ARIZONA CHRONIC DISEASE STRATEGIC PLAN

2012 - 2015

ACKNOWLEDGEMENTS

Chronic Disease Collaborative Leadership Team

Thank you to the members of the Chronic Disease Collaborative Leadership Team, who spent many hours developing this plan for their leadership, their expertise and their dedication to chronic disease prevention and control.

The Chronic Disease Collaborative Leadership Team includes representatives from:

- Alliance for a Healthier Generation
- American Cancer Society
- American Diabetes Association
- American Heart Association
- American Lung Association
- Arizona Department of Administration
- Arizona Department of Education
- Arizona Department of Health Services Bureaus of Health Systems Development, Nutrition & Physical Activity, Tobacco & Chronic Disease, & Women & Children's Health
- Arizona Public Health Association
- Greater Valley Health Education Center
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I. Executive Summary

The Arizona Chronic Disease Strategic Plan is a 3-year plan designed to address chronic disease prevention and control. The vision guiding this plan is:

Arizona Communities Coming Together to Address Chronic Disease

To support this vision, the strategic plan was developed by Arizona stakeholders, both those who currently are and are not engaged in chronic disease prevention and control. To ensure the plan is not "top down" and driven by priorities identified by the state health department, community stakeholders were engaged in developing this strategic plan from the start. This plan was created through a community process and represents voices from across the state.

It is important to note that this plan has been designed to provide guidance and does not identify specific Arizona Department of Health Services' (ADHS) activities or allocation of resources. Those decisions will be made during the development of a subsequent Arizona Chronic Disease Action Plan. Creating the strategic plan was determined to be an essential foundational step in the process of developing a state plan that would be useful to the community.

As community stakeholders came together, they identified the following expectations which they would like incorporated into the strategic plan:

- Provide efficient and effective strategies to address chronic disease.
- Leverage and coordinate efforts to address chronic disease throughout Arizona.
- Provide a framework to address chronic disease that is easy to understand.
- Offer a menu of strategies from which communities can choose how they would like to address chronic disease.
- Address health disparities.
- Develop a coordinated approach to addressing chronic disease rather than one that is focused on categorical diseases.
- Strengthen the capacity for communities to access health data and make data driven decisions to address chronic disease.

To accomplish these expectations, a framework has been developed that provides goals, objectives, and matrices of evidence-based chronic disease policy, systems and environmental change strategies addressing chronic disease. This framework is presented by the areas of Where We Live, Learn, Work and Receive Care because community members felt these terms were easy to understand and can, therefore, be utilized by a wider audience. Additionally, since community stakeholders felt that a "one size fits all" approach to addressing chronic disease does not take into account the differing needs of Arizona's many communities, a matrix[1] of strategies from which communities can choose how to address chronic disease has been developed and is a part of this framework. Arizona's state plan allows

[1] *Additional information about the matrices may be found in Section VII.*

for communities to choose the specific strategies that best suit their community's needs to address chronic disease.

This plan is designed to support other efforts in Arizona to address health improvement including the community health assessments and community health improvement plans that counties will be engaging in the near future if they choose to apply for public health accreditation. As other planning efforts such as this one are occurring simultaneously, community stakeholders felt that it is important to synchronize the chronic disease state plan with these other planning efforts and related initiatives.

The Arizona Chronic Disease Strategic Plan and the framework that is presented within it are considered to be the beginning of a new coordinated process to address chronic disease in Arizona. The next steps in this process include creating an action plan which identifies the roles and expected outcomes for different community stakeholders including the state and county health departments. The action plan, which will be developed during the fall of 2012, will again engage a community-based process of seeking feedback and guidance from stakeholders across Arizona.

II. Overview of Strategic Plan Development

In September 2011, the Arizona Department of Health Services (ADHS), Bureau of Tobacco & Chronic Disease (BTCD) was awarded its CDC Chronic Disease Prevention and Health Promotion (CDPHP) grant, also known as Coordinated Chronic Disease Program (CCDP). A key deliverable of the CCDP is the creation of a statewide chronic disease plan which focuses on the prevention, early detection, and effective management of the leading chronic diseases in Arizona, specifically heart disease, stroke, diabetes, cancer and arthritis.

Community Input

Utilizing resources provided by the CCDP, BTCD held a series of stakeholder sessions across Arizona to seek input from community members on what some of the greatest needs are in Arizona when it comes to chronic disease. Specifically BTCD sought community member input on what the needs are within the areas of "Where We Work", "Where We Live", "Where We Learn" and "Where We Receive Care". Sessions were held in the communities of Yuma, Phoenix, and Tucson. An additional session was scheduled for Flagstaff, however due to inclement weather it had to be cancelled. In addition, input was sought through a statewide online survey. Through this process, more than 200 individuals, representing 98 different organizations provided input. Key partners included the Arizona Departments of Education, Administration and Transportation (Safe Routes to School); Community Health Centers, voluntary health organizations (American Cancer Society, American Diabetes Association, American Lung Association, American Heart Association, etc.), University of Arizona, Arizona State University, city planning, community based organizations, etc.

Focus Groups and In-Depth Interviews

Taking the input from these partners, BTCD then conducted focus groups with various populations adversely impacted by chronic disease. In partnership with Riester, a Phoenix-based marketing and communications firm, Focus groups were conducted with impacted populations across the state, including older adults, adults and children who are obese or overweight, caregivers, administrators, human resources representatives, teachers, nurses, and representatives from the Tohono O'odham,

Navajo and Salt River Pima Tribal Communities. While not comprehensive in scope, due to limited resources, the focus groups did provide a brief snapshot of some of the major issues these populations experience around chronic disease.

In addition, in-depth interviews were conducted with community leaders. The objective of the one-on-one interviews was to comprehend the stakeholders' perspective of chronic disease in Arizona; their perceptions of the general public's understanding of chronic disease as well as their awareness of any existing programs, best practices and/or successful initiatives which impact chronic disease.

Key findings from the focus groups and in-depth interviews include:

- Foundational behaviors must be learned at an early age, and built upon year over year. Core competencies have to be established within the home environment, demonstrated more so than taught. Most people are not privy to this type of upbringing and consequently, they lack the skill set needed to carry out these actions on their own.

- A holistic approach to the prevention and care of chronic disease is a must. The information that most individuals receive regarding health and wellness tends to focus on the physical sense of "health." The role that stress plays on one's well being is often overlooked. Further, most people view the mind (mental health), body (physical appearance, physical health) and soul (spiritual wellness and emotion), as contributors to "health."

- Taken as a whole, the challenge for chronic disease outreach is substantial. Many believe there are additional opportunities to further educate populations on the importance of disease prevention, the impact of personal behavior and choice on health outcomes, and causal relationship between decisions and health outcomes. For example, the cause and effect relationship between a healthy diet and a substantial reduction in the chances of contracting diabetes may not be understood by many Arizonans.

- Efforts need to be positioned in a manner that accomplishes two synergistic but essentially discrete objectives:
    - First, enable the at risk population to recognize they are at risk.
    - Second, sufficiently motivate the at-risk population to change their behaviors to successfully avoid contracting preventable chronic diseases or mitigate the impact of a chronic preventable disease once it is contracted.

CDC Chronic Disease Prevention and Health Promotion Domains

Arizona recognizes that in order to effectively prevent and control chronic disease in Arizona, work in the following four domains is essential:

- Epidemiology and surveillance,
- Environmental approaches that promote health and support and reinforce healthful behaviors (statewide in schools, worksites, and communities),

- Health system interventions to improve the effective delivery and use of clinical and other preventive services in order to prevent disease, detect diseases early, and reduce or eliminate risk factors and mitigate or manage complications, and
- Strategies to improve community-clinical linkages ensuring that communities support and clinics refer patients to programs that improve management of chronic conditions.

Strategies to address each of these domains are woven throughout the following strategic plan and highlight ADHS and community partners' existing resources in each of the areas. Opportunities to expand capacity in these domains also are included and provide insight into our envisioned future.

Additional information regarding the CDC Four Domains to Chronic Disease Prevention and Health Promotion can be found in Appendix A.

III. Chronic Disease Burden in Arizona

In 2010, chronic disease – including cancer, heart disease, chronic lower respiratory disease, Alzheimer's disease, diabetes, and chronic liver disease & cirrhosis were responsible for seven of the ten leading underlying causes of death in Arizona. When combined, these chronic diseases were responsible for more than 29,500 Arizona deaths in 2010. (Arizona Health Status & Vital Statistics, 2010).

In addition to 9,719 deaths that had heart disease assigned as the underlying cause, another 6,789 deaths had diseases of the heart assigned as the other than underlying cause. The sum of these two counts (16,508) is the total number of deaths that had any mention of diseases of the heart on the 2010 death certificates.

In 2010, diseases of the heart were the leading cause of death for American Indians. Cancer was the number one cause of death for Asians or Pacific Islanders, Blacks or African Americans, Hispanic or Latinos, and White non-Hispanics.

These leading causes of mortality and morbidity share common primary risk factors, including obesity, commercial tobacco use, poor nutrition and physical inactivity. However, their relationship is not limited to common indicators. Quite often, the populations most burdened by these conditions overlap; diabetes, for example, is also a significant risk factor for cardio-vascular disease (CVD).

When looking at burden of chronic disease in Arizona, the following can be found:

- In 2009 heart disease was the first leading and cancer was the second leading cause of death in Arizona however in 2010 cancer was the leading cause of death (22.7% of all deaths), followed by heart disease (21.2% of all deaths). When combined, cancer and diseases of the heart were the underlying cause of 43.9% of all Arizona deaths in 2010.

- In 2008, 7.8% of Arizona adults had been told by a doctor that they have diabetes. In 2009 this percentage increased to 8.4% and in 2010 to 9.0% (CDC – BRFSS). When accounting that a third of the population with diabetes is undiagnosed, it is not unreasonable that there are nearly 600,000 adults with diabetes in Arizona. (Arizona Diabetes Burden Report – 2011)

- Nearly 1.2 million people in Arizona are obese, 477,649 more people than 10 years ago. Arizona is tenth in the nation for obesity.

- While recent declines in smoking prevalence in the United States have become stagnated, smoking prevalence in Arizona has significantly decreased from18.6 in 2000 to 13.5 in 2010 (CDC – YRBS). The 2010 Arizona Youth Survey indicated that 22.9 percent of seniors had smoked in the past 30 days; 3.6 percent reported smoking half pack or more daily. The 2010 Kids Count data (2007-08 data) found that nine percent of 12-17 year olds and 33 percent of 18-25 year olds had used cigarettes in the past month.

Geography and Burden

According to the 2010 Arizona Health Status and Vital Statistics report, cancer and diseases of the heart are the two top causes of death for both urban and rural populations in Arizona. Cancer is the lead with urban males, urban females, and rural females while diseases of the heart are the lead for rural males. Of note is that chronic lower respiratory disease was 4th on the list for three of the four designations (urban male and female and rural male) and third on the list for rural females. Statistics from the Behavioral Risk Factor Surveillance System indicate that some of the most rural Arizona counties are at particularly high risk for chronic disease.

The incidence of chronic disease and risk factors varies by county. For example, the two counties with the highest age-adjusted estimates (2009) for adults with diagnosed diabetes are Apache and Navajo County, which are both above 10.2. An additional six counties had age-adjusted rates between 8.5 and 10.1: Yuma, Gila, Graham, Greenlee, La Paz, Mohave, and Pinal. (BRFSS, 2009) The incidence of diabetes has more than doubled in the state between 1997 and 2010.

The proportion of the 2009 Arizona population demonstrating risk factors for chronic disease also varies by county. BRFSS data indicates that 24.5% of Arizona adults have a body mass index of 30 or higher. Seven of 15 Arizona counties have high rates of obesity: Apache, Graham, Greenlee, La Paz, Navajo, Pinal, and Yuma.

Access to Care and Burden

According to the U.S. Health Resources and Services Administration, there are 270 medically underserved areas/populations (MUA/P) in Arizona. The designated MUA/Ps include whole counties (Apache, Gila, Graham, Navajo, Santa Cruz, and Yavapai) as well as service and primary care areas within counties. All 15 Arizona counties have designated MUA/P. Across the 15 Arizona counties there are also 670 Health Professional Shortage Areas (HPSA), which are designated by population (e.g., general, low income, or Native American Tribal population) and/or geographic catchment (e.g., Native American health service facility, health center, census tract, service area, or county). Shortages of medical personnel inhibit early detection and treatment of chronic disease. This leads to inaccurate estimates of the number of people impacted by disease, higher treatment costs, and higher rates of pre-mature mortality.

