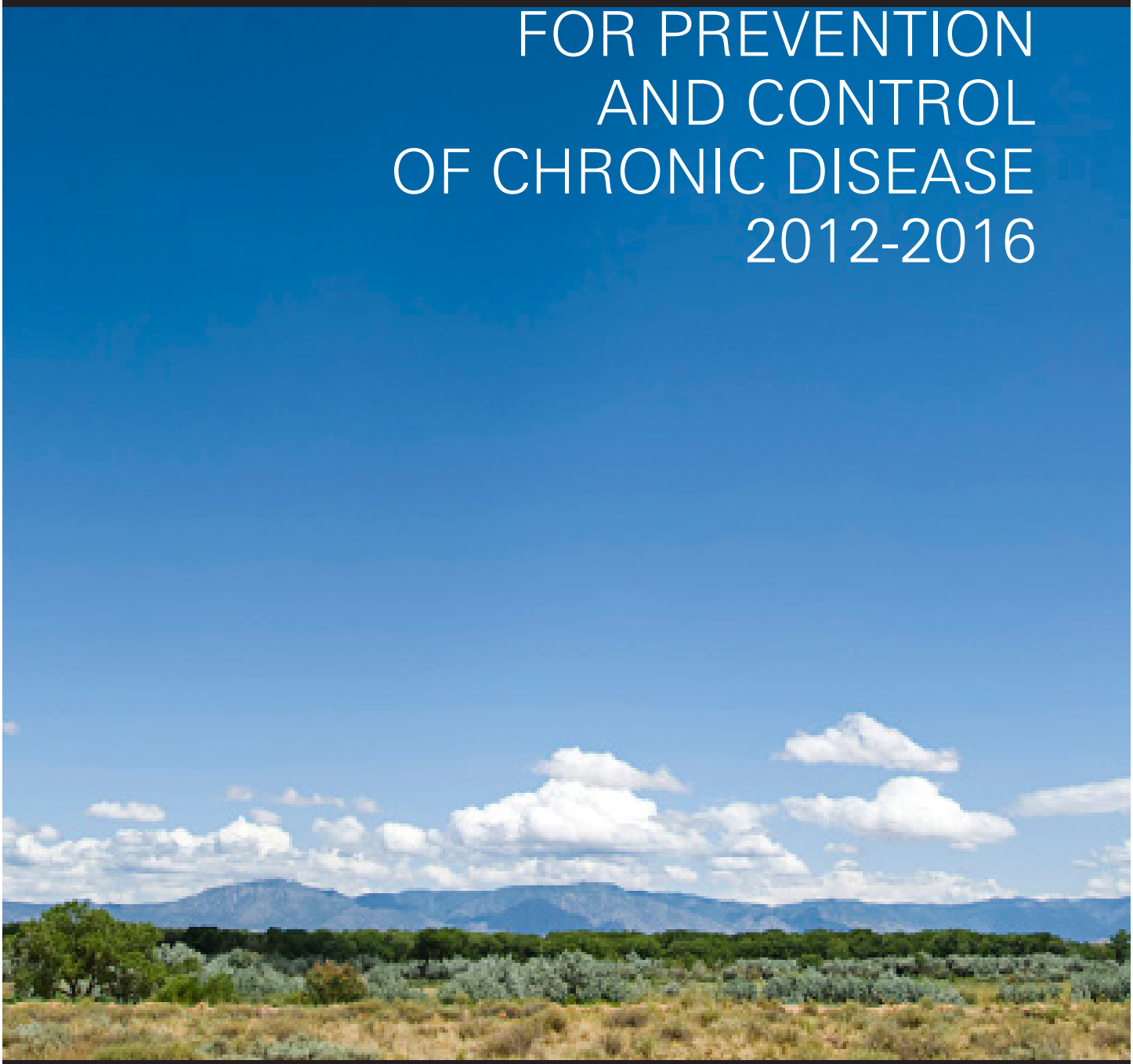
NEW MEXICO SHARED STRATEGIC PLAN

FOR PREVENTION AND CONTROL OF CHRONIC DISEASE 2012-2016



CDPC NM CHRONIC DISEASE PREVENTION COUNCIL

www.chronicdiseasenm.org
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Executive Summary

The New Mexico Shared Strategic Plan (NMSSP) for Prevention and Control of Chronic Disease is a response to the increasing health needs of New Mexicans. Chronic diseases constitute the majority of the leading causes of death in New Mexico and are responsible for over 60% of all deaths in the state. In addition to escalating medical costs, chronic diseases generate significant costs due to absenteeism and decreased productivity in the workplace. Many New Mexicans suffer from multiple chronic diseases, and as the population ages, the trend is expected to increase. The NMSSP focuses on lessening the burden of chronic disease by addressing cancer, diabetes, heart disease and stroke as well as the risk factors of tobacco use, obesity, and arthritis.

The NMSSP promotes prevention strategies, and aims to improve health at both the individual and community level. The priorities and objectives in the NMSSP are correlated with one or more of the four domains established in 2012 by the Centers for Disease Control and Prevention:


epidemiology and surveillance


strategies that support and reinforce healthful behaviors


health systems interventions


community-clinical linkages enhancement

The NMSSP includes disease and risk-factor specific priorities and objectives, as well as priorities and objectives shared between diseases. One of the diabetes specific priorities is to actively implement best practices that are known to work in communities statewide to stop the progression of pre-diabetes to diabetes. Some of the objectives listed under this priority are focused on health systems interventions, which will improve the effective delivery of clinical services to prevent chronic diseases. Others have a community-clinical linkage to ensure that communities' support and clinics refer patients to programs that improve management of chronic conditions. Lead organizations, who are already doing related work and who share common goals, will provide leadership on the priorities and objectives. The Healthier Weight Council Complete Streets Leadership Team and the New Mexico Arthritis Alliance are examples of current lead organizations.

An example of a shared strategic objective is the collaboration of the New Mexico Chronic Disease Prevention Council (CDPC) with transportation, public health, community and other partners to strengthen transportation policy that promotes physical activity and implementation of these policies at state, tribal, and local levels. Innovative partnerships such as those needed to move this priority forward will result in a more collaborative approach. Additionally, the NMSSP seeks to address the issues of health equity and social determinants of health, integral to chronic disease prevention and control. One of the CDPC's objectives is to partner with at least four community organizations by 2015 to raise awareness among policy makers of the interdependence between educational achievement, income, and health.

The CDPC is facilitating the implementation of the NMSSP. The CDPC was formed in 1997 as a multidisciplinary body of experts seeking to reduce chronic disease in New Mexico. Members from lead organizations, including transportation, education, and housing, as well as representatives from traditional health organizations, will provide valuable expertise and diverse perspectives, guiding the implementation of the NMSSP by building statewide partnerships. The council, as a forum of collaboration and communication, will ensure the success of the plan.

The NMSSP will be implemented between 2012-2016 with progress tracked and evaluated by the CDPC. Quarterly meetings and communication activities, including a website (www.chronicdiseasenm.org), will serve as a forum to highlight members' NMSSP related work. The plan will be shared with the public to help influence advocacy efforts and legislation related to chronic disease. The New Mexico Shared Strategic Plan for Prevention and Control of Chronic Disease will empower New Mexicans to make changes to create healthier communities, reducing the burden of chronic diseases throughout the state.

Why a Shared Plan?

Within the public health community, there is now a better understanding of which risk factors have the most impact on the development of chronic disease.* These risk factors could be considered "equal opportunity" in that they contribute to the development of a variety of chronic conditions and behaviors that affect millions of people worldwide, including arthritis, cancer, diabetes, cardiovascular disease (e.g., heart disease and stroke), obesity, poor nutrition, physical inactivity, and tobacco use. In addition to escalating medical costs, chronic diseases generate significant costs due to absenteeism and decreased productivity in the workplace. The impact is staggering on all levels - personal, societal, and financial.

The relatively new concept of health equity* is an important consideration for chronic disease prevention and control. In our society, wealth is the strongest predictor of health and longevity.[1] Income plays a significant role in the development of chronic disease, as well as in the likelihood of using tobacco. People living in poverty are more likely to use tobacco and develop cardiovascular disease (CVD) and diabetes.[2] A recent study found that living at less than 200% of the federal poverty level imposes a greater societal health burden in the US than either using tobacco or being obese.[3]

In addition to income and education and their impact on the development of chronic disease, arthritis, cancer, CVD, diabetes, obesity, poor nutrition, physical inactivity, and tobacco use interact with each other to result in poor health outcomes. CVD is the most common complication of diabetes. In addition, smoking and secondhand smoke adversely affect people at risk for and with diabetes and CVD. People with diabetes who smoke are up to 12 times more likely to die from CVD than people without diabetes who do not smoke. There is also mounting evidence that smoking may play a role in the development of type 2 diabetes.

Consequently, in New Mexico, as well as the rest of the country, "business as usual" is no longer an option. This understanding led to the creation of the New Mexico Shared Strategic Plan for Prevention and Control of Chronic Disease.

Many of the most effective strategies for reducing chronic disease are also shared across chronic diseases. As a result of cross-cutting risk factors, common prevention and control strategies, limited resources, and skyrocketing health care costs, there is a trend at both state and national levels to coordinate across "disease specific" programs and with multiple and diverse partners. This is coupled with a much needed movement to implement policy, system, and environmental changes that support individual behavior change. Providing effective programs that improve the health behaviors of individuals in conjunction with higher impact policy, system, and environmental changes is more successful than simply offering these programs on their own. Individuals will be less successful in maintaining a healthy lifestyle when they live in an environment that is not conducive to positive behavior change. Clean indoor air laws are an excellent example of this – not only do they help people quit smoking, they also reduce exposure to secondhand smoke for the population at large. Furthermore, this change in policy is more effective when widely available smoking cessation services are also offered. Clean indoor air policies, walkable communities, access to healthy food, and safe and available physical activity options are all examples of larger impact strategies that help individuals make and sustain behavior change.

This plan to prevent and manage arthritis, cancer, diabetes, heart disease, stroke, obesity, poor nutrition, physical inactivity, and tobacco use requires the diverse expertise, skills, and perspectives of traditional and non-traditional partners including public health, education, transportation, health care, and others, working beyond individualized special interests. The partnerships and strategies included in this plan are crucial to making a substantial and sustainable impact on chronic disease in New Mexico. In addition to improving long-term health outcomes, the implementation of this shared strategic plan will wisely and effectively use public resources.

* Terms with asterisks can be found in the definition section starting on page 24.

Strategic Planning Process Overview

To respond to the health status and needs of New Mexicans with regard to diabetes, heart disease, stroke, and tobacco use, a group of state leaders first convened in August 2010 to create a strategic process that would work across diseases and risk factors. While it necessarily included relevant information about these individual conditions, the larger issues of leadership and inclusion were essential to a comprehensive statewide approach.

The initial meeting started with a review of public health surveillance data demonstrating the current burden of diabetes, tobacco use, CVD, and their intersecting influences in New Mexico (see Appendix A). A Leadership Team was established to oversee the process and set direction, while a broader Strategic Planning Group was recruited to provide key input and feedback, listed on page 1. In considering the challenges of implementation, the New Mexico Chronic Disease Prevention Council (NMCDPC) was asked to facilitate the application of the plan. Proving to be an excellent fit by creating additional impact, NMCDPC accepted the role.

During 2010 and 2011, these groups met several times for strategic thinking and dialogue that led to essential decision-making. Interim work by a number of sub-groups performed much of the detailed writing and review tasks.

The Importance of Oral Health

In 2014, the Office of Oral Health brought the lack of oral health presence in the NMSSP to the attention of the Chronic Disease Prevention Council and it was decided that an oral health aspect should be added. As the Office of the Surgeon General stated in 2004 oral health is integral to overall health and well-being. Not only is oral health important in and of itself, evidence has shown oral health is important in the prevention and control of chronic diseases. Poor oral health is associated with major chronic diseases, and a chronic disease can lessen with good oral health and can worsen with poor oral health.

It is important to note that oral diseases are largely preventable. The most common oral diseases are caries (tooth decay) and periodontitis (also known as gum disease). Periodontitis is inflammation affecting the tissues that surround and support the teeth. Both can be prevented by practicing good oral hygiene. Approximately 70% of adults have periodontal disease. Tobacco use contributes to the incidence of oral and pharyngeal cancers. Dental caries is the most common chronic disease of children.

Oral health issues and major diseases share common risk factors. There are many studies documenting the link between periodontal disease and other chronic diseases. A few are included below.

Arthritis: Research projects have found a link between oral health and rheumatoid arthritis. Arthritis is more prevalent in people who have periodontitis. A recent study has shown the presence of a particular enzyme in periodontal disease is linked to joints becoming painful and swollen. People with rheumatoid arthritis are more likely to have poor oral hygiene, which can lead to periodontal disease.

Cancer: Certain reactive proteins from periodontal inflammation have been linked to pancreatic cancer.

Diabetes: There is a two-way relationship between periodontitis and diabetes. Periodontitis increases the severity of diabetes, and severe diabetes is a risk factor for severe periodontitis. Adults over age 45 who have poorly controlled diabetes are almost three times as likely to have periodontitis. People who have diabetes are more likely to have periodontitis than those who do not.

