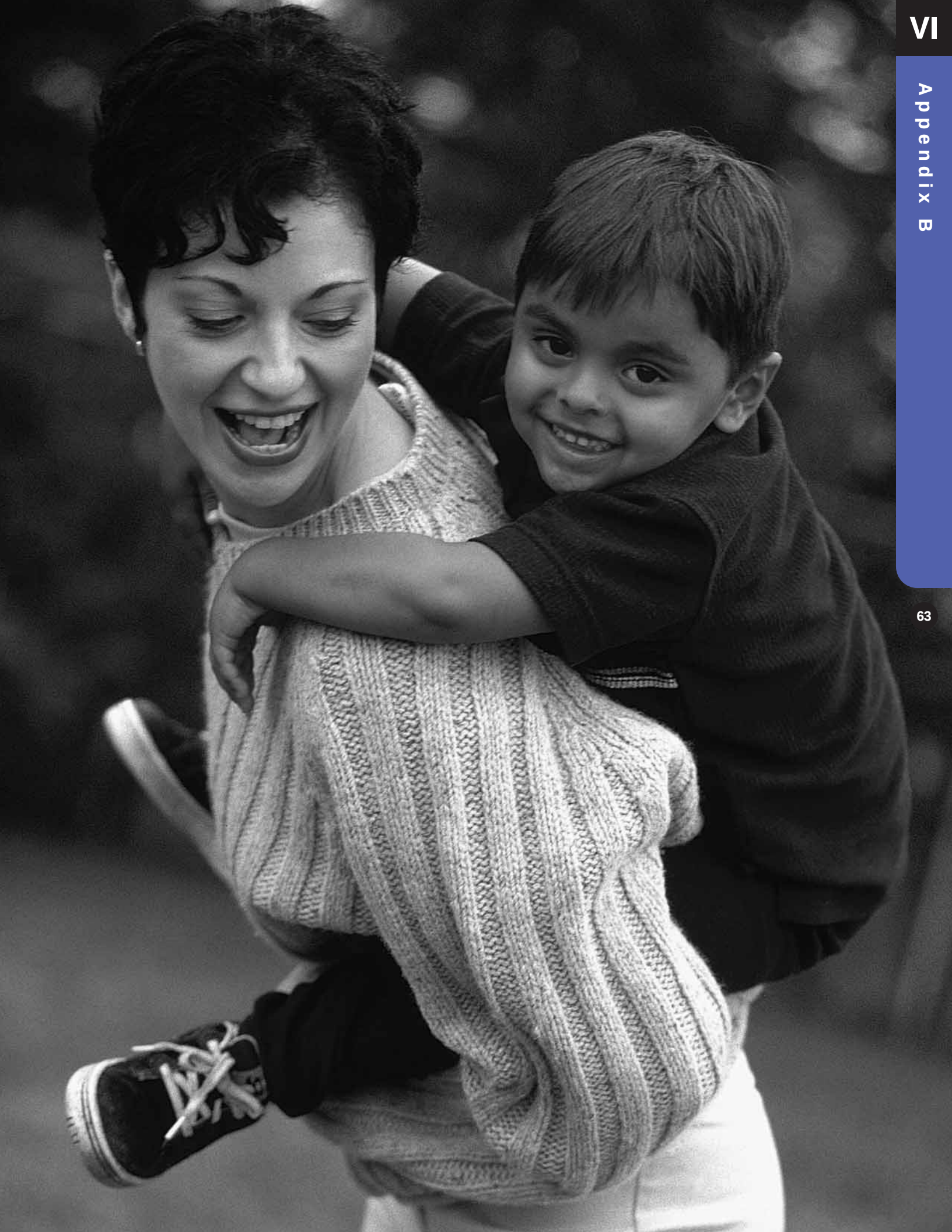
36-778. Proposition 204 protection account

(Caution: 1998 Prop. 105 applies)

A. The proposition 204 protection account is established consisting of monies deposited pursuant to section 36-770. The Arizona health care cost containment system administration shall administer the account.

B. The administration shall use account monies to implement and fund programs and services required as a result of the expanded definition of an eligible person prescribed in section 36-2901.01.

C. The administration shall spend the balance of monies in the account before it spends monies from the Arizona tobacco litigation settlement fund established by section 36-2901.02.



Appendix C:
Arizona Department of Health Services Healthy Eating Guidelines

The purpose of these guidelines is to ensure uniform healthy eating messages are utilized in programs, services, and materials provided by the Arizona Department of Health Services.

Healthy eating messages and materials should:

- Be based on the U.S. Dietary Guidelines, 6th edition, and U.S. Food Guide.
- Be tailored to meet the specific nutrient needs of target populations such as children and adolescents, pregnant women, breastfeeding women, and older adults. Please refer to the Arizona Department of Health Services, Office of Chronic Disease Prevention and Nutrition Services, Nutrition Standards for guidance.
- Recommend exclusive breastfeeding for all infants unless a specific contraindication exists.
- Reflect a 2,000 calorie per day reference intake for sample menus, examples, and recipes unless the materials are specifically for a target population with differing needs (such as teen age or the older adult).
- Utilize terminology consistent with the Food Facts Label and the U.S. Dietary Guidelines.
- Include foods, recipes, and cooking methods that reflect the culture of the target audience.
- Promote indigenous foods grown as close to consumers as possible.
- Be developed utilizing social marketing approaches, including with formative research of the target audience. When formative research for a specific audience cannot be conducted, messages should be selected from nationally developed campaigns including: Healthy Lifestyles from the U.S. Department of Health and Human Services; 5 A Day from the National Cancer Institute; Eat Smart, Play Hard from the U.S. Department of Agriculture; Verb from the Centers for Disease Control and Prevention; Milk Matters from the U.S. Department of Agriculture; and Small Steps, Big Rewards from the National Diabetes Education Program.