Age and Burden

Children: The risks associated with chronic disease, as well as chances of being diagnosed with a chronic condition increase with age; however, this does not exclude younger populations from the burdens associated with chronic conditions and their major risk factors.

In Arizona, almost 12 percent (760,960 people) of the population is school-age children with almost 43 percent of those children qualifying for free or reduced-price school lunches. Showing the association of poverty and poorer health, a study published in a May issue of the Archives of *Pediatrics & Adolescent Medicine* reported that Arizona's youth posted the biggest increase in childhood obesity prevalence of all states between 2003 and 2007.

The 2012 Kids Count Data Book[2] ranks Arizona in the bottom third (36 of 50) of states when comparing the overall health of children in each state. According to Kids Count:

- Arizona has the 3rd highest percent of children who do not have health insurance in the nation.
- Thirty-one percent of Arizona children and teens (10-17 years old) are overweight;
- Forty-nine percent of children and teens are not exercising regularly;
- Seventeen percent of children in Arizona are children with special health care needs; and
- Nine percent of Arizona's children have asthma problems.

Unfortunately, because of enrollment freezes in the Arizona Health Care Cost Containment System (AHCCCS) that started in January 2010, the number of children eligible for publicly funded medical care (SCHIP) will likely decrease, thereby decreasing the number of children who receive regular health checks.

Older adults: By 2020, older adults will compose one quarter of Arizona's population (US Census, Aging 2020). Of those 65 and older, 85% report at least one chronic disease with the greatest burden occurring within minority populations.

Race/Ethnicity and Burden

Arizona has a large minority population with approximately 40% of its population belonging to a racial or ethnic minority group. Hispanics/Latinos comprise 29.6%, American Indians 4.6%, African Americans 4.1%, and Asian/Pacific Islanders account for 3.0% of the state's population.[3] Existing data shows disparate health outcomes among these four priority population groups in Arizona. In 2009, the lowest rank in overall health status in Arizona was the African-American community, followed by American Indians and Hispanics/Latinos.[4] In 2010, Blacks and American Indians had higher total mortality rates than White non-Hispanics, Hispanics and Asians.[5]

Cancer is the leading cause of death in Arizona, closely followed by diseases of the heart, causing approximately 23 percent and 21 percent of all deaths in Arizona, respectively.[3] In Arizona, the African American community has the highest mortality rate (177.7 per 100,000) due to diseases of the heart.[3] This rate is similar to that of the African American residents in Maricopa County (170.9 per 100,000).[3] African Americans in Arizona additionally have the highest mortality rate due to stroke (46.7 per 100,000) and cancer (182.6 per 100,000) as compared to the other race/ethnicities.[3]

From the 2010 BRFSS, 9.1 percent or about 1 in 11 people in Arizona have diabetes.[6] American Indians have the highest mortality rate from diabetes (79.3 per 100,000), 3.9 times higher than the diabetes

[2] 2012 KidsCount Data Book, Available at http://datacenter.kidscount.org
[3] US Census Bureau, Quick Facts. Available at: www.census.gov
[4] Arizona Department of Health Services. Arizona Health Status and Vital Statistics, 2008
[5] Arizona Department of Health Services. Differences in the Health Status Among Race/Ethnic Groups, Arizona, 2009.
[6] Arizona Department of Health Services. 2010 Health Status and Health Risk Behaviors of Arizonans

mortality rate for all Arizona residents (20.1 per 100,000).[3] This rate is even larger for the American Indian population in Maricopa County (123.1 per 100,000). [3]

The disparity in access to care based on race/ethnicity is alarming. The percent of Hispanic and Black Arizonans reporting that they could not afford needed health care (23.1% and 27.4%, respectively) was more than double the percent for White, American Indian, and Asian / Pacific Islander populations.[7]

According to the *Healthy Development of Arizona's Youngest Children A 21st Century Profile of Opportunity and Challenge; Arizona Health Survey 2010 Survey Data for Children 0-5*:

> There are very significant differences in insurance coverage by ethnicity. A much larger percentage of young Hispanic/Latino children are uninsured. In fact, they represent 56 percent of the total uninsured population. Parents report almost all of these children (99 percent) as being born in the United States. Therefore, they are citizens eligible for coverage under AHCCCS (Arizona's Medicaid) and KidsCare (Arizona Children's Health Insurance Program). However, if some of these children have parents who are undocumented, the parents may be reluctant to apply for coverage due to concerns that an application for public benefit may raise immigration issues for all members of the household. Outreach from trusted messengers is likely to be a key to raising enrollment levels among eligible Hispanic and Latino children.

The Arizona Department of Health Services collected data on the overall health status by race/ethnic groups (2009), which demonstrates existing health disparities; more than 60 percent of both American Indian and Black respondents indicated that their health was worse than average as compared to about 20 percent of Whites and Hispanics and a little over 10 percent of Asian/Pacific Islander respondents.

The Arizona Department of Health Service's titled, *2010 Health Status and Health risk Behaviors of Arizonans,* describes the Arizona's health using data from the 2010 administration of the Behavior Risk Factor Surveillance System survey stated the following, "Either a lack of health care insurance or inadequate coverage prevents many from getting required care because they are unable to pay for services without the help of insurance. People with health insurance are normally more likely to have a primary care provider and to receive necessary preventative care, such as immunizations, health screen tests, and prenatal care.

Economics and Burden

Efforts to reduce the chronic disease burden in Arizona are complicated by budget cuts in education and commercialism. For example, budget cuts in education have resulted in school systems reducing the availability of physical education and other physical activities and health classes in elementary and middle schools. Convenience stores commonly advertise and sell high sugar content foods to youth after-school. The Food Research and Action Center[8] reports that, in general, lower cost foods tend to be higher in fat and simple carbohydrates. Furthermore, low-income neighborhoods tend to have higher concentrations of fast-food retailers and lower concentrations of full service grocery stores. Lower income populations also tend toward cycles of food deprivation and overeating.

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[7] BRFSS 2010 Health Status and Health Risk Behaviors of Arizonans

[8] Food Research and Action Center research citations can be found at http://frac.org/initiatives/hunger-and-obesity/why-are-low-income-and-food-insecure-people-vulnerable-to-obesity/

Additionally, the tobacco industry has developed fruit and candy-flavored cigars that are sold in singles and small packs. These cigar products are not as regulated as cigarettes and, because they can be sold as singles and small packs, are an affordable alternative to cigarettes. These tobacco products are also sold at convenience stores and small groceries across Arizona and are seen as a growing trend among youth tobacco users.

The Future and Arizona's Chronic Disease Burden

DeVol, Ross, and Armen Bedroussian the Milken Institute's report, "*The Economic Burden of Chronic Disease on Arizona" (2007),* discusses the incredible human and economic costs of chronic disease focusing on treatment expenditures and lost productivity. Their report also shows optimism, suggesting that "reasonable improvements in preventing and managing chronic disease [could] avoid 944,000 cases of chronic conditions in 2023." The authors go on to indicate that these improvements could reduce the economic burden of chronic disease by 26% in 2023 through lowered treatment costs and improved worker productivity.

IV. Guiding Principles for Arizona Chronic Disease Strategic Plan

The Arizona Chronic Disease Strategic Plan has been designed to guide future efforts to address chronic disease throughout the state. By providing a framework for Arizona stakeholders, whether state and county health departments, or community-based partners, the Arizona Chronic Disease Strategic Plan is structured to ensure activities align. As mentioned prior, this plan is to provide guidance however does not identify specific ADHS activities or allocation of resources. Those decisions will be made during the development of a subsequent Arizona Chronic Disease Action Plan. Similar to the strategic plan's development, broad community and stakeholder input will be sought on the development of the subsequent action plan.

The Arizona Chronic Disease Strategic Plan can be utilized in the following ways:

To provide a framework for approaching chronic disease that utilizes a coordinated approach.

The Arizona Chronic Disease Strategic Plan encourages state and county health departments to streamline categorical program efforts and create a coordinated approach to chronic disease rather than one that operates in disease-specific silos. The process of creating the plan has included many strategic planning sessions about how programs can effectively and efficiently work together to coordinate chronic disease efforts. ADHS anticipates that this is just the beginning and that these conversations will continue. As efforts are evaluated there is recognition that some strategies to achieve a coordinated response to chronic disease may change--- however, the goal of addressing chronic disease in a coordinated manner will not, and this plan has been designed to help achieve that goal.

To engage communities throughout Arizona in efforts to prevent and control chronic disease.

A fundamental principle guiding efforts has been to include community members in the planning process and create a plan that will help Arizona communities address chronic disease. The Arizona Chronic Disease Strategic Plan is designed to engage community members by providing a roadmap to address chronic disease. Recognizing that communities have different characteristics, The Arizona Chronic Disease Strategic Plan allows for communities to choose evidence-based strategies that meet their specific needs.

To address health disparities to achieve health equity.[9]
The guiding principal that will be cross-cutting throughout the planning and implementation process of the Arizona Chronic Disease Strategic Plan and subsequent action plan will be the strong adherence to focusing attention to reducing the burden of health disparities across Arizona. Health disparities — differences in health outcomes that are closely linked with social, economic, and environmental disadvantage — are often driven by the social conditions in which individuals live, learn, work and play. Health disparities represent preventable differences in the burden of key risk factors, disease and disability, or opportunities to achieve optimal health.

A basic principle of public health is that all people have a right to health. Centering attention on the social determinants of health with the goal of achieving health equity across Arizona will be a key determining factor in making improvements in chronic diseases statewide. Truly, the process of achieving health equity will take a coordinated approach with all partners synchronizing efforts to make lasting impact.

To work collaboratively to align efforts and leverage resources.
A key component of the Arizona Chronic Disease Strategic Plan is working collaboratively with partners to align simultaneous planning and data collection efforts. Recognizing that the existence of multiple plans addressing similar issues can lead to confusion and a lack of action, a desired outcome of the chronic disease plan is the future alignment of efforts with those conducting Community Health Assessments (CHA) and developing Community Health Improvement Plans (CHIP).

For state and local health departments seeking accreditation, a Community Health Improvement Plan is required.* Key components of a CHIP[10] include:

- Assessment data about health of population
- Community health priorities, improvement strategies, and performance measures
- Needed policy changes
- Individuals / organizations with responsibility for strategies
- Outcomes/indicators to monitor progress

**Although not all Arizona counties plan to apply for accreditation, they all are planning to conduct a Community Health Assessment and a Community Health Improvement Plan.*

Since assessing communities' health needs and identifying priorities provides a strong foundation for addressing chronic disease, it was decided to align efforts to create a chronic disease strategic plan that supports Arizona communities in their efforts to create a Community Health Improvement Plan (CHIP).

To this end, the Arizona Chronic Disease Strategic Plan provides a framework for communities to choose evidence-based strategies that address chronic disease based on the needs and priorities that they identify through the CHA and the CHIP process. While the goals to address chronic disease remain consistent throughout the plan, strategies to reach those goals may vary by community based on

[9] Sources: http://minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf and http://www.nccp.org/publications/pdf/text_995.pdf

[10] (Source: http://www.cdc.gov/stltpublichealth/nphii/NPHIIMeeting/meetingdocs/accredidation/2.%20Accreditation_PHDepts_LizaCorso_2011.pdf)

specific needs and priorities identified in the CHA/CHIP. Through matrices of evidence-based recommended and promising practices, communities can select evidence-based strategies by sector (where they live, learn, work or receive care), chronic disease, risk factor, and/or level of the Prevention Institute's Spectrum of Prevention. The matrices also provide information about which strategies are cross-cutting and which of the above-mentioned, four domains are being addressed.*

An example of how this is underway is with the Maricopa County Department of Public Health (MCDPH). MCDPH realized the value of the coordinated approach to chronic disease and is organizing their CHIP by the sectors of Where We Live, Where We Learn, Where We Work, and Where We Receive Care. Providing consistencies across agencies can help facilitate conversations among various stakeholders and can help to further efforts.