Heart Disease & Stroke: Periodontitis and total loss of teeth are associated with greater risk for cardiovascular disease. A person with fewer than ten teeth is seven times more likely to die of heart disease than someone with who has 25 teeth or more. The relationship between periodontitis and acute myocardial infarction is well documented. One study has even suggested the severity and magnitude of chronic periodontitis associates to the size of an infarction. Bacteria in the mouth that causes periodontal disease travels into the blood stream. People with periodontitis are twice as likely to have heart disease, and studies have found that poor oral health is associated with stroke.

Obesity: There is evidence that obesity is associated with periodontitis and caries. People who are obese are more likely to have periodontitis than those who are not obese. Also, it has been shown that adolescents with a higher number of decayed, missing or filled teeth tend to be obese.

Tobacco use: Smokers are four times more likely to suffer from poor dental health than those who never smoked. Smoking and chewing increase the risk of periodontal disease, caries, oral cancer, and pharyngeal cancer. Tobacco use contributes to the incidence of oral and pharyngeal cancers.

As the partnerships and strategies included in this plan are crucial to making a substantial and sustainable impact on chronic disease in New Mexico, oral health must be integrated with chronic disease prevention and control. Good oral health care can reduce costs of chronic diseases. It is imperative oral health promotion be incorporated with general health promotion as it is more efficient and effective than targeting a single disease. Oral health practitioners need to provide referrals for chronic diseases and general health practitioners need to provide referrals for oral diseases.

Regarding Surveillance and Epidemiology

As noted on page 5, the first step in the development of the New Mexico Shared Strategic Plan was a review of relevant public health surveillance data by the Leadership Team to assess current burden and distribution of chronic disease and risk factors in our state. This data driven approach has been used as the NM Shared Strategic Plan has been expanded to include additional chronic disease topics, and in the development of priorities and objectives. Detailed information regarding chronic disease data, and surveillance and epidemiology resources and capacity in New Mexico is provided in Appendices B and C.

Missions and Goals

The Leadership Team adopted existing mission and goal statements from state programs housed at the New Mexico Department of Health (NMDOH) and modified them to be applicable to statewide needs. Given the effort expended in developing those statements over many years, the high degree of participation by many individuals in those processes, and the strong alignment with language and practices from the Centers for Disease Control and Prevention (CDC), adoption with modification was an extremely efficient solution. It also had the benefit of effectiveness since the foundation was carefully developed.

In the absence of a state program or mission statement for Heart Disease and Stroke Prevention, the decision was made to have this material developed and included when a state program is launched in the near future. In the interim, it proved to again be efficient and effective to adopt CDC goals to guide strategic thinking.

No mission or goals were established for the shared arena. It was determined that the missions and goals for the separate content areas were sufficient.

When the NMDOH received CDC funding for a Coordinated Chronic Disease Program (CCDP) in September 2011, the decision was made to use the existing draft strategic plan as the core for a statewide New Mexico Shared Strategic Plan for Chronic Disease Prevention and Control (NMSSP) to fulfill a key CCDP requirement. This required expanding the draft plan to also include arthritis, cancer, and obesity. Missions and goals for these additional topics were also adopted from state programs housed at the NMDOH.

Arthritis

MISSION
An improved quality of life for New Mexicans living with arthritis.

GOALS

1. Deliver physical activity and self-management programs that are proven to improve the quality of life of people with arthritis and other chronic conditions.

2. Increase awareness through education about the prevalence, burden and management of arthritis.

3. Promote policies that help people living with arthritis and other chronic conditions.

Cancer Control

MISSION
Increase access to information, prevention and treatment using innovative and effective programs and policies, thus reducing the human and economic burden of cancer and improving the outcomes and quality of life for New Mexicans.

GOALS

1. Improve access to culturally and linguistically competent, appropriate and effective cancer prevention, education, screening, diagnosis, treatment, care and survivor services.

2. Improve the quality of life for New Mexicans living with cancer throughout the cancer journey.

3. Ensure equal access to pain management, palliative care, complementary and alternative services with proven evidence based efficacy, and end of life services.

4. Increase culturally and linguistically competent and effective education about appropriate screening services for the early detection and/or prevention of cancer among New Mexicans.

5. Reduce the rates of cancers caused by social, economic, and physical environment factors.

6. Reduce disparities and inequities in access to appropriate and effective cancer prevention, screening, diagnosis, treatment, care, and survivor services.

Diabetes

MISSION
Prevent, delay and control diabetes and its complications.

GOALS

1. Prevent diabetes.
2. Prevent complications, disabilities and burden associated with diabetes.
3. Eliminate diabetes-related health disparities.*

Missions and Goals continued

Heart Disease and Stroke

MISSION
Promote cardiovascular health for all New Mexicans across the lifespan, and reduce the impact of heart disease and stroke, especially in priority populations.

GOALS

1. Prevent risk factors for heart disease and stroke.
2. Increase detection and treatment of risk factors.
3. Increase early detection and treatment of heart disease and stroke.
4. Decrease recurrences of heart attacks and strokes.
5. Foster a skilled and engaged public health workforce.

Obesity Prevention

MISSION
Prevent obesity, especially in children and youth.

GOALS

1. Increase healthy eating.
2. Increase active living.
3. Increase healthy weights.
4. Eliminate obesity related health disparities.

Tobacco Use

MISSION
Improve lives by eliminating the harm from tobacco through the implementation of effective strategies that incorporate an anti-oppression model.

GOALS

1. Prevent tobacco use among youth and young adults.
2. Promote tobacco use cessation among adults and youth.
3. Eliminate exposure to secondhand smoke.
4. Identify and eliminate tobacco-related health disparities.

* Terms with asterisks can be found in the definition section starting on page 24.

Strategic Priorities and Objectives

Strategic Priorities and Objectives were developed in an ongoing process between the Leadership Team and the Strategic Planning Group.

They initially took direction from the Missions and Goals best practices* for prevention and control of diabetes, heart disease, stroke, and tobacco use. The process was then taken further to identify areas of common ground. With the expansion of the plan to include arthritis, cancer, and obesity, priorities and objectives were approved and submitted for inclusion in the NMSSP by the NM Arthritis Alliance, the NM Cancer Council Executive Committee, and the Office of Nutrition and Physical Activity. See page 1 for list of participants.

* Terms with asterisks can be found in the definition section starting on page 24.

Relating NMSSP Priorities and Objectives to the 4 Key CDC Domains

for Chronic Disease Prevention and Health Promotion

The majority of work on the NMSSP was begun in 2010 and 2011, prior to CDC Coordinated Chronic Disease Program funding and development of the related four key domains:

1. **Epidemiology and surveillance**

   Gather, analyze, and disseminate data and information and conduct evaluation to inform, prioritize, deliver, and monitor programs and population health.

2. **Strategies that support and reinforce healthful behaviors**

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

3. **Health systems 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.

4. **Community-clinical linkages enhancement**

   Strategies to ensure 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.

Despite their independent development, there is a strong relationship between the four key CDC domains and the priorities and objectives of the NMSSP. The majority of the priorities and objectives fall under Domain 2, since the NMSSP is primarily focused on coordinated statewide efforts to improve population health through policy and environmental approaches. However, implementing the NMSSP and its related communication and evaluation plans will help New Mexico make progress in developing capacity and taking action in each of the four key domains. To highlight the connection between the four key domains and the NMSSP, relevant priorities and objectives will be marked by the following domain symbols:


epidemiology and surveillance


strategies that support and reinforce healthful behaviors


health systems interventions


community-clinical linkages enhancement

Arthritis Priorities and Objectives

Arthritis includes over 100 rheumatic diseases and conditions that affect joints, the tissue that surrounds joints, and other connective tissue. Common forms include osteoarthritis, rheumatoid arthritis (RA), lupus, fibromyalgia, and gout. Arthritis is the leading cause of disability in the United States; the most recent national data estimates that 50 million American adults report doctor-diagnosed arthritis. As the US population ages, this number is projected to increase to 67 million by 2030. In 2009, it is estimated 375,000 New Mexican adults reported doctor-diagnosed arthritis. Of these, it is estimated 191,250 adults in New Mexico reported activity limitations attributable to arthritis. Furthermore, over one-third of New Mexicans between ages 18–64 with arthritis are affected by work limitations attributable to their condition. The total direct and indirect costs of arthritis and other rheumatic conditions in New Mexico in 2003 is estimated at $770 million.[4]

The New Mexico Department of Health Arthritis Program works to improve the quality of life for New Mexicans with arthritis by promoting increased access and use of evidence-based physical activity and self management interventions, sharing information about arthritis burden and management, and gathering support for partnerships to promote policies that help people with arthritis and other chronic conditions.

The Arthritis Program is working with various statewide partners to increase implementation of evidence-based exercise and self-management programs for people with arthritis. The two primary programs being implemented throughout the state include the Senior Services of Seattle's *Enhanced Fitness* exercise program and Stanford University's *Chronic Disease Self-Management Program* (CDSMP) in English and Spanish, known locally as the *Manage Your Chronic Disease* (MyCD) program.

July 2012 Update: Despite years of high performance, the NMDOH Arthritis Program lost CDC funding due to Congressional budget constraints. The NM Arthritis Alliance (formerly the NM Arthritis Advisory Group), Arthritis Foundation, and providers of arthritis self-management programs remain active in New Mexico, under the current guidance of the New Mexico Chronic Disease Prevention Council.

Arthritis Strategic Priority #1

Increase access to evidence-based, affordable, and appropriate self-management opportunities for people with arthritis and support healthcare practitioners' adoption of evidence-based guidelines for diagnosis, treatment, and self-management referrals for people they treat who may have arthritis.

Objective 1

By October 1, 2013, financially support the existing infrastructure of at least three regional programs designed to educate the general public, through the Stanford University-developed evidence-based Chronic Disease Self-Management Program (CDSMP), EnhanceFitness, and other evidence-based programs about self-management strategies, to reduce the negative impact of arthritis and related health conditions on the quality of life.

Lead organization: NM Arthritis Alliance

Objective 2

By 2013, partner with two health care organizations to disseminate information to healthcare providers, provider training programs, regulatory agencies, home health professionals, health plan case managers, and Indian Health Service professionals, on current practices related to physical activity assessment, counseling, and follow-up with mid-life and older patients.

Potential lead organization: NM Arthritis Alliance

Objective 3

By March 1, 2013, remove access-to-services barriers in hard to reach populations throughout New Mexico by providing access to the evidence-based on-line self-management program known as *"Better Choices – Better Health."*

Potential lead organization: NM Arthritis Alliance

Objective 4

By 2014, partner with two health care organizations to adopt payment/reimbursement systems for evidence-based exercise and self-management programs for people with arthritis in New Mexico, including pharmacological treatments for rheumatoid arthritis in reimbursement packages.

Potential lead organization: NM Arthritis Alliance

Arthritis Strategic Priority #2

Increase collaboration between agencies and organizations that serve New Mexicans with arthritis and other chronic diseases that have similar disease management approaches by educating professionals and communities on the prevalence of arthritis in New Mexico, cost-effective self-management strategies, research-tested interventions, and access-to-service barriers facing New Mexicans with arthritis.

Objective 1

Partner with three professional organizations to facilitate referrals to evidence-based chronic disease self-management programs, research-tested interventions, and informational resources by December 2012.

Potential lead organization: NM Arthritis Alliance

Objective 2

Reach three agencies and organizations with the power to advocate for people with arthritis in New Mexico with consistent messages on prevalence, management, and costs by 2013.

Potential lead organization: NM Arthritis Alliance

Objective 3

By July 1, 2012, transform the current Arthritis Advisory Group into the New Mexico Arthritis Alliance, elect Alliance leadership, and establish formal membership status with the existing New Mexico Healthy Aging Collaborative.

Potential lead organization: NM Arthritis Alliance, Healthy Aging Collaborative

Cancer Control Priorities and Objectives

In addition to being a major cause of illness and suffering in our state, one of every five deaths in New Mexico is caused by cancer, making cancer the second leading cause of death among New Mexicans. The good news is that New Mexico cancer mortality rates have been declining for the past three decades, which can be attributed to advances made in the areas of cancer prevention, early detection, treatment, and quality of life efforts for cancer survivors. But much still remains to be done to truly reduce the personal, social, and economic toll of cancer on the citizens of New Mexico.

A comprehensive approach to cancer control that spans a continuum of care encompassing prevention, early detection and screening, elimination of disparities, access to care, quality of life, and effective coordination and collaboration among organizations conducting cancer control and prevention programs will allow for better outcomes for people affected by cancer.

Healthy lifestyles, regular cancer screenings, and immunizations can reduce the risk of developing some types of cancer and reduce the risk of secondary cancers in cancer survivors.* In the cases of cervical and colorectal cancer screening, pre-cancerous conditions can be detected, which when treated, can prevent cancer from developing. Vaccines are available that protect against the hepatitis B virus, which can cause liver cancer, and also protect against the types of human papillomavirus (HPV) that cause most cervical cancers. Ensuring that cancer survivors receive appropriate social support services in order to maintain their expected quality of life is also an important aspect of cancer control. In addition, developing strategies to ensure that all segments of the population in New Mexico benefit equally from cancer prevention and control efforts can alleviate differences in the cancer burden.