Programs, services, and materials for the general public should reflect the following key recommendations.

Adequate Nutrients Within Calorie Needs

Key Recommendations:

- Consume a variety of nutrient-dense foods and beverages within and among the basic food groups while choosing foods that limit the intake of saturated and trans fats, cholesterol, added sugars, salt, and alcohol.
- Meet recommended intakes within energy needs by adopting a balanced eating pattern, such as the USDA Food Guide or the DASH Eating Plan.

Weight Management

Key Recommendations:

- To maintain body weight in a healthy range, balance calories from foods and beverages with calories expended.
- To prevent gradual weight gain over time, make small decreases in food and beverage calories and increase physical activity.

Food Groups to Encourage

Key Recommendations:

- Consume a sufficient amount of fruits and vegetables while staying within energy needs. Two cups of fruit and 2 1/2 cups of vegetables per day are recommended for a reference 2,000 calorie intake, with higher or lower amounts depending on the calorie level.
- Choose a variety of fruits and vegetables each day. In particular, select from all five vegetable subgroups (dark green, orange, legumes, starchy vegetables, and other vegetables) several times a week.
- Consume 3 or more ounce-equivalents of whole-grain products per day, with the rest of the recommended grains coming from enriched or whole-grain products. In general, at least half the grains should come from whole grains.
- Consume 3 cups per day of fat-free or low-fat milk or equivalent milk products.
- All women capable of becoming pregnant should consume 400 micrograms of synthetic folic acid daily, from fortified foods or supplements, or a combination of the two, in addition to folate in foods from a varied diet.

Fats

Key Recommendations:

- Consume less than 10% of calories from saturated fatty acids and less than 300 mg/day of cholesterol, and keep trans fatty acid consumption as low as possible.
- Keep total fat intake between 20 to 35% of calories, with most fats coming from sources of polyunsaturated and monounsaturated fatty acids, such as fish, nuts, and vegetable oils.
- When selecting and preparing meat, poultry, dry beans, and milk or milk products, make choices that are lean, low-fat, or fat-free.
- Limit intake of fats and oils high in saturated and/or trans fatty acids, and choose products low in such fats and oils.

Carbohydrates

Key Recommendations:

- Choose fiber-rich fruits, vegetables, and whole grains often.
- Choose and prepare foods and beverages with little added sugars or caloric sweeteners, such as amounts suggested by the USDA Food Guide and the DASH Eating Plan.
- Reduce the incidence of dental caries by practicing good oral hygiene and consuming sugar- and starch-containing foods and beverages less frequently.

Sodium and Potassium

Key Recommendations:

- Consume less than 2,300 mg (approximately 1 tsp of salt) of sodium per day.
- Choose and prepare foods with little salt. At the same time, consume potassium-rich foods, such as fruits and vegetables.

Alcoholic Beverages

Key Recommendations:

- Those who choose to drink alcoholic beverages should do so sensibly and in moderation—defined as the consumption of up to one drink per day for women and up to two drinks per day for men.
- Alcoholic beverages should not be consumed by some individuals, including those who cannot restrict their alcohol intake, women of childbearing age who may become pregnant, pregnant and lactating women, children and adolescents, individuals taking medications that can interact with alcohol, and those with specific medical conditions.
- Alcoholic beverages should be avoided by individuals engaging in activities that require attention, skill, or coordination, such as driving or operating machinery.

Food Safety

Key Recommendations:

- To avoid microbial food borne illness:
  - ► Clean hands, food contact surfaces, and fruits and vegetables.
  - ► Separate raw, cooked, and ready-to-eat foods while shopping, preparing, or storing foods.
  - ► Cook foods to a safe temperature to kill microorganisms.
  - ► Chill (refrigerate) perishable food promptly and defrost foods properly.
  - ► Avoid raw (unpasteurized) milk or any products made from unpasteurized milk, raw or partially cooked eggs or foods containing raw eggs, raw or undercooked meat and poultry, unpasteurized juices, and raw sprouts.

Messages and materials for consumers should include these key points:

- Make smart choices from every food group.
- Find your balance between food and physical activity.
- Get the most nutrition out of your calories.

A healthy eating plan is one that:

- Emphasizes fruits, vegetables, whole grains, and fat-free or low-fat milk and milk products.
- Includes lean meats, poultry, fish, beans, eggs, and nuts.
- Is low in saturated fats, trans fats, cholesterol, salt (sodium), and added sugars.

Some general recommendations include:

Focus on fruits. Eat a variety of fruits. Choose fresh, frozen, canned, or dried fruit. Go easy on fruit juice.

Vary your vegetables. Eat more dark green vegetables like broccoli, spinach, and other dark leafy greens. Eat more orange vegetables like carrots, sweet potatoes, and winter squash. Eat more dry beans and peas, such as pinto beans, kidney beans, and lentils.

Make half your grains whole. Eat at least 3 ounces of whole-grain cereals, breads, crackers, rice, or pasta every day. One ounce is about 1 slice of bread, 1 cup of breakfast cereal, or 1/2 cup of cooked rice or pasta. Look to see that grains such as wheat, rice, oats, or corn are referred to as "whole" in the list of ingredients.

