Annual Impact Report

2013 NACDD

Promoting Health Preventing Disease

Contents

2013 NACDD Annual Report

NATIONAL ASSOCIATION OF
CHRONIC DISEASE DIRECTORS
Promoting Health. Preventing Disease.

2013 was a year of great vision and expectation for NACDD as it celebrated its 25 year anniversary. Founded in 1988, NACDD has grown from a single project and less than $100,000 to over 100 projects and an average of $10 million annually. This year also marked the second year of a new five year strategic plan, increasing membership and expanding the association's reach to better serve communities and consumers.

All the while, NACDD's core mission remained front and center — to increase collaboration, through efficiency and effectiveness of state and territorial chronic disease programs. That central focus is upheld by a foundation of highly proficient state, federal, and local public health professionals.

For 25 years, NACDD has worked to improve America's health while ensuring good stewardship of the dollars received. Today, over 80% of all Americans will experience at least one chronic disease and over 80% of all Medicare costs will be expended on those with two or more chronic conditions. NACDD invests 84 cents of every dollar into its programs. That is our pledge to quality and value.

Thanks to the commitment of its 3,500 member volunteer-army of chronic disease professionals and its cadre of subject matter experts, NACDD is still the only association of its kind serving and representing every state and US territory's chronic disease division.

Just as in 1988, NACDD's primary partner remains the Centers for Disease Control and Prevention, yet today it shares its unique expertise with multi-national companies, leading health organizations and venerable academic institutions.

NACDD's future role will continue to be that of standing in the gap, linking resources with its member-experts and together creating a safer, healthier and more equitable America.

Warm regards,

S. Grinnell

Sue Grinnell
NACDD President

John W. Robitscher

John W. Robitscher, MPH
NACDD Chief Executive Officer

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Chronic Disease

at a Glance...

Many cases of chronic disease could be prevented or delayed. Today 75% of all health care costs are spent treating chronic diseases. 80% of Americans will have one or more chronic diseases in their lifetime. Nearly 1 in 3 Americans have prediabetes and are poised to develop diabetes. Costs are high and stand to grow exponentially without swift, corrective action on the part of Americans to change lifestyles and environments. Surveys indicate that most Americans are unaware of the extent to which they could prevent or delay chronic diseases.

NATIONAL ASSOCIATION OF
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75%

of Healthcare Costs are Associated with the Treatment of Chronic Diseases

21%

of Adults Meet Federal Guidelines for Physical Activity

32%

of Children are Over-weight and Obese

78 million

U.S. Adults are Hypertensive

$201.5 billion

Total Estimated Cost of Cancer

$245 billion

Total Estimated Cost of Diagnosed Diabetes

25 years ago, the leadership at the Centers for Disease Control and Prevention (CDC), along with a handful of state chronic disease directors, decided to create a national, nonprofit, association of chronic disease professionals. Hence, the National Association of Chronic Disease Directors was born and with it, a new public health network across all 50 states and U.S. Territories.

This dynamic network is as unique as it was at its founding in 1988. Disease specific program directors and their staffs can share knowledge across the country, partner with each other on national and regional projects, disseminate best practices and develop evidence-based interventions that have literally changed the face of public health.

Because 45% of Americans or an estimated 109 million people currently experience one or more chronic diseases, such as diabetes, cancer, heart disease or arthritis, both the economic and lifestyle burden is crippling. 75% of every health care dollar is currently spent on treating or preventing chronic disease with a total estimated cost of $4.2 trillion costs and lost economic output.

Currently, nearly 80 million Americans are at-risk for diabetes and less than 10% are aware of it. Such statistics require a new level of sobriety when it comes to the strategic deployment of public health interventions.

Through targeted funding partners, both federal and private, NACDD has been successful year after year improving individual lives in each state, community and neighborhood across America by helping state health departments learn from each other, share current information, have access to funding, projects and programs to help treat and prevent chronic diseases.

NACDD's founding partner, the CDC, remains its chief source of both funding and project development. Working hand-in-hand with the CDC's Center for Chronic Disease Prevention and Health Promotion, NACDD helps to formulate the best approaches for states and community health departments to deliver public health.

Over the last decade, NACDD has entered into a growing number of project-related partnerships with private industry. Whether funding academic summits, white paper research, technology development or demonstration projects in health clinics, an increasing number of private companies have discovered the unique capabilities of NACDD's subject matter experts.

NACDD is headquarted in Atlanta, Georgia and welcomes the opportunity to have conversations with all parties focused on helping improve the heath of the public.

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About NACDD
(An Association Overview)

2013 was a historical year of legislative landmarks and societal shifts.

Following the landmark passage of the Patient Protection and Affordable Care Act, health exchanges entered the American lexicon, Medicaid was expanded in many states and a national healthcare insurance portal was launched for the first time in history at www.healthcare.gov.

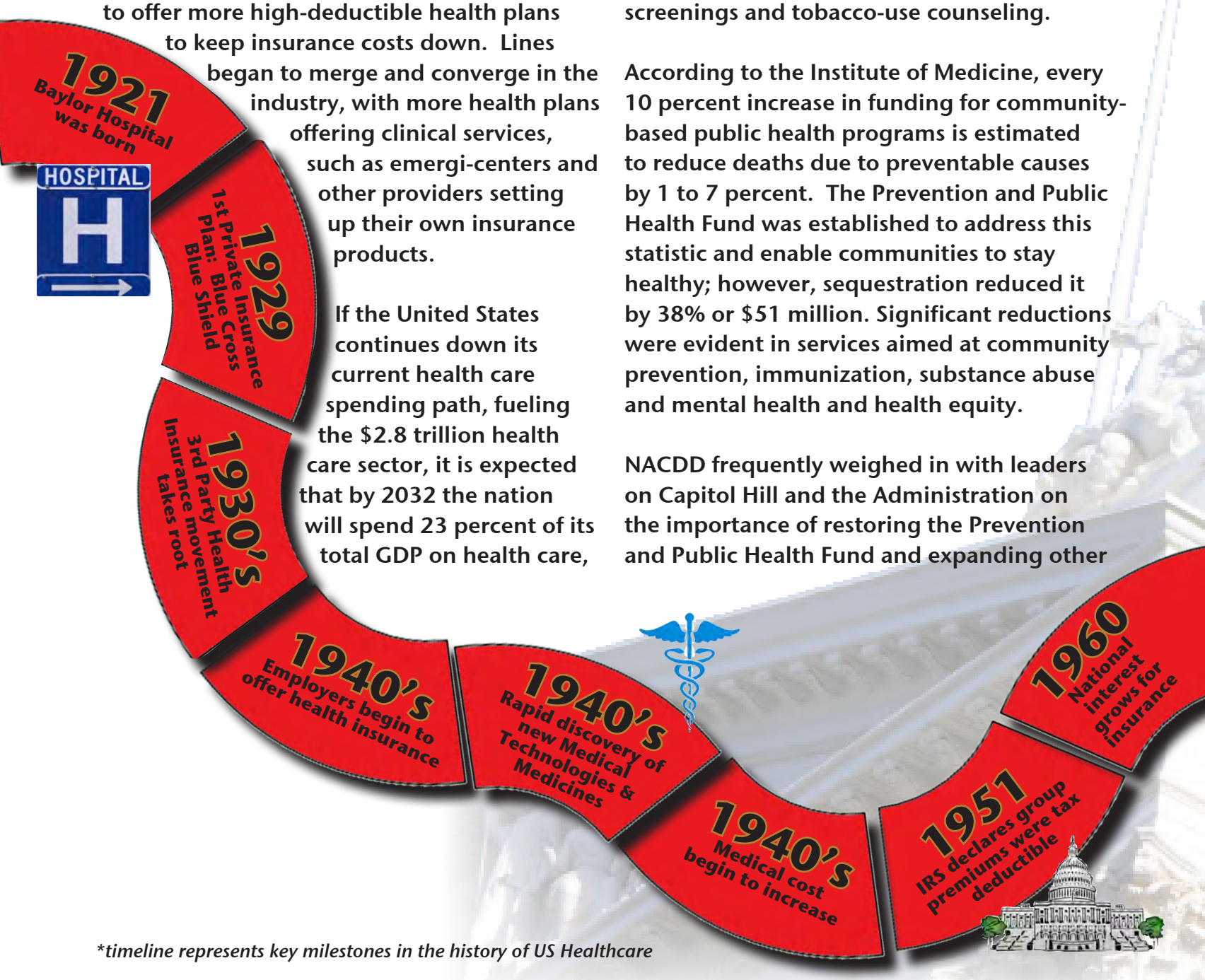
Health systems began to adjust to the national healthcare rollout with mergers and acquisitions while insurance companies began to offer more high-deductible health plans to keep insurance costs down. Lines began to merge and converge in the industry, with more health plans offering clinical services, such as emergi-centers and other providers setting up their own insurance products.

If the United States continues down its current health care spending path, fueling the $2.8 trillion health care sector, it is expected that by 2032 the nation will spend 23 percent of its total GDP on health care, almost twice the level of other industrialized countries. Therefore, healthcare payers, providers and consumers must work together to find a solution to holding down costs and determining a new path toward health, wellness and disease prevention.

The Centers for Disease Control and Prevention continued to focus on stroke prevention with Million Hearts™ initiatives, the TIPS anti-smoking awareness campaign, Newborn Screening Quality Assurance Program, food safety, children's mental health and preventive services for children such as blood pressure screenings and tobacco-use counseling.

According to the Institute of Medicine, every 10 percent increase in funding for community-based public health programs is estimated to reduce deaths due to preventable causes by 1 to 7 percent. The Prevention and Public Health Fund was established to address this statistic and enable communities to stay healthy; however, sequestration reduced it by 38% or $51 million. Significant reductions were evident in services aimed at community prevention, immunization, substance abuse and mental health and health equity.