Policy, systems, and environmental changes are also useful strategies for addressing chronic diseases such as cancer because they affect large numbers of people. Examples of broad scale approaches to reducing the burden of cancer include insurance coverage for cancer screening and treatment, tobacco excise taxes, clean indoor air ordinances, regulation of indoor tanning devices, policies to improve nutrition and increase physical activity, and implementation of patient navigation systems.

Cancer Control Strategic Priority # 1

Improve access to culturally and linguistically competent, appropriate and effective cancer prevention, education, screening, diagnosis, treatment, care, and survivor services.

Objective 1

By 2014, develop a Colorectal Cancer public awareness and education media campaign for New Mexico and promote it annually in March to highlight Colorectal Cancer Awareness month.

* Terms with asterisks can be found in the definition section starting on page 24.

Potential lead organization: NMDOH Colorectal Program or NM Cancer Council Colorectal Cancer Work Group, Indian Health Services, Albuquerque Area Indian Health Board.

Objective 2

By 2016, provide 16 trainings on cancer to promotores and healthcare workers to improve healthcare delivery in New Mexico.

Potential lead organizations: Cancer Awareness Prevalence Prevention and Early Detection (CAPPED), Comadre a Comadre, University of New Mexico (UNM) Cancer Center Community Outreach, NM Cancer Council, NM Cancer Center Foundation, NMDOH, Breast Cancer Resource Center, Susan G. Komen for the Cure

Objective 3

By 2016 , provide 20 trainings to civic organizations, businesses, churches, etc. on cancer prevention, education, screening, diagnosis, treatment, and survivor services.

Potential lead organizations: Cancer Awareness Prevalence Prevention and Early Detection (CAPPED), Comadre a Comadre, University of New Mexico (UNM) Cancer Center Community Outreach, NM Cancer Council, NM Cancer Center Foundation, NMDOH, Breast Cancer Resource Center, Susan G. Komen for the Cure

Cancer Control Strategic Priority # 2

Improve the quality of life for New Mexicans living with cancer throughout the cancer journey.

Objective 1

By 2016, develop (or promote existing) talking points to help people with cancer address quality of life issues with their providers

Lead organization: NM Cancer Council Survivorship Workgroup.

Objective 2

By 2016, distribute the materials that describe the talking points to survivorship* organizations for dissemination to cancer survivors and their families.

Lead organization: NM Cancer Council Survivorship Workgroup.

Cancer Control Strategic Priority # 3

Increase culturally and linguistically competent and effective education about appropriate screening services for the early detection and/or prevention of cancer among New Mexicans.

Objective 1

By 2016, increase awareness about accessing cancer detection and treatment programs among the general public in New Mexico.

Potential lead organizations: NM Cancer Council, NM Cancer Council Native American Work Group, NM Cancer Council Rural Issues Work Group, CAPPED, Comadre a Comadre, UNM Cancer Center Community Outreach, NM Cancer Center Foundation, NMDOH, Breast Cancer Resource Center, Susan G. Komen for the Cure

Cancer Control Strategic Priority # 4

Reduce disparities and inequities in access to appropriate and effective cancer prevention, screening, diagnosis, treatment, care, and survivor services.

Objective 1

By December 2015, support efforts to analyze data on cancer disparities in New Mexico in order to identify strategies to reduce inequalities in cancer control and prevention. Promote data reports to Council members through listserv and to legislators, the Governor's Office and the press prior to the start of the 2016 legislative session.

Potential lead organizations: NM Cancer Council, NM Cancer Council Policy and Advocacy Work Group, NM Tumor Registry, NMDOH, American Cancer Society

Objective 2

By June 2014, assess the need for/feasibility of a financial assistance fund for individuals diagnosed with Colorectal Cancer.

Potential lead organizations: NM Cancer Council, NM Cancer Council Policy & Advocacy Work Group, NM Cancer Council Colorectal Cancer Work Group, American Cancer Society Cancer Action Network

* Terms with asterisks can be found in the definition section starting on page 24.

Diabetes Priorities and Objectives

Despite the concerted efforts of health care system and community-based partners, diabetes continues to rise in New Mexico, in the United States, and throughout the world. While New Mexico and US diabetes prevalence rates have been similar over the last decade, New Mexico's diabetes death rates are higher than the national diabetes death rates. Diabetes was the sixth leading cause of death in New Mexico in 2010. Currently, at least 157,000 New Mexicans have diabetes and only 116,000 are aware they have the disease. It is estimated that diabetes costs New Mexico $1.36 billion annually.[5]

There is an established body of evidence about what works to prevent and manage diabetes. The National Diabetes Prevention Program* (NDPP) clinical trial funded by the National Institutes of Health and CDC, demonstrated that among overweight people with pre-diabetes,* moderate weight loss of 5 to 7%, along with at least 150 minutes of physical activity a week, reduced the risk of progressing to type 2 diabetes by up to 71%. The CDC and some states are now developing community-based lifestyle intervention programs that replicate the NDPP efforts to prevent or delay type 2 diabetes in those with a higher risk.

For diabetes management, complications can be prevented through effective control of glucose, blood pressure, and blood lipids; regular eye, foot and kidney screenings and care; and reduced exposure to tobacco smoke. Strategies include disease management programs such as Diabetes Self-Management Education and the Stanford University's Chronic Disease Self-Management Program; case management interventions; and policy, system, and environmental changes.

Diabetes Strategic Priority # 1

Actively implement best practices that are known to work in communities statewide to stop the progression of pre-diabetes to diabetes.

Objective 1

By June 30, 2014, develop a prediabetes training infrastructure for all members of the health care team.*

Lead organizations: NM Health Care Takes On Diabetes, Zia Association of Diabetes Educators, UNM Project Extension for Community Healthcare Outcomes (ECHO), Molina Healthcare, United Health

Objective 2

By the 2015 legislative session, introduce a bill that requires all health insurers operating in New Mexico to reimburse for all pre-diabetes identification, education, and care.

Potential lead organizations: To be decided

Objective 3

Implement National Diabetes Prevention Programs* in at least three priority population areas with infrastructure by June 30, 2015, that will lead to statewide implementation. Implementation to include identification and referral systems, reimbursement policies, program and community infrastructure, and follow up and maintenance.

Lead organization: NMDOH Diabetes Prevention and Control Program

Diabetes Strategic Priority # 2

Promote the consistent delivery of and adherence to accepted professional standards of care for control of diabetes by healthcare providers.

Objective 1

Partner with professional organizations to provide four continuing education sessions by 2015 to increase healthcare provider knowledge and adherence to standards of diabetes care including but not limited to A1C*, Blood pressure, Cholesterol, Smoking (ABCS), and cardiovascular disease.

Lead Organizations: NM Diabetes Advisory Council, UNM, NM Healthcare Takes on Diabetes

Objective 2

Partner with three health care organizations by 2015 to disseminate best practices and systems supports (e.g. policies, clinic flow, reminder systems, and multidisciplinary disease management teams) that increase health care providers' adherence to standards of diabetes care.

Potential Lead Organizations: NM Primary Care Association, Albuquerque Indian Health Board

* Terms with asterisks can be found in the definition section starting on page 24.

Heart Disease and Stroke Priority and Objectives

Heart disease and stroke are the first and fifth leading causes of death in New Mexico, respectively. Together, they account for over 25% of all deaths in our state each year, and are leading causes of disability. Preventing, identifying, and controlling major risk factors, such as tobacco use, diabetes, high blood pressure and high cholesterol, are important steps toward decreasing heart disease and strokes. Management of chronic disease becomes important when cardiovascular disease is present, and must include patient engagement, team based health-care and quality in health systems. Living in communities that provide easy and affordable access to healthy foods, physical activity opportunities, smoke-free places, and primary health care is a necessary pre-requisite to making significant progress in chronic disease prevention and control.

In the event of a heart attack or stroke, it is crucial that the symptoms are recognized early and that rapid emergency transport and treatment are supported by efficient systems and well-trained personnel. For some of New Mexico's most remote communities, coordinated efforts and use of appropriate technology is vital. When a community* has all of these resources in place, residents will benefit from fewer heart attacks and strokes, as well as increased survival and improved outcomes. Increasing capacity in communities throughout the state will ultimately result in a comprehensive statewide system for the prevention and control of heart disease and stroke in New Mexico.

Heart Disease and Stroke Strategic Priority

Work with communities to build a comprehensive heart disease/stroke prevention and control system statewide.

Objective 1

By 2016, continue to build the state's capacity to prevent and control cardiovascular disease across all key domains, by responding to and working with state and national level stakeholders including the Centers for Disease Control and Prevention, National Association for Chronic Disease Directors, American Heart Association, and others.

Potential Lead Organizations: NMDOH, American Heart Association

Objective 2

By 2016, continue to implement and operationalize the Million Hearts® Initiative in New Mexico. The Initiative aims to prevent one million heart attacks by 2017, through improved clinical care and community activation. New Mexico will engage in health systems improvement including meaningful use of electronic health records, promotion of team-based healthcare and community activation for increased awareness of cardiovascular disease prevention and control.

Lead Organization: NMDOH, CDPC Million Hearts Workgroup

Objective 3

By 2016, expand coordinated telehealth and telemedicine* systems for cardiovascular disease risk management and acute stroke care throughout New Mexico. This includes the long-term goal to increase the number of stroke centers.*

Potential Lead Organization: To be decided

Objective 4

By 2016, train 80% of Emergency Medical Technicians and first responders to recognize stroke symptoms and make appropriate transport to stroke centers. Explore options for engaging Emergency Medical Services personnel in cardiovascular disease prevention education such as blood pressure monitoring and smoking cessation education.

Potential Lead Organization: To be decided

Objective 5

By 2016, promote education, certification, and utilization of Community Health Workers in chronic disease prevention and control.

Potential Lead Organization: To be decided

Obesity Prevention Priorities and Objectives

Obesity is a growing problem in the nation and in New Mexico. In 2010, one in four (25.6%) adults living in New Mexico was

* Terms with asterisks can be found in the definition section starting on page 24.

obese. What is particularly alarming is that obesity is occurring at younger ages, signifying that children are developing unhealthy eating and sedentary behaviors earlier, making it more difficult to adopt a healthy lifestyle later. In 2011, 22% of 3rd grade students in New Mexico were obese. Even more disturbing is the racial disparity with one-in-three American Indian 3rd grade students being obese. Obese children are more likely to become obese adults and suffer from chronic diseases. In addition, physiological risk factors for heart disease and stroke are being seen in younger ages and in larger numbers. According to the Centers for Disease Control and Prevention, approximately 60% of overweight children ages 5 to 10 years had at least one physiological risk factor for heart disease and stroke, including elevated total cholesterol, triglycerides, insulin, and blood pressure. This is an alarming statistic negatively impacting the health of our children's future and the future of New Mexico.

Healthy eating and active living are two important factors that can decrease the risk for obesity. Yet, like many Americans, the majority of New Mexican children and adolescents eat poorly and do not get enough physical activity. In 2011, only 24% of high school students ate five or more servings of fruits and vegetables a day. In terms of physical activity, only 26% of high school students met recommended levels of either moderate or vigorous physical activity. A major contributor to physical inactivity is the large increase of time spent watching TV and playing video games. In 2011, 29% of New Mexico high school students watched 3 or more hours of TV a day, and 25% played video games for 3 hours a day.

Creating state and local policy, systems, and environmental changes that expand opportunities for healthy eating and active living are effective strategies to address the obesity problem. The strategies described below focus on preschool and elementary school age children. Behaviors are still being shaped in childhood and the extent of childhood obesity is troubling. Children, however, do not live in isolation nor are they autonomous in decision-making. They live in family contexts, in neighborhoods and communities, going to and from school, and enjoying time with friends and families, all of which display the need for public health interventions that impact the community at large.

Obesity Prevention Priority #1

Coordinate statewide collaborative efforts and messages to increase physical activity, healthy eating and prevent obesity.

Objective 1

By June 2015, implement a Healthy Kids 5.2.1.0 Challenge.*

Lead Organization: Healthy Kids New Mexico and the NM Interagency Council for the Prevention of Obesity

Objective 2

By 2016, increase the percentage of schools and school districts that increased availability and variety of healthy food and beverage options from 0% to 50% of the 28 school districts participating in the Healthy Kids Healthy Community Initiative.*

Potential Lead Organization: NM Public Education Department, Public Education School Districts, NM Interagency Council for the Prevention of Obesity and NMDOH Obesity, Nutrition, and Physical Activity Program (ONAPA)

Obesity Prevention Priority #2

Build, expand and support community-wide obesity prevention efforts.

Objective 1

By June 2015, establish in at least 10 counties and 3 tribal communities Healthy Kids Healthy Community initiatives focusing on increasing opportunities in the built environment, education system, and food system to support healthy eating and active living for children, families, and community members.

Potential Lead Organizations: NMDOH ONAPA and the Healthy Kids Healthy Communities Leadership Group

Objective 2

Implement the 90 Day Healthy Body Challenge to target obesity as a health disparity that will include free morning and evening exercise and healthy living classes.