Go lean with protein. Choose lean meats and poultry. Bake it, broil it, or grill it. Vary your protein choices with more fish, beans, peas, nuts, and seeds.

Get your calcium-rich foods. Get 3 cups of low-fat or fat-free milk—or an equivalent amount of low-fat yogurt and/or low-fat cheese (1 1/2 ounces of cheese equals 1 cup of milk)—every day. If you don't or can't consume milk, choose lactose-free milk products and/or calcium-fortified foods and beverages.

Check servings and calories. Look at the serving size and how many servings you are actually consuming. If you double the servings you eat, you double the calories and nutrients, including the % Daily Values (DV).

Make your calories count. Look at the calories on the label and compare them with what nutrients you are also getting to decide whether the food is worth eating. When one serving of a single food item has over 400 calories per serving, it is high in calories.

Don't sugarcoat it. Since sugars contribute calories with few, if any, nutrients, look for foods and beverages low in added sugars. Water would be a good substitute for sugar-containing beverages. Read the ingredient list and make sure that added sugars are not one of the first few ingredients. Some names for added sugars (caloric sweeteners) include sucrose, glucose, high fructose corn syrup, corn syrup, maple syrup, and fructose.

Know your fats. Look for foods low in saturated fats, trans fats, and cholesterol to help reduce the risk of heart disease (5% DV or less is low, 20% DV or more is high). Most of the fats you eat should be polyunsaturated and monounsaturated fats. Keep total fat intake between 20% to 35% of calories.

Reduce sodium (salt), increase potassium. Research shows that eating less than 2,300 mg of sodium (about 1 tsp of salt) per day may reduce the risk of high blood pressure. Most of the sodium people eat comes from processed foods, not from the salt shaker. Also look for foods high in potassium, which counteracts some of sodium's effects on blood pressure.

Play it safe with food. Know how to prepare, handle, and store food safely to keep you and your family safe:

- Clean hands, food-contact surfaces, fruits, and vegetables.
- Separate raw, cooked, and ready-to-eat foods while shopping, preparing, or storing.
- Cook meat, poultry, and fish to safe internal temperatures to kill microorganisms.
- Chill perishable foods promptly and thaw foods properly.

About alcohol. If you choose to drink alcohol, do so in moderation. Moderate drinking means up to 1 drink a day for women and up to 2 drinks for men. Remember that alcoholic beverages have calories but are low in nutritional value.

Description of DASH Diet

Two major studies have shown that blood pressure can be lowered by following a particular eating plan, the Dietary Approaches to Stop Hypertension (DASH) Diet Eating Plan, and reducing the sodium in one's diet. The eating plan alone lowers blood pressure, but the combination of the eating plan and reduced sodium intake gives the biggest benefits and may help prevent the development of high blood pressure.[1, 2]

The DASH Diet Eating Plan emphasizes fruits, vegetables and low-fat dairy products. It is moderate in total fat and low in saturated fat and cholesterol. It includes whole grains, poultry, beans, fish and nuts.

The following publication includes a week's worth of sample menus, recipes for heart healthy dishes and a summary of the findings from the "Dietary Approaches to Stop Hypertension" clinical study. It has a form to track food habits before starting the plan and a chart to help with meal planning and grocery shopping.

Facts About the DASH Eating Plan, 24 pages, NIH Publication No. 03-4082 is available online and single orders are free.

See *www.nhlbi.nih.gov/health/public/heart/hbp/dash* or

NHLBI Health Information Center
P.O. Box 30105
Bethesda, MD 20824-0105
Phone: 301-629-3255

A reference page to the DASH Eating Plan at 1,600-, 2,000-, 2,600-, and 3,100- Calorie Levels is also part of the 6th edition of the Dietary Guidelines available at *www.health.gov/dietaryguidelines/dga2005/document/html/appendixA.htm.*

1. Appel LJ, Moore TJ, Obarzanek E, Vollmer WM, Svetkey LP, Sacks FM, et al. A clinical trial of the effects of dietary patterns on blood pressure. DASH Collaborative Research Group. N Engl J Med. 1997; 336:1117-1124.

2. Vollmer WM, Sacks FM, Ard J, Appel LJ, Bray GA Simons-Morton, DG, Conlin PR, Svetkey LP, Erlinger TP, Moore TJ and Karanja N. Effects of Diet and Sodium Intake on Blood Pressure: Subgroup Analysis of the DASH-Sodium Trial. DASH Collaborative Research Group. Ann Intern Med. 2001; 135:1019-1028.

Appendix D:
Top Priorities From Categorical Plans

TOP PRIORITIES FROM CATEGORICAL PLANS

	CARDIOVASCULAR	CANCER
PREVENTION	• Increase the number of hospitals participating in the American Heart Association program "Get With The Guidelines."	• To reduce the risks for developing cancer among all Arizonans by promoting and engaging in healthy behaviors.
EARLY DETECTION	• Increase the number of people who are aware and can recognize the signs and symptoms of a stroke and know the next step that needs to be taken. • Increase the number of people who are aware and can recognize the signs and symptoms of a heart attack or myocardial infarction. • Increase the number of women who are aware of the symptoms of a heart attack, which are very different from the signs of a heart attack for men.	• To promote, increase, and optimize the appropriate utilization of high-quality cancer screening & follow-up services • Increase the proportion of women aged 40 and over who have received a mammogram and clinical breast exam within the past year to 70% by 2010 • For adults aged 50 and over, increase the proportion of the population who has been screened for colorectal cancer using colonoscopy, sigmoidoscopy, or fecal occult blood test to 50% by 2010