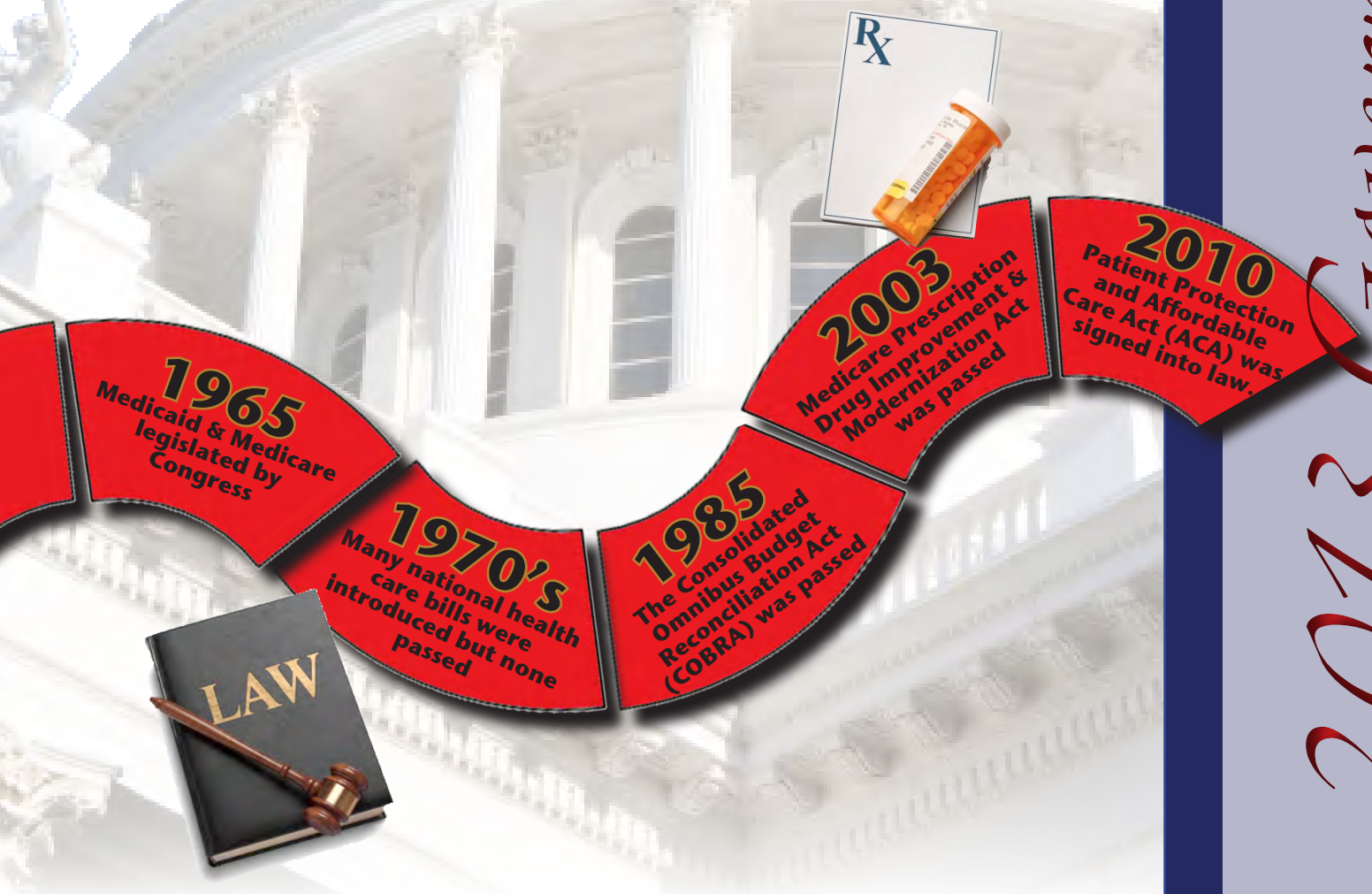
NACDD frequently weighed in with leaders on Capitol Hill and the Administration on the importance of restoring the Prevention and Public Health Fund and expanding other



timeline represents key milestones in the history of US Healthcare

prevention and public health programs with special emphasis on the impact of such funding at the state level. This approach resulted in major program funding successes at the CDC and within the Prevention and Public Health Fund in FY 2014, including: the doubling from $75 million to $160 million of the Preventive Health and Health Services Block Grant that was proposed for elimination; a doubling of Heart Disease and Stroke funding from $52 million to $128 million; the doubling of Diabetes spending from $61 million to $137 million; and, the inclusion of $104 million for Cancer Control and Prevention, the first time a significant amount of funding has been included from the Prevention Fund for cancer control and prevention - all this in a climate of budget cutting and program retrenchment.

NACDD also continued its work with key national partners to advance common priorities.



1,900+

Individuals have been reached since 2012, by evidence-based programs such as EnhanceFitness, through a partnership between NACDD and the national Y-USA network.

120+

Participants attended a three part webinar series facilitated by NACDD's Arthritis Initiative and developed with the expertise of the Consortium for Older Adult Wellness. The webinars provided technical assistance on how to work with Patient-Centered Medical Homes to support self-management opportunities and expansion of evidence-based programs like EnhanceFitness, the Chronic Disease Self-Management Program, and Arthritis Foundation Programs for Better Living.

70+

Leaders attended two policy roundtable meetings hosted by NACDD to discuss arthritis and multiple chronic conditions. These roundtables were held in Florida and Michigan and brought together participants from diverse organizations at the national, state and local levels resulting in greater communications and collaboration to address life with Arthritis. The roundtable outcomes will be used to guide mini-grant funding to local level organizations in 2014.

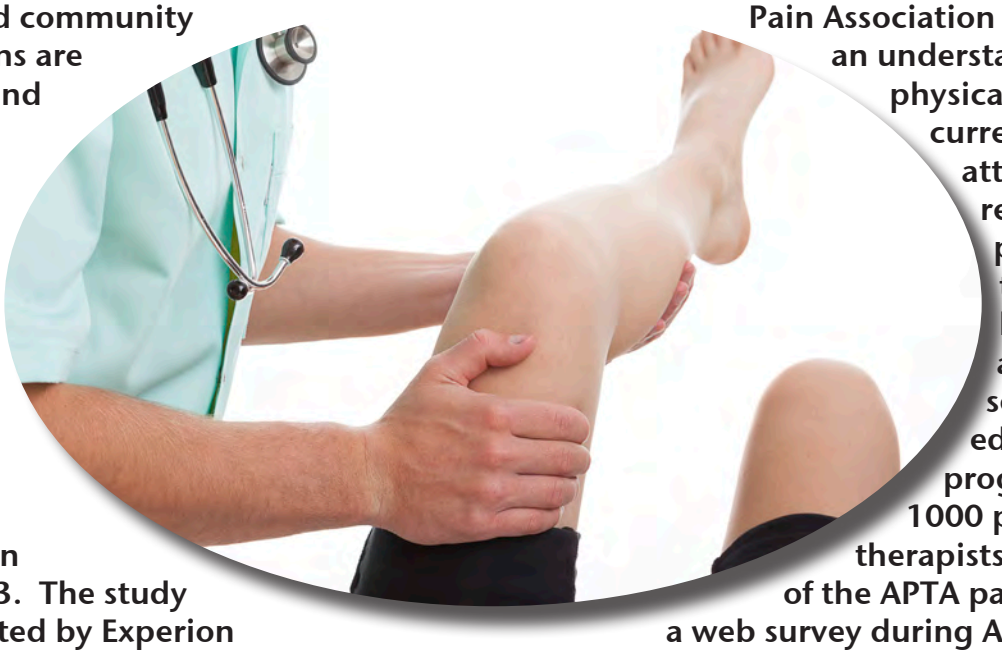
Arthritis

Program Contact: Mari Brick, MA

Arthritis

Efforts to expand and support Evidence-Based Programs to improve the quality of life for people living with Arthritis, continue through established partnerships between NACDD, Y-USA, Centers for Disease Control and Prevention (CDC), American Physical Therapy Association (APTA), and WESTAT among others.

- As a new member of the National Council on Aging's National Resource Center on Chronic Disease Self-Management Education Programs advisory panel, NACDD is in position to ensure that the needs of states and community organizations are being met and to serve as a content expert when needed.
- NACDD partnered to conduct a focus group with NCSL State Legislators in August 2013. The study was conducted by Experion Healthcare Group, LLC in partnership with NACDD, CDC, and the National Council of State Legislators. The focus group results will be used to develop materials and other resources to share with states and partners that will improve the quality of life for people living with Arthritis.
- A study was led by WESTAT with support from NACDD, CDC, APTA and the Chronic Pain Association to develop an understanding of physical therapists' current knowledge, attitudes, and recommended practices related to community-based physical activity and self-management education programs. Almost 1000 physical therapists and members of the APTA participated in a web survey during August and September 2013. Survey results will be used to develop meaningful resources to increase physical activity and self-management education for patients with Arthritis.



Program Contact: Frank Bright, MS

Cancer

5

State health departments were funded by NACDD to develop plans to work with their respective Medicaid agencies to assure cancer screening for clients who may move from the CDC funded Breast and Cervical Cancer Early Detection programs to Medicaid programs under Medicaid expansion and/or the implementation of the Affordable Care Act (ACA). These states (Mississippi, Nevada, New York, Oregon and Utah) joined Michigan, North Carolina and Washington as having developed such plans. Registered participants attended quarterly

63+

Council meetings and other scheduled webinars where the NACDD Cancer Council has established a strong emphasis on professional development and has worked with partners such as CDC and the American Cancer Society to bring best and promising practices to our members. These meetings are used to present information regarding cancer survivorship, tobacco use prevention, cancer registry work, adapting to changes and impacts brought about by the ACA, information sharing among the members concerning Medicaid expansion and implementation of the ACA in their respective jurisdictions.

Outcomes of professional development include better understanding about working cooperatively with Medicaid and raised awareness of issues and concerns of state resident's related to changes in health care. States expressed appreciation, noting that they are now able to work with diverse agencies and programs in new ways or for the first time.

American Cancer Society®

Medicaid

AFFORDABLE CARE ACT

Cancer

Program Contact: Margaret Casey, RN, MPH

Cardiovascular Health

As a Million Hearts® partner, NACDD was active in 2013 promoting the initiative, assisting states in aligning their work with Million Hearts®, and providing technical assistance to states to help them engage their partners in this work. Million Hearts® is a national initiative to prevent 1 million heart attacks and strokes in the U.S. by 2017.

- In 2013, NACDD worked with the states of Illinois, Pennsylvania and Wisconsin as each held a one day Million Hearts® Stakeholders Workshop with more than twenty partner agencies participating. State staff and partners shared their current efforts in hypertension control, sodium reduction and linking clinical services to the community. Small group sessions allowed partners to discuss how to better coordinate and support each other's efforts. Workgroups were formed so that states and their partners can continue to align their efforts with the Million Hearts® initiative.
- As a member of the Million Hearts® Partnership Collaborative, NACDD worked with partners including the American Heart Association, the National Forum to Prevent Heart Disease and Stroke, Association of State and Territorial Health Officials (ASTHO) and National Association of County and City Health Officials (NACCHO) to assist all states, local health agencies and organizations to align their work with the goals of the Million Hearts® initiative. NACDD collaborated with ASTHO to create The Million Hearts® State Engagement Guide, assisting states and their partners to take an active role in reducing heart attacks and strokes.
- NACDD is collaborating with the CDC, national organizations and selected state health departments to implement a two-pronged approach to the State-level Million Hearts® Initiative that includes (1) implementing a data validation project that supports the Million Hearts® Hypertension Control Challenge (MHHCC) and 2) providing state-based technical assistance and programmatic workshops that support community and clinical linkages as well as coordination and collaboration at the national, state and local levels and assist states in improving hypertension control.

astho™

NACCHO
National Association of County & City Health Officials

CVH

Program Contact: Walter "Snip" Young, PhD, MA

CVH Biomarkers Standardization

A little known fact is that clinical laboratory tests are NOT standardized or certified to assure reliable and accurate measurement from clinic to clinic. Consequently, test results for the same blood sample can vary from one laboratory to the next.