Lead Organizatios: NM Office of African American Affairs

Obesity Prevention Priority #3

Monitor progress toward environmental, policy, behavior, and health outcome changes related to physical activity, healthy eating, and healthy weights.

* Terms with asterisks can be found in the definition section starting on page 24.

Objective 1

Every winter, distribute annual report on prevalence of childhood and youth obesity.

Lead Organizations: Healthy Kids NM

Tobacco Use Priority and Objectives

The progress made in fighting tobacco use ranks among the "ten great public health achievements" of the first decade of the 21st century according to the CDC. This powerfully affirms that the fight against tobacco can be won by implementing proven measures, including smoke-free air laws, well-funded tobacco prevention and cessation programs, higher tobacco taxes, and effective regulation of tobacco products and marketing.

While New Mexico has reduced adult smoking by 25% since 2001 and youth smoking by 20% since 2003, the battle against tobacco is far from over: youth tobacco use rates in New Mexico remain above the national average; people who live or work on tribal lands are not covered by the state's clean indoor air law; and many people living in multi-unit housing are exposed to secondhand smoke significantly increasing their health risks. Tobacco use is still New Mexico's number one cause of preventable death, killing more than 2,100 and resulting in $954 million in health care costs and lost productivity each year. These deaths and costs are entirely preventable. In addition, some specific population groups have higher smoking rates than the general population, and require focused attention and resources to address these disparities. For example, adults who have lower education, are lower income, are unemployed, or are uninsured are significantly more likely to smoke cigarettes than the general population. Continued progress will require leadership, persistence, and resources. Action must be taken to continue reducing the impact of New Mexico's leading preventable killer.

Tobacco Use Strategic Priority

Actively implement best practices that are known to work concerning commercial tobacco* at community and state levels

Objective 1

By April 1, 2014, convene key stakeholders to develop and implement a policy advocacy agenda related to commercial tobacco prevention and cessation in New Mexico. Possible policy advocacy:

a. Advocate for funding for comprehensive tobacco prevention and cessation programs
b. Increase tobacco taxes and ensure tax parity across all tobacco products
c. Support Clean Indoor Air policies statewide and on tribal lands
d. Support smoke free multi-unit housing
e. Implement statewide retail tobacco outlet licensing

Lead Organization: CDPC Tobacco Control Policy Workgroup, American Cancer Society Cancer Action Network

Objective 2

Enact a statewide law requiring licensing of retail tobacco outlets by 2015.

GOALS

a. Decrease outlet density
b. Decrease point of sale marketing
c. Increase compliance with Food and Drug Administration, sales to minors, etc.
d. Increase counter-advertising campaigns, and make requirement for licensing

Potential Lead Organization: To be decided

Objective 3

Implement education campaigns by 2012 to grow awareness of community-based policies made possible under the federal Family Smoking Prevention & Tobacco Control Act 2009.*

Potential Lead Organization: NMDOH Tobacco Use Prevention and Control (TUPAC) and its contractors

* Terms with asterisks can be found in the definition section starting on page 24.

Objective 4

In fiscal year 2012 (July 1, 2011- June 30, 2012) and following fiscal years, make stable funding and program resources to support priority population networks a NMDOH TUPAC priority.

Potential Lead Organization: NMDOH TUPAC

Objective 5

Continue to maximize use of data and media to support policy advocacy and to address tobacco related inequities.

Lead Organization: NMDOH TUPAC, American Lung Association in NM, American Cancer Society Cancer Action Network

Objective 6

By 2012 the Tobacco Use Prevention and Control program will contract for web-based smoking cessation services that include social networking capacity.

Lead Organization: NMDOH TUPAC, American Lung Assocation in NM, American Cancer Society Cancer Action Network

Shared Priorities and Objectives

Shared efforts by a variety of partners to prevent and control arthritis, cancer, diabetes, heart disease, stroke, obesity, and tobacco use are essential. Some of the most critical risk factors for chronic disease extend beyond those we have traditionally considered to be important. We now know that income plays a significant role in the development of chronic disease, as well as in the likelihood of using tobacco. People living in poverty are more likely to use tobacco and develop CVD and diabetes. In New Mexico, a significantly higher percentage of those earning less than $10,000 annually report CVD than those earning $50,000 or more a year. There is generally an income gradient in risk factor prevalence, where those earning less are more likely to experience high blood pressure, diabetes, tobacco use, exposure to secondhand smoke, and physical inactivity. Similar to income, a significantly higher percentage of those with less than a high school diploma report a higher level of certain risk factors (i.e., tobacco use, poor nutrition, physical inactivity, and obesity) than those with a college degree or higher. The income and education gradient, which is present for CVD and its risk factors, exists not only in New Mexico, but also nationally.[6] In addition to income and education, housing and access to affordable healthy food are important factors associated with effective diabetes management. A Canadian study noted that "…insufficient income, inadequate and/or insecure housing and food insecurity emerged as key barriers to the effective management of type 2 diabetes." [7]

Due to these common risk factors, individuals often experience more than one of these chronic diseases. This is especially true for people with diabetes, since CVD is the most prevalent complication of diabetes. In addition, smoking and secondhand smoke adversely affect people at risk for and with diabetes and CVD. People with diabetes who smoke are up to 12 times more likely to die from CVD than people without diabetes who do not smoke. There is also mounting evidence that smoking may play a role in the development of type 2 diabetes.[8]

Tobacco use is a well-established risk factor for the development of numerous types of cancer. There is mounting evidence of the important roles of obesity and physical inactivity in the development and/or poorer prognosis of several common cancers. Objectives that address tobacco use, obesity prevention, and physical inactivity are crucial public health strategies for cancer prevention and control.

Physical activity is a key element in maintaining function and controlling pain for persons with many forms of arthritis. It can also be useful in the prevention or management of obesity, which is a major risk factor for the development of the most common type of arthritis. In persons who experience both CVD and arthritis, studies have shown that arthritis pain can be a limiting factor in the physical activity necessary for cardiac rehabilitation and prevention of future cardiac events. Providing opportunities and encouragement to be physically active to persons with multiple chronic conditions can enhance their health in many ways.

Policy, system, and environmental changes are important population-based strategies to prevent and control arthritis, cancer, diabetes, heart disease, stroke, and other chronic conditions that share the common risk factors of tobacco use, poor nutrition, physical inactivity, and obesity. Many of these strategies, such as clean indoor air policies, walkable communities, and healthy and safe food and physical activity options are included in this section of the plan. They represent a more progressive and inclusive effort among a spectrum of partners to prevent and manage arthritis, cancer, diabetes, heart disease, stroke, and tobacco use in New Mexico's communities.

* Terms with asterisks can be found in the definition section starting on page 24.

These partnerships and strategies are crucial to making a substantial and comprehensive impact on chronic disease prevention and control in our state.

Shared Strategic Priority # 1

Ensure the inclusion and voice of priority populations* in the planning, design, implementation, and evaluation of all strategic priorities.

Lead organization: New Mexico Chronic Disease Prevention Council

Objective 1

Build list of statewide priority contacts by March 2013.

Objective 2

Utilize the lead organization contacts to priority populations and assist with filling gaps.

Objective 3

Introduce and educate communities about statewide strategic plan by date to be decided by NMCDPC Steering Committee.

Objective 4

Community contacts will introduce and educate their community about the NMSSP by date to be decided by NMCDPC Steering Committee. In assessing community responses, the NMCDPC will acknowledge the diversity of possible forms of support.

Objective 5

Continue to cultivate a network of community contacts to share resources, information, and build capacity statewide.

Shared Strategic Priority # 2

Create environments that promote safe, convenient physical activity throughout New Mexico.

Lead Organization: Healthier Weight Council Complete Streets Leadership Team

Objective 1

By October 31, 2013, NMCDPC and task force members will join and/or actively partner with transportation, public health, community, and other partners to strengthen transportation policy that promotes physical activity and implementation of policies at state, local, and tribal levels.

Objective 2

By December 31, 2013, the partnership built in Objective 1 will work with local coalitions, public health offices and others to cultivate a network of local walkability* and bikeability* advocates.

Objective 3

By June 30, 2015, the walkability and bikeability network will advocate for state, local, and tribal policies that include effective strategies such as health impact assessments and Complete Streets.*

Shared Strategic Priority # 3

Implement policies, programs and organizational structures in communities that make physical activity, nutritious eating, and other healthy choices easy.

Objective 1

By 2015, provide support to School Health Advisory Councils to facilitate implementation of New Mexico School District Wellness policies that increase physical activity and healthy food for students in 35% of schools.

Potential Lead Organization: NM Public Education Department, NM Office of School and Adolescent Health

Objective 2

By 2015, increase workplace wellness programs by 20%. This will include employers of 25 employees or more and use cost savings data to educate employers.

Potential Lead Organization: To be decided

Objective 3

By 2015, NMCDPC and task force members will partner with rural communities and county planners to reduce food deserts* by 5% statewide.

Potential Lead Organization: NM Chronic Disease Prevention Council

* Terms with asterisks can be found in the definition section starting on page 24.

Objective 4

By 2015, work with community-based organizations (e.g. health care organizations, civic organizations and clubs, businesses) to promote and market policies, programs, and organizational/ environmental structures that increase physical activity and access to healthy food.

Potential Lead Organization: University of New Mexico

Objective 5

By 2016, increase the percentage of NM licensed childcare centers and homes with healthy eating and beverage options, physical activity, and limited screen time from 0% of facilities to 50%.

Potential Lead Organization: NM Children, Youth and Families Department, NM Interagency Council for the Prevention of Obesity and NMDOH Office of Nutrition and Physical Activity

Objective 6

By June 2015, implement at least 3 collaborative efforts across members in the Interagency Council for the Prevention of Obesity.

Potential Lead Organization: NM Interagency Council for the Prevention of Obesity

Objective 7

Every fall, submit a set of annual policy recommendations to the NM Health and Human Services Cabinet Secretaries for consideration in the Governor's state policy proposals.

Potential Lead Organization: NM Interagency Council for the Prevention of Obesity

Objective 8

Every spring, work with NM Healthier Weight Council members to develop policy priorities for upcoming year.

Potential Lead Organization: NM Healthier Weight Council

Shared Strategic Priority # 4

Develop and apply practices that promote health equity.*

Lead Organization: NM Health Equity Partnership, Pathways to a Healthy Bernalillo County, CDPC Youth Health Equity Workgroup

Objective 1

Initially and annually critique each objective in the NMSSP to ensure that it promotes health equity.

Objective 2

NMCDPC and task force members will partner with at least four community organizations by 2015 to raise awareness among policy makers of the interdependence between educational achievement, income, and health.

Shared Strategic Priority # 5

Collaborate with tribal communities to ensure that people who live, work and play on tribal lands are protected from commercial tobacco secondhand smoke (SHS).

Objective 1

By June 2014, collect resource information pertaining to education efforts on secondhand smoke, tobacco cessation, heart disease and stroke prevention, cancer, arthritis, and diabetes in tribal lands and other organizations in New Mexico in order to provide information to tribes.

Potential Lead Organizations: Albuquerque Area Southwest Tribal Epidemiology Center, American Cancer Society Cancer Action Network, TUPAC

Objective 2

By June 2013, TUPAC, DPCP and advocates partner with tribal coalitions, tribal health officials, and elected officials in developing smoke-free policies on tribal lands and increase tobacco taxes as a new revenue source.

Potential Lead Organization: To be decided

* Terms with asterisks can be found in the definition section starting on page 24.

Evaluation

The New Mexico Chronic Disease Prevention Council has accepted the role of facilitative leader for the New Mexico Shared Strategic Plan. This aligns with the NMCDPC purpose of serving as a coordinating body for addressing chronic disease prevention in New Mexico. The NMCDPC will engage with partners, including the NMDOH, for implementation and evaluation of the NMSSP. Communication, reporting, and monitoring will be adopted into the regular business of the organization. (See Appendix D for Communication Plan).

Once partners are engaged, an evaluation plan will be created that will include an overview of the timeframe and reporting of activities related to evaluation of the NMSSP. The evaluation plan will include a description of the evaluation components and primary data sources that will be utilized. Contracted evaluation professionals from the Wyoming Survey and Analysis Center (WYSAC) at the University of Wyoming will host annual in-person evaluation days with the NMCDPC.

WYSAC will provide technical assistance for evaluating implementation of the NMSSP, including evaluation planning, guidance, and evaluation capacity-building. This will include revising and updating logic models and evaluation plans for the NMSSP. In addition, WYSAC will provide guidance to the NMCDPC in collecting, reporting, and applying data pertinent to NMCDPC evaluation plans.

The operational plan for the implementation and evaluation of the NMSSP will be created during an annual retreat of the NMCDPC Steering Committee. An initial logic model was created in June 2012 by WYSAC (Appendix E). It focuses on Shared Strategic Priorities #3 and #4 because the NMCDPC is the lead on objectives in these priorities. Council operations will be strategized to facilitate the implementation and evaluation of the NMSSP, such as meeting activities, the formation of work groups, and the creation of annual progress reports.