V. Arizona Categorical Programs

Traditionally programs impacting chronic disease within state and local health departments have been broken up into categorical programs. For example, the Arizona Department of Health Services has individual categorical programs which address the prevention and control of cancer, diabetes, heart disease and stroke, obesity and tobacco as well as health disparities and healthy aging. While ADHS is fortunate to have these categorical programs, with many receiving funding from the Centers for Disease Control and Prevention, the approach of having individual programs has created silos within the health department. As an unintended consequence, many programs are unaware of the goals and objectives of their partner programs. Subsequently, by not knowing each program's respective goals and objectives, resources were not being leverage, duplicity of efforts often occurred, and opportunities to connect partners and communities were missed.

Through a coordinated approach of addressing chronic disease burden and health, many of those unintended consequences will hopefully be avoided. In addition, through coordination of efforts, it is the hope that the categorical programs will better be able to address their respective program goals and objectives while not losing significance.

The following is a description of the ADHS Categorical Programs. It is important to note that this is not a description of all activities and partners within each area. This information was provided as a demonstration of ADHS' current activities and potential future approaches to better align the efforts within the Agency around chronic disease burden in Arizona.

Arizona Cancer Control Programs

History

The Well Woman HealthCheck Program (WWHP) is a CDC and state funded program providing breast and cervical cancer screening to uninsured and underinsured women in Arizona. The program is 20 years old and is based on using evidence based strategies to increase screening rates and provide high quality screening resulting in better/healthier outcomes for women screened within the program. While this program was initially focused on providing breast and cervical cancer screening for the uninsured, the focus has changed to increasing the breast and cervical cancer screening rates for all women in Arizona.

The Fit at Fifty HealthCheck Program (FFHP) is a CDC and Tobacco Tax Revenue supported program providing colorectal cancer screening for Arizonans 50 and older. This is a young program that has only been in existence for five years. Only 20% of the CDC funds can be used for screening purposes, the

remainder of the funds support systems change and the use of evidence based strategies to increase the colorectal cancer screening rates of all Arizonans.

The Arizona Cancer Control Program is a CDC funded program that has been in place for 10 years. The goal of the program is to leverage partner resources across the state to lower the burden of cancer in Arizona. The program is currently being revised to keep step with CDC's changing program requirements. The program used to be focused on networking and education. However, now the focus is on measureable impact.

Current Activities

Well Woman HealthCheck Program (WWHP)

The WWHP, FFHP and Arizona Cancer Control Program are integrated. Program management, finances and support are located within the Bureau of Health Systems Development. Many of the activities are cross cutting.

The Well Woman HealthCheck Program is focused on preparation for a future focused on improving screening quality standards across the state. It is not only important that women get screened, but that the follow up services are appropriate and timely. The WWHP has achieved all of the quality standards set by CDC for the past four years.

The WWHP is responsible for review of all applications for the Breast and Cervical Cancer Treatment Program (BCCTP). This has created increased time requirement since the expansion of the program on August 2, 2012. At this point women no longer need to be diagnosed with cancer in the WWHP to be eligible for the BCCTP. All uninsured Arizona women, at or below 250% of the Federal Poverty Level are now eligible for the BCCTP.

The WWHP provides contractor education on a quarterly basis. These quarterly training events encompass community resources, clinical education, CDC updates, best practices and changes in the contract scope of work. Program fidelity is critical due to the performance based budgeting approach used by the CDC.

Population based approaches to systems change, at the clinical level, are the program focus at this time. All contractors are required to determine their breast and cervical baseline screening rates annually and to use evidenced based strategies to increase the screening rates of all women using their clinics. When the clinics reach Healthy People 2020 screening goals, we will then shift to a community focus.

Fit at Fifty HealthCheck Program (FFHP)

This is a young program and from a clinical standpoint colorectal cancer screening is also a young process. Screening standards have been in place for breast and cervical cancer for a long time; however, that is not the case for colonoscopy. Therefore, nationally, everyone is at the beginning of the learning curve. All contractors are required to hold CMEs to support ongoing clinical improvement in colonoscopies and their associated reporting. Standards for colonoscopy and associated reports have been created. It is now our goal to educate Arizona's providers about those standards.

Using evidence based strategies and systems change approaches to increase the screening rate for the total clinic population are is already happening. Ongoing monitoring from annual screening baseline determinations occurs. All contracted clinics demonstrate an increase in colorectal cancer screening rates. This effort will continue. The goal is to reach 80% by 2014.

Arizona Cancer Control

CDC program requirements have changed and the Arizona Cancer Control Program needs to change to keep in step with the funding agency. All program activities are targeting measureable impact. The program will target the areas described below:

- Increase the reporting of cancer cases to the Arizona Cancer Registry
- Increase breast, cervical and colorectal, skin and prostate cancer screening across Arizona
- Determine screening program service gaps and monitor over time
- Create a policy committee focused on:
    - Increasing funding for the WWHP
    - Secure a state line item for the Colorectal Cancer Screening Program
    - Increase purchases of the Pink Ribbon License Plate
    - Secure a mandate that all insurance programs provide no cost colorectal cancer screening.

Arizona Cancer Leadership Team

All of the activities for the cancer programs described above are shared with and receive guidance from the Arizona Cancer Leadership Team. The Arizona Cancer Leadership Team, please see graphic below, is comprised of community partners from across the state. This team serves as the Steering Committee for the Arizona Cancer Coalition (under the Arizona Cancer Control Program). The input and support of this group of partners has had a positive impact on Arizona's Cancer Programs for the past two years. Several of these partners were responsible for the advocacy effort that expanded the BCCTP in 2012.

While the Arizona Cancer Leadership Team provides guidance, support and advocacy, there is another team responsible for supporting program implementation; the Core Team. The Core Team is comprised

of the following staff: Arizona Cancer Registry Office Chief, Chronic Disease Office Chief, Health Disparities Center Office Chief, Arizona Cancer Control Program Manager, Arizona Cancer Control Epidemiologist, and the HealthCheck Programs Office Chief.

Future Approaches

All of Arizona's Cancer Control Programs will be impacted by changes in the health care environment. It would be easy to assume that the Affordable Care Act would end the need of the screening programs. CDC is preparing the screening programs to continue providing screening for the uninsured (they will not all be folded into health insurance products) while adding a component of improving the screening rates and the quality of the screening and diagnostic process in the private sector. This description encompasses the WWHP and FFHP.

Both screening programs will be tasked to work with health plans. While health plans have not traditionally worked with public health, we now know that their screening rates and follow up on abnormal results are less than that allowed for CDC screening programs. This will create an opportunity to forge new partnerships while improving the quality of services provided to all Arizonans.

Arizona Cancer Control and the HealthCheck Programs will continue to support the gap analysis and gap resolution activities resulting from the HSAG analysis of FQHC ability to use their electronic medical records to report on the Physician Quality Standards being implemented by CMS (Medicare). We know from the initial gap analysis that training and attention to IT enhancements will be necessary across the state.

Arizona Diabetes Prevention and Control Program

History

Since the inception of the Arizona Diabetes Prevention and Control Program (DPCP) in 1994, the program has worked diligently to reduce the incidence and prevalence of diabetes and the debilitating complications associated with the disease. The AZ DPCP is dedicated on integrating its preventative efforts with other programs to identify and address strategies that would improve the lives of people at risk or living with diabetes in Arizona. Over the course of the years, the DPCP has worked closely with stakeholders and partners, such as the American Diabetes Association, the National Association for Diabetes Educators, Arizona Diabetes Coalition (ADC), and the Arizona Diabetes Leadership Council (ADLC) to carry forward the mission of reducing the burden of diabetes on individuals, families, and communities in Arizona.

Current Activities

The Arizona DPCP objectives and activities align with the four domains that have been identified by the CDC. Strategies were developed that addressed primary prevention, patient centered care and treatment, provider improved care and treatment, availability and accessibility to diabetes care and education. For example, the Arizona DPCP will continue its efforts in collecting and disseminating surveillance data via the Behavioral Risk Factor Surveillance System (BRFSS). These data will be utilized in the creation of future Arizona Status Reports and other measurable indicator reports that will guide the goals and objectives of the ADC surveillance committee and other ADC partners. The ADC has established four work groups to help reduce the burden of diabetes in Arizona, to include those of high risk or vulnerable populations:

- Diabetes Self-Management Work Group: Advancement of increased utilization of the recognized/accredited Diabetes Self-Management Training (DSMT) programs in Arizona (evidence based programs).
- Pre-diabetes Work Group: Actively raise awareness of pre-diabetes and support evidence based prevention programs.
- Advocacy Work Group: Participate in advocacy efforts to make DSMT available to all persons with diabetes in Arizona.
- Electronic Health Record Work Group: Learn and understand the role of the electronic health record a diabetes and its potential impact in the provision of medical care and services including DSMT.

Future Approaches

Within the scope of the four domains, the AZ DPCP also works in reinforcing interventions that aim in promoting physical activity and healthy nutrition through the CDC-led National Diabetes Prevention Program (DPP). The AZ DPP at the YMCA works in identifying those individuals that are pre-diabetic to delay the onset of type 2 diabetes. The DPP teaches participants through a lifestyle coaching mechanism to incorporate physical activities through worksite wellness initiatives and educating its participants on the availability of healthy foods throughout the community. The AZ DPCP commits its continued collaboration with the YMCA DPP to implement strategies that create a healthy environment for individuals at high risk for diabetes.

Through health systems interventions, the ADC Electronic Health Record Work Group has been established and key leadership roles have been assigned to effectively propose the utilization of electronic health records to decrease the barriers of chronic disease screenings (i.e., diabetes and A1C control checks). With the integration of health care information systems, physicians and other health care providers will be able to alert/remind patients who are at risk for diabetes or living with diabetes on the importance of screening and clinical follow-up to mitigate or avert secondary complications associated with diabetes. Furthermore, electronic health records can be vital in leveraging epidemiologic surveillance efforts as a current registry for the disease does not exist in Arizona.

Evidenced lifestyle programs such as the Diabetes Self-Management Training/Education (DSMT/E) programs have demonstrated to improve the quality of care and treatment of those individuals newly diagnosed or diagnosed with diabetes. In order to increase the number of participants in DSMT/E programs, DSMT/E programs will work together with clinical care providers to enhance provider referrals of people with pre-diabetes or at risk for diabetes. DMST/E programs have also developed guidelines for people with diabetes to improve glycemic control, prevent acute and chronic complications of diabetes, and offer health coping and behavioral health skills to achieve optimal quality of care.

The AZ DPCP's expectation is that the state's coordinated chronic disease plan will change how the program will accomplish its objectives. It is hoped that attention is focused more on prevention of obesity than it currently does. Furthermore, the AZ DPCP is expecting to be able to leverage the expertise and resources of the other internal programs, as well as that of other organizations involved,

to produce a comprehensive chronic disease burden report that will help guide future strategies and interventions to reduce chronic diseases in Arizona. The AZ DPCP will utilize data from other programs to frame a scope of work that is common across the bureau. The 2011 AZ Diabetes Status Report indicates that physical inactivity and poor nutrition are risk factors for diabetes, and thus the AZ DPCP would hope to integrate other internal programs along with the help of current existing partners to decrease these risk factors and ultimately contribute to the prevention of diabetes and decrease the burden in Arizona.

Arizona Health Disparities Center

History

The Arizona Department of Health Services' official federally recognized State entity for Department of Health and Human Services, Office of Minority Health is the Arizona Health Disparities Center (AHDC). The AHDC was been in existence since October 1993 when then Director Jack Dillenberg, DDS, MPH created the AHDC.

The creation of the AHDC evolved from a series of proceedings including the publication of the 1991 "Closing the Decade" report. This report documented Arizona's ethnic minority populations above average incidences of death and disease. Following the release of this report, the chief of the ADHS' Office of Local Health held meetings with the director and staff in Region IX Office of Minority Health to discuss the creation of a minority health entity. In 1992, ADHS held its first minority health conference, followed by a second in 1993 which lead to the creation of the Center for Minority Health (CMH).

Over the course of the years that followed, the Center's activities began to diminish due to the lack of funding. However, the CMH was re-established in February 2004 within the Office of Health Systems Development. In August 2006, CMH officially changed its name to the Arizona Health Disparities Center.