TOP PRIORITIES FROM CATEGORICAL PLANS

LUNG (COPD)	NUTRITION / PHYSICAL ACTIVITY	TOBACCO
• Increase awareness of the medical community, public health officials and the general public that COPD is a serious public health problem in Arizona. • Promote healthy living practices, which provide the most effective method of preventing COPD (tobacco abstinence, periodic health checks, avoidance of unhealthy work environments).	• Promote and encourage all Arizona residents to make healthy lifestyle choices. • Establish a comprehensive healthy school environment with support of staff, students, parents and community members in all Arizona school districts. • Encourage, recommend and support work cultures that promote and are conducive to physical activity and healthy eating. • Deliver a health marketing campaign about measures that can be taken to prevent obesity that provides culturally sensitive & intergenerational media messages promoting preventive screening, healthy weight and physical activity options. • Educate residents about and promote healthy design of Arizona communities. • Integrate a culture of physical activity throughout Arizona communities.	• To prevent and reduce tobacco use among all Arizonans. • To reduce all Arizonans' exposure to secondhand smoke.
• Improve early detection and diagnosis of COPD.		

TOP PRIORITIES FROM CATEGORICAL PLANS

	CARDIOVASCULAR	CANCER
TREATMENT	• Increase the number of primary stroke centers in Arizona from six to 15. • Increase the number of those diagnosed with heart and cerebro-vascular disease that participate in cardiac rehabilitation and other formal, multidisciplinary approaches to secondary prevention of the heart and cerebrovascular disease. • Increase the number of people that are being referred to the appropriate professionals to receive medical nutrition therapy and a formal exercise prescription to treat high cholesterol and high blood pressure. • Increase the availability of automated external defibrillators in the public, beginning where people congregate in large numbers and where EMS availability may be delayed.	• Increase access to appropriate and effective cancer diagnosis and treatment services. • Educate the public regarding the importance and relevance of participating in cancer clinical trials.
QUALITY & ACCESS TO CARE		• By 2007, utilize telemedicine to increase access to state-of-the-art diagnosis and treatment techniques and expertise as well as second opinions and resources. • By 2008, increase access to quality information and patient navigation sites across the state and identify barriers to access. • Increase access to the comprehensive management of acute, chronic, and delayed effects of cancer and its treatments. • Create the opportunity for optimal utilization of local, state, and national resources. • Increase support for health care providers and payers in directing those affected by cancer to quality of life services. • By Fall 2005, create a health disparities work group that will research and identify current barriers to care as well as draft strategies to reduce inequalities in cancer care.

TOP PRIORITIES FROM CATEGORICAL PLANS

LUNG (COPD)	NUTRITION / PHYSICAL ACTIVITY	TOBACCO
• Educate health care providers to manage patients with COPD to increase longevity & quality of life, & reduce exacerbation of the disease. • Promote better care for patients with COPD in AZ according to established guidelines. • Improve access to pulmonary rehabilitation programs for Arizonans with COPD to prevent and forestall premature morbidity & mortality. • Improve self-management knowledge and behavior in people with COPD, their families and other caregivers.		• To provide and support accessible, affordable and effective cessation services and systems. • To provide and support effective cessation services, including pharmacotherapy. • To work with health care systems to provide intervention protocols for health care professionals. • To identify, reduce and eliminate tobacco-related health disparities and tobacco use.

TOP PRIORITIES FROM CATEGORICAL PLANS

	CARDIOVASCULAR	CANCER
DATA		
POLICY & ENVIRONMENTAL CHANGE	• Implement protocols whereby a paramedic/EMT unit may bypass a hospital in order to transport a stroke victim to a primary stroke center, thereby increasing their chance of survival with less severe disabilities.	
RESEARCH		• Promote participation in cancer clinical trials in Arizona, specifically among underserved populations. • Establish a clearinghouse/database for cancer researchers to access and use in Arizona.
OTHER		• Support a capacity building conference, promoting collaboration among existing agencies in order to disseminate information about current and developing screening methods and tools by 2010.

TOP PRIORITIES FROM CATEGORICAL PLANS

LUNG (COPD)	NUTRITION / PHYSICAL ACTIVITY	TOBACCO
• Establish a surveillance system to accurately track the mortality and morbidity of COPD in Arizona and measure its impact on the economy of the state.	• Create multiple mechanisms for community health care agencies to exchange information to solidify a universal message/program.	
• Advocate and support policies to reduce the prevalence of tobacco use and secondhand smoke exposure among Arizonans.		
• Support research into COPD etiology and clinical management, as well as health care policies and outcomes particularly as the activities relate to state issues.		