Examples of measurable outcomes related to various implementation strategies are outlined in the following table:

Implementation Strategy	Measurable Outcome
Collaborate with agencies working to prevent and manage chronic disease	Number of integrated activities
Increase council membership	Number and percentage of members representing priority populations
Increase participation	Number of priority populations who are implementing objectives in the NMSSP
Develop culturally appropriate education materials for outreach	Number of culturally appropriate materials

References

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New Mexico Shared Strategic Planning Definitions

A1C Test: The A1C test is a common blood test used to diagnose type 1 and type 2 diabetes and then to gauge how well you are managing your diabetes. The A1C test result reflects your average blood sugar level for the past two to three months. The higher your A1C level, the poorer your blood sugar control and the higher your risk of diabetes complications

Best Practice: A technique, process, or activity, which is regarded as more effective for delivering a particular outcome than any other technique, method, or process when applied to a particular condition or circumstance. Best practices may also be the most efficient (least amount of effort) and effective (best results) way of accomplishing a task, based on repeatable procedures that have proven themselves over time for large numbers of people.

Bikeability: The extent to which biking is readily available as a safe, connected, accessible, and pleasant mode of transport.

Cancer Survivor: An individual who has been diagnosed with cancer, from the time of diagnosis through the balance of his or her life. Family members, friends, and caregivers are also impacted by the survivorship experience and are therefore included in this definition.

Chronic Disease: Chronic disease is a long-lasting condition that can be controlled but not cured. Chronic illness affects the population worldwide. As described by the Centers for Disease Control, chronic disease is the leading cause of death and disability in the United States. It accounts for 70% of all deaths in the U.S., which is 1.7 million each year. Data from the World Health Organization show that chronic disease is also the major cause of premature death around the world even in places where infectious disease are rampant. Although chronic diseases are among the most common and costly health problems, they are also among the most preventable and most can be effectively controlled. (www.http//cmcd.sph.umich.edu/what-is-chronic-disease.html)

Commercial Tobacco: Tobacco grown, produced, processed, and sold with the goal of creating addiction and generating profits. This is in contrast to traditional tobacco used by some American Indians.

Community: Usually refers to a group of people who share a common location, common interests, common characteristics, or common need. A community encompasses a diverse set of entities, including voluntary health agencies; civic, social, and recreational organizations; labor groups; health care systems and providers; professional societies; schools and universities; faith communities; and different socioeconomic classes and organizations for racial and ethnic groups.

Complete Streets: Streets designed and operated to enable safe access for all users. Creating complete streets means transportation agencies must change their orientation away from building primarily for cars. Instituting a complete streets policy ensures that transportation agencies routinely design and operate the entire right of way to enable safe access for all users. Places with Complete Streets policies are making sure that their streets and roads work for drivers, transit users, pedestrians, and bicyclists, as well as for older people, children, and people with disabilities.

Environmental Change: A physical or material change to the economic, social, or physical environment. For example, a city can build new trails and paths to encourage pedestrian mobility and use of bicycles, or a convenience store near a school can stop advertising tobacco products in its windows.

Family Smoking Prevention and Tobacco Control Act: The Family Smoking Prevention and Tobacco Control Act gives the U.S. Food and Drug Administration the authority to regulate the manufacturing, marketing and sale of tobacco products. The law preserves state and local authority. It does not preempt state and local governments from enacting other tobacco control measures, including tobacco taxes, smoke-free workplace laws and fire-safety standards for cigarettes. States are free to adopt measures related to the sale, distribution and possession, exposure to, or access to tobacco products. State and local governments have new authority to restrict the time, place and manner of cigarette advertising, consistent with the First Amendment.

Food Desert: An area with limited access to affordable and nutritious food that is typically available at supermarkets or large grocery stores. A key concern for people who live in areas with limited access is that they rely on small grocery stores that may not carry all the foods needed for a healthy diet and that may offer these foods and other food at higher prices. In small-town and rural areas with limited food access, the lack of transportation infrastructure is the most defining characteristic. Urban areas with limited food access are characterized by higher levels of racial segregation and greater income inequality.

Health Care Team: A group of health care workers from various disciplines (includes: primary care providers, nurses, social workers, promotores, community health workers) that provide specific services in a cooperative, collaborative, integrated manner that ensures continuity of care.

Health Disparities: Differences in health status among population groups or communities that can be shown with statistics (e.g. death rates, rates of occurrence of disease). To have disparities, one group has to have lower rates or risk and another group has to have higher rates or risk.

Health Equity: Fair access to the conditions for good health, such as healthy food, good housing, good education, safe neighborhoods and freedom from racism and other forms of discrimination, resulting in the distribution of disease, disability, and death that does not more severely burden a particular population.

Healthy Kids 5.2.1.O Challenge: A state and local challenge that encourages elementary school age children to:

5 - Eat 5 or more fruits and vegetables a day;

2 - Limit TV and video game time to 2 hours a day; read, share stories, work on a hobby instead;

1 - Move at least 1 hour a day; and

O - Drink lots of H_2O

Healthy Kids Healthy Community Initiative: Sponsored by the New Mexico Department of Health's Healthy Kids NM program and state and local partners to expand opportunities for healthy eating and active living for children where they live, learn, and play.

National Diabetes Prevention Program (NDPP): A research study demonstrated that people at risk for developing diabetes can prevent or delay the onset of diabetes by losing a modest amount of weight through diet and exercise. Based on these findings, the CDC and partners are implementing the National Diabetes Prevention Program nationwide. This program delivers a proven 16-week intervention called Lifestyle Balance that focuses on diet and exercise for preventing diabetes in patients at risk.

Pre-diabetes: A metabolic state between normal glucose and type 2 diabetes glucose levels and which represents increased risk for type 2 diabetes. It includes impaired fasting glucose and impaired glucose tolerance. One can have impaired fasting glucose alone, impaired glucose tolerance alone or both, and be considered to have pre-diabetes.

Priority Populations: Groups with higher rates of disease, risk behaviors, inadequate access to resources, poor health outcomes, and groups that are oppressed. Public health programs prioritize these populations for focused attention. For example, the NMDOH Diabetes Program priority populations are those more likely to be diagnosed with diabetes (African American, American Indian, Hispanic, low income) or to experience higher death rates from diabetes (American Indians, low income). The NMDOH Tobacco Program priority populations are those with higher tobacco use rates (lower income and education, students with poor academic performance, homeless, lesbian/gay/bisexual/transgender), those being targeted by tobacco industry advertising, and those with greater exposure to secondhand smoke (American Indian communities are not covered by the Dee Johnson Clean Indoor Air Act).

Safe Routes to School: Sponsored by the New Mexico Department of Transportation and state and local partners to increase the number of schools with walking and biking to school initiatives.

Stroke Center: A specialized facility within a hospital where a group of people who specialize in stroke care work together to diagnose, manage, and rehabilitate stroke patients.

Survivorship: In cancer, survivorship covers the physical, psychosocial, and economic issues of cancer, from diagnosis until the end of life. It includes issues related to the ability to get health care and follow up treatment, late effects of treatment, second cancers, and quality of life.

Telehealth: See telemedicine

Telemedicine: The use of medical information exchanged from one site to another via electronic communications to improve patients' health status. Closely associated with telemedicine is the term telehealth, which is often used to encompass a broader definition of remote healthcare that does not always involve clinical services. Videoconferencing, transmission of still images, e-health including patient portals, remote monitoring of vital signs, continuing medical education and nursing call centers are all considered part of telemedicine and telehealth.

Walkability: The extent to which walking is readily available as a safe, connected, accessible, and pleasant mode of transport.

APPENDIX A

Current Burden of Diabetes, Tobacco Use, Cardiovascular Disease And Their Intersecting Influences In New Mexico

Tobacco, Diabetes & Cardiovascular Disease Presentation Slides

Tobacco, Diabetes & Cardiovascular Disease

Susan Baum, MD, MPH
Statewide Strategic Plan Leadership Team
August 30, 2010

Tobacco Use in New Mexico

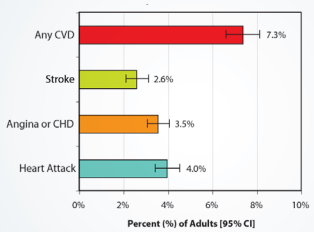
Adult smoking has declined from 23.8% in 2001 to 17.9% in 2009.

Smoking is most prevalent among young adults and people who are unemployed, lower income, lower education, uninsured, or lesbian/gay/bisexual.

In 2009, about 60% of smokers made a quit attempt in the previous year.

1

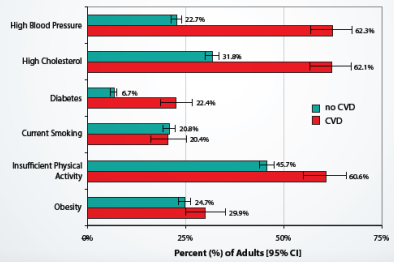
NM Adults with History of CVD(2007)



This translates to over 109,000 New Mexico adults living with CVD statewide.

2

NM Adults with CVD Risk Factors by CVD History (2007)



3

Diabetes in New Mexico

In 2009, 8.6% of NM adults had diagnosed diabetes increase from 6.5% in 2004.

About 30% of persons with diabetes are undiagnosed.

Diabetes prevalence increases with age:
60 years and older (16%) vs. 18-39 year olds (2%)

Diabetes is also more prevalent among people with lower income and lower education, African Americans, Hispanics, and American Indians.

4

Diabetes and Risk of CVD

People with diabetes are 2-4 times more likely to die from heart disease or stroke than people who don't have diabetes

Heart disease and stroke cause ~65% of deaths in people with diabetes

CVD risk factors in people with diabetes should be controlled as strongly as in people who have already had a heart disease or stroke

5

TOBACCO, DIABETES & CARDIOVASCULAR DISEASE PRESENTATION SLIDES

How much does smoking increase the risk of CVD in people with diabetes?

People with diabetes who smoke are up to 3 times more likely to die from heart disease or stroke as people with diabetes who don't smoke

This is in addition to the already elevated risk of death from CVD for people with diabetes

6

More Bad News

Smoking also increases risk of other diabetes complications:

- Kidney disease and failure
- Nerve damage
- Ulcers and infections that may lead to amputations
- Possibly eye damage

Smoking may even have a role in development of Type 2 diabetes

7

NM Adults with History of CVD (2007)

Selected Conditions	Percentage of NM Adults	Estimated Number of NM Adults
Diagnosed Diabetes Prevalence	7.7	115,400
Current Smoking Prevalence	20.1	301,300
Prevalence of Smoking AND Diagnosed Diabetes	1.2	17,900

Sources: 2006-2008 NM Behavioral Risk Factor Surveillance System (BRFSS) and 2009 US Census Bureau NM Adult Population estimates. Estimated numbers of adults have been rounded down.

New Mexican adults with diagnosed diabetes are significantly less likely to smoke (15.8%) than people without diabetes (20.4%).

8

Adolescent smokers with diabetes

Most start smoking after diagnosis of diabetes

Smoking rate same as adolescents without diabetes

ADA recommends all health care providers consistently repeat advice not to initiate tobacco use among children and adolescents with diabetes under age 21

9

Secondhand Smoke (SHS)

Higher levels of carbon monoxide and nicotine in SHS compared to mainstream smoke

Evidence conclusive that SHS causes heart disease and impaired function of blood vessels and platelets

SHS causes >35,000 heart attack deaths in U.S. each year, plus non-fatal heart attacks & angina

April 2006: first report that SHS increases development of glucose intolerance

10

Adult Exposure to SHS in New Mexico

Secondhand Smoke (SHS) Measures	Percentage
New Mexicans not protected by 2007 Dee Johnson Clean Indoor Air law (people working or living on tribal lands)	8%
Adults Reporting Exposure to SHS at Work	8%
Adults Reporting Smoke-free Vehicles Rule	77%
Adults Reporting Smoke-free Home Rule	85%

Sources: 2001-2009 BRFSS and 2009 NM Adult Tobacco Survey. No statistical differences exist in SHS measures between people with and without diabetes.