Current Activities

The AHDC works to coordinate statewide efforts and implement work activities specific to minority health. The AHDC seeks to build the capacity of the State through education, training, advocacy, and coalition building to address health disparities. The AHDC provides technical assistance on culturally and linguistically appropriate services standards, cultural competency, health literacy, and other health disparities-related areas.

Two initiatives the AHDC is currently leading includes language access services and a comprehensive community health planning process with a focus on racial and ethnic communities in Maricopa County (REACH CORE project). In the October 2010, the AHDC in partnership with ADHS Refugee Health Program developed an ADHS Language Access Taskforce. The purpose of the taskforce is to assess and address how to improve meaningful language access to health services within ADHS through cross collaboration. The taskforce created a language access services needs assessment survey for all employees to complete on a voluntary basis. One of the recommendations from the assessment is to provide more training opportunities for ADHS staff. Therefore, the AHDC will be providing a series of trainings on the knowledge and tips of medical interpretation and how to interact with the public who do not speak English well in Arizona. The first training of the series will begin in late August of 2012.

Furthermore, in Spring 2012, the Arizona Department of Health Services, in partnership with the Arizona Association of Community Health Centers and Asian Pacific Community in Action, administered a survey to determine what is working well and the barriers to language access services for limited English proficient (LEP) patients. A survey was developed to assess language access knowledge, opinions and needs of healthcare professionals at community health centers in Arizona.

The Racial and Ethnic Approaches to Community Health (REACH) Communities Organized to Respond and Evaluate (CORE) grant is a project funded by CDC to reduce health disparities related to diabetes, cardiovascular disease and other conditions among racial/ethnic populations in Maricopa County using the Mobilizing for Action through Planning and Partnership (MAPP) framework. The MAPP provides the platform to convene multidisciplinary community partners to create and implement a community action plan. In a true collaborative effort, the ADHC has been partnering with the MCDPH and over twenty community organizations in implementing the REACH grant. The AHDC and community partners have been working together in designing and implementing the various stages of the MAPP process which includes conducting four community assessments and developing a Community Action Plan to be implemented in the next five years. Next steps for the REACH grant include implementation and evaluation of the policy, systems, and environmental (PSE) improvement strategies outlined in the plan.

In addition, the AHDC has recently identified new partners to implement identified strategies through the REACH project in south Phoenix. The AHDC in partnership with the Roosevelt School District, ASU Southwest Interdisciplinary Research Center (SIRC), Tigermountain Foundation, MCDPH and other community partners will implement a community school model approach to addressing PSE improvement strategies to reduce obesity and hypertension among racial and ethnic populations in south Phoenix.

Future Approaches

Arizona Health Disparities Center (AHDC) expects the Arizona Health Equity plan will align with the State Chronic Disease Plan as both plans bring awareness and increase focus on measures to reduce health disparities for all Arizonans in particular among racial/ethnic and other vulnerable populations. The Arizona Health Equity plan outlines recommendations aimed at increasing awareness of the significance of health disparities; increasing access to culturally and linguistically appropriate healthcare services; promoting a diverse health-related workforce; and ensuring all Arizonans have equal opportunity to access healthy environments, make healthy choices, and manage their health to reduce disparities in obesity which is a risk factor for all chronic diseases.

The AHDC in collaboration and coordination with the Bureau of Tobacco and Chronic Diseases will ensure AHDC and chronic disease activities align to address obesity-related disparities. In particular, the AHDC will provide expertise in addressing CDC Four Domain with a health equity lens to meet the needs racial and ethnic communities in Arizona. While the AHDC recognizes that eliminating health disparities is a daunting challenge, the AHDC pledges to continue efforts to improve the health of all Arizonans. The AHDC believes that by working together with partners throughout Arizona health equity is ACHIEVABLE!

Arizona Healthy Aging

History

The Arizona Healthy Aging (AHA) was conceived to make healthy aging a priority at ADHS through strategic planning, resource leveraging, and cross-cutting collaborations that address the health needs and disparities for older Arizonans, with particular focus on those persons born between 1946-1964, aka "the Boomers."

The demand for health services will grow as the population of older Arizonans continues to increase at unprecedented rates through the year 2030. It will affect every aspect of community life–from the jobs we hold, to the public transportation we use, and to the neighborhoods we live in. In such a demographic transformation, the over-60 population will continue to grow, and by 2030, 1 in 4 Arizonans will be over 60.

As our population ages, more Arizonans (nearly 70% of people aged 65 years or more) will have multiple chronic conditions requiring medical treatment. Also, nearly 70% of Medicare dollars will be spent on people with five or more chronic conditions.

While this phenomenon will occur across the U.S., Arizona will encounter unique pressures. Already home to more older adults than many other states, in the last decade Arizona has seen its 60-plus population increase 41.5%, from 870,000 to over 1.2 million. In that same time period, there has been a 51% increase in those over 85 years of age (from 68,525 to 103,400). These trends will continue to impact our state for decades to come.
Cities and other units of local government, as well as nonprofits and the business sector, need to strategically allocate resources now to avert more costly remedial measures in the future. But accelerating, or even maintaining current services will become increasingly difficult in the face of current economic trends. Skyrocketing housing and healthcare costs will outpace Social Security increases at the same time that fewer retirees receive traditional pensions. The ADHS has been among the state agencies charged to respond to this phenomenon in the priority setting and strategic planning processes currently underway in the Governor's Aging 2020 plan.

Current Activities

The current activities of AHA are consistent with and transparent through each of the recommended realms at the time of its conception:

- Convene an Arizona Healthy Aging workgroup comprised of key program areas.
- Demonstrate ADHS Commitment to Health Aging.
- Incorporate "Boomer"/aging adult image in all media messaging.
- Develop usable data r*eports and demographic analysis.*
- Align and coordinate efforts with key external partners including the Governor's Council on Aging, Area Agencies on Aging and other related organizations.

The AHA vision is to *Provide the opportunity for every Arizonan to enjoy health well-being, longevity and quality-of-life choices within strong, healthy communities.*

Future Approaches

In the future, the AHA will work to reduce the burden of adverse health conditions (including Chronic Disease) among older adults, 55 years of age and older, resulting from poor health or sedentary behavior of Arizonans. To accomplish this, the AHA will utilize many strategies including initiatives which improve the present health status of Arizonans, prevent age-related disease and improve overall quality of life.

In addition the AHA aims to server older adults by:

- Increasing participation in chronic disease self-management education, through systematic approaches;
- Providing access to information and services to improve the quality of lives among older adults;
- Providing opportunities for community involvement;
- Providing support for family members providing care;
- Providing collaboration with other state and local agencies and;
- Providing web links to health topics relevant to older adults.

Arizona Heart Disease and Stroke Program

History

The Heart Disease and Stroke Prevention Program was created through a CDC Capacity-building grant in 2007. The program initially focused on the "acute event" of heart disease and stroke care. The majority of program goals involved supporting the local stroke and heart disease initiatives as they applied to clinical intervention in the emergency department (rapid identification and treatment of stroke patients and "tele-stroke"), or first responder interventions (CPR-training initiatives), as well as public awareness campaigns to improve awareness of heart disease and stroke warning signs.

Current Activities

The HDSP Program has shifted its focus to stay aligned with changes in program strategy at the National level. This shift brought about a greater focus on managing the risk factors which could lead to heart disease or stroke. Specifically, the program's new (and current) direction implements programs aimed at system-level changes with how at-risk patients are identified and managed in the clinical setting, and policy changes in the food-procurement setting. Concurrently, the HDSP is still invested in improving clinical quality performance in the acute-interventional setting, and has dedicated resources to continue with that program. These projects of clinical quality improvement, patient/risk factor management and policy change rely heavily on partnerships with state and county public health agencies, quality improvement organizations, healthcare delivery organizations, and related coalitions and organizations with similar goals.

Future Approaches

The HDSP's future approach will require it to work in collaboration with other chronic disease programs in order to have the greatest impact. The primary focus will be on the management of disease risk factors through system-change inside of the community healthcare setting, or through government policy changes. By focusing on healthcare system improvement and policy change, the HDSP Program

touches upon all of the CDC's primary domain areas of Surveillance and Epidemiology, Clinical and Community Linkages, Health Systems Interventions, Healthy Behaviors.

Arizona Obesity Prevention and Control

History

The Arizona nutrition and physical activity state plan was developed by the Arizona Department of Health Services (ADHS) in 2005 with the input of over 400 stakeholders to serve as the guiding document for obesity prevention in Arizona. The goals of the 2005 state plan were to promote and enable the citizens of Arizona to eat smart and to promote and enable active lifestyles in Arizona residents. Key objectives for obesity prevention for ADHS that were developed from this plan continue to be the strategic areas today and include: physical environments, families and environments, healthcare, worksites, and schools.

In the spring of 2009, an internal assessment of obesity programs within the division of Public Health Prevention Services was conducted by staff from the Bureau of Nutrition and Physical Activity. The purpose of the assessment was to provide a "point-in-time" picture of resources and services for obesity-related programs in ADHS. The assessment identified that 75% of obesity prevention efforts are carried out through the Bureau of Nutrition and Physical Activity, 14% within the Bureau of Health System Development, 6% within the Bureau of Tobacco and Chronic Disease, and 5% within the Bureau of Women's and Children's Health. With support from ADHS leadership, the results of the obesity program assessment were used to make obesity prevention efforts a high priority throughout Arizona, to develop consistent goals and objectives within ADHS across bureaus and programs, to focus on sustainable efforts that are creative and realistic given the current economic realities, feature agency-wide collaboration, and to ensure that ADHS moves forward in addressing the health and economic burdens caused by obesity.

In February 2010, the Arizona Department of Health Services (ADHS) was selected by the Centers for Disease Control and Prevention (CDC) to take part in the Communities Putting Prevention to Work (CPPW) Program and received a two-year American Recovery and Reinvestment Act of 2009 (ARRA) grant to promote wellness and prevent chronic disease through statewide policy, system and environmental change. CDC charged ADHS with planning and implementing evidence-based initiatives that will reduce chronic disease associated with obesity, poor nutrition and lack of physical activity through sustainable, high impact policy, systems and environmental change in Arizona. The Arizona Champions for Change: Communities Putting Prevention to Work Program focused its efforts on increasing access to healthy foods and drinks and decreasing access to unhealthy foods and drinks in child cares and schools, increasing access to opportunities for physical activity in child cares and schools, and increasing social support and services for breastfeeding in hospitals and worksites.

Current Activities

As a step in the public health accreditation process, ADHS developed a new strategic plan and updated the Agency's mission and vision. The ADHS Strategic Map has identified obesity prevention as a strategic priority and winnable battle. The Bureau of Nutrition and Physical Activity Strategic Plan for 2012-2016 guides current obesity prevention priorities to align with the ADHS strategic plan and includes efforts

targeted to reduce hunger, increase breastfeeding, and decrease obesity through healthy eating and active living to improve health and well-being for people and communities in Arizona. This accomplished across multiple program activities within the Bureau of Nutrition and Physical Activity including the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), Commodity Supplemental Food Program (CSFP), Farmers' Market Nutrition Program (FMNP), Breastfeeding Peer Counseling and the Supplemental Nutrition Assistance Education Program (SNAP-Ed) within Nutrition Education and Obesity Prevention, known as the Arizona Nutrition Network (AzNN). Core social marketing messaging is incorporated under the theme of "Champions for Change" to empower Arizona families in healthy eating and active living.

Future Approaches

The future approaches for ADHS obesity prevention efforts are to continue to achieve targeted improvements in obesity prevention outcomes by leveraging efforts across bureaus and programs. This will be achieved by implementing and supporting statewide policy, system, and environmental approaches supporting access to healthy foods and increasing opportunities for physical activity where Arizonans live, learn, play, and work. This will continue to align with existing nutrition and physical activity education efforts within WIC and AzNN to increase access to and consumption of fruits and vegetables, increase breastfeeding support across programs and systems, and increase opportunities for physical activity.