Appendix E:
Arizona Department of Health Services

Office of the Director

Office of Public Information

The Public Information Office is committed to providing the public and the media with health information in a timely, accurate, and helpful manner. This Office provides news releases, health alerts, publications, the 2004 Annual Report, and other health agency resources.
(602) 542-1001
www.azdhs.gov/diro/pio/index.htm

Employee Wellness Council

The mission of the ADHS Employee Wellness Council is to enhance the overall health and well-being of ADHS employees by providing quality programs and creating an environment that promotes and supports healthy lifestyles.
(602) 364-2401

Native American Liaison

The propose of the Native American Liaison position is to serve as an advocate, resource, and communication link between the Arizona Department of Health Services and Arizona's Native American health care community comprised of 21 tribal health offices, three Urban Indian Health Programs, three Indian Health Service Area Offices, Inter Tribal Council of Arizona, Inc., and other agencies and entities providing direct or indirect public health services to Arizona's Native American communities.
(602) 364-1041
www.azdhs.gov/phs/tribal/index.htm

Division of Public Health Services

Local Health Liaison

The Local Health Liaison strengthens coordination and collaboration between the Arizona Department of Health Services and local health departments through communication, advocacy, and consultation. The Local Health Liaison coordinates the direct and per capita reimbursement grants to county health departments.
(602) 364-2401
www.azdhs.gov/phs/local_health/index.htm

Physical Activity Program

The Physical Activity Program goal is to reduce the prevalence of chronic disease such as cardiovascular disease, diabetes, osteoporosis, and some types of cancer by increasing the number of Arizonans who get 30–60 minutes of moderate to vigorous intensity physical activity on most days of the week. Programs include state and county level work groups and coalitions, statewide intervention programs, as well as the Walk Everyday & Live Longer Program.
(602) 364-2402
www.azdhs.gov/phs/physicalactivity/

Bureau of Epidemiology & Disease

The goal of the Bureau is to monitor, prevent, and control diseases in Arizona through program activities.
(602) 364-3860
www.azdhs.gov/phs/edc/index.htm

Office of Chronic Disease Prevention and Nutrition Services

The Office of Chronic Disease Prevention and Nutrition Services and its partners empower Arizonans to achieve optimal health through nutrition and disease prevention and control services.
(602) 542-1886
www.azdhs.gov/phs/oncdps

Asthma Control Program

The primary functions of the Asthma Control Program include the development of a surveillance system and collaboration with Arizona's asthma coalitions to improve the lives of persons with asthma. The program's goal through the Office of Chronic Disease Prevention and Nutrition Services is to eliminate complications and deaths from asthma in Arizona.
www.azdhs.gov/phs/oncdps/asthma/index.htm

Cardiovascular Risk Reduction Program

The goal of this program is to increase the cardiovascular health of all Arizonans and decrease the burden of heart disease and cerebrovascular disease. Prevention and education information is provided to those individuals who have been diagnosed with some form of cardiovascular disease in order to decrease the risk of stroke and/or heart attack. Surveillance and assessment of the status of cardiovascular disease, particularly in relation to health education and policy, is conducted through various community partnerships.

Community Nutrition Program

The Community Nutrition Program provides nutrition services for 12 rural counties, including a standardized series of four "5 A Day" classes for low-income third grade students. These interactive classes are designed to address the increasing rates of obesity and overweight among children and focus on increasing consumption of fruits and vegetables to five or more servings each day by children and their families. The program includes three classroom sessions that promote the "5 A Day" message and one produce tour at a local grocery store.

Comprehensive Cancer Control Program

The mission of this program is to reduce the overall burden of cancer through prevention and early detection of cancer, effective treatment for cancer, and improvement of the quality of life for those living with cancer. This is achieved through a partnership of public and private stakeholders, including American Cancer Society, the University of Arizona's Arizona Cancer Center and College of Public Health, Arizona Health Care Cost Containment System, Phoenix Indian Medical Center, and many more organizations.
www.azcancercontrol.gov

Diabetes Prevention and Control Program

The Diabetes Prevention and Control Program assists with the prevention of diabetes; develops the state's capacity to reduce the incidence and severity of primary and secondary complications related to diabetes; coordinates educational and training opportunities that involve state leadership, health professionals, and communities; and promotes coordinated approaches to the provision of diabetes care and services through the state.
www.azdhs.gov/phs/oncdps/diabetes/index.htm

Nutrition and Physical Activity Program

The mission of this program is to improve the health and quality of life of Arizona residents by reducing the incidence and severity of chronic disease and obesity through physical activity and nutrition interventions. "Eat smart. Get active. Be healthy."
www.azdhs.gov/phs/oncdps/opp/

Well Woman Healthcheck Program

The Well Woman Healthcheck Program is a statewide program that provides free cancer screenings to women who qualify. Women on the program may receive a clinical breast exam, mammogram, pelvic exam, and pap test.
www.azdhs.gov/phs/oncdps/wellwoman/index.htm

Special Supplemental Nutrition Program for Woman, Infants, and Children Program

Arizona Women, Infants, and Children (WIC) is a federally-funded program that provides Arizona residents with nourishing supplemental foods, nutrition education, and referrals. The participants of WIC are either pregnant, breastfeeding, or postpartum women, and infants and children who have nutritional needs and meet income guidelines.
www.azdhs.gov/phs/oncdps/wic/index.htm

Arizona Nutrition Network

The Arizona Nutrition Network (AzNN) is comprised of an ever-expanding group of public and private organizations committed to working together to shape food consumption in a positive way, promote health, and reduce disease among lower income Arizonans through nutrition education and a social marketing campaign.
www.eatwellbewell.org

Arizona Commodity Supplemental Food Program

The Arizona Commodity Supplemental Food Program, also known as Food Plus, is a federal food distribution program. The participants include pregnant, breast feeding, and postpartum women, children, and elderly persons who meet income and residence guidelines.
www.azdhs.gov/phs/oncdps/csfp/index.htm

Arizona Farmers' Market Nutrition Program

The Arizona Farmers' Market Nutrition Program goal is to increase the fruit and vegetable consumption among low income women, children, and seniors while supporting local farmers' markets.
www.azdhs.gov/phs/oncdps/azfmnp/index.htm