11

APPENDIX B

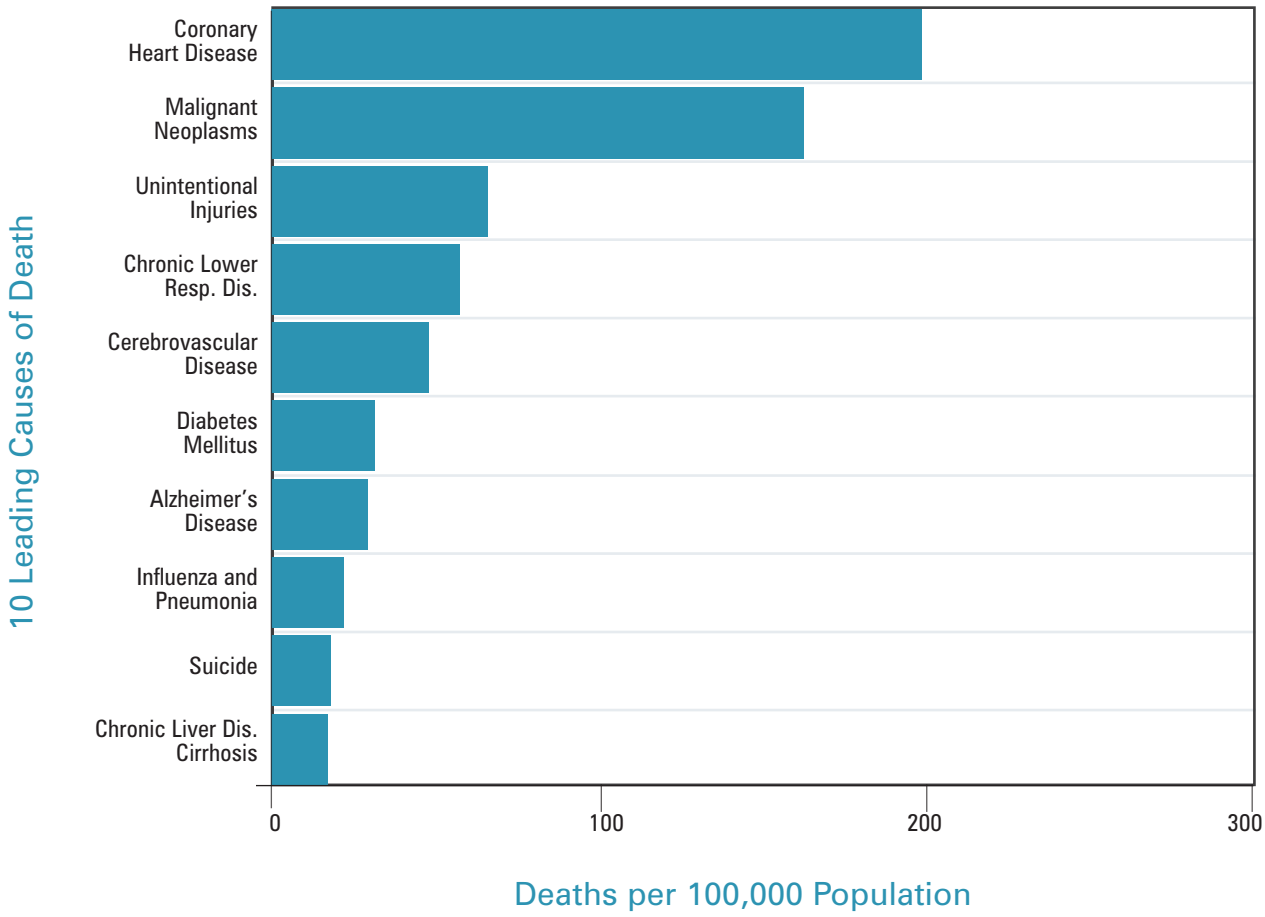
Burden of Chronic Diseases and Risk Factors in New Mexico Population

Burden of Chronic Diseases and Risk Factors in New Mexico Populations

Chronic diseases constitute most leading causes of death in New Mexico (see Figure 1) and are responsible for over 60% of all deaths in our state. Although chronic diseases are more common among older adults, they affect people of all ages. In addition to escalating medical costs, chronic diseases generate significant costs due to absenteeism and decreased productivity in the workplace. Many New Mexicans suffer from multiple chronic diseases, and as our population ages this trend is expected to increase.

New Mexico has a rich multi-cultural heritage that has resulted in unique population demographics. It is sometimes referred to as a "minority majority" state with a racial/ethnic distribution in 2009 as follows: American Indian/Alaska Native 11%; Asian/Pacific Islander 2%; Black/African American 3%; Hispanic 41%, and White 43%. The rank of leading causes of death by race and ethnicity in NM varies by group, as demonstrated in Table 1; the rankings for heart disease, cancer, stroke, and diabetes deaths have been highlighted in bold font for each group. Many factors

Figure 1: Death Rates for the 10 Leading Causes of Death, New Mexico, 2009



may contribute to different rankings of causes of death by race/ethnicity, including variations between groups in age distribution, access to healthcare services, and social determinants of health (e.g., income, education, employment, discrimination, neighborhood safety, etc.). Of note, heart disease, cancer and unintentional injuries are included in the top four leading causes of death in NM across all five racial and ethnic groups represented in Table 1 [below].

In addition to being leading causes of death, chronic diseases can also lead to disability, decreased productivity, and poorer quality of life. Arthritis is the leading cause of disability among NM adults. In 2009, more than one in four adults in NM reported having been diagnosed with a form of arthritis. Although arthritis prevalence was highest in the 65+ age group at 52%, it was also high among working age adults ages 55-64 (43%) and 45-54 (29%). Women were significantly more likely to report being diagnosed with arthritis than men.

There are a number of shared risk factors for the leading causes of death and disability that can be most effectively addressed through thoughtful coordination among chronic disease prevention programs. Tobacco use is the leading preventable cause of death as a well-established risk factor for heart disease, stroke, many cancers, and chronic lower respiratory diseases. The NM adult smoking rate dropped significantly between 2001 (23.8%) and 2009 (17.9%). Smoking rates are highest among adults who are young (18-24 years); low-income (under $20,000/yr); unemployed; uninsured; lesbian, gay, or bisexual; and/or have low education levels (less than high school diploma). Smoking by NM high school youth declined from 30.2% in 2003 to 24% in 2009 but was still higher than the 2009 U.S. rate of 19.5%.

Obesity is another commonly shared risk factor for deadly and disabling chronic diseases including diabetes, heart disease, stroke, arthritis, and at least seven cancers. The estimated 2010 rate of adult obesity in NM is 26%. Among adults, American Indians, Blacks, and Hispanics have significantly higher rates of obesity than Whites and Asians. Adults in households earning less than $25,000 annually are significantly more likely to be obese than those in households earning more than $50,000, and there is a similar disparity associated with educational attainment. Survey data from 2009 show an estimated obesity rate of 13.5% among NM high school students, with rates significantly higher for American Indian and Hispanic students compared to Whites. Perhaps most concerning are the results of a 2010 BMI surveillance initiative conducted by the Office of Nutrition and Physical Activity in NM elementary schools showing that 13.2% of kindergarten and 22.6% of third grade students are obese. The prevalence of obesity among American Indian kindergarten children is almost three times (25.5%) that of White children (8.8%) and almost twice that of Hispanic children (12.9%). In order to improve quality of life and health

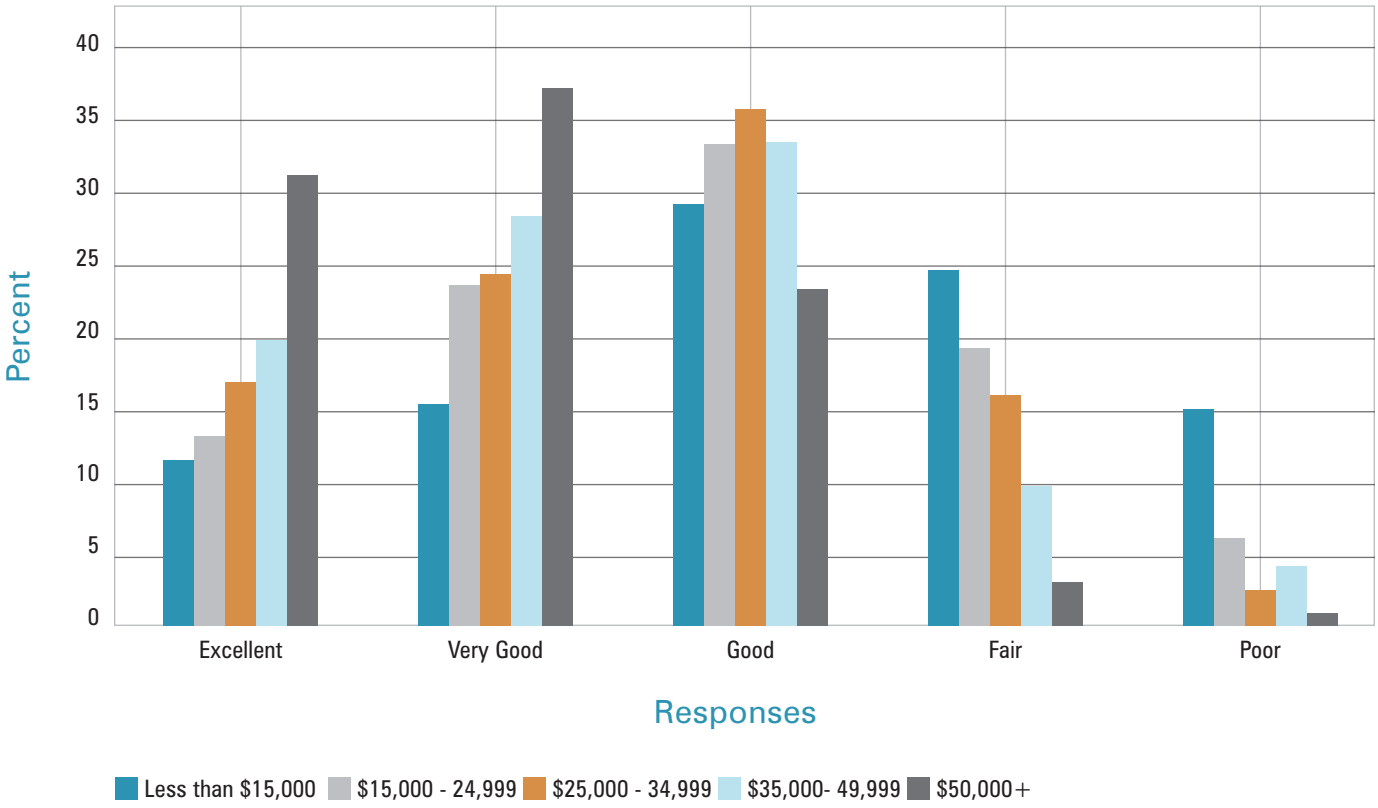
Table 1: 10 Leading Causes of Death (ranked by total number) by Race and Ethnicity, New Mexico, 2007-2009

Rank (by # of deaths)	American Indian/Alaska Native	Asian/Pacific Islander	Black/African American	Hispanic	White
1	Unintentional Injuries	Cancer	Heart Disease	Cancer	Heart Disease
2	Cancer	Heart Disease	Cancer	Heart Disease	Cancer
3	Heart Disease	Stroke	Unintentional Injuries	Unintentional Injuries	Chronic Lower Respiratory Diseases
4	Diabetes	Unintentional Injuries	Diabetes	Diabetes	Unintentional Injuries
5	Chronic Liver Disease	Diabetes	Stroke	Stroke	Stroke
6	Suicide	Chronic Lower Respiratory Diseases	Chronic Lower Respiratory Diseases	Chronic Lower Respiratory Diseases	Alzheimer's Disease
7	Influenza and Pneumonia	Suicide	Homicide	Chronic Liver Disease	Diabetes
8	Stroke	Homicide	Suicide	Suicide	Suicide
9	Homicide	Perinatal Conditions	Kidney Disease	Influenza and Pneumonia	Influenza and Pneumonia
10	Kidney Disease	Alzheimer's Disease	Essential Hypertension	Kidney Disease	Kidney Disease

outcomes related to obesity, it will be crucial to enact cross-cutting environmental and policy changes to improve nutrition and physical activity in our schools, worksites, and communities.

In our society, wealth is the strongest predictor of health and longevity. A recent study found that living at less than 200% of the federal poverty level imposes a greater societal health burden in the U.S. than either tobacco use or obesity. However, it isn't just a question of "the rich" versus "the poor." On average, middle class Americans live shorter lives and are less likely to report good health than those who are wealthy. Recent data for NM confirm a strong association between income and self-reported health status for adults (Figure 2), much of which is driven by the presence or absence of chronic disease. A coordinated approach to preventing chronic diseases and their risk factors in NM must ultimately reach beyond our health department to include effective long-term strategies for decreasing poverty, creating healthier neighborhoods, and improving educational attainment at the population level.

Figure 2: General Health of NM Adults by Income, 2010



APPENDIX C

Chronic Disease Surveillance and Epidemiology Resources and Capacity in New Mexico

Chronic Disease Surveillance and Epidemiology Resources and Capacity in New Mexico

NM Department of Health

A. Chronic Disease Prevention & Control Bureau Epidemiology Staff

There has been a tradition of strong NM Department of Health support for chronic disease surveillance and epidemiology. The epidemiology-trained medical director for the Chronic Disease Prevention & Control Bureau serves as the chronic disease epidemiologist with designated responsibility for coordinating/integrating epidemiology reports and other surveillance activities across categorical programs. She works with experienced masters- and doctoral-level epidemiologists who are embedded within the programs for Tobacco Use Prevention & Control, Diabetes Prevention & Control, the Office of Nutrition and Physical Activity, and the Cancer Prevention and Control Section. The medical director and cancer section epidemiologist serve as two-year mentors for fellows through the CDC/Council of State and Territorial Epidemiologists Applied Epidemiology Fellowship Program. A doctoral-level fellow is currently being hosted by the Bureau from August 2011 to August 2013, and her assignments include integrated surveillance, epidemiology, and evaluation across Bureau programs. Resources made available through CDC Coordinated Chronic Disease program funding have been used to increase data analysis capacity among current chronic disease epidemiology staff by providing biostatistical software licenses for the latest version of Stata and training on using this software for analyses of complex survey data from public health surveillance systems that are discussed below.