When shopping at the grocery store for produce or fueling your car at a gas station, you expect that these certified scales and gas pumps are accurate, so you get what you paid for. Grocery store scales and fuel pumps are tested and certified (standardized) to assure that they are accurate no matter which grocery store you shop in or which station fuel pump you use.

When having your blood drawn and tested for cholesterol, kidney functioning, liver profile and other chronic diseases, you expect the laboratory to accurately and reliably measure these biological markers for disease and that these values are standardized to established clinical values.

In May of 2013 NACDD's Cardiovascular Biomarker Standardization Steering Committee conducted a symposium for health care and public health professionals concerned about high quality patient care to:

1) Inform stakeholders about the importance of standardized, accurate, and reliable laboratory tests to assure appropriate and cost effective patient care; and

2) Familiarize stakeholders with standardization processes and the organizational structure of the Clinical Chemistry Laboratory of CDC's Division of Laboratory Sciences.

At the conclusion of the Cardiovascular Biomarker symposium a discussion summarized the barriers to improved standardization and opportunities to improve accuracy and reliability. This year was an important year for CDC's Clinical Chemistry Branch of the Division of Laboratory Sciences. Congress increased funding for this program in the 2014 Omnibus Spending Bill, including an appropriation of $4.2 million, "to develop standardized cardiovascular disease biomarkers."

/H Biomarkers

Program Contact: Jeanne Alongi, MPH, DrPH

Coordinated CD

Promoting Collaboration Across Categorical Programs

2013 has been an active one for the Coordinated Chronic Disease Learning Community. Members from all states and territories have participated in Learning Community activities that provided them with peer-to-peer learning opportunities, access to national experts in management and leadership strategies, and technical assistance developing a coordinated approach to chronic disease prevention and health promotion.

Coordinated Chronic Disease Core Functions Assessment

A workgroup made up of evaluators, epidemiologists, and program practice experts in states and CDC came together to develop an assessment tool that could be used to measure the impact of a coordinated approach to chronic disease. This tool was fielded in August and provided useful insight to how state chronic disease practice has evolved over the last three years. This tool will be fielded annually.

Regional Training and Networking

Chronic Disease Directors and Block Grant Coordinators came together to learn from each other about what is working in coordinated chronic disease practice and to connect more closely with colleagues at the national level. Our members shared ideas about the direction of innovation in their practice.

Visits with States

We had the privilege of visiting several states including – Connecticut, Nevada, New York, Montana, and South Dakota. We gleaned from their wisdom, explored questions together, and heard from their partners about the shared work that is happening at all levels and across sectors.

CCD

Program Contact: Miriam Patanian, MPH

Diabetes Leadership Iniative

The Diabetes Leadership Initiative (DLI) was a three-year project spearheaded by NACDD and supported by the Boehringer Ingelheim and Eli Lilly and Company alliance to improve the health of people with diabetes by building awareness for the need to detect, delay, and manage the important but often under-recognized major diabetes complications including retinopathy, neuropathy, diabetic kidney disease, and cardiovascular disease.

- Michigan, New York, North Carolina, Washington and Wisconsin were selected to lead demonstration projects focused on diabetes complications: diabetic kidney disease (DKD) initially with later expansion to an additional major complication based on needs of the individuals served by the health care partner(s) participating in the state project. Each state identified a health care partner(s) - defined as a health system, community health center, or primary care clinic – to collaborate on systems changes designed to improve care management for patients with diabetes.

- Key learnings that participants (states, partners, and NACDD) will take from the initiative and apply to future health systems change projects include:

  - **Establishing a functional team is very important to health systems change.** All (physicians, nurses, registered dietitians, patient care coordinators, community health workers, leadership staff, IT staff and vendors) – must be involved in planning and executing health systems changes for the most efficient and effective result.
  - **Public health should enter systems-change partnerships with an eye to sustaining and extending expected successes and health system improvements**. This means an upfront assessment of partner's readiness and potential for sustaining and extending changes.
  - **Every level in a clinic setting is essential** to implementing systems changes. All clinic staff needs to know how their work relates to quality improvement and how it supports patient management.
  - **Health systems improvement projects should relate to meaningful use;** use data to correct system design and collect data with the intent to improve the system. Most DLI project measures that partners reported are aligned with meaningful use measures.
  - **Health systems quality improvement projects should align with reporting requirements** to increase motivation of providers to participate.
  - **Data collection is vital** since ongoing review of the data can drive system improvements.

Lilly

Boehringer Ingelheim

Diabetes

State

In October 2012 NACDD, with support from CDC, entered into a year long cooperative agreement, working with 8 state health departments to engage in statewide or regional/large city efforts promoting increased use of lifestyle change programs that can prevent or delay type 2 diabetes among people at high risk. States were selected based on the established strengths of their current work and capacity in primary prevention such as established connections with key primary prevention partners.

NACDD's objectives were to support states' current primary prevention activities, assist states in developing a plan for scaling those activities, and document the unique contribution state health departments make to support diabetes prevention efforts.

From 24 submitted applications, Colorado, Kentucky, Michigan, Minnesota, New Mexico, New York, Washington and West Virginia were selected for funding.

NACDD, along with CDC, the National Business Coalition on Health, and the Directors of Health Promotion and Education, provided technical support in the form of webinar trainings, site visits, and the development of a peer-learning network.

Program Contact: Marti Macchi, MPH

Diabetes Prevention Program

~4,000,000

Individuals is the estimated reach of the 10 marketing campaigns developed by participating states.

45,000+

Employees from 192 businesses were educated about the National Diabetes Prevention Program and the value of offering it as a covered benefit.

170,000

Individuals will be served through the development of partnerships with 51 healthcare systems.

678

Adult patients have been referred to the National Diabetes Prevention Program.

~9,000,000

Individuals will be reached through the cumulative efforts of the states in developing 25 system partners focused on referrals.

Challenges

- limited funding and staffing at the state health departments
- programmatic delays when working through the state contract system
- insufficient systems to identify current evidence-based lifestyle change program providers within states; including identifying upcoming program dates and locations
- challenged when working with insurers and employers because of a lack of experience, expertise, and partnerships
- insufficient amount of time to implement and sustain strategies to the degree states had initially planned

Specific success of individual states will be highlighted in a document called State Diabetes Prevention Project: Stories of Success 2013. This publication was released in March 2014 at the State Diabetes Prevetion Project Capstone Summit.

Behavioral Risk Factor Surveillance System (BRFSS)

BRFSS is recognized by CDC as the nation's largest continuously conducted system of health-related telephone surveys that collect state data about U.S. residents regarding their health-related risk behaviors, chronic health conditions and use of preventive services.

Behavioral Risk Factor Surveillance System Social Context Module

In 2013, NACDD worked with sixteen state BRFSS programs that chose to include the optional BRFSS Survey Social Context Module in their 2013 questionnaire. Participating states included Alabama, Arkansas, California, Connecticut, District of Columbia, Georgia, Iowa, Kansas, Louisiana, Maine, Minnesota, Nebraska, Nevada, New Mexico, New York and Virginia. The module asked seven questions affecting a person's health including worry or stress over ability to pay for housing or nutritious foods over the past 12 months, employment status, how survey respondent is compensated and if respondent voted in the 2012 presidential election.

NACDD also competitively awarded BRFSS support grants to American Samoa, Alabama, Georgia, Iowa and District of Columbia to include and collect data for the 2014 BRFSS Vision Health Module.

Epi Staffing

NACDD's Epidemiology Staffing Program is supported by NACDD's cooperative agreement with CDC and provides funding to hire and retain Senior Chronic Disease Epidemiologists in state health department chronic disease programs, or to increase state capacity in applied chronic disease epidemiology.

In 2013, NACDD provided a third and final year of salary support to both Oklahoma and Pennsylvania while Kansas received its second year of salary support. All epidemiologist positions continue to be funded with federal and non-federal resources.

Epidemiology Mentoring

The CDC / NACDD National Mentorship in Applied Chronic Disease Epidemiology Program (Mentoring Program) was created to address the shortage of technical expertise in state and local chronic disease epidemiology by working with partners to support the development of a highly functioning cadre of chronic disease public health professionals nationwide. Through the mentoring program, a junior epidemiologist and a senior-level epidemiologist are placed into mentor/mentee pairs (MMP) for a year-long mentoring experience. Mentees receive guidance in completing a chronic disease epidemiology project and technical assistance in competency areas needed for them to assume the role of a state or local chronic disease epidemiologist.

In 2013, NACDD established seven MMPs for mentees employed at state and local health departments in Illinois, Indiana, Tennessee, West Virginia and Texas (3 mentees). Mentors were recruited from state government, local government and universities. The Illinois MMP

examined hospitalization data for select respiratory and cardiovascular conditions to determine the health impact of the Smoke-Free Illinois Act. The Indiana MMP studied the ratio of controller-to-total asthma medications in Indiana's Medicaid population. The Tennessee MMP developed a program evaluation for the Take Charge of Your Diabetes – Diabetes Self-Management Program reviewing impact of self-management education on chronic disease risks. The West Virginia MMP used the state's BRFSS survey data to look at health-related quality

of life for people with diabetes and cardiovascular disease. The project particularly sought to determine if BRFSS survey data could be used to assess how well individuals within this population take care of themselves. Mentees in Texas worked on independent projects with their respective mentors. One project studied the county health department's efforts to align chronic disease epidemiology needs with a community health improvement process and performance measurement; another project reviewed excessive alcohol consumption among adults with chronic medical conditions and a third project analyzed individual-level data for the Texas Diabetes Prevention and

BRFSS

Control Programs and offered recommendations for improved data collection and management.

To develop oral communication and presentation skills, mentees had the opportunity to attend the 2013 Council of State and Territorial

EPI

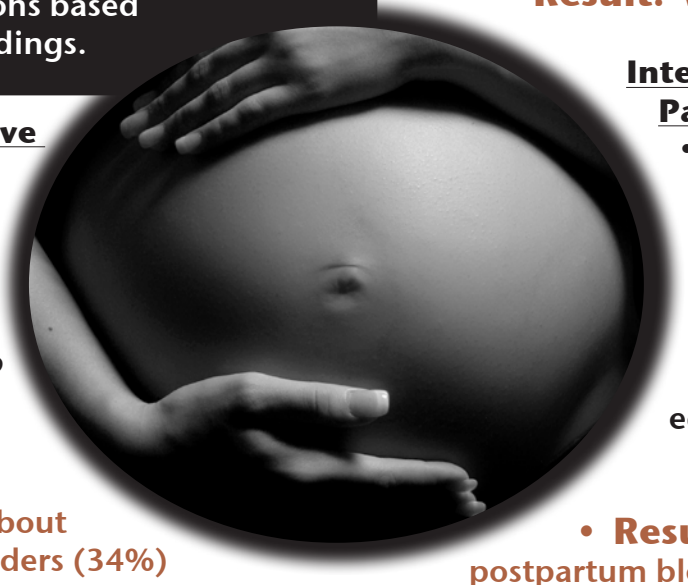
Epidemiologists annual conference and presented at the mentoring program's breakout and roundtable sessions.