Arthritis Program

Arthritis is the most prevalent chronic disease and the leading cause of disability in the U.S. and Arizona. The Arthritis Program works with members of the Arizona Arthritis Partnership to improve the quality of life for people with arthritis.
(602) 542-1886
www.azdhs.gov/phs/oncdps/arthritis/index.htm

Early Childhood Nutrition Program

Provides consultation and training for licensed child care centers. Nutrition consultation, technical assistance, and workshops are provided for licensed child care programs to better the quality of the nutrition component of their programs.
(602) 542-1886
www.azdhs.gov/phs/oncdps/earlychildhood/index.htm

Folic Acid Education & Distribution Program

Participants in the Folic Acid Education and Distribution Program receive a year supply of multivitamins (with 400 micrograms of folic acid) in addition to education.
(602) 542-1886
www.azdhs.gov/phs/oncdps/folicacid/index.htm

Children with Special Health Care Needs

The Office of Chronic Disease Prevention and Nutrition Services provides nutrition consultation and technical assistance for CRS dietitians, professional staff, and caregivers of children with special health care needs.
(602) 542-1886
www.azdhs.gov/phs/oncdps/children/index.htm

Steps to a Healthier Arizona Initiative

The goal of the Steps to a Healthier Arizona Initiative is to reduce the burden of asthma, diabetes and obesity and address the related risk factors of inadequate dietary intake, physical inactivity and tobacco use in Cochise, Santa Cruz and Yuma Counties and the Tohono O'odham Nation. Program partners include the Arizona Department of Health Services, the Arizona Department of Education, Cochise County Health Department, Mariposa Community Health Center (Santa Cruz County), University of Arizona Cooperative Extension (Yuma County), Department of Human Services (Tohono O'odham Nation), and the University of Arizona Mel & Enid Zuckerman Arizona College of Public Health. Numerous community subcontractors also partner with these agencies.

Office of Border Health

The Office of Border Health promotes and protects the health of all border area residents through sound, competent public health practices along the Arizona-Sonora border. The Office of Border Health coordinates and integrates public health program efforts to identify, monitor, control and prevent adverse health events in border communities, as well as strengthen cross-border public health collaboration with Sonora, Mexico. Programs include Binational Terrorism and Public Health Emergency Response, U.S.-Mexico Border Health Commission Arizona Delegation, Diabetes Education and Outreach Arizona-Sonora, Border Binational Health Week, Sonora Arizona Health Office (Mexico), Action Border Health Conference, Arizona Mexico Commission, and Border Health Studies.
(520) 770-3110
www.azdhs.gov/phs/borderhealth/index.htm

Office of Tobacco Education and Prevention Program

Broad-based, statewide distribution of tobacco information is an Office of Tobacco Education and Prevention Program goal. Key components include print media, toll-free telephone services, onsite training and technical assistance, face-to-face community outreach, and the Internet to reach the citizens of Arizona. Services offered cover a wide range of issues such as tobacco use prevention and education, public access to information, help in quitting tobacco, analysis and research into smoking policies for work sites, school, and restaurants, and training and technical assistance for those who want to learn more about tobacco.
(602) 364-0824
www.azdhs.gov/phs/tepp/index.htm

Office of Health Systems Development

Health Systems Development supports a variety of programs and services meant to improve access to high quality primary health care, particularly for the uninsured and other vulnerable populations.
(602) 542-1219
www.azdhs.gov/hsd/index.htm

Arizona Loan Repayment Program

The purpose of the AZ Loan Repayment Program is to provide an incentive for primary care providers and dentists to provide services in the underserved areas of the State. Program funds are used to repay qualifying

educational loans in return for primary care service provisions in federally designated Health Professional Shortage Areas.
www.azdhs.gov/hsd/az_loan_repayment.htm

Arizona Medically Underserved Areas

The Arizona Medically Underserved Areas designation may be used for planning for delivery of primary care services.
www.azdhs.gov/hsd/azmuadesignation.htm

Arizona Primary Care Area Statistical Profiles

Community Health Profiles are available for 87 incorporated towns and cities in Arizona with aggregate data from various agencies to improve the accessibility of health-rated data. These profiles can assist interested parties in addressing a number of health issues and facilitate health program planning, implementation, and improvement in communities.
www.azdhs.gov/hsd/profiles2005

Health Professional Shortage Areas

The federal Health Professional Shortage Area (HPSA) designation identifies an area or population as having a shortage of dental, mental, and primary health care providers. HPSA designation is used to qualify for state and federal programs aimed at increasing primary care services to underserved areas and populations.
www.azdhs.gov/hsd/hpsa.htm

Healthy Arizona 2010 Program

This is a comprehensive statewide prevention agenda designed to improve the health of all Arizonans over the next decade. Whether through participation as part of an organization, or through a personal commitment to change, this plan is designed to help you determine what you can do to improve your health and the health of your community.
www.azdhs.gov/phs/healthyaz2010/index.htm

Healthy Aging 2010 Initiative

Working in partnership with the Healthy Arizona 2010 Initiative, this project promotes health and good quality of life for older adults in Arizona.
www.azdhs.gov/phs/healthyaging2010/index.htm

Healthy Communities

Healthy Communities was established with the mission to identify, link, and support Arizona communities that are using collaborative approaches to health planning, disease prevention, and the promotion of healthy lifestyles.
www.azdhs.gov/phs/hcc