The ultimate goal of epidemiological support is to increase the effective use of surveillance and program data to support strategic planning, resource allocation, evaluation, and ongoing improvement of coordinated chronic disease efforts across the Department in cooperation with community, state, and tribal partners. This will be accomplished by chronic disease program managers' ongoing inclusion of their epidemiologists as integral team members across the spectrum of these activities. Epidemiologists serve a key role in using public health data to identify health disparities and inequities that chronic disease program managers, staff, and advisory councils can target in strategic planning. For example, by mapping out regional arthritis prevalence rates as well as the locations of arthritis self-management programs, the NM Arthritis Program and its statewide Advisory Group were able to identify underserved communities that could be better served through focused resource allocation. This action was included in the development of a multi-year state arthritis plan. The epidemiologists also provide the rest of their team and partners with ongoing updates on data trends that can be used, when appropriate, to modify program strategies and activities. This is currently occurring with the updating of the Cancer in New Mexico publication by the cancer section epidemiologist, which, in turn, will be used in strategic plan updating and program modification within the Bureau cancer programs and by the NM Cancer Council.

B. Cancer Concerns Working Group Partnership

Chronic disease epidemiologists also serve as liaisons with their counterparts within other divisions of the Department and in other agencies. For example, the medical director and cancer section epidemiologist partnered in establishing a Cancer Concerns Working Group with the Department's environmental health epidemiologists and the director of the state tumor registry at the University of New Mexico. The intent of the working group is to more effectively respond to public queries regarding perceived cancer clusters, the majority of which are believed by the caller to be related to shared exposures to environmental toxins in a community or workplace. The working group is developing a secure web-based platform that will be built onto the Environmental Public Health Tracking (EPHT) System to streamline intake, data assessment, and response capabilities. Because the EPHT houses geo-coded bio-monitoring and cancer data that can be analyzed at the census tract level, it provides enhanced capacity for small area analyses of communities, when indicated.

C. Behavioral Risk Factor Surveillance System

Ultimately, the output of chronic disease epidemiologists is only as good as the surveillance systems that collect and provide them with data. Within the Department, the Survey Section conducts the ongoing Behavioral Risk Factor Surveillance System (BRFSS) and other telephone surveys, e.g., the triennial Adult Tobacco Survey. These datasets are the "gold mine" of population-level chronic disease indicators for adults. The BRFSS has been used as a primary surveillance tool in New Mexico for chronic diseases since 1986. A BRFSS Advisory Committee that includes chronic disease staff and community partners has been established to provide a structured process to propose and

evaluate data needs that could be fulfilled through the BRFSS. The committee is integral in making recommendations on state-added questions and modules for each year's questionnaire.

BRFSS is the primary source of data for estimating the prevalence of major chronic diseases and their risk factors among NM adults. The richness of its data supports coordinated initiatives between chronic disease programs, such as targeting tobacco cessation efforts toward adults with diabetes and following trends over time. It also provides measurable outcomes for assessing performance objectives, such as reducing the prevalence of disabling arthritis. The impact of health promotion policies and environmental changes can be assessed at the population level through BRFSS data on quality of life, physical activity levels, fruit and vegetable consumption, weight status, appropriate use of clinical preventive services, and participation in self-management classes by persons diagnosed with conditions such as diabetes or arthritis.

Beginning in 2011, the New Mexico BRFSS has been able to correct a fundamental sample bias by increasing the percent of cell phones included in the sample to 20% of the total sample. Recent research indicates that inclusion of more cell phones will provide better data on younger people, Hispanics and people with lower incomes. This information is necessary for identifying health disparities among the diverse populations of New Mexico. Data from cell phone interviews will be combined with land line interviews and weighted. The resulting data will provide information on education and income in addition to race, age and sex. This additional information can be used by chronic disease prevention and control programs, coalitions, and community health councils to assist in further targeting appropriate populations within the state. The cost of conducting cell phone interviews, however, is significantly higher than land line interviews. Resources made available through CDC Coordinated Chronic Disease program funding is being used to offset some of this increased cost.

New Mexico has a number of counties and sparsely populated areas for which the sample is so small that it is extremely difficult to get reliable data. It is crucial, therefore, to maximize the number of completed BRFSS interviews in order to generate reliable estimates for New Mexicans living in rural and frontier areas, which constitute 30 of the state's 33 counties. For the last two years the number of completed BRFSS interviews has been growing. Resources made available through CDC Coordinated Chronic Disease program funding helps to ensure that New Mexico meets its annual goals for completed BRFSS interviews.

D. Youth Risk and Resiliency Survey

The Youth Risk and Resiliency Survey (YRRS) is New Mexico's equivalent of the Youth Risk and Behavior Survey conducted by CDC. YRRS is an anonymous pencil and paper survey conducted biennially in NM high schools and middle schools that generates estimates for chronic disease risk and protective factors among adolescents, such as tobacco use, physical activity, weight status, and nutritional habits. This data is incorporated into the strategic planning and evaluation efforts of chronic disease programs throughout the Department, as well as being disseminated broadly to schools, parents, and policy makers. The YRRS is implemented as a joint initiative between DOH and the state Public Education Department.

E. BMI Surveillance in Elementary Schools

This initiative was first conducted in 2010 under the direction of the DOH Office of Nutrition and Physical Activity. It provides crucial data on the weight status of a sample of New Mexican elementary school students, and has documented marked disparities in childhood obesity by race and ethnicity.

F. Mortality Data

Reducing age-adjusted mortality rates from chronic diseases will be monitored through data provided via the Department's Bureau of Vital Records and Health Statistics. This is a longer term objective that will require years of coordinated population level policy and environmental changes to show significant impact.

G. Interactive/Queryable Online System

In recent years, epidemiologists within the Department's Community Health Assessment Program have made great progress in providing easier access to public health surveillance data through New Mexico's Indicator-Based Information System (NM-IBIS). NM-IBIS provides web-based access to several public health datasets relevant to chronic disease issues, including death data, hospital inpatient discharge data, and health surveys (e.g., BRFSS, YRRS, and the Pregnancy Assessment Monitoring System). Epidemiologists from across the Department also develop user-friendly IBIS Indicator Reports, which provide descriptive data summaries stratified by county, sex, and race/ethnicity. This information has proven invaluable to health councils, grant writers, legislators, students, and other private and public partners. The data are also used by Department staff who conduct legislative bill analyses to support data-driven public policy related to chronic disease prevention and other health priorities.

New Mexico Tumor Registry

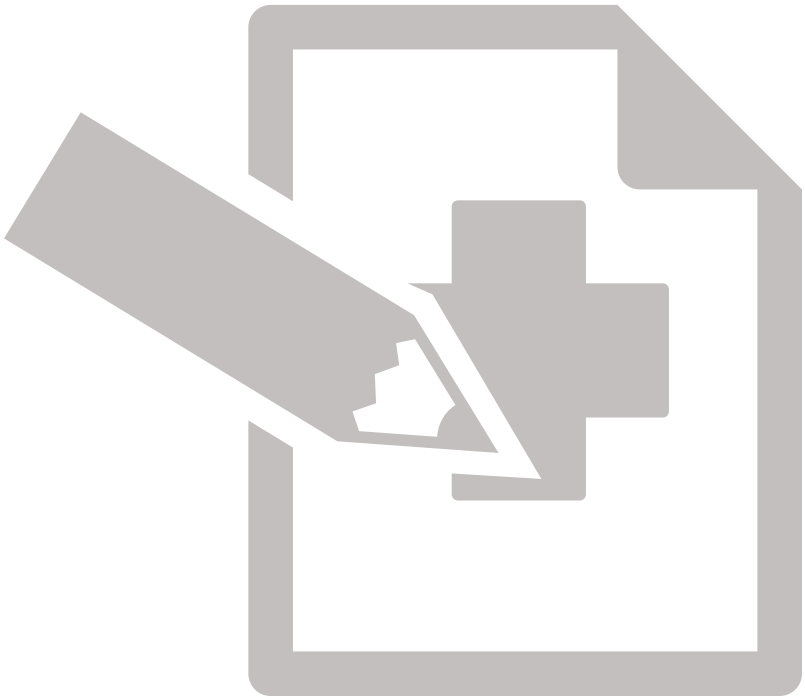
The New Mexico Tumor Registry (NMTR) was established at the University of New Mexico in 1966 and serves as a population-based cancer registry for the State of New Mexico. The NMTR provides high quality cancer surveillance data to support scientific research and a broad spectrum of cancer control activities. The NMTR is a founding member of the National Cancer Institute's Surveillance, Epidemiology, and End Results (SEER) Program and has continuously participated in that program since 1973. The NMTR also collaborates with the Arizona Cancer Registry and the Indian Health Service to provide population-based cancer surveillance for Native American populations in Arizona. Cancer surveillance in New Mexico is conducted in accordance with standards set by the SEER Program, the Centers for Disease Control and Prevention, the North American Association of Central Cancer Registries, and the American College of Surgeons.

New Mexico Community Data Collaborative

The New Mexico Community Data Collaborative (NMCDC) uses ArcGIS Online interactive mapping software to share neighborhood data with local organizations that promote community assessment, child health, and participatory decision making. NMCDC maps contain aggregated data organized by sub-county areas such as census tract, zip code, school districts and other administrative boundaries. In addition, the user can find site specific information for public schools, licensed facilities and other public services. A number of the maps address chronic diseases and their social determinants, e.g., diabetes hospitalizations by zip code; causes of death by small areas; the food environment; and education, poverty, income, and unemployment. NMCDC has provided training to members of the Chronic Disease Prevention Council and to the group working on the Bernalillo County Community Transformation grant. NMCDC is supported by the New Mexico Early Learning Advisory Council and its Early Childhood Data Warehouse Project.

APPENDIX D

New Mexico Coordinated Chronic Disease Prevention and Health Promotion Communication Plan



New Mexico Coordinated Chronic Disease Prevention And Health Promotion Communication Plan

The New Mexico Coordinated Chronic Disease Prevention and Health Promotion Communication Plan contains external and internal components. This document describes our communication plans to support the mission of the New Mexico Coordinated Chronic Disease Prevention and Health Promotion Program. The external component will be coordinated by the New Mexico Chronic Disease Prevention Council. The purpose of the New Mexico Chronic Disease Prevention Council is to serve as a coordinating body for addressing chronic disease prevention in New Mexico. The NMCDPC has accepted the role of facilitative leader for the NM Shared Strategic Plan. The internal component will be lead by the Coordinated Chronic Disease Program Manager.

External Communication Plan

Purpose: To help achieve priority strategies of the New Mexico Shared Strategic Plan for Prevention and Control of Chronic Disease (NMSSP) that will impact large numbers of people and lower the chronic disease burden and/or risk factors in the state.

Audience: The audience for the external communication plan includes partners, the general public, decision-makers and other stakeholders who can contribute to the achievement of major strategies in the NMSSP.

Communication Type	Objective of Communication	Medium	Frequency	Audience	Owner	Deliverable & Target Dates
Website www.chronicdiseasenm.org	Continue to update website on a regular basis with Chronic Disease Prevention Council member materials and educational resources including the NMSSP	website	Monthly	Council members, potential stakeholders and lead organizations, general public	NMCDPC Executive Director	Website *Ongoing monthly*
NM Shared Strategic Plan for Prevention and Control of Chronic Disease (NMSSP)	Provide updated draft of NMSSP, educate stakeholders and lead organizations about NMSSP at quarterly meetings and during presentations	Website, in person	Continual	NMCDPC members, partners, stakeholders, general public	NMCDPC Executive Director	Link on website and presentations *October 2012, ongoing*
NMCDPC Meetings	Full council meetings to build community of chronic disease partners, provide updates on the progress of the NMSSP and other key chronic disease issues	Meetings	Quarterly	NMCDPC members, partners, stakeholders	NMCDPC Executive Director	*September 2012, ongoing*
NMCDPC Communications Work Group meetings	Meetings with 8-10 member work group to complete group communication activities	Meetings	Monthly	Staff, leadership, and stakeholders	NMCDPC Communications Work Group; NMCDPC Executive Director	Meetings *Monthly*
NMCDPC Communication Work Group members will receive training on creating collaborative interactive maps	Translate data for stakeholders, policy and decision makers, partners, funders and the public	Training	One time training and ongoing collaboration planned with the NM Community Data Collaborative	General Public	NM Community Data Collaborative	Training *September 2012*
Letters to Key Partners and Stakeholders (Education; Environmental; Housing; Tribal; Transportation; Worksite Wellness; Las Cruces; Food Deserts)	Introduce NMCDPC; introduce NMSSP; invite to participate as partner organization; invite to become member of NMCDPC	Letter	One initial, ongoing as needed	List of priority contacts developed; public health and other professionals engaged in work directly related to NMSSP statewide	NMCDPC Communications Work Group; NMCDPC Executive Director	Introduction letters *September 2012, ongoing*
Direct contacts with Key Partners and Stakeholders (above)	Answer questions; determine interest in partnership	Telephone call	1-3 as needed	Priority contacts above	NMCDPC Executive Director	List of potential key partners *September – October 2012, ongoing*
Presentation at Key Partner and Stakeholder meetings	Present NMCDPC objectives, NMSSP, possible role for partners	In person presentation (with PowerPoint)	1 per key partner or stakeholder	Priority contacts above	NMCDPC Executive Director	PowerPoint presentation; list of new partners and members to NMCDPC *September – November 2012, ongoing*