Arizona Tobacco Prevention and Control

History

In 1994, Arizona voters passed the Tobacco Tax and Health Care Act (Proposition 200), which increased the state sales tax on tobacco products to fund several programs: healthcare for the medically needy, medically indigent, and low income children; tobacco education and prevention; and, tobacco-related research. The Tobacco Education and Prevention Program was established in 1995, funded by 23 percent of the tax revenue. In 2002, Arizona voters passed Proposition 303, which increased the state tax on cigarettes by 60 cents per pack and taxed other tobacco products. In addition to funding a number of programs such as emergency health services, this proposition established that tobacco tax monies would be voter protected. Two percent of this tax was set aside for a chronic disease fund which is administered by the Arizona Department of Health Services, Bureau of Tobacco and Chronic Disease (ADHS-BTCD).

Propositions 200 and 303 charged ADHS-BTCD with implementing programs for the prevention and reduction of tobacco use among the general population and among minors and culturally diverse populations. ADHS-BTCD responded by establishing a comprehensive tobacco control program, which included the highly successful launch of a public education campaign, known as the "Tumor Causing, Teeth Staining, Smelly, Puking Habit" campaign, in January of 1995. This campaign, geared primarily at youth, generated a flurry of statewide and national news coverage.

In November 2006, Arizona voters approved the Smoke-Free Arizona Act, which took effect May 1, 2007. This act bans smoking in all indoor public buildings with the exception of retail tobacco stores, veteran and fraternal clubs, designated smoking hotel rooms, and outdoor patios. The Arizona

Department of Health Services, Office of Environmental Health is responsible for monitoring compliance with the law.

Current Activities

Since its inception, ADHS-BTCD has supported efforts to:

- Inform the general public, youth and adult smokers about the dangers of tobacco through statewide media campaigns.
- Provide cessation services to individuals interested in quitting tobacco.
- Enforce state regulations preventing the sale of tobacco products to minors.
- Establish and maintain local tobacco programs in every county in Arizona.
- Advance policy initiatives aimed at reducing exposure to secondhand smoke.
- Collect, analyze and evaluate data pertaining to the efficacy of state tobacco control programs as well as data regarding the prevalence of tobacco use among various populations in Arizona.

Youth Prevention

The education and prevention of tobacco initiation has been at the forefront of ADHS-BTCD youth initiatives. Early methods included school-based educational courses that were administered through approved curricula to primary school aged youth in grades 4-8. The programs sought to educate youth on the composition and negative health consequences of tobacco use including initiation and eventual addiction. This method proved successful initially but with the increased health awareness promoted in the classroom, via local community partners and through statewide marketing channels, a change was needed to reach the youth.

In February 2009, ADHS-BTCD launched a new campaign targeted at youth ages 12-17. “Venomocity: Brought to you by Addiction” campaign personified addiction through an aggressive marketing campaign including local and statewide outreach efforts. The campaigns success continued with the transition of message from traditional forms of advertising through TV and radio to digital mediums termed ‘social media.’ The message was to resist addiction and in-turn corporate tobacco’s influence over their lives.

In 2010, ADHS-BTCD focused efforts into the development of youth coalitions throughout Arizona. Youth have transitioned from a point of learning about the harms of tobacco to understanding the addictive nature of nicotine. The next logical step was for Arizona youth to be empowered to make effect social change in their community with respect to tobacco. Focus locally and on a statewide level is now on policy change.

Cessation

With adult tobacco prevalence at 24 percent in 1994 and with the creation of the Tobacco Education and Prevention Program in 1995, Arizona began to focus on tobacco cessation. ADHS-BTCD initially focused on two methods of cessation, in-person instruction and quitline services.

Through local partnerships with the county health departments in all fifteen counties, emphasis was placed on in-person cessation programs. While successful in small numbers, the classroom-style

cessation programs were not cost-effective and did not provide the reach needed to lower Arizona's tobacco prevalence level. In 2007 focus transferred exclusively to the state's quitline.

In 1995, Arizona became just the third state with its own cessation quitline service. Located at the University of Arizona and funded by the state tax on tobacco products, the Arizona Smokers' Helpline (ASHLine) has offered free telephone services. In 2008 web-based quit services became available with additional social media options including the iQuit phone app in 2011. Included are free quit coach services and free/reduced cost nicotine replacement therapy (NRT) and/or medication.

Through comprehensive statewide media campaigns including traditional mediums such as TV, radio, outdoor, in-theatre and print, calls to the ASHLine continue. With an increased effort to include outreach, active referrals as well as provide free training and technical assistance to healthcare providers statewide, the ASHLine continues to be the most successful cessation tool available to Arizona smokers.

Future Approaches

Moving forward, the ADHS BTCD tobacco program's future approach to addressing the leading cause of chronic disease death in Arizona is to focus on the advancement of policies, systems and environmental approaches which impact the reduction in youth initiation, the reduction is exposure to secondhand smoke, the increased use of policy around tobacco cessation within worksite wellness, and the outreach to disparate populations.

Specifically, future approaches around tobacco prevention and control will focus on the:

- Increase in the number of multi-housing units and property managers which implement clean indoor air policies, thus reducing exposure to the toxins found within secondhand smoke;
- Further utilization of evidence-based, telephonic counseling services such as ASHLine within Arizona worksites, behavioral health service providers, and amongst disparate populations, including Arizona's Asian – Pacific Islander populations.
- Engagement of youth leaders and groups on the cessation efforts amongst Arizona's youth as well as engagement of youth leaders and groups on advancement of policies impacting point-of-sale and product placement within Arizona communities.

As BTCD advances into the next phase of tobacco prevention and control, an organizational systematic approach will be utilized to ensure evaluation and data drive activities, community drives initiatives, and linkages are established between tobacco prevention & control and chronic disease prevention & control efforts. This linkage would occur within the environments of Where We Work, Where We Live, Where We Learn, and Where We Receive Care.

VI. Arizona Chronic Disease Strategic Plan Vision and Framework

The vision guiding the Arizona Chronic Disease Strategic Plan is:

Arizona Communities Coming Together to Address Chronic Disease.

To meet this vision, stakeholders developed a strategic framework consisting of goals, objectives and strategies that has been organized into the following four areas:

- Where We Learn
- Where We Work
- Where We Live
- Where We Receive Care

Stakeholders believed that approaching chronic disease via these four areas would broaden the reach of current chronic disease efforts by simplifying the language associated with chronic disease and by providing strategies to address chronic disease in places in which people spend significant amounts of time. By targeting these four areas that reach many Arizonans living with or at risk for chronic disease, this approach appealed to stakeholders as it was considered to be comprehensive and population-focused.

The framework also incorporates elements from the following:

a) The CDC's following 4 domains:
   - Epidemiology and surveillance,
   - Environmental approaches that promote health and support and reinforce healthful behaviors (statewide in schools, worksites, and communities),
   - Health system interventions to improve the effective delivery and use of clinical and other preventive services in order to prevent disease, detect diseases early, and reduce or eliminate risk factors and mitigate or manage complications, and
   - Strategies to improve community-clinical linkages ensuring that communities support and clinics refer patients to programs that improve management of chronic conditions.

b) Other health improvement planning efforts including the community health assessments and community health improvement plans which are required components for public health accreditation. Although not all Arizona counties are applying for public health accreditation, each county is conducting a Community Health Assessment and a Community Health Improvement Plan.

With the four areas of where we live, learn, work and receive care serving as the foundation for the framework, the following goals were developed. These goals are consistent with the CDC's recommended approach to chronic disease and specifically incorporate language from the above-mentioned four domains.

Strategic Area	Goal
Where We Learn	Maximize environmental approaches (policy, system and environmental) that promote health and support and reinforce healthful behaviors in Arizona schools.
Where We Work	Maximize environmental approaches (policy, system and environmental) that promote health and support and reinforce healthful behaviors in Arizona worksites.
Where We Live	Maximize environmental approaches (policy, system and environmental) that promote health and support and reinforce healthful behaviors in Arizona communities.
	Improve clinical-community linkages ensuring that communities support and clinics refer patients to programs that improve management of chronic conditions.
Where We Receive Care	Foster health systems change to improve the effective delivery and use of clinical and other preventive services in order to prevent disease, detect diseases early, and reduce or eliminate risk factors and mitigate or manage complications.

An additional goal was created to reflect the growing emphasis on addressing chronic disease through a coordinated approach:

Strategic Area	Goal
Coordination	Fostering a coordinated approach to chronic disease that leverages resources and maximizes impact on health outcomes.

To achieve these goals, potential objectives and strategies that support chronic disease prevention and control in each of these areas were developed. When reviewing the following objectives and strategies it is important to note several things. One is that while some of these activities will be driven by the state or local health departments, others may be driven by Arizona's community-based organizations. During subsequent planning, role delineation and coordination will be critical.

Another thing to note is that although there are differences in each of the areas of where we live, learn, work and receive care, consistent themes also can be found in each of these areas. Specifically, community members felt that in order to meet the goals identified above, the following objectives needed to be reached *in each of the areas* of where we live, learn, work and receive care:

- Assess needs and develop priorities related to chronic disease prevention and control;
- Create or support at least one workgroup that focuses on implementing evidence-based initiatives;
- Increase the number of implemented evidence-based policy, systems and environmental change strategies that improve chronic disease prevention and control;
- Increase community-supported messaging related to chronic disease prevention and control initiatives; and
- Increase evaluation efforts.

One final thing to note is that in order to meet the need expressed by community stakeholders to provide options to address chronic disease, matrices organized by where we live, learn, work and receive care were developed and are discussed further in this document. Rather than presenting a "one size fits all" approach, these matrices provide options for communities to choose evidence-based, policy, systems and environmental change strategies that are best-suited to meet their needs. They can be found in Appendix B.

Strategic Area: Where We Learn

Goal: Maximize environmental approaches (policy, system and environmental) that promote health and support and reinforce healthful behaviors in Arizona schools.

Arizona schools reach millions of people each day including students, teachers and parents. Focusing on environmental approaches that promote health and support and reinforce healthful behaviors through tools such as policy and systems change provides the opportunity to have broad-reaching, cost-effective, sustained health impact on many people who live in our state. By making the healthy choice the easy choice, school environments can contribute to chronic disease prevention and control efforts and protect people's health throughout their lifetimes.

Objective 1: By 2015, increase the number of schools that have assessed their needs and developed priorities related to chronic disease prevention and control.

Throughout the chronic disease planning process, stakeholders emphasized the importance of needs assessments related to chronic disease prevention and control in schools. Strategies to meet this objective may include the following:

- Utilize the School Health Advisory Council (SHAC)/School Health Index (SHI) process to build capacity for communities to conduct school health assessments in their schools.
- Develop a collaborative team consisting of staff from the Department of Education, the Department of Health Services and key stakeholders that will create a matrix identifying state-level school health surveillance data by December 31, 2012.
- Collect and synthesize existing information and data sources that address community needs & priorities.
- Implement priorities identified within the School Health Improvement Plans (SHIP).

Objective 2: By 2015, create or support at least one workgroup (taskforce, coalition, etc.) that focuses on implementing evidence-based healthy school initiatives.

Stakeholders felt that engaging decision-makers to achieve participation and buy-in to the concept and process of creating healthy school environments would be very important in maximizing environmental approaches to creating healthier environments. As a result, creating or supporting a workgroup that consists of decision-makers was deemed to be a necessary step. Functioning as an advocate of healthy schools, this group would address needs, priorities and environmental solutions. Strategies to meet this objective may include the following:

- Identify supporting stakeholders and gatekeepers for one or more evidence-based school health initiative.

- Prioritize by subject, support and sector (region, district, etc) initiative(s) to be implemented.
- Convene (or attend existing) workgroup around selected initiatives and create timeline-to-implementation plan.

Objective 3: By 2015, increase the number of implemented evidence-based policy, systems and environmental change strategies that improve chronic disease prevention and control in Arizona schools.

Strategies to meet this objective may include the following:

- Create a library and menu of options of evidence-based policy, systems and environmental change strategies that are relevant to healthy school environments and align with CDC findings/recommendations. Update semi-annually. (A menu of options can be found in Appendix B.)
- Provide technical assistance to partners and stakeholders on how to choose and apply the menu of evidence-based strategies based on schools' identified needs, priorities and resources.
- Provide technical assistance, training and support to local school health coalitions and partners to facilitate advocacy and implement policy efforts.

Objective 4: Increase the number of schools that create and distribute community-supported messaging that targets and reaches those impacted by school environments.