Program Contact: Natasha McCoy, MPH

Program Contacts: Joan Ware, RN, MSPH and Adeline Yerkes, MPH

Gestational Diabetes

Gestational Diabetes Mellitus (GDM) is a strong predictor of type 2 diabetes in women, but far too many women who develop GDM are not receiving the postpartum care needed to help them prevent or delay their progression to type 2 diabetes. An important step to reach women with GDM is to improve public health surveillance, which helps to improve data collection, GDM diagnosis documentation, outreach, patient education, and timely interventions. The multi-state and tribal GDM Collaborative developed quality improvement interventions based on the data gaps and findings.



Interventions to improve healthcare providers' care

- In 2013, *Utah* completed a survey of provider practices similar to a 2010 *Ohio* survey and noted the following:

- **Result:** First, only about one-third of the providers (34%) could correctly identify that type 2 diabetes risk, after a history of GDM, is >40%. This is similar to Ohio's result of 33%. Second, only 20% of providers reported testing glucose of women with GDM at post-partum visits "all of the time." This differs significantly from Ohio physicians, with 42% reporting testing "all the time." Results from the survey have been used to develop a professional education program and Web-site for providers.

- *Idaho* completed a survey of Certified Diabetes Educators to determine counseling practices and perceived communication barriers between educators and patients, and educators and referring providers.

- **Result:** The results of this survey were used in the development of a Statewide GDM Summit, held in December 2013 for all GDM providers to develop a plan to address GDM in Idaho.

- *West Virginia* has developed a provider GDM Web-based Education Program; this program was featured at their annual collaborative meeting.

- **Result:** Webinar has had 600 hits.

Interventions to Improve Patient Outcomes

- *Utah* conducted mail outreach to mothers with live births and GDM identified on the birth certificates as a reminder to them of the need for post-partum testing and to educate them about GDM.

- **Result:** Rates of self-reported postpartum blood sugar testing increased by 35%, from a pre-intervention baseline of 36% to a post-intervention rate of 49%. *Oklahoma* is currently replicating the *Utah* mail outreach intervention to mothers with live births and GDM to improve their postpartum visit rate. All women who had a live birth who were identified as having either GDM or abnormal glucose received a postcard reminding them of the need for a post-partum visit. Fact sheets were sent at two points in time to 8,000 providers as a booster to the outreach effort.

- *Chickasaw Nation* collaborated with Brigham Young Women's Center to conduct focus groups of postpartum

women with GDM as to their pre-pregnancy and pregnancy behaviors.

- **Result:** Over 70% of the women (28 women) recruited during the focus group process completed the focus group.

- *Arkansas* developed and implemented a tele-medicine GDM management course for women in 4 underserved counties. Classes began in January 2013

- **Result:** Over an 8 month period, 49 women enrolled in the course; 50% of them were Spanish-speaking. Overall 78% of women enrolled completed a tele-medicine class.

- *North Carolina* conducted a pilot project in Henderson County to improve GDM education through an integrated team approach utilizing WIC, OB Care Managers, and GDM clinic staff.

- **Result:** This project used a team approach to providing GDM education. The 7 women had a shortened time interval for achieving glucose control and reported more positive lifestyle changes after motivational interviewing (from 20% to 80%).

400+

Providers have completed the GDM web-based provider education program developed by Ohio.

5,000+

Women have received information packets on GDM since 2009.

863

Packets were sent out to Utah mothers with live births and GDM identified on birth certificates as a reminder of the need for post-partum testing and to provide education about GDM.

GDM

Health Equity: State Health Department Organizational Self-Assessment for Achieving Health Equity Toolkit and Guidance (Self-Assessment)

This year the Health Equity Council completed the second phase of work on state health department strategic planning guidance to promote health equity. The Self-Assessment was modeled after one developed by the Bay Area Regional Health Inequities Initiative for local health departments. Three pilot states implemented all tools and guidance and provided recommendations for modifications through monthly conference calls and written reports. Based on this feedback, the Self-Assessment was revised and formatted for publication. Plans for 2014 include a series of web-based trainings to orient state health department teams to the tools and guidance followed by technical assistance to help states get started and to provide on-going support.

PHAB

(The Public Health Accreditation Board)

The HEC worked closely with PHAB and ASTHO make recommendations for strengthening the of new standards and measures to include equity in more detail. The Council made major contributions for all the standards and included of how health departments can meet the revised Version 1.5 will go into effect for all departments on or after July 1, 2014.

Workforce Development

In collaboration with the Science and Committee, the Health Equity Council developed to help state health departments improve their to address health disparities and achieve equity. The web-based training focused on understanding of the relationship between economic factors and health outcomes, especially populations experiencing a disproportionate poor health. These factors include: education, wealth, race and ethnicity, sexual orientation, and geography.

Health Equity

Moving From Institutional Racism to Institutional Equity

The Health Equity Council developed a screening tool and a process for identifying institutional racism within the organizations where we work. Council members examined sample strategic plans and practices to see if organizations clearly combat racism through practices like: increased health workforce diversity and competency through recruitment, retention, promotion and training of racially, ethnically, and culturally diverse individuals; and planning documents that convey the message of racial equity.

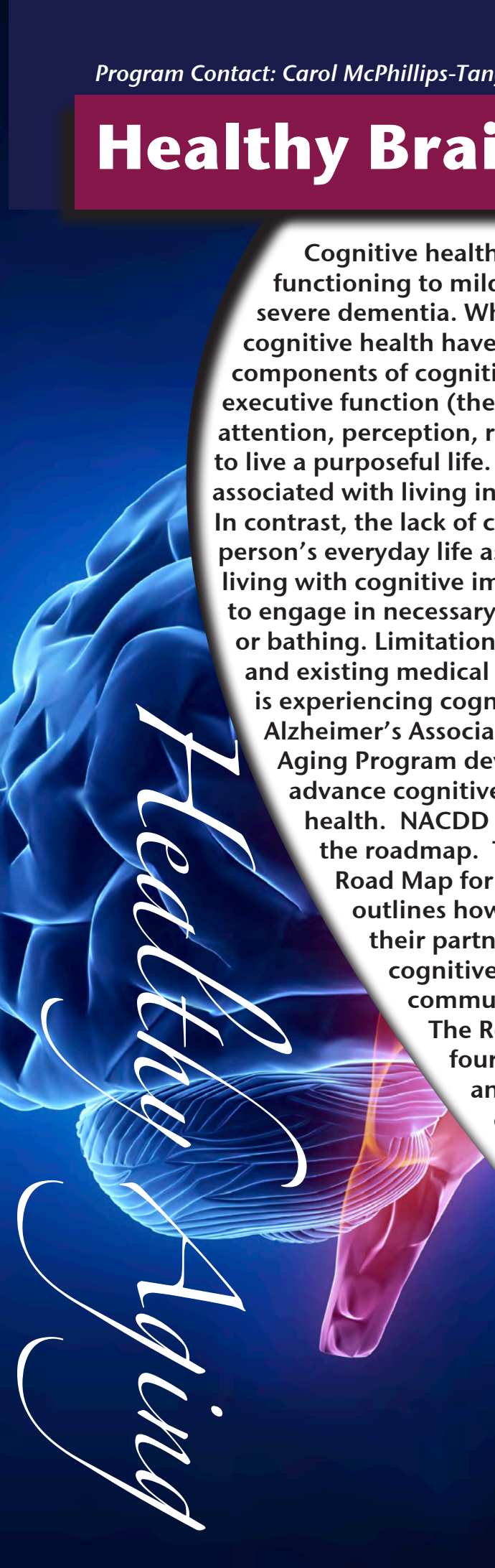
PHAB
Advancing public health performance

astho™

Program Contact: Gail Brandt, EdD, MPH

Program Contact: Carol McPhillips-Tangum, MPH

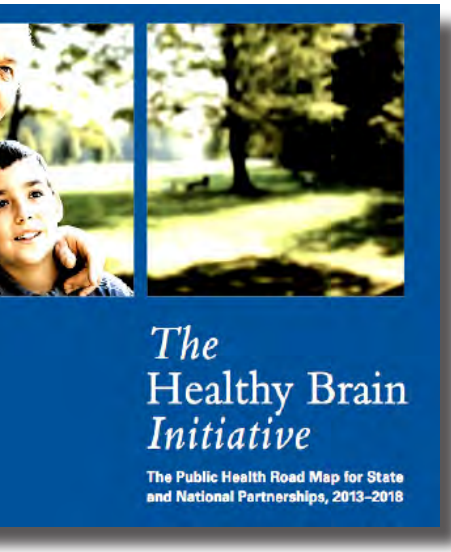
Healthy Brain Initiative



Cognitive health can be viewed along a continuum, from optimal functioning to mild cognitive impairment to Alzheimer's disease and severe dementia. While standardized, widely accepted definitions of cognitive health have yet to be adopted, most experts agree that the components of cognitive functioning include language, thought, memory, executive function (the ability to plan and carry out tasks), judgment, attention, perception, remembered skills (such as driving), and the ability to live a purposeful life. Cognitive health, like physical and mental health, is associated with living independently, quality of life and social engagement. In contrast, the lack of cognitive health can have profound implications for a person's everyday life as well as the lives of their friends and families. Persons living with cognitive impairment may be unable to care for themselves or to engage in necessary activities of daily living, such as preparing meals or bathing. Limitations in the ability to effectively manage medications and existing medical conditions are of particular concern when a person is experiencing cognitive impairment or dementia. In 2013, the Alzheimer's Association and CDC's Healthy Aging Program developed the second in a series of road maps to advance cognitive health as a vital, integral component of public health. NACDD members contributed to the development of the roadmap. The Healthy Brain Initiative: The Public Health Road Map for State and National Partnerships, 2013–2018, outlines how state and local public health agencies and their partners can promote cognitive functioning, address cognitive impairment for individuals living in the community, and help meet the needs of care partners. The Road Map includes 35 action items addressing four traditional domains of public health: monitor and evaluate, educate and empower the nation, develop policy and mobilize partnerships, and assure a competent workforce. In the Road Map, public health agencies and private, non-profit, and governmental partners at the national, state, and local levels are encouraged to work together on those actions that best fit their missions, needs, interests, and capabilities.