External Communication Plan continued

Communication Type	Objective of Communication	Medium	Frequency	Audience	Owner	Deliverable & Target Dates
Letters to identify Lead Organizations	Introduce NMCDPC; introduce NMSSP; invite to participate as lead organization; invite to become member of NMCDPC	Letter	1-3	List of interested lead organizations	NMCDPC Communications Work Group; Executive Director	Introduction letters *September 2012, November 2012, ongoing*
Direct contacts with Lead Organizations (above)	Answer questions; determine interest in participation as lead organization	Telephone call	1-3 as needed	List of interested lead organizations	NMCDPC Executive Director	List of potential lead organizations *September – October 2012, ongoing*
Presentation at Lead Organization meetings	Present NMCDPC objectives, NMSSP, role for lead organizations	In person presentation (with PowerPoint)	1 per lead organization	Lead organizations	NMCDPC Executive Director	PowerPoint presentation; list of lead organizations *September – November 2012, ongoing*
Contract with marketing professional	Develop messages for variety of audiences utilizing social media processes	Social media	Once	NMCDPC and NMDOH	NMCDPC and NMDOH	Contract with marketing contractor *November 2012 – August 2013*
Fact Sheet Series, using data from chronic disease surveillance and epidemiology system, GIS mapping, etc.	Identify chronic disease burden and impact on New Mexico, specifically high priority strategies from the NMSSP	Website, email, other	3-10 fact sheets, beginning	Decision-makers at the NMDOH and state level; public health professionals; stakeholders and partner organizations; general public	NMCDPC Communications Work Group; NMCDPC Executive Director	Fact sheets *October 2012 – August 2013*
Other communication activities	Constant Contact system to update members; brochures, educational and policy materials	Email, printed documents	Ongoing	Decision-makers at the NMDOH and state level; public health professionals; stakeholders and partner organizations; general public	NMCDPC Communications Work Group; NMCDPC Executive Director	Various *October 2012 – August 2013*
Develop chronic disease feature stories and disseminate through the Chronic Disease Prevention Council website, health sections of local newspapers, television and radio news, and/or talk programs	Illustrate the need for chronic disease prevention and health promotion strategies	Media		General public	CCDP Program Manager and Contracted media professional	Monthly feature stories to be placed on web landing page and other communication domains *October 2012 – August 2014*
New Mexico's Indicator-Based Information System (NM-IBIS)	Web-based open access to query public health datasets and information on New Mexico's priority health issues	http://ibis.health.state.nm.us/	Ongoing	General public	NMDOH Epidemiology & Response Division	Updated indicator reports and public health surveillance datasets *Ongoing*

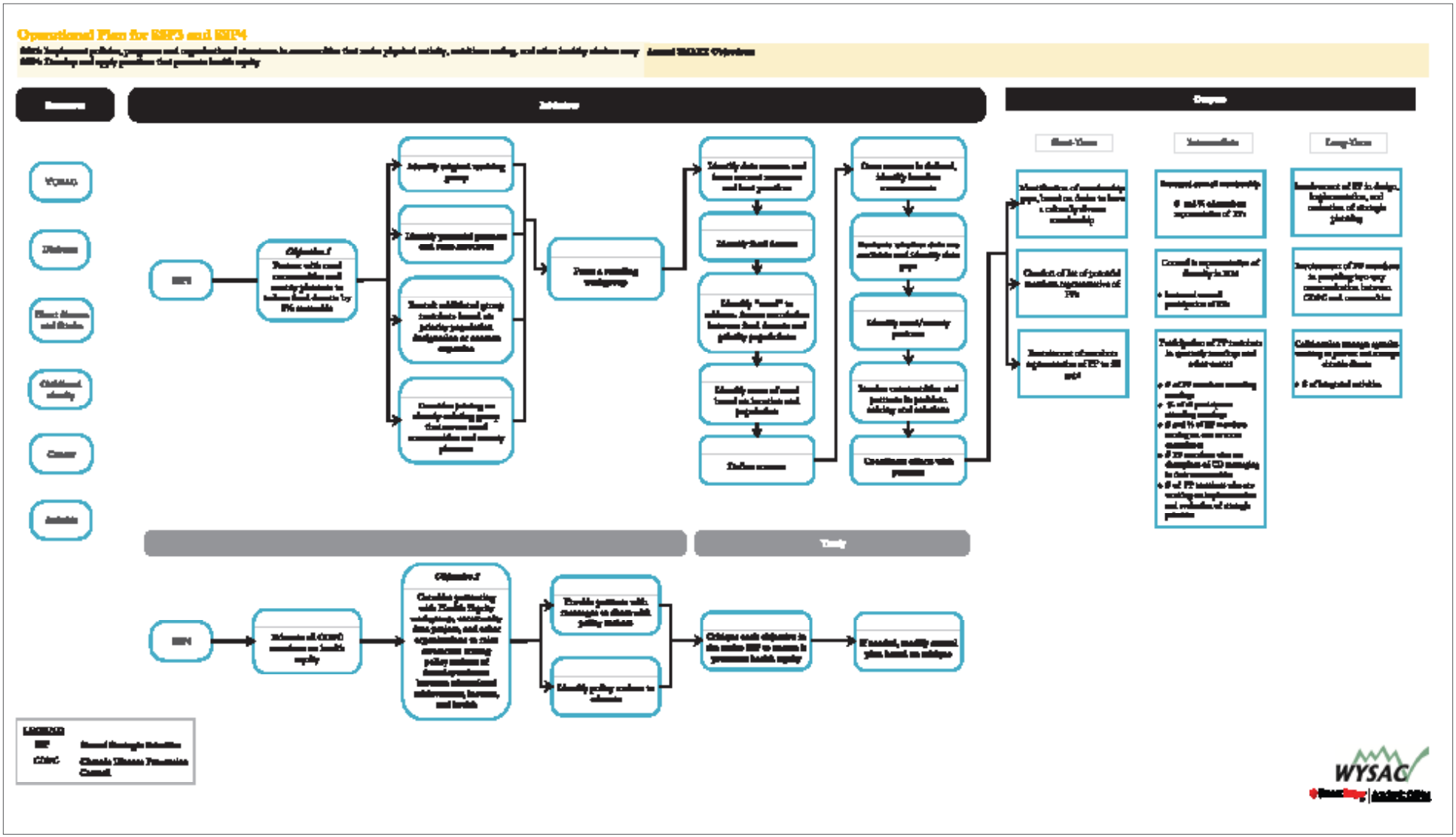
Internal Communication Plan

As with other organizational change processes, communication within the New Mexico Department of Health (NMDOH), and with partners and stakeholders is key to the success of organizational self-assessment efforts and achievement of a coordinated approach to chronic disease prevention and health promotion.

Purpose: To effectively engage internal stakeholders in an efficient organizational change process within the NMDOH; and, to update staff, leadership, and stakeholders throughout the process.

Communication Type	Objective of Communication	Medium	Frequency	Audience	Owner	Deliverable & Target Dates
Chronic Disease Prevention Council website	Raise awareness about NM's coordinated chronic disease prevention and health promotion plans among existing programs, units, and interested stakeholders	Website	Continual	NMDOH	NMCDPC Executive Director working with Marketing Contractor	Website Ongoing
NM Shared Strategic Plan for Prevention and Control of Chronic Disease	Provide NMSSP to raise awareness about NM's coordinated chronic disease prevention plan among programs	Document	Continual	NMDOH staff	CCD Program Manager	Document Due to CDC *August 24, 2012*
Fact Sheet Series, using data from chronic disease surveillance and epidemiology system, Geographic Information System (GIS) mapping, etc.	Raise awareness about New Mexico's coordinated chronic disease prevention and health promotion plans among existing programs, units, and interested stakeholders	Website, email, other	3-10 fact sheets	Decision-makers at the NMDOH and state level; public health professionals; stakeholders and partner organizations; general public	NMCDPC Communications Work Group; Executive Director	Fact sheets *October 2012 – August 2013*
Chronic Disease Prevention and Control Bureau Management Team Meetings	Fully engage leadership from all chronic disease programs within NMDOH in organizational assessment, analysis, recommendations and planning	Meetings	Monthly	CDPCB Management staff	CCD Program Manager	Meetings *October 2012 – August 2013*
Training on organizational assessment and coordinating efforts to be provided by Nonprofit Impact to CDPCB Management Team	Undertake processes to fully engage staff in organizational self-assessment, recommendations for changes, action plan and implementation	Training	3 training sessions	CDPCB Management Team	CCD Programs Manager and contractor	Training *October 2012 – December 2012*
Coordinated Chronic Disease Program Manager to attend Health Promotion Management Team Meetings	Fully engage leadership from health promotion programs within NMDOH in recommendations and planning for the NMSSP	Meetings	Quarterly	Health Promotion Management staff	CCD Program Manager	Meetings *January 2013 – August 2013*
Identify communication experts from each of the collaborating chronic disease programs	Provide ongoing updates regarding internal activities and decisions made	Meetings	Quarterly	NMDOH	CCD Program Manager	*November 2012 – August 2013*
Coordinated Chronic Disease Health Educator Work Group	Engage staff from all chronic disease programs in organizational assessment, analysis, recommendations, and planning	Meetings	Monthly	CDPCB Health Educator staff	Health educators co-facilitated by CCD Program Manager	Meetings *October 2012 – August 2013*
Interfacing with Regional Health Promotion Staff and Office of Nutrition and Physical Activity (ONAP) and	Fully engage leadership from health promotion programs and ONAP within NMDOH in recommendations and planning for the NMSSP	E-mails, face to face meetings,	Continual	Staff, leadership, and stakeholders	CCD Program Manager	Meetings *October 2012 – August 2013*
CDPCB all staff meetings	Provide staff with opportunities to provide input on a periodic basis	Meetings	Semi-annual	Staff, leadership, and stakeholders	CCD Program Manager	Meetings *January 2013 – January 2014*
CCD Program Manager to attend NMCDPC meetings and serve as conduit between external stakeholders and internal DOH staff	Establish systems and identify specific planned activities for communication with external stakeholders throughout the change process	Meetings	Quarterly	Staff, leadership, and stakeholders	CCD Program Manager	Meetings *October 2012 – August 2013*
Feedback from NMCDPC & NMCDPC Steering Committee as well as other external partners	Reflection or input from stakeholders external to the NMDOH	CCD Program Manager	Quarterly	External stakeholders	CCD Program Manager	Meetings *September 2012 – August 2011*
Submit a set of annual policy recommendations to the NM Health and Human Services Cabinet Secretaries for consideration in the Governor's state policy proposals	See NMSSP Shared Strategic Priority #3, Objective 7	Document	Yearly	Stakeholders	NM Interagency Council for the Prevention of Obesity	*October 2013*
Submit a set of annual policy recommendations to the NM Health and Human Services Cabinet Secretaries for consideration in the Governor's state policy proposals	See NMSSP Shared Strategic Priority #3, Objective 7	Document	Yearly	Stakeholders	NM Interagency Council for the Prevention of Obesity	*October 2013*

APPENDIX E
Evaluation Logic Model


Operational Plan for SIP3 and SIP4
Outputs
Outcomes
Short-Term
Intermediate
Long-Term
Yearly
SIP3
SIP4
Objective 1
Objective 2
Form a working subgroup
Identify potential partners and their services
Identify additional group members based on priority population designation or concern expansion
Coordinate planning on already existing plans that assess and accommodate and remedy planners
Identify data sources and focus on most accessible and best practices
Identify "need" to address. Assess correlation between food deserts and priority populations
Identify areas of need based on location and population
Define concern
Once concern is defined, identify baseline measurements
Analyze adaptive data and identify data gaps
Identify need/remedy practices
Develop recommendations and partners to facilitate, advising and initiatives
Coordinate efforts with partners
Identification of knowledge gaps, based on data to have a culturally diverse membership
Conduct of list of potential members representative of SVIs
Development of members representative of SIP3 and SIP4
Recruit overall membership
6 and 9% attendance representation of SVIs
Council is representative of diversity in SIP4
Increased overall participation of SVIs
Track fidelity of SIP members in quarterly meetings and other tasks
# of SIP members meeting meetings
% of all participants attending meetings
# and % of SIP members meetings see success committees
# SIP members who see disruption of CD messages in their communities
# of SIP members elevate meetings on implementation and evaluation of change priorities
Involvement of SIP in design, implementation, and evaluation of strategic planning
Involvement of SIP members in providing two-way communication between CDHC and communities
Collaborative manage agenda meeting or partner and manage shared efforts
# of integrated activities
Increase # of CDHC members on health equity
Coordinate partnering with Health Equity workgroups, community data partners, and other organizations on cross awareness among policy makers of disproportionate between educational achievements, incomes, and health
Provide partners with messages to share with policy makers
Identify policy makers to educate
Critique each objective in the entire SIP to ensure it promotes health equity
If needed, modify annual plan based on critique
Yearly
LEGEND
SIP Racial Strategic Initiative
CDHC Chronic Disease Prevention Council
WYSAC