Throughout all of the strategic areas, creating community-supported messaging that targets those affected by environmental change was identified as an objective. Stakeholders expressed a concern that there is a lack of awareness on health issues and environmental approaches to improving health outcomes which they felt is an essential component to being able to affect change. The following strategy was identified which may help meet this objective:

- Develop a marketing plan for improving school health that (1) includes the message that health is tied to academic achievement, (2) provides a clear message of what a healthy school environment is, (3) identifies the most effective messaging vehicles and methodologies to reach educational stakeholders and create buy-in, and (4) collaborates with other agencies (when possible) to maximize resources and reach.

Objective 5: Increase the number of schools that utilize evaluation methods to assess both processes and outcomes of their policy, systems and environmental change efforts in the area of creating healthier school environments.

To support this work in schools and to affect change, stakeholders recognized the need to evaluate efforts in order to maximize environmental approaches as well as health outcomes. Strategies to meet this objective may include the following:

- Develop a mechanism that has a limited number of variables to meaningfully share data and evaluation information to assist communities in creating healthy school environments.

- Assess existing evaluation resources to implement and incorporate these into evaluation processes.
- Develop evaluation training and resources that (1) encourage and empower communities to conduct evaluation, and (2) help communities and health departments implement policy, systems and environmental changes strategies.
- Research and identify data and evaluation sources.
- Develop a methodology to assess the Chronic Disease Prevention and Health Promotion (CDPHP) efforts in the area of healthy school environments and conduct annual evaluation of those efforts.

Strategic Area: Where We Work

Goal: Maximize environmental approaches (policy, system and environmental) that promote health and support and reinforce healthful behaviors in Arizona worksites.

As in schools, worksites provide the opportunity to reach many Arizonans and their families every day. Focusing on environmental approaches that promote health and support and reinforce healthful behaviors through tools such as policy and systems change can help employers reduce costs associated with healthcare, can maximize return on investment, and can result in a healthier workforce with a lower incidence of chronic disease.

Momentum to create healthier worksites continues to rise as employers face increasing costs associated with health care and health-related issues (e.g., absenteeism and presenteeism both of which affect productivity). In addition, there is an increased focus on healthy worksite initiatives as a result of the Affordable Care Act which, beginning on January 1, 2014, will allow group health plans to provide up to a 30% discount on health insurance premiums to employees who participate in a wellness program and/or meet certain criteria (non-smoker, for example). Currently, group health plans can only provide up to a 20% discount on health insurance premiums to employees in this area.

Objective 1: Increase the # of worksites that have assessed their needs and developed priorities related to chronic disease prevention and control.

Helping Arizona employers understand the issues they face related to their employees' health and wellness is considered to be a cornerstone in creating a healthy worksite initiative. Once employers develop an understanding of their biggest cost drivers related to health and wellness, they can then develop strategies to address those needs.

Strategies to meet this objective may include the following:

- Collect and synthesize existing information and data sources to assess needs & establish priorities to create healthy worksites.
- Identify and promote evidence-based health risk assessment practices that include a focus on chronic disease self-management
- Develop partnerships between business associations, business leaders and health departments to increase awareness and use of tool to assess needs.
- Increase the number of state employers that conduct a comprehensive health risk assessment for their employees.

Objective 2: Create or support at least one workgroup (taskforce, coalition, etc.) that focuses on implementing evidence-based healthy worksite initiatives.

Creating or supporting at least one workgroup was thought to be an important element in increasing participation in healthy worksite initiatives. Strategies to meet this objective may include the following:

- Identify business leaders.
- Convene stakeholders via symposiums and trainings, including small business associations as well as school boards.
- Create a strategy for employers to work with and mentor each other.
- Create a program that recognizes employers in the efforts to create healthy worksites.
- Prioritize by subject, support and sector (region, district, etc.) initiative(s) to be implemented.
- Convene (or attend existing) workgroup around selected initiatives and create timeline-to-implementation plan.

Objective 3: Increase the number of implemented evidence-based policy, systems and environmental change strategies that improve chronic disease prevention and control at worksites.

Strategies to meet this objective may include the following:

- Create a library and menu of options of evidence-based policy, systems and environmental change strategies that are relevant to healthy work environments and align with CDC findings/recommendations. Update semi-annually. (A menu of options can be found in Appendix B.)
- Provide technical assistance to partners and stakeholders on how to choose and apply menu of evidence-based strategies based on worksites' identified needs, priorities and resources.
- Provide trainings annually to Arizona employers on topics related to creating healthy worksite.
- Provide technical assistance, training and support to business associations, employers, and partners to facilitate advocacy and implement policy efforts.
- Identify priority businesses to target with healthy worksite initiatives.

Objective 4: By 2015, develop messaging which promotes the benefits of healthy worksites for Arizona employers.

Strategies to meet this objective may include the following:

- Develop a marketing plan for healthy worksites for the state and/or counties that includes a component that helps stakeholders understand the concept of worksite wellness/healthy worksites.

Objective 5: By 2015, increase the number of worksites that utilize evaluation methods to assess both processes and outcomes of their policy, systems and environmental change efforts to address chronic disease.

To support this work in worksites and to affect change, stakeholders recognized the need to evaluate efforts to maximize environmental approaches as well as health outcomes. Strategies to meet this objective may include the following:

- Develop a mechanism that has a limited number of variables to meaningfully share data and evaluation information to assist communities in creating healthy worksites.
- Assess existing evaluation resources to implement and incorporate these into evaluation processes.
- Develop evaluation training and resources that encourage and empower worksites to conduct evaluation.
- Research and identify data and evaluation sources.
- Develop a methodology to assess the Chronic Disease Prevention and Health Promotion (CDPHP) efforts in the area of healthy worksites and conduct annual evaluation of those efforts.

Strategic Area: Where We Live

Goal 1: Maximize environmental approaches (policy, system and environmental) that promote health and support and reinforce healthful behaviors in Arizona communities.

There are several factors which influence the health of populations, including the environment where people live. As decision makers such as city planners, mayors, council members and other public officials periodically assess the needs of Arizona's communities, factoring in how conducive the environment is to health outcomes is critical to the prevention and reduction of chronic disease in Arizona. Whether it is ensuring that:

- Communities have safe access to walking and biking paths, public recreation areas, and clean drinking water;
- Neighborhoods have access to nutritious and affordable food including but not limited to grocery stores, community gardens and farmers' markets or;
- Public transportation is readily available and affordable so individuals have a means to travel to primary care providers for screening and treatment of chronic disease;
- The environment in which one lives plays a major role in the overall outcome of one's health.

Objective 1: By 2015, increase the # of communities that have assessed their needs and developed priorities related to chronic disease prevention and control.

Strategies to meet this objective may include the following:

- Develop a strategy for AZ communities to conduct a community needs assessment.
- Collect and synthesize existing information and data sources that address community needs and priorities.
- Research methodologies for conducting needs assessments and identify recommended methodology.
- Engage community partners and stakeholders in the process of identifying needs and developing priorities.
- Build capacity to conduct health impact assessments.

Objective 2: By 2015, create or support at least one workgroup (taskforce, coalition, etc.) that focuses on implementing evidence-based healthy community initiatives.

Strategies to meet this objective may include the following:

- Identify community leaders who can play a role in healthy community design and are representative of the community as a whole.
- Develop a state agency coalition consisting of community leaders and include representatives from the Arizona Department of Transportation, the Arizona Department of Environmental Quality, and the Arizona Department of Education.
- Prioritize by subject, support and sector (region, district, etc) initiative(s) to be implemented.
- Convene (or attend existing) workgroup around selected initiatives and create timeline-to-implementation plan.

Objective 3: By 2015, increase the number of implemented, evidence-based policy, systems and environmental change strategies in the areas of community planning, transportation and land-use in Arizona communities.

Strategies to meet this objective may include the following:

- Create a library and menu of options of evidence-based policy, systems and environmental change strategies that are relevant to healthy community design and align with CDC findings/recommendations. Update semi-annually. (A menu of options can be found in Appendix B.)
- Provide technical assistance to partners and stakeholders on how to choose and apply menu of evidence-based strategies based on communities' identified needs, priorities and resources.
- Provide technical assistance, training and support to local coalitions and partners to facilitate advocacy and implement policy efforts.

Objective 4: By 2015, increase the number of communities that create and distribute community-supported messaging that targets and reaches those reaches those impacted by community design initiatives.

Strategies to meet this objective may include the following:

- Develop a marketing plan for healthy community design for the state and/or counties that includes use of (1) social media, (2) methods for engaging the community, and (3) strategies for normalizing the concept of incorporating health impact into the community planning process.
- Identify and implement an approach that incorporates community members into the process of creating and disseminating messages.

Objective 5: By 2015, increase the number of communities that utilize evaluation methods to assess both processes and outcomes of their PSE efforts in the area of creating healthier school environments.

Strategies to meet this objective may include the following:

- Develop a mechanism to meaningfully share data and evaluation information to assist communities in their healthy community design initiatives.

- Develop evaluation training and resources that (1) encourage and empower communities to conduct evaluation, and (2) helps communities and health departments understand how evaluation fits into the process of creating healthier communities.
  - Research and identify data and evaluation sources.
- Develop a methodology to assess CDPHP efforts in the area of healthy community design and conduct annual evaluation of those efforts.

Goal 2: Improve clinical-community linkages ensuring that communities support and clinics refer patients to programs that improve management of chronic conditions.

Objective 1: Create a "community support network" around each community health center.

Strategies to meet this objective may include the following:

- Invite both geographic and non-geographic support services that are available to constituencies to participate in a community health center "open house" to foster relationships between all community support entities available to the community using the CHC as a conduit.
- Track and monitor referral utilization and patterns.

Strategic Area: Where We Receive Care

Goal: Foster health systems change to improve the effective delivery and use of clinical and other preventive services in order to prevent disease, detect diseases early, and reduce or eliminate risk factors and mitigate or manage complications.

Health systems interventions improve the clinical environment to more effectively deliver quality preventive services and help Americans more effectively use and benefit from those services. The result: some chronic diseases and conditions will be avoided completely, and others will be detected early, or managed better to avert complications and progression and improve health outcomes. Health system and quality improvement changes such as electronic health records, systems to prompt clinicians and deliver feedback on performance, and requirements for reporting on outcomes such as control of high blood pressure and the proportion of the population up-to-date on chronic disease screenings can encourage providers and health plans to focus on preventive services. Effective outreach to consumers and reducing barriers to accessing these services is also key, as coverage alone will not ensure use of preventive services.[11]

Objective 1: By 2015, Increase the number of health care providers that have assessed their needs and develop priorities related to chronic disease prevention and control.

Strategies to meet this objective may include the following:

- Develop and/or identify methodologies for Arizona health care providers to assess needs and develop priorities related to chronic disease prevention and control.)
- Engage the U.S. Health and Human Services' Centers for Medicare and Medicaid Services (CMS) designated quality improvement organization (QIO) and the Health Resources and Services Administration's (HRSA) designated primary care association (PCA) in Arizona on increasing the

[11] Source: CDC Chronic Disease Prevention and Health Promotion Domains

implementation of organized systems of care which deliver high-quality clinical and other preventive services.

Objective 2: Create or support at least one workgroup (taskforce, coalition, etc.) that focuses on implementing evidence-based health care policy, systems and/or environmental changes.

Strategies to meet this objective may include the following:

- Convene a workgroup of primary care providers, Arizona's QIO and PCA representatives, AHCCCS (Arizona's Medicaid), federally qualified community health centers, and other stakeholders who will advance health system interventions at a statewide level.
- Conduct a Strength, Weaknesses, Opportunities, and Threat Analysis (SWOT) to identify environmental factors impacting the delivery of clinical preventive services to Arizona's uninsured and underinsured populations.

Objective 3: Increase the number of implemented evidence-based policy, systems and environmental change strategies that improve chronic disease prevention and control by health care providers

Strategies to meet this objective may include the following:

- Development of patient-centered team care approaches within primary care settings.
- Referral of patients with chronic diseases to community-based organizations offering evidence-based disease self-management education.
- Increased utilization of promotoras and patient navigators within community and clinical settings.
- Create a library and menu of options of evidence-based policy, systems and environmental change strategies that are relevant to healthy community design and align with CDC findings/recommendations. Update semi-annually. (A menu of options can be found in Appendix B.)