J-1 Visa Waiver Program

The Arizona Department of Health Services J-1 Visa Waiver Program supports waivers for primary care physicians (family or general practice, pediatrics, obstetrics/gynecology, and general internal medicine) in federally designated Health Professional Shortage Areas, Medically Underserved Areas, or Medically Underserved Populations, and for psychiatrists in mental health Health Professional Shortage Areas. The J-1 Visa Waiver Program supports waivers for J-1 physicians in specialties when exceptional need for the specialty is substantiated.
www.azdhs.gov/hsd/visa_waiver.htm

Medically Underserved Areas/Populations

The federal Medically Underserved Area/Population (MUA/MUP) designation identifies areas or populations as having a need for medical services on the bases of demographic data. These designations are important when seeking a Community and Migrant Health Center or Federally Qualified Health Center status.
www.azdhs.gov./hsd/mua_mup.htm

National Health Service Corps

The National Health Service Corps (NHSC) recruits and places health professionals at eligible sites within federally designated HPSAs. NHSC recruits primary care physicians, nurse practitioners, physician assistants, certified nurse-midwives, dentists, dental hygenists, and mental health professionals. These providers serve in community-based systems of care in return for scholarship or loan repayment assistance.
www.azdhs.gov/hsd/nhsc.htm

Primary Care Programs

Two Primary Care Programs have been established to provide access to primary care health services for uninsured, low-income Arizona residents of all ages.
www.azdhs.gov/hsd/primary_care.htm

Office of Environmental Health

Environmental Health Consultation Services Program

The Environmental Health Consultation Services Program conducts public health assessments and consultations for the United States Environmental Protection Agency (USEPA) superfund sites in Arizona. Most of the health reports completed by the program discuss the health effects at USEPA superfund sites. Consultations for other environmental exposures upon request.
(602) 364-3118
www.azdhs.gov/phs/oeh/atsdr.htm

Food Safety and Environmental Services Program

The Food Safety and Environmental Services Program is responsible for managing a statewide Food Safety Program and a voluntary Food Biosecurity Program.
(602) 364-3118
www.azdhs.gov/phs/oeh/fses

Children's Environmental Health Section

In accordance with the Governor's Children's Environmental Health Project Initiative, the Office of Environmental Health assessed the environmental factors that most affect Arizona's children. The Arizona's Children and the Environment report details information to assist organizations and individuals interested in developing specific objectives for helping reduce exposures.
(602) 364-3118
www.azdhs.gov/phs/oeh/invsurv

SunWise School Program

This program encourages elementary schools to adopt sun-safe policies and promote sun-safe educational programs to educate children about sun safety and to encourage life-long sun-safe behaviors.
(602) 364-3118
www.azdhs.gov/phs/sunwise

Office of Health Registries

Arizona Cancer Registry

The Arizona Cancer Registry is a population-based surveillance system that collects, manages, and analyzes information on the incidence, survival, and mortality of persons having been diagnosed with cancer.
(602) 542-7320
www.azdhs.gov/phs/phstats/acr/index.htm

Appendix F:
National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care

Standard 1. Health care organizations should ensure that patients/consumers receive from all staff members effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.

Standard 2. Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.

Standard 3. Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.

Standard 4. Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.

Standard 5. Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.

Standard 6. Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).

Standard 7. Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

Standard 8. Health care organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.

Standard 9. Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations.

Standard 10. Health care organizations should ensure that data on the individual patient's/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated.

Standard 11. Health care organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.

Standard 12. Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.

Standard 13. Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers.

Standard 14. Health care organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.

More detailed information can be obtained on each of the Standards above through:

U.S. Department of Health and Human Services. Office of Minority Health. *National Standards for Culturally and Linguistically Appropriate Services in Health Care.* March 2001. Retrieved July 15, 2005 from *http://www.omhrc.gov/omh/programs/2pgprograms/finalreport.pdf*