The Road Map was informed by a concept mapping process that solicited and then organized action items into domains

using input from a broad group of stakeholders. Using results from the concept mapping process, a subset of action items were identified and subjected to an iterative Delphi technique, a structured method to obtain feedback designed to achieve convergence of opinion. A group of NACDD experts, including chronic disease directors and select local representatives who had relevant expertise or experience, were invited to participate. The purpose was to identify a subset of 4-6 priority actions for state public health practitioners to promote cognitive health or address cognitive impairment and care partners issues in the next 3 to 5 years. Two rounds of the Delphi process were conducted. Round one included a subset of action items, based on those rated with highest criticality and feasibility. Participants in the Delphi process rated each item using a scale from 1 (lowest) to 5 (highest). As a result of the input from participants, the highest priorities included the following six action items from the Road Map:



1. Promote incorporation of cognitive health and impairment into state and local public health burden reports [Develop Policy and Mobilize Partnerships (P), P-03]
2. Use surveillance data to enhance awareness and action in public health programming (e.g. link Behavioral Risk Factor Surveillance System questions on cognition to health-related quality of life or falls prevention) [Monitoring and Evaluate (M), M-02].
3. Develop strategies to help ensure that state public health departments have expertise in cognitive health and impairment related to research and best practices [Ensure a Competent Workforce (W), W-01].
4. Collaborate in the development, implementation and maintenance of state Alzheimer's disease plans [P-01].
5. Engage national and state organizations and agencies to examine policies that may differentially impact persons with dementia, including Alzheimer's disease. [P-05]
6. Integrate cognitive health and impairment into state and local government plans (e.g., aging, coordinated chronic disease, preparedness, falls and transportation plans) [P-02].

This project has led to NACDD's recent release of a Request for Application (RFA) to state and territorial public health departments and their partners to implement one or more priority action items identified previously that address cognitive health or impairment, including Alzheimer's disease, and support the needs of care partners. In 2014, NACDD expects to award funding for up to eleven health departments. The funded health departments will begin work on their funded activities from April 2014 through March 2015. During the funding period, health departments and their partners will receive training and technical assistance from NACDD and CDC, and participate in a Community of Practice.

Program Contact: Karma Edwards, MSPH

HOPE
(Healthy Opportunities through Prevention and Education)

The HOPE Project has proved beneficial in providing NACDD with the opportunity to share its Healthy Communities experiences, to accelerate the number of new communities and states trained on the five-phased Healthy Community model, and to engage in innovative, cost-efficient strategies to augment chronic disease prevention efforts on the local level.

- NACDD Developed 11 community success stories representating each of the funded ACHIEVE national partner organizations. The success stories compendium entitled *Celebrating Change -Community Success Stories from NACDD and National Partners* can be found on the NACDD website (3 of the included success stories are featured in this publication).
- In Collaboration with 11 partnering mentor communities, the Community Mentor Model: The Innovative Framework of Community Partnership guidance document was developed and disseminated to more than 3,500 NACDD members and affiliates of the ACHIEVE National Partnership.
- The Healthy Communities Multi-sectoral Model to Improve Community Health - A Resource Compendium was developed to showcase Healthy Community resources from NACDD and the ACHIEVE National Partnership.
- Through collaboration with the Winter Park Health Foundation, NACDD co-authored the case study Winter Park Health Foundation Making the Case for Foundation Collaboration and Support to showcase this health foundation's Healthy Community (ACHIEVE) successes and lessons learned in three target communities, as well as to provide ample consideration for how health and community foundations can accelerate the Healthy Communities model.
- Individually and collectively with national partner organizations, NACDD led development efforts of two journal articles - one was published and the other was submitted and not yet published.
- NACDD performed 13 outreach activities through the NACDD outlets of Impact Brief articles (e-Bulletin) and General Member webinars to promote ongoing Healthy Communities efforts, news, and successes to more than 3,500 NACDD members - more than doubling the intended reach.
- Community-Clinical Linkage five-month project mini-grants, successfully administered in five existing NACDD Healthy Communities, augmented their existing chronic disease prevention efforts by building community capacity to increase access to preventive services that help community residents better manage their chronic conditions. Collectively, these five communities successfully trained 80 community health workers, established six patient navigators, leveraged

additional funding, created two community resource databases, and implemented and sustained one chronic disease self-management program (potential reach = 914,000)

- A total of 186 public health professionals representing 253 new "approved but unfunded" communities and 8 states were trained on the five-phased Healthy Community model through participation in a five-part webinar series last year - exceeding projected reach by a multiple of more than 25.

HOPE

Background:

In 2008 the Pacific Chronic Disease Council (PCDC) was established with the support of CDC Division of Diabetes Translation and the National Association of Chronic Disease Directors. Comprised of representatives appointed by their Ministers of Health in the 6 US Affiliated Pacific Islands (USAPI), the PCDC made 7 recommendations to federal agencies, including: 1) conduct and publish an assessment of *non-communicable diseases* (NCDs) in the region and 2) establish a pilot PCDC-led 18-month NCD Collaborative in Majuro, Republic of the Marshall Islands (RMI), and the Federated States of Micronesia (FSM) (Yap, Pohnpei, Kosrae, Chuuk).

PCDC

Program Contact: Augusta Rengiil, MPH, BSN, RN

Pacific Chronic Disease

The Pacific Chronic Disease Council, convened an 18-month Non-Communicable Disease Collaborative pilot project in the Federated States of Micronesia (FSM) and Majuro, Republic of Marshall Islands (RMI)

In 2011, the PCDC began development of the NCD Collaborative. The goal of the Collaborative is to reduce health disparities in NCD risk factors and morbidity and mortality by attending to 6 elements: 1) self-management, 2) decision support, 3) clinical information system, 4) delivery system design, 5) organization of health care, and 6) community linkages. An effective NCD Collaborative requires a cyclinical and iterative process (plan, do, study, and act) with at least 4 learning sessions (18-month period) engaging 3-5 member health teams from each site.

In June 2012, each of the 4 states of FSM, and Majuro, RMI, established a team physicians, nurses, public health workers, data analyststo focus on a population of 50 randomly selected patients with diabetes.

In September, 2013 the five teams, their Ministers of Health or designees, trainers, representatives from the Pacific Island Health Officers Association (PIHOA), Cancer Council of the Pacific Islands and the Pacific Basin Dental Association all gathered together to display culturally-grounded storyboards, the teams depicted their progress in rapidly improving the quality of care for people with diabetes.

NCD Collaborative Impact:

Ministry of Health representatives from each jurisdiction responded to the reports of outcome at the Summit, documented on video.

The Teams cross-walked American Diabetes Association Recommendations and World Health Organization PEN (Package for essential non-communicable disease interventions for primary health care: cancer, diabetes, heart disease and stroke, and chronic respiratory disease) Guidelines, adapting standards of care for consistent application accross RMI and FSM.

Five teams elected to sustain the Collaborative, increasing their population of focus to at least 100 patients in their CDEMS registries.

Plans are to expand to other NCDs, with additional funding and training support.

With continued DOI support, continued improvements projected and learning/ reporting sessions will invite other USAPI to participate in evidence-based pilot project to prevent and manage NCDs across the region.

American Diabetes Association®

World Health Organization

Program Contact: Doug Joiner

Safe Routes to School

The Metro Atlanta Region of Safe Routes to School National Partnership (SRTS)continues to be funded by the Kaiser Foundation Health Plan of Georgia, Inc. Our three (3) objectives are:

- Continue to Grow Regional Network
- Continue to promote a SRTS Metro Atlanta Regional Platform
- Continue to promote the School Siting agenda at state and regional levels

Successes in 2013

- Served on the American Heart Association's Advocacy Committee and supported efforts that passed GA HB 382: To amend Chapter 1 of Title 51 of the Official Code of Georgia Annotated, relating to general provisions for torts, so as to limit liability for a governing authority of a school that enters into a recreational joint-use agreement with a private entity; to provide for definitions; to provide for specifications for a recreational joint-use agreement.

- Partnering with various social and public agencies and neighborhood organizations within the Atlanta area we are working with the Pittsburgh Community Improvement Association (a housing rehab organization), the Mayson Avenue Community Collaborative, the City of Atlanta's Pittman Park Recreational Center, the Boys and Girls Club, Families First, Annie Casey and others to train their parent leadership groups by utilizing Safe Routes to School to develop their organizational and leaderships skills with low income communities.

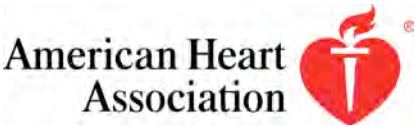
- Newtown County and the Newton County School Board have formally agreed to locate schools in town and village centers. The county's 2050 plan says the framework for school locations will maximize the number of students within walking distance of schools and will reduce bus mileage by about 40 percent.

- We have been able to include in the DeKalb County's Transportation Plan, still being developed by Kimberly-Horn and Associates, language that includes any road projects that involve Safe Routes to School would gain additional points for their project proposal.

- We participated in the first ever joint state bicycle conference sponsored by the state's bicycle advocacy group Georgia Bikes.

- Together with South Carolina's Department of Transportation Safe Routes to School, we hosted well received breakout sessions for participants on how to make Safe Routes work in their community.

- Our partnerships expanded to include the American Heart Association, Georgia Conservancy, Governor Deal's Childhood Obesity Initiative - SHAPE, Fire Up Your Feet (a national incentive program promoting daily activity supported by Kaiser Permanente), Georgia Tech, the Atlanta Beltline and others.



Program Contact: Rachelle Chiang, MPH

School Health

As CDC funding for school health shifted from state education agencies to state health agencies, NACDD proactively met the need for guidance for state health agency staff and produced *Speaking Education's Language: A Guide for Public Health Professionals Working in the Education Sector*. NACDD also partnered with the National Association of State Boards of Education to provide a related webinar training on how to work more effectively with the education sector around health which 45 states participated in. Finally, the Journal of Adolescent Health published NACDD's groundbreaking meta-analysis of the link between health risk behaviors and academic achievement in children and youth. This article meets a big need in the school health area - strong evidence for the relationship between health and achievement.