Objective 4: Develop community-supported messaging to increase utilization of preventive care within clinical settings.

Strategies to meet this objective may include the following:

- Use of small media and group education tactics focused around increasing population-based screening for certain chronic disease including breast, cervical, and colorectal cancers; diabetes, and hypertension.
- Increased use of culturally appropriate and sensitive messaging amongst Arizona's Native American, African American, Asian – Pacific Islander, and Spanish speaking populations.

Objective 5: Increase the number of health care providers that utilize evaluation methods to assess both processes and outcomes of their PSE efforts to address chronic disease.

Strategies to meet this objective may include the following:

- Utilization of systems which ensure adequate follow-up for abnormal screening tests, and timely treatment.
- Provider assessment and feedback interventions on the basis of sufficient evidence of effectiveness in increasing screening for chronic condition.

Strategic Area: Coordination

Goal: Foster a coordinated approach to chronic disease that leverages resources and maximizes impact on health outcomes.

Fostering a coordinated approach to chronic disease is important for many reasons. One is that coordination provides the opportunity to address common risk factors and leverage program-specific resources which, in turn, can provide greater returns. Additionally, the CDC has been emphasizing the importance of coordinating efforts to address chronic disease which could impact future funding.

Movement towards a coordinated approach to chronic disease has begun at the state level at the Arizona Department of Health Services (ADHS), but there is still much work that needs to be done both in health departments and in the community to make this a success.

Objective 1: Create a statewide strategic action plan addressing chronic disease in Arizona. (To be completed in Fall 2012)

Strategies to meet this objective may include the following:

- Convening of a Collaborative Leadership Team (CLT) which includes representation of both government and non-government stakeholders.
- Identification of resources and capacity in Arizona to address and meet Arizona's populations' needs.
- Increased identification of chronic disease burden in Arizona.
- Develop and implement an effective communication plan which educates Arizona decision makers and populations on the burden of chronic disease and evidence-based approaches to address burden.

Objective 2: By 2015, develop a chronic disease burden report.

Strategies to meet this objective include the following:

- Define width and breadth of "chronic diseases" to be addressed in a coordinated approach.
- Conduct chronic disease data inventory to establish burden baselines across all reputable and reliable sources to measure effectiveness over 3-year strategic plan.

Objective 3: By 2015, develop a framework to evaluate coordinated approaches to chronic disease.

Strategies to meet this objective include the following:

- Utilizing data selected for each chronic condition to be measured, establish baselines in burden or system-related areas of intervention.

Objective 4: By 2015, develop a statewide chronic disease coalition.

Strategies to meet this objective include the following:

- Recruit steering/selection committee to form structure and membership of chronic disease coalition.
- Establish Chronic Disease Coalition framework of tasks and expected outcomes.
- Recruit appropriate membership with clear levels of commitment.

VII. Matrix of Potential Strategies

As was mentioned earlier, a key component involved in developing Arizona's Chronic Disease Strategic Plan has been working collaboratively with partners to align simultaneous planning and data collection efforts. As Arizona counties work to conduct a community health assessment (CHA) and, from that, develop a community health improvement plan (CHIP), the chronic disease team aimed to provide a framework in which communities could choose the evidence-based strategies that would best suit the needs and health priorities that they identify.

To accomplish this, the chronic disease team worked with the Maricopa County Department of Public Health (MCDPH) to create matrices from which Arizona communities can choose their evidence-based strategies to address chronic disease prevention and control. These matrices are organized by strategic area (Where We Live, Learn, Work, and Receive Care), by risk factor, by chronic disease, and by level on the Prevention Institute's Spectrum of Prevention. This approach acknowledges the efforts that communities are investing to address their health needs, and it provides evidence-based options that are based on the most recent research findings.

During Fall 2012 these matrices will be used by the Collaborative Leadership Team on the development of the Arizona Chronic Disease Action Plan. (Please see Appendix B for an Evidence-Based Matrix.)

VIII. Evaluation of Coordinated Chronic Disease

Program evaluation staff will regularly collect data to determine the degree to which stakeholders at the state and local level are implementing the Arizona Chronic Disease Strategic Plan. More specifically, staff and partners will assess the degree to which:

1) A coordinated multi-disciplinary approach is established and maintained to address chronic disease issues in Arizona, at the local and state level.
2) Local communities use strategic planning processes and clearly defined logic models to develop action plans that detail selected strategies, activities, timelines and measurable objectives to address chronic disease "where we live, work, go to school, and receive care."
3) Local action plans include steps to more effectively and efficiently collect and regularly use data to support: a) accurate determinations of burden; b) early detection of disease; c) efficient and effective coordination of care; and d) reductions in community risk factors.
4) Local communities integrate the following components into their action plans to address chronic disease:
    a. training and skill building of stakeholders;
    b. Evidence-based practices;
    c. Environmental approaches in their chronic disease action plans; and
    d. Strategies to reduce disparities in access to health care.
5) Local community plans are regularly reviewed and updated.

This process evaluation will have two components, one focused on stakeholder group functioning and the second focused on the planning process.

<u>Measurement tools and administration timeline</u>
The following tools will be used to monitor the process variables.

Table XX: Process measurement tools and data collection schedule

Measurement Tool	How will data be collected?	Who will collect?	When will it be collected?
Attendance logs	An identified stakeholder group leader will circulate attendance log during each meeting/session	Stakeholder group leader will collect and store	At every meeting/ session
Group meeting notes	Meeting minutes will be taken at each stakeholder meeting/session	Stakeholder group leader will collect and store	At every meeting/ session
Stakeholder group functioning scale	Group functioning measures will be collected through an on-line survey distributed to all known stakeholder participants	On-line survey	Twice annually
Stakeholder member satisfaction scale	Satisfaction survey data will be collected though an on-line survey distributed to all known stakeholder participants	On-line survey	Twice annually
Document (Plan) review	The evaluator will request a copy of the updated plan from the stakeholder group leader twice annually	Stakeholder group leader will send to evaluator	Twice annually
Interviews	Evaluator will conduct up to 20 stakeholder interviews each year.	Evaluator	In December and May

Data Analysis
A database will be developed to store all collected information.

The evaluator will work with ADHS staff to determine the optimal stakeholder sectors to be represented in the local planning processes. The evaluator will use this sector list to assess the degree to which stakeholder sectors are fully represented in the planning process. Care will be taken to recognize differences in the availability of stakeholder representative based on size of community and geographic setting (e.g., rural, suburban, and urban).

Survey responses will be analyzed using descriptive statistical procedures (e.g. totals, percentages, averages, and other quantitative methods). Text documents will be analyzed using content analysis to identify themes.

In the process of conducting record review, the evaluator will quantify data to demonstrate the numbers of participants and levels of satisfaction, and use content analysis of qualitative information to identify themes that can inform program improvements.

Data Reporting

Written and multi-media summaries of findings will be disseminated at least annually to specific stakeholder groups and to ADHS and its partners. Annually, the evaluator will also be available to facilitate a process by which local communities and the state use the findings to inform their initiatives.

IX. Advancing the Arizona Chronic Disease Strategic Plan

During the fall of 2012, both government and non-government stakeholders from across Arizona will convene to develop the Arizona Chronic Disease Action Plan. A key part of this process will be the identification of what resources are available in Arizona to address the many needs and burdens around chronic disease. Included within this resource assessment will be a review of categorical programs and budgets, identification of new revenue opportunities, and identification of new public-private partnerships in which funding can be leveraged.

In addition to development of the Arizona Chronic Disease Action Plan, during the next three years ADHS will seek ways in which it can provide additional guidance and technical assistance to communities as they advance the strategies within Where We Work, Where We Live, Where We Learn, and Where We Receive Care. In turn, ADHS will also seek technical assistance from community partners, recognizing that in order to successfully address chronic disease Arizona's many communities and partners will need to come together.

Finally, ADHS and the community partners engaged in the development of the Arizona Chronic Disease Strategic Plan recognize that success will only be achieved as long as effective and efficient communication occurs between partners and key decision makers. Therefore, a key component of the subsequent communication plan will be the development of communication mediums which accurately translate the burden of chronic disease into tools which can be used by communities, decision makers, and those working within public health policy. These tools could include data-briefs, dashboards, burden synopsis documents, as well as other educational materials which can be used when decisions are made within the areas of Where We Work, Where We Live, Where We Learn, and Where We Receive Care.

X. Appendices

Appendix A: CDC Chronic Disease Prevention and Health Promotion Domains

Appendix B: Evidence-Based Strategies Impact Chronic Disease and Health Promotion Matrix

Appendix A - Chronic Disease Prevention and Health Promotion Domains

Chronic disease public health practitioners must make measurable contributions to the prevention and control of chronic disease – and by doing so, improve quality of life, increase life expectancy, improve the health of future generations, increase productivity and help control health care spending.

It is increasingly recognized that individual health depends on societal health and healthy communities. In addition to having strong medical care systems, healthy communities promote and protect health across the lifespan, across a variety of sectors, and through a range of policies, systems and environmental supports that put health in the people's hands and give Americans even greater opportunity to take charge of their health.

Transforming the nation's health and providing Americans with equitable opportunities to take charge of their health requires work within four key domains.

Domain 1: Epidemiology and Surveillance: Gather, analyze, and disseminate data and information and conduct evaluation to inform, prioritize, deliver, and monitor programs and population health.

Making the investment in epidemiology and surveillance provides states with the necessary expertise to collect data and information and to develop and deploy effective interventions, identify and address gaps in program delivery, and monitor and evaluate progress in achieving program goals. Data and information come with the responsibility to use it routinely to inform decision makers and the public regarding the effectiveness of preventive interventions and the burden of chronic diseases and their associated risk factors, public health impact, and program effectiveness. The need to publicize widely the results of states' work in public health and demonstrate to the American people the return on their investment in prevention has never been greater.

Examples of Activities

- Collect appropriate data to monitor risk factors and chronic conditions of interest through surveillance systems (such as the BRFSS, NPCR and other cancer screening data systems, Vital Statistics, and Medicare data sets), rapidly develop and disseminate data reports in easy-to-use and understand formats, describe multiple chronic conditions, and use data to drive state and local public health action.
- Conduct surveillance of behavioral risk factors, social determinants of health, and monitor environmental change policies related to healthful nutrition, physical activity, tobacco, community water fluoridation, and other areas.
- Collect cancer surveillance data to assess cancer burden and trends, identify high risk populations, and guide planning and evaluation of cancer control programs (e.g., prevention, screening and treatment efforts).
- Conduct youth and adult surveillance of tobacco-related knowledge, attitudes and behaviors (ATS/NATS, YTS/NYTS); translate and disseminate data and information for action.
- Collect, use, and disseminate data on oral diseases and risk factors and use of preventive oral health services.

- Examine administrative datasets for factors associated with risk for all-cause and cardiovascular disease mortality.
- Conduct surveillance of health behaviors and policies for women before, during, and after pregnancy using the Pregnancy Risk Assessment Monitoring System (PRAMS) to translate and disseminate data for action and collaborate with state PRAMS coordinators in using findings for program strategies and policies as appropriate.
- Link administrative, vital records, and hospital discharge data to conduct surveillance on the prevention of preterm births and pregnancy complications.

Domain 2: Environmental approaches that promote health and support and reinforce healthful behaviors (statewide in schools, worksites, and communities).
Improvements in social and physical environments make healthy behaviors easier and more convenient for Americans. A healthier society delivers healthier students to our schools, healthier workers to our businesses and employers, and a healthier population to the health care system. These types of interventions support and reinforce healthy choices and healthy behaviors and make it easier for Americans to take charge of their health. They have broad reach, sustained health impact and are best buys for public health.

<u>Examples of Activities</u>

Expand access to and availability of healthy foods and beverages through a variety of strategies, including:

- Nutrition standards for food and beverages offered in settings including state, local and tribal governments, private sector businesses, schools, child care and education facilities, senior centers and other facilities serving older adults, and other settings.
- Accessible, available, and affordable healthful foods in communities, including provision of full service grocery stores, farmers markets, small store initiatives, mobile vending carts, and restaurant initiatives.
- Comprehensive school strategies to promote healthful nutrition, such as:
    - Implementing IOM recommendations on competitive foods (e.g., vending or a la carte items);
    - Increasing access to healthy foods and beverages in schools through a variety of strategies, such as offering drinking water free of charge throughout the day and implementing farm-to-school initiatives.