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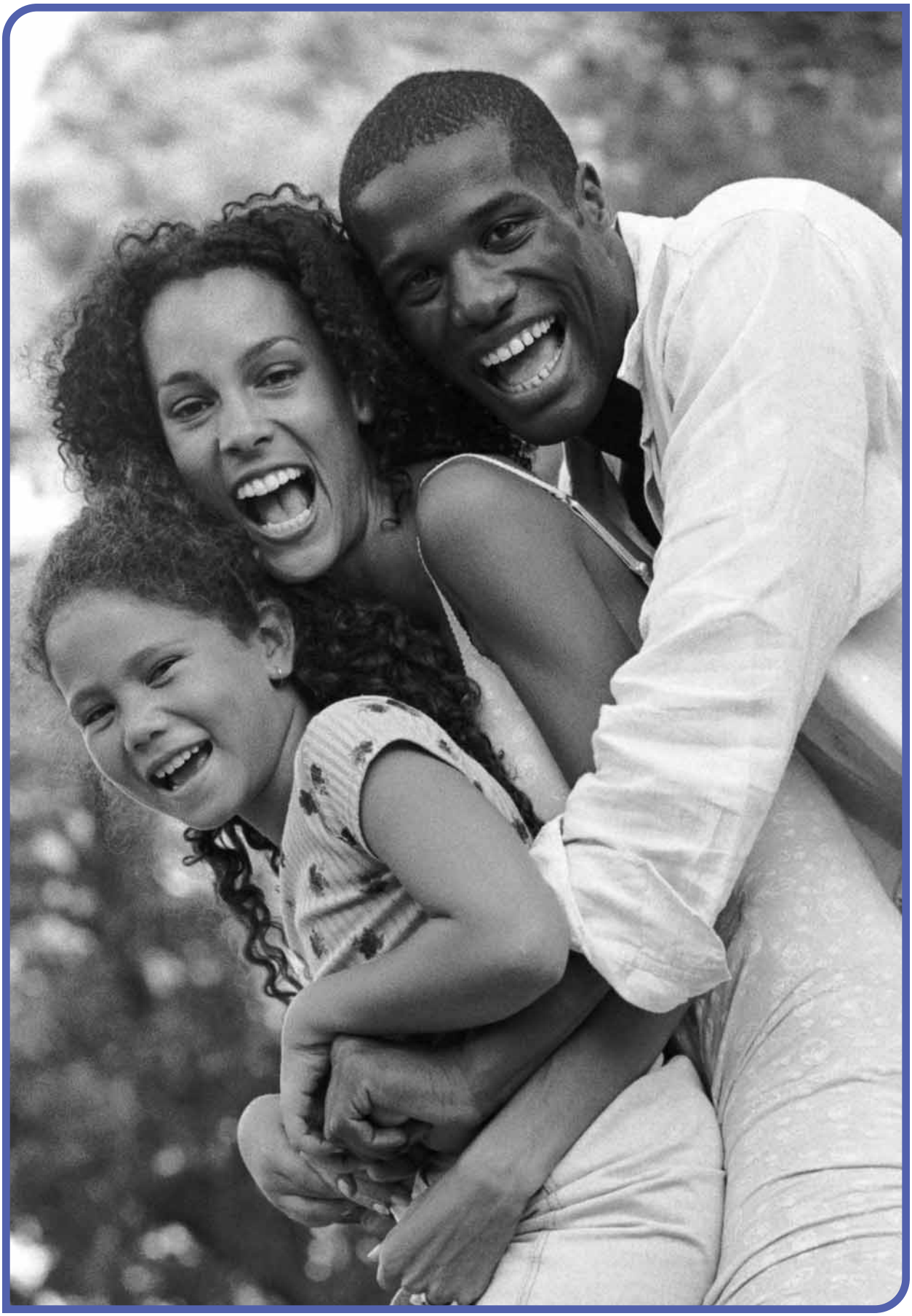

Appendix H:
Glossary

Advocacy: The act of pleading or arguing in favor of something, such as a cause, idea, or policy; active support of any of the above.

Collaboration: Working in partnership with other individuals, groups, or organizations toward a common goal.

Community: A social unit that can encompass where people live and interact socially (a city, county, neighborhood, subdivision or housing complex). It can be a social organization wherein people share common concerns or interests. Often, a community is a union of subgroups defined by a variety of factors including age, ethnicity, gender, occupation, and socioeconomic status.

Cultural Competence or Cultural Responsiveness: A set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals to work effectively in cross-cultural situations. Operationally, cultural competence is the integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices, and attitudes used in appropriate cultural settings to increase the quality of services; thereby producing better outcomes.

Diagnosis: Identifying a disease by its signs or symptoms, and by using imaging procedures and laboratory findings.

Disparities: Health disparities are differences in the incidence, prevalence, mortality, and burden of chronic disease that exist among specific population groups in the United States. These population groups may be characterized by gender, age, ethnicity, education, income, social class, disability, geographic location, or sexual orientation.

Early Detection: Procedures, examinations, screening tests performed according to recommended guidelines for the purpose of detecting the presence of disease as early as possible in individuals who are otherwise asymptomatic.

Healthy Eating: An eating pattern that is consistent with the USDA Dietary Guidelines for Americans. Individual and cultural preferences can be accommodated within an eating pattern that is considered healthy (see complete definition in Appendix C).

Infrastructure: An underlying base or foundation especially for an organization or system, or the basic facilities, services, and installations needed for the functioning of a community or society.

Policy: A plan or course of action, as of a government, political party, or business, intended to influence and determine decisions, actions, and other matters.

Primary Prevention: Preventing or reducing risks of developing a disease done through promotion of modifying individual lifestyle changes or at the system level through policy and environmental changes.

Screening: Early detection of disease in persons without signs or symptoms suggestive of the disease.

Secondary Prevention: Identifying and treating people with established disease and those at very high risk of developing disease, or treating and rehabilitating patients who have a disease to prevent a reoccurrence (e.g., cardiac rehabilitation to prevent another heart attack).

Social Marketing/Health Marketing: The application of traditional commercial advertising and marketing concepts to the analysis, planning, implementation and evaluation of programs and advertising campaigns intended to influence the voluntary behavior change of a target audience in order to improve personal welfare and that of society. Like traditional marketing, social marketing uses research to precisely tailor messages for a particular target audience.

Surveillance: A continuous, integrated and systematic collection of health-related data.

Tobacco: References in the AzCD Plan regarding the prevention and/or cessation of tobacco use, tobacco-free healthy lifestyle, and/or tobacco as a risk factor for chronic disease relate to the commercial or recreational use of manufactured tobacco products. Those references do not include the traditional practices and/or ceremonial use of tobacco that is an integral part of Native American religious beliefs and culture.

Treatment: Administration or application of remedies to a patient for a disease or injury; medicinal or surgical management; therapy.

The Arizona Chronic Disease Plan

Arizona Department of Health Services

Division of Public Health

Office of Chronic Disease Prevention and Nutrition Services

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