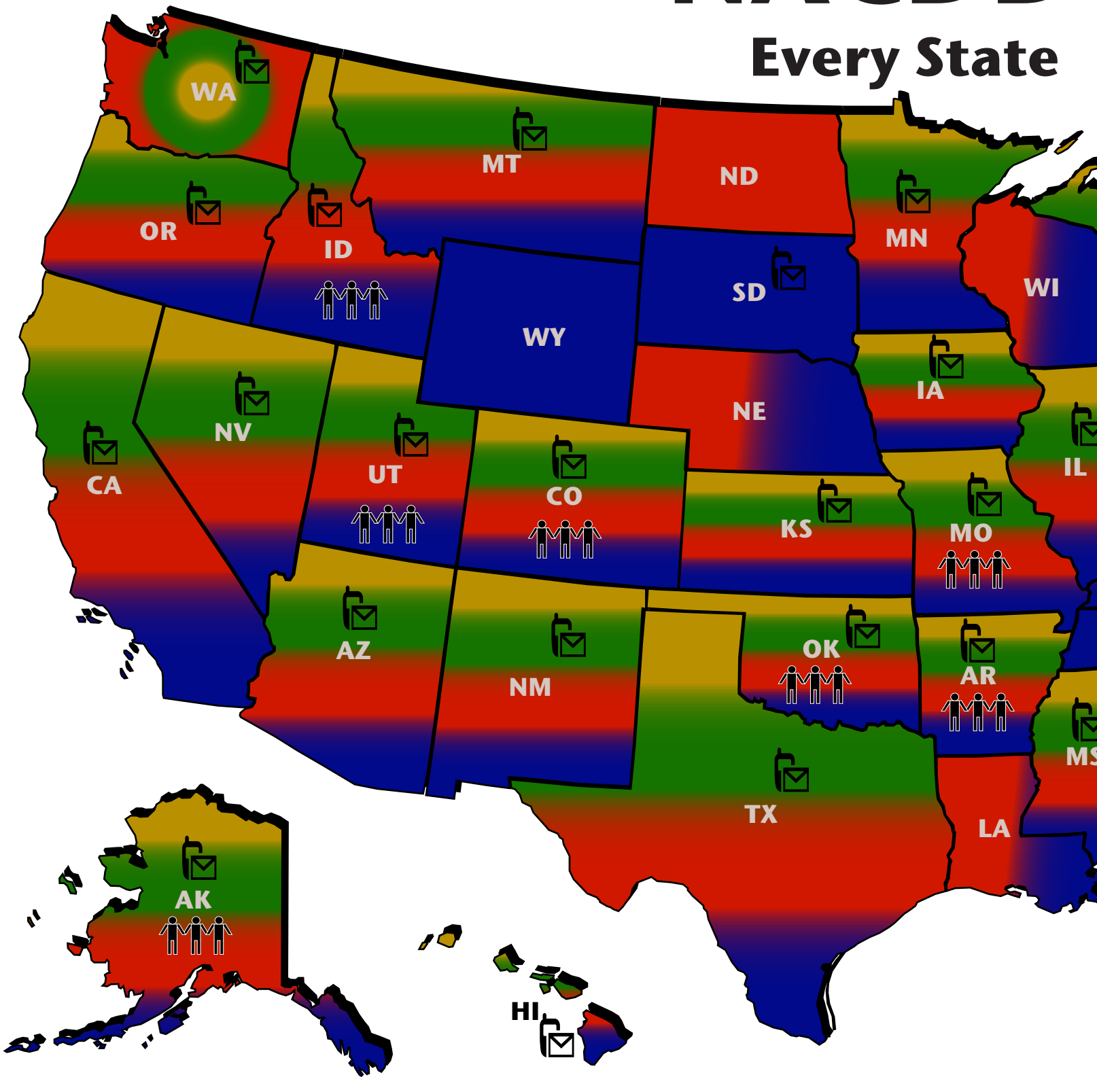
Program Contact: Ellen Jones, PhD, MS

STAR (State Technical Assistance & Review)

NACDD's State Technical Assistance and Review program completed another successful cycle of STAR visits and follow-up technical assistance services for state and local health departments. STAR visits included self-study, on-site expert review and recommendations in the areas of chronic disease unit organization, strengthening statewide chronic disease strategic plans and policy development. Since 2007, 17 sites have participated in a STAR visit. New in 2013 was the addition of local STAR site visits beginning in Sedgwick, Co, Kansas. STAR visits focus on context specific opportunities to transform public health practice utilizing the NACDD framework for Comprehensive Chronic Disease Programs and on successful preparation for PHAB accreditation.

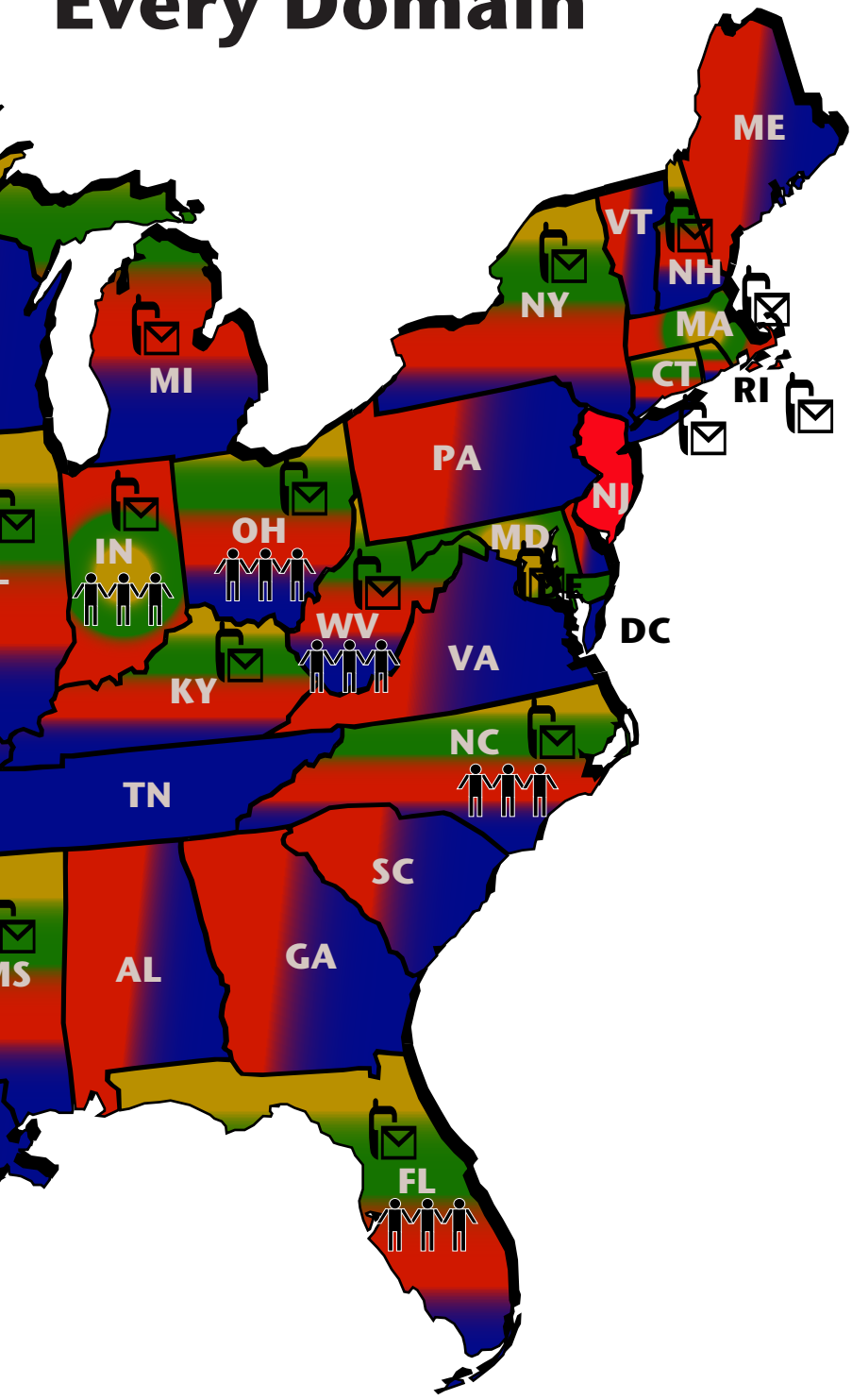
NACDD

Every State



- AS (American Samoa)
- FM (Federated States of Micronesia)
- GU (Guam)
- MH (Marshall Islands)
- PR (Puerto Rico)
- PW (Palau)

IMPACT
Every Domain



VI (Virgin Islands)

Navaho Nations

Chickasaw

Choctaw

Chronic Disease Prevention and Health Promotion Domains

- Domain 1: Epidemiology and Surveillance
- Domain 2: Environmental Approaches
- Domain 3: Health System Interventions
- Domain 4: Community-Clinical Linkages

Note: All states and territories received basic technical assistance (TA) in All 4 domains. The map reflects Intense TA received by domain.

- All 4 Domains
- Domains 1 & 2
- Domains 2, 3 & 4
- Domain 2
- Domain 1
- Domains 3 & 4
- Domains 2 & 3
- Basic TA
- Workforce Development
- Communication & Info Dissemination

Professional Development is a foundational priority at NACDD. For more than 25 years, NACDD has provided quality learning opportunities and workforce trainings for its members. Our organization employs innovative professional development strategies and approaches to meet the needs of the chronic disease practitioners at the state level. Our members are state health department public health practitioners who have a compelling need for professional development in key areas of practice such as epidemiology, health system change, and working to promote community-clinical linkages, to name just a few.

Training Meets States Needs

Academies

NACDD's Annual Chronic Disease Academy has historically provided a robust menu of courses and capacity-building trainings for its members. One state director attributed her continued success and constancy in chronic disease prevention to NACDD's Chronic Disease Academy.

> "The Chronic Disease Academies were instrumental in my success in public health. I did not have a background in public health. The academies taught me how to transition from individual [health] to population health and gave me the competencies to lead a chronic disease unit."
>
> ~ Marisa Marino, Former Acting Director Health Promotion/CCDPHP Grant Mgr Louisiana Department of Health & Hospitals

NACDD also offers smaller state-specific chronic disease academies. There is an increased demand for educational offerings and workforce development opportunities in states due in part to substantial budget cuts, high employee turnover and the changing landscape of public health at large. Despite the pecuniary challenges, NACDD continues to provide critical training and workforce development to states. NACDD has even added new courses to its course catalog and continues to assess current educational offerings and work with states to determine their most urgent technical assistance, training and educational needs.

In 2013, NACDD subject matter experts planned and conducted a training to assist the Washington, DC Department of Health with their coordinated chronic disease plan. This training included specific focus on the four chronic disease domains for health department staff and partners.

NACDD's training efforts also reach beyond the boundaries of the continental US. NACDD's Pacific Chronic Disease Coalition conducted a Non-Communicable Disease Collaborative Training Session. This training resulted in updates for local health care systems for diabetes patients. The following territories were represented at the training: Majuro, Republic of the Marshall Islands; Federated States of Micronesia - Chuuk, Kosrae, Pohnpei, and Yap.

Professional DEVELOPMENT

Webinars

NACDD has made significant strides in providing states with the needed trainings and educational content via live trainings, course offerings and online learning opportunities.

In an effort to disseminate key information to stakeholders and states, NACDD's Professional Development Department provided a total of 68 webinar events in FY 2013 (*See Table 1*).

The General Member Webinars (also known as General Member Calls) allow members to hear various educational topics presented (January through December) in a 1 ½ hour webinar session (previously one-hour) on the fourth Thursday at 3:00 pm ET. Monthly topics are based on needs assessment data from NACDD membership and are also related to 1) NACDD Domains and Competencies, 2) Chronic Disease Prevention and Health Promotion Domains, and 3) PHAB Standards.

NACDD provided technical assistance services via STAR to Puerto Rico, Nevada and also conducted its first ever assessment for a local health department in Wichita, Kansas in 2013.

NACDD values its members and their time commitment to professional development activities. In 2013, in an effort to enhance webinar value to members NACDD began the application process to have the General Member Webinars accredited to offer CME, CNE, CHES, and CEU continuing education credits for doctors, nurses, certified health education specialists and others.

Table 1: NACDD Webinar Offerings from January -October 2013

*GMC - General Member Call; ACA - Affordable Care Act

Type/Category	# of Webinar Events
GMC	8
Other Webinars	17
In-Kind Support (1305 & ACA)	8
Consultant Call Webinars	11
Healthy Communities	6
Diabetes	12
Cancer	6
Total ---->>>>	**68**

NACDD has also expanded its reach in terms of increasing member interest in webinar offerings. During FY 2013, NACDD saw an increase in General Member Call Registrations compared to 2012 (See Figure 1). Webinar attendance also increased drastically from previous years. During the year, NACDD also had several record-breaking webinars in terms of registrations and attendance. Overall, there was a combined total of 4979 webinar registrations and a total of 3278 webinar attendees during the year.