Promoting increased physical activity through a variety of strategies, including:

- Increasing the amount of daily, quality physical education in schools;
- Increasing the amount of daily physical activity through standards in early care/after school settings;
- Increasing access to physical activity for employees through worksite wellness initiatives;
- Facilitating joint use agreements to increase the number of safe, accessible places for physical activity in communities;
- Implementing strategies for the built environment that promote active transportation (e.g., complete street designs, safe routes to school programs, promoting bicycling as a mode of transportation, health impact assessments).

Reducing tobacco use, preventing youth initiation, and eliminating exposure to secondhand smoke through a variety of evidence-based strategies, including:

- Comprehensive smoke-free air policies in workplaces and public places; smoke-free policies in multi-unit housing and outdoor areas; and tobacco-free campus policies for colleges, workplaces, and health care settings, among others;
- Strategies to reduce youth access to tobacco products (e.g., reducing the affordability, availability, and visibility of tobacco products).

Increasing the proportion of the U.S. population served by community water systems with optimally fluoridated water.

Domain 3: Health system interventions to improve the effective delivery and use of clinical and other preventive services in order to prevent disease, detect diseases early, and reduce or eliminate risk factors and mitigate or manage complications.

Health systems interventions improve the clinical environment to more effectively deliver quality preventive services and help Americans more effectively use and benefit from those services. The result: some chronic diseases and conditions will be avoided completely, and others will be detected early, or managed better to avert complications and progression and improve health outcomes. Health system and quality improvement changes such as electronic health records, systems to prompt clinicians and deliver feedback on performance, and requirements for reporting on outcomes such as control of high blood pressure and the proportion of the population up-to-date on chronic disease screenings can encourage providers and health plans to focus on preventive services. Effective outreach to consumers and reducing barriers to accessing these services is also key, as coverage alone will not ensure use of preventive services.

<u>Examples of Activities</u>

- Delivery of high-quality screening for breast, cervical, and colorectal cancers that promotes high rates of appropriate use, including timely referral and follow-up.
- Organized systems of care to deliver high-quality clinical and other preventive services (as recommended by the U.S. Preventive Services Task Force and the Community Guide):
    - Electronic health records with registry function, decision support, and electronic reminders;
    - Team-based care;
    - Population care across panel of patients;
    - Systems to ensure adequate follow-up of abnormal screening tests, and timely treatment;
    - Patient-centered medical and dental home.
- Health care information systems with automated physician prompts or patient reminder letters for screening and follow-up clinical counseling or referral.
- Quality improvement of clinical care for cancer screening and control of A1C, blood pressure, BMI, and cholesterol.

- Birthing hospitals using Baby Friendly Hospital Initiative policy recommendations and implementing "Ten Steps for Successful Breastfeeding in Hospitals."
- Delivery of smoking cessation services and treatments - including providing quitline coaching and cessation treatments as covered benefits.
- Increase access to and use of clinical and preventive oral health services
- Provision of quality, accessible, and confidential family planning services, including contraceptive methods and services.

Domain 4: Strategies to improve community-clinical linkages ensuring that communities support and clinics refer patients to programs that improve management of chronic conditions. Such interventions ensure those with or at high risk for chronic diseases have access to quality community resources to best manage their conditions or disease risk.

Community-clinical linkages help ensure that people with or at high risk of chronic diseases have access to community resources and support to prevent, delay or manage chronic conditions once they occur. These supports include interventions such as clinician referral, community delivery and third-party payment for effective programs that increase the likelihood that people with heart disease, diabetes or prediabetes, and arthritis will be able to "follow the doctor's orders" and take charge of their health – improving their quality of life, averting or delaying onset or progression of disease, avoiding complications (including during pregnancy), and reducing the need for additional health care.

<u>Examples of Activities</u>

- Available, accessible arthritis, diabetes, chronic disease self-management education programs, including physical activity programs, to reach at risk populations in community settings, such as worksites, YMCA/YWCAs, schools, senior centers, and other local organizations.
- Increase use of the CDC-approved evidence-based lifestyle change program to prevent or delay onset of type 2 diabetes among people at high risk.
- Implement systems to increase provider referrals of people with prediabetes or multiple diabetes risk factors to sites offering the CDC-approved lifestyle change program.
- Use of allied health professionals to enhance management of high blood pressure/cholesterol, A1C (e.g., pharmacist and/or dental provider model).
- Use of allied health providers (nurses, dentists, etc.), community health workers, and/or patient navigators in supporting control of high blood pressure, high cholesterol, and A1C.
- Develop guidelines and systems within clinical care and community settings to address cancer survivorship by ensuring appropriate follow up care and promoting lifestyle interventions to reduce risk of recurrence.
- Effective outreach to the population to increase use of clinical and other preventive services.
- Delivery of school-based dental sealant programs.
- Safe and effective use of contraception appropriate for women and men with chronic medical conditions.
- Coverage/reimbursement for diabetes self-management education and chronic disease self-management support programs.

Evidence-based Strategies Impacting Chronic Disease

Where We Live	Topic	Spectrum of Prevention	CDC Domain	Source	EBP Status (with external link)	Alternative EBPs (with external link)
Provide incentives to food retailers to locate and/or offer healthy food and beverage choices in underserved areas to improve availability of healthy food options.	N	1 2	2	Community	Recommended	
Create public/private partnerships to open and sustain full-service grocery stores in communities without access to healthy food.	N	3	2	Community	Recommended	
Community partnerships and collaboration that helps incentivize and encourage convenience stores and bodegas to offer healthy food options.	N	3	2	Community	Recommended	
Education programs and campaigns to increase and enhance application of nutrition information on menus (chain restaurants, publicly funded property) and informed use of info by customers to encourage healthy eating.	N	1	2	Community	Promising practice	
Increase accessibility, availability, affordability, and identification of healthful foods in communities, including provision of full service grocery stores, farmers markets, small store initiatives, mobile vending cars, and/or restaurant initiatives.	N	1 2	2	Comm + PHPI		
Provide incentives to food retailers to locate and/or offer healthy food and beverage choices in underserved areas to improve availability of healthy food options.	N	2	2	Community	Recommended	
Improve geographic availability of fresh food vendors.	N	1	2	Community	Recommended	
Impose portion limits in restaurants.	N	1	2	Community	Non-EBP	Similar: Incentivize and encourage restaurants to offer reasonably sized portions and low fat or low calorie menus
Provide incentives to produce and procure healthy foods from local farms.	N	1	2	Community	Recommended	
Establish sites for community gardens in institutional settings and/or underserved areas.	N	2	2	PHPI County Doc		
Promoting affordable healthy food and beverage: improve geographic availability of supermarkets in underserved areas in order to increase access to healthy food.	N	6	2	Community	Recommended	
Industry develops and adheres to marketing and advertising guidelines that minimize the risk of obesity for youth.	N	1 2	2	Community	Promising practice	
Food and beverage companies use creativity, resources, and marketing to advertise and promote healthful diets for children and youth.	N	1	2	Community	Promising practice	
List main ingredients.	N	2	2	Community	Non-EBP	
Food served or sold in government facilities (including schools, prisons, administrative buildings) meets the USDA guidelines for Americans.	N	2	2	Community	Promising practice	
Soda excise taxes to reduce consumption of soda while raising revenue (with proceeds going to Medicaid, higher education, or public health prevention programs).	N	1	2	Community	Promising practice	
Strategies to create safe communities that support physical activity: zone for mixed-use development.	P	1	2	Community	Recommended	
Community-wide campaigns and multicomponent strategies to increase physical activity and physical fitness.	P	1	2	Community	Recommended	
Strategies to create safe communities that support physical activity: improve access to public transportation.	P	1 2	2	Community	Recommended	
Interim land use policies that promote nutrition and physical acitvity: permit use of vacant lots for gardens, recreational space, or public art displays.	P N	1 6	2	Community	Promising practice	

Evidence-based Strategies Impacting Chronic Disease

Where We Live	Topic	Spectrum of Prevention	CDC Domain	Source	EBP Status (with external link)	Alternative EBPs (with external link)
Strategies to create safe communities that support physical activity: enhance personal safety in mixed use areas.	P	1	2	Community	Recommended	
Require a min% of highway funds to be allocated for walkways & bike paths.	P	1	2	Community	Promising practice	
Enhance infrastructure to support biking.	P	1	2	Community	Recommended	
Enhance infrastructure to support walking.	P	1	2	Community	Recommended	
Promote active lifestyeles: facilitate joint-use agreements between communities and schools.	P	3	2	Community	Recommended	
Creation of, or enhanced access to places for physical activity combined with information outreach to increase physical activity and fitness levels.	P	1	2	Community	Recommended	
Establish community design standards to make streets safe for all users, including pedestrians, bicyclists, and user of public transit.	P	1	2	Comm + PHPI		
Establish community design protocols through Health Impact Assessment's (HIA's) to assess the impact of community design changes on community health and wellbeing.	P	1	2	Comm + PHPI		
Increase tobacco use cessation: mass media campaign combines with other interventions.		6	2	Community	Recommended	
Reducing tobacco use initiation: mass media campaign combined with other intervention to raise tobacco prices, provide school-based education, or other community-based education program.	T	6	2	Community	Recommended	
Use of online networks and resources (viral marketing, social networks, and blogs) for targeted, tailored tobacco control messaging.	T	6	2	Community	Recommended	
Increase tobacco use cessation: increasing unit price of tobacco products.	T	1	2	Community	Recommended	
Reducing tobacco use initiation: increasing unit price of tobacco products to reduce use among adolescents and adults, reduce population level consumption, and increase cessation.	T	1	2	Community	Recommended	
Tobacco free living: policies that prohibit smoking or all tobacco products on residential, commercial, or health care facility properties.	T	1 2		Community	Recommended	
Reducing secondhand smoke exposure: smoking bans and restrictions, used alone or as part of a multicomponent community or workplace intervention.	T	1	2	Community	Recommended	
Restricting minors' access to tobacco products: sales laws directed at retailers, implemented alone.	T	1	2	Community	Insufficient Evidence	
Restricting minors' access to tobacco products: community mobilization combined with additional interventions (laws, enforcement, reatailer education).	T	3	2	Community	Recommended	
Support and/or facilitate tobacco prevention and/or control coalition developments, and links to related coalitions with shared goals	T	3	2	Community	Recommended	
Social media to increase health services utilization per ACA.	A	2	2	Community	Non-EBP	Similar: Mass media interventions to increase health services utilization
Outreach strategies that expand health insurance coverage among eligible children.	A	6	2	Community	Promising practice	
Promote insurance coverage to include tobacco use treatment.	T	1 2	3	Community	Recommended	

Evidence-based Strategies Impacting Chronic Disease

Where We Live	Topic	Spectrum of Prevention	CDC Domain	Source	EBP Status (with external link)	Alternative EBPs (with external link)
Improve tobacco cessation incentives.	T	1	3	Community	Non-EBP	
Specialist outreach programs and outreach clinics to improve access to care, quality of care, health outcomes and patient satisfaction.	A	2	3	Community	Promising practice	
Multicomponent interventions targeting health professionals and health organizations at primary care, outpatient, or community settings that increase continuity of care and diabetes management.	A	2	3	Community	Recommended	
Self-management education programs led by lay leaders for people with chronic conditions.	A	5	3	Community	Promising practice	
Fund SNAP programs.	N	1	4	Community	Non-EBP	Similar: Fund and design WIC and SNAP (food stamps) to meet the needs of hungry families that supports nutritious choices
Promote inclusion of focus on children and youth/young adults with special health care needs when addressing procurement policy.	P	1	4	PHPI County Doc		
Multiple risk factor interventions using counseling and educational methods aimed at behavior change to reducing coronary heart disease mortality in high-risk hypertensive and diabetic populations.	T	6	4	Community	Promising practice	
Tobacco cessation: expand and tailor culturally competent quit line services for diverse populations and languages.	T	6	4	Community	Promising practice	
Obesity prevention and control: technology supported multicomponent coaching or counseling interventions to reduce weight.	A	2	4	Community	Recommended	
Implement chronic disease-based treatment protocols and/or self management programs.	A	6	4	Comm + PHPI		