NACDD provides a venue for collaboration and cross pollination of ideas. In 2013, state health department employees (General Members) typically made up about 41% of the audience at General Member webinars. Approximately 59% of the audience was made up of other public health practitioners and partners (Associate, Organizational, Federal,. and Student Members). The General Members Webinars and featured topic webinars are now archived in NACDD's new webinar library, which was also created in 2013. Based on registrations and attendance, the most popular topics for the General Member Webinars were: health equity, school health, manuscript publishing, and healthy aging.

Figure 1: This graph shows General Member Webinar Registrations for several months - comparing 2012 to 2013

Online Learning Opportunities

In 2013, NACDD continued its work with Georgia State University School of Public Health and CDC to formally introduce a new online Chronic Disease Certificate Program for the public health workforce. NACDD has been collaborating with Georgia State University and CDC throughout the entire development process and is now able to share the program with the public. The first cohort is expected to begin coursework in 2014.

NACDD also embarked upon the initial stages of translating several of its live courses to a virtual eLearning format in 2013. Providing online courses/trainings is a vital progression to meet the growing and evolving educational needs of the chronic disease workforce in states. With this development, states can opt for live and/or virtual courses and learning opportunities.

Member Engagement

The "I Count" campaign began as an effort to better know and understand NACDD's members, their needs, and what NACDD as an association can do to better serve members in their work and facilitate their professional growth.

The "I Count" method has provided NACDD with a simple, yet effective way to keep our membership records current, and NACDD looks forward to what the campaign will allow us to do for member engagement in 2014 and beyond.

In 2013, NACDD approached each State Chronic Disease Director with a simple, standard spreadsheet template, requesting basic information for all chronic disease employees in their state. With that information, we were able to improve the fidelity of NACDD's general member database. Prior to the "I Count" campaign, the database had a 40% undeliverable email rate due to state employee turnover.

3,293

Total Members in the Association, this group is comprised of General members (State Health Department Employees), Associate members, and Organizational members.

Since the implementation of "I Count," NACDD more than doubled the active contacts in the NACDD general member database (up by 175%) and increased our email deliverability rate to 88%. Additionally, NACDD saw significant increases in member participation in General Member Calls and NACDD council enrollment.

Northeast Connecticut

Implementing environmental approaches and systems changes to improve nutrition, reduce smoking and exposure to secondhand smoke, and encourage physical activity, reduces risk factors for chronic disease and provides a way to make the healthy choice the easy choice for the people of Northeast Connecticut.

Challenges

- According to the Connecticut Department of Public Health, 26% of Connecticut children are obese. Less time in the school day for physical education classes and recess has reduced children's physical activity, potentially impacting their fitness as well as their academic performance.
- Northeast Connecticut has higher than average rates of diabetes and cardiovascular disease, both of which are nutrition-, physical activity- and obesity-related conditions.

6,500

Students and staff members in 15 schools have participated in the WriteSteps School Walking Initiative that consists of a ten-minute walk during the school day. Data from one school suggest that as a result of the initiative disciplinary referrals decreased, writing scores improved, and the percentage of students passing the physical fitness component of the Connecticut Mastery Test increased dramatically.

impact

Healthy

A Healthier Community

9,600

Residents and thousands of visitors are protected from secondhand smoke exposure due to smoke-free policies implemented by more than 15 municipal parks and properties in the town of Putnam, Connecticut.

32,942

Children and their families now have access to physical activity opportunities along a nearly one-mile stretch of the Putnam Rivertrail that includes an interactive story path to promote walking and reading.

1,350

Pounds were lost and 675 inches by the 129 women who were helped through *The Heart Truth* Community Action Program.

Sustaining the Movement

The Northeast District Department of Health and their public health system partners in the HealthQuest Northeast Connecticut Coalition are continuing their policy/systems/environmental change work.

Communities Success

Ashland Kentucky

Changing policy and environments to improve nutrition, reduce smoking and exposure to secondhand smoke and encourage physical activity reduces risk factors for chronic disease and provides a way to make the healthy choice, the easy choice for the people of Ashland.

Challenges

- Kentucky has an adult obesity rate in the top ten for all states.
- The counties surrounding Ashland, Kentucky have an overweight/obesity rate of nearly 73%, which is higher than the state average of 67%.
- More than a third of the area's 86,000 residents do not exercise at all.
- Obesity and overweight conditions impact 16.5% of Kentucky high school students.
- The smoking rate in Kentucky is the highest in the nation at 29% which is more than 2½ times higher than the state with lowest smoking rate.

5,600+

Students spend the school day in smoke-free environments due to implementation of comprehensive tobacco-free school policies in two school districts.

fight

Healthy

A Healthier Community

7,000

Employees and daily visitors to the hospital in Ashland have increased physical activity opportunities as a result of creation of a new one-mile walking path and reduced secondhand smoke exposure since the hospital grounds became smoke-free.

3,500+

Children in 12 elementary schools have more opportunities to be physically active during outdoor and indoor recess due to new school standards that institutionalize active recess.

1,000+

Preschool-aged children receive at least 60 minutes of physical activity for each full day they are in care at 21 licensed childcare facilities, which adopted new physical activity policies.

543

Employees are allowed physical activity breaks due to newly adopted policie at five worksites; 588 employees benefit from adoption of healthy food option policies by six worksites.

4,688

Students and 735 employees at five worksites have reduced exposure to secondhand smoke.

Sustaining the Movement

A $213,990 Safe Routes to School grant supports sidewalk construction in a neighborhood bordering two elementary schools and will enable 500 children to walk or bike to school safely.

Communities Success

Mason County
Washington

Changing policy and environments to improve nutrition, reduce smoking and exposure to secondhand smoke and encourage physical activity reduces risk factors for chronic disease and provides a way to make the healthy choice, the easy choice for the people of Mason County.

Challenges

- Mason County has the 2nd highest coronary heart disease and lung cancer mortality rates out of 39 counties in the state of Washington.
- Adult smoking, a risk factor for these conditions, is high, with a rate of 26% compared to 16% for the state as a whole.
- Mason County adults are more likely to be obese at the rate of 31% compared to the 27% obesity rate in Washington state overall.

~10,000

Residents of the City of Shelton in Mason County now have access to smoke-free outdoor recreation areas due to implementation of an ordinance designating all Shelton parks as smoke-free.

477

Hawkings Middle School students have healthier food options as a result of new school policies on using non-food rewards and incentives in the classroom and providing healthier foods at school celebrations.

Healthy

change

A Healthier Community

730

Pioneer Middle School students have increased access to resources for reducing smoking and exposure to secondhand smoke with the implementation of a peer-to-peer tobacco prevention curriculum to reduce tobacco initiation and use by youth.

500

Local farmer's market patrons now have better access to healthy food through implementation of EBT technology that enables their use of Supplemental Nutrition Assistance Program (SNAP) benefits.

60,000

Mason County residents have increased access to physical activity opportunities as a result of the completion of the two-mile Oakland Bay Park Trail.

Sustaining the Movement

Pedestrian improvements to make walking and biking safer for residents and the 490 students attending the Evergreen School will be implemented through a 2013 Washington State Department of Transportation grant awarded to the Shelton Safe Routes to School Committee.

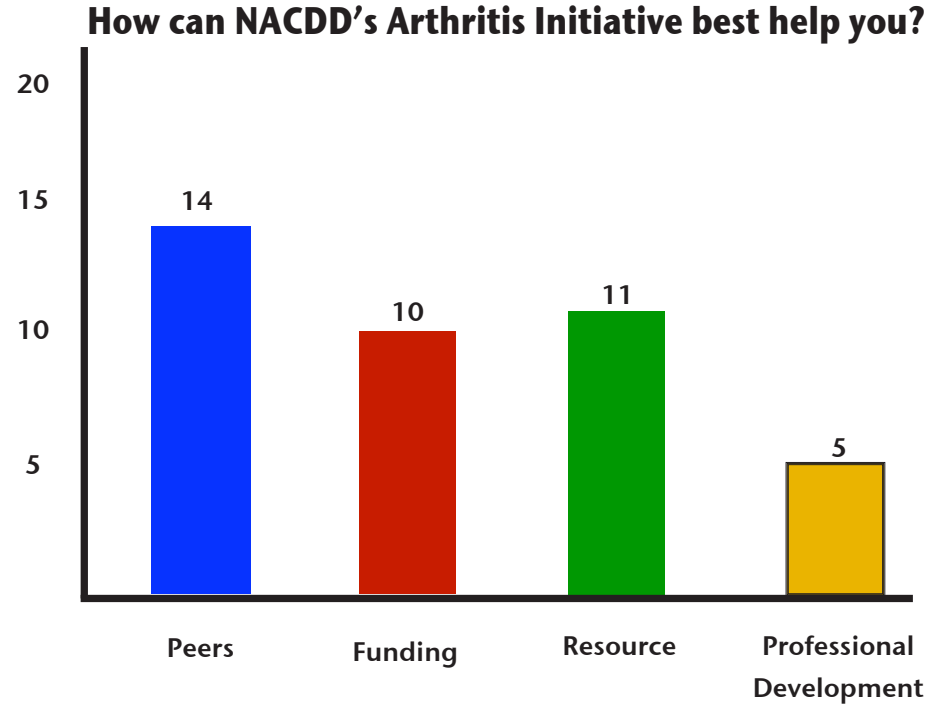
Communities Success

Achieving Quality Assurance:
Evaluating All Programs & Processes

In 2013, NACDD continued to use stringent evaluation methods to review and improve efforts. The focus areas for this evaluation are NACDD's initiatives, activities, and overall Association success. Several new evaluation strategies were added this year, as described below.

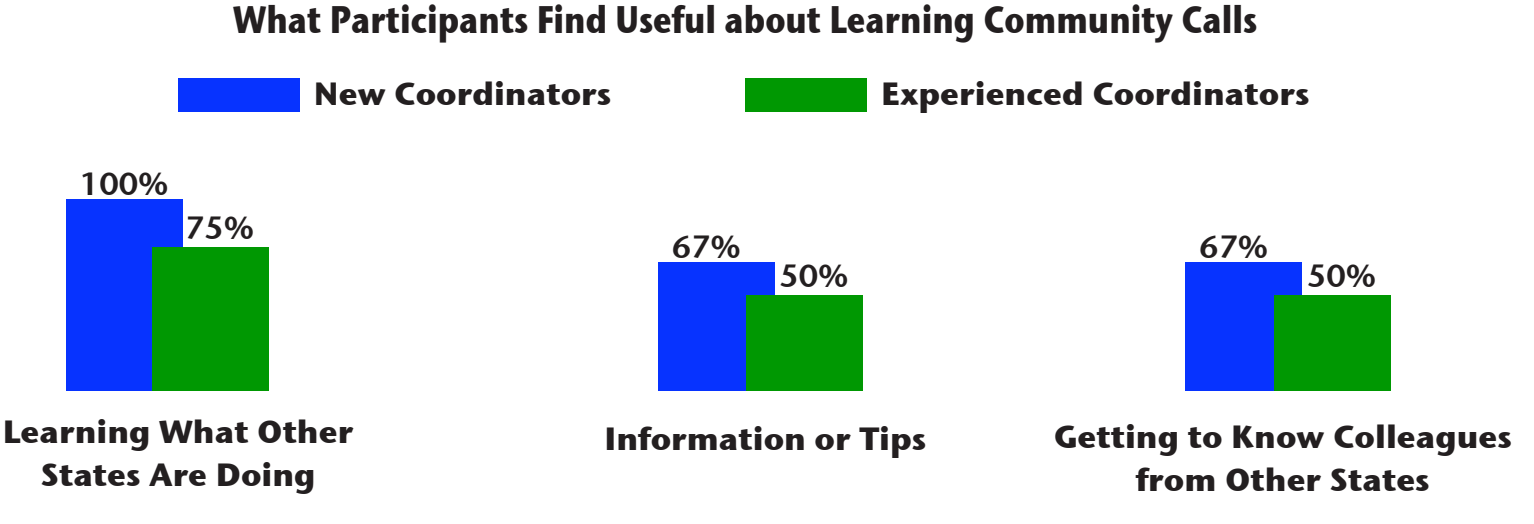
Initiatives:

As described throughout this report, NACDD members are involved in numerous initiatives. Ongoing evaluation occurs by and for these groups, to ensure they are providing members with valuable information and services. This chart displays feedback received by NACDD's Arthrtis initiative, when leaders asked members about their experience with the group.



New for 2013:

NACDD began offering additional opportunities for peer learning and collaboration. With Learning Communities, state chronic disease staff have the chance to meet with each other to address topics of interest. NACDD evaluated these efforts to learn if this method is useful for and needed by states.

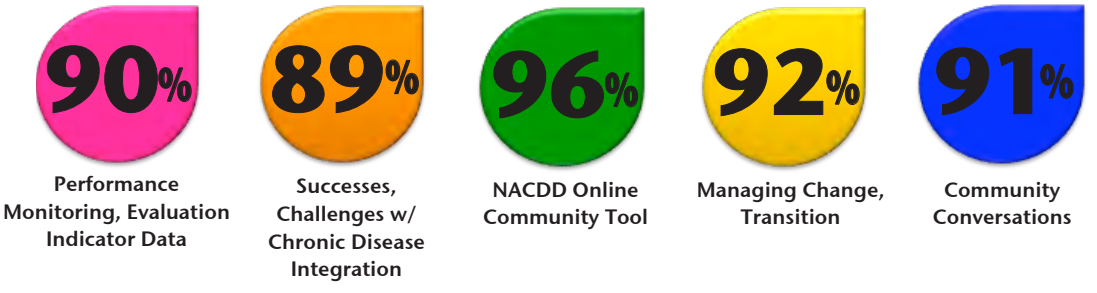


Activities:

In 2013, NACDD continued its efforts to evaluate all activities and programs, including webinars, training sessions, and learning opportunities. The percentages below display the results NACDD's Diabetes initiative received after learning sessions, when participants were asked if the event *added to their level of knowledge*.

Diabetes Initiative Feedback per Activity

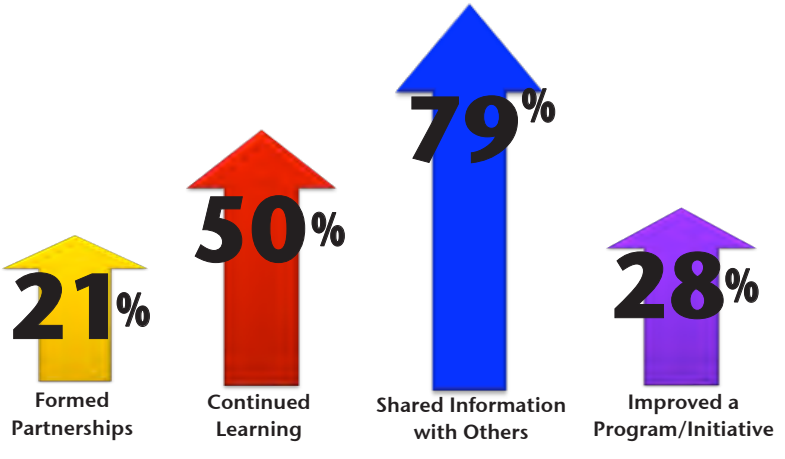
% of Participants Responding that the Event "Added to My Level of Knowldege"



New for 2013:

In addition to the immediate post-event surveys, NACDD began following up with particpants 3-months after events, to measure intermediate outcomes. The chart shows feedback NACDD received 3-months after a General Member webinar. This innovative process will allow NACDD to identify the impact its work has on members and participants.

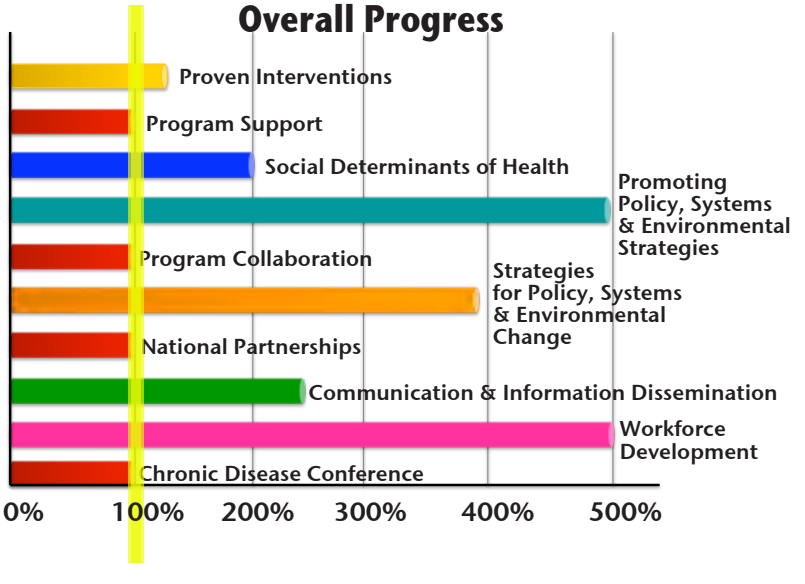
Feedback 3-months Post Webinar



Overall Goals:

In 2013, NACDD continued to track all goals and objectives as required by funders. As with prior years, the Association meets or exceeds all funded objectives. The chart shows NACDD's overall success in reaching objectives as part of our largest cooperative agreement with CDC.

Overall Progress



Communication serves the message collection, translation and dissemination needs of any organization. NACDD's Communications Department is no different, recording, publishing and ultimately broadcasting the work of the Association as well as continually tracking and analyzing the messages and needs of its members.

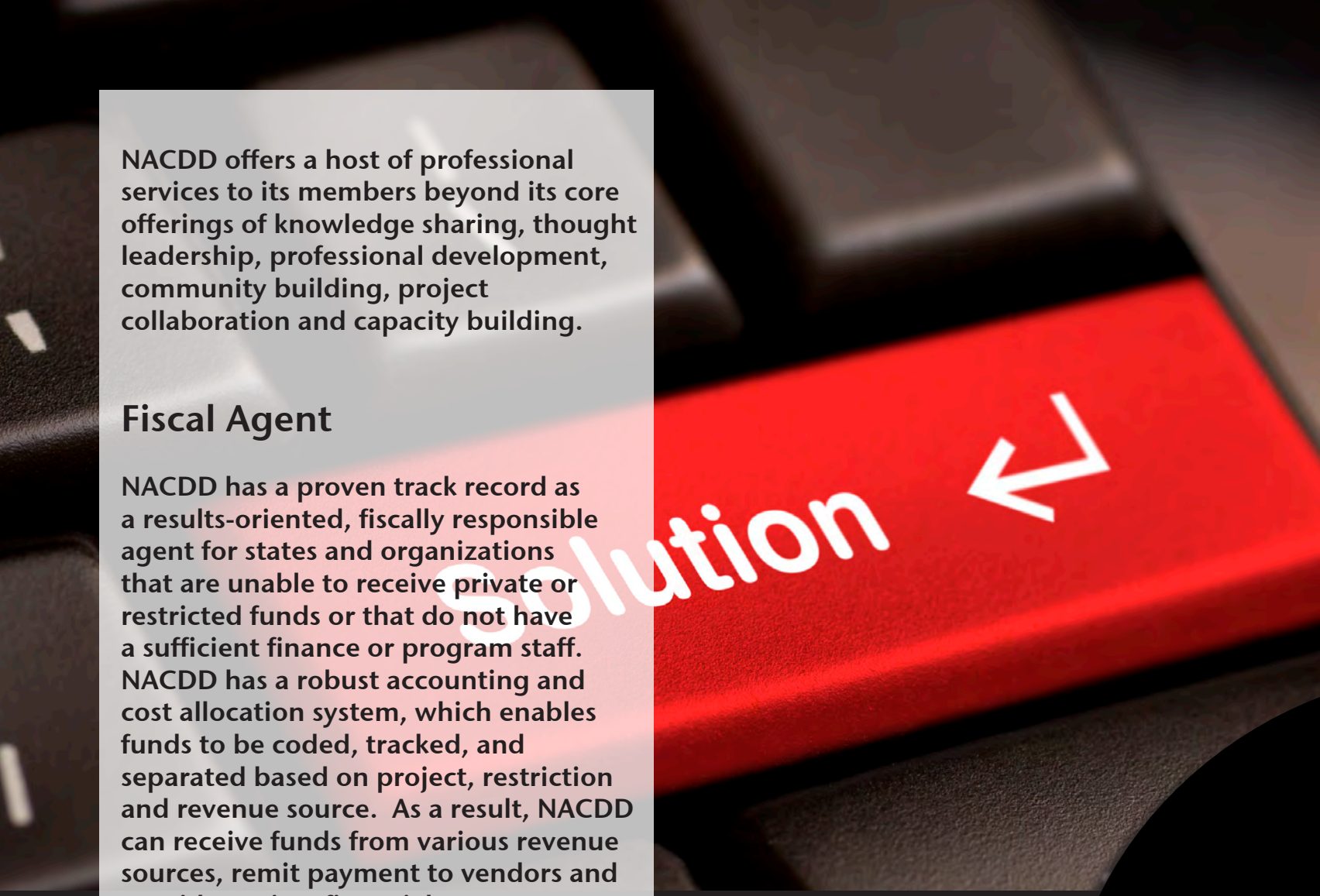
Utilizing various communications analytic tools, the department is able to design products and configurations that meet the specific nature of its members serving in state health departments, while preparing products for dissemination to multiple audiences throughout government and the general public.

Additionally the department grows and manages a robust, web-based community and document sharing library through its CRM software and website. Reports and articles as well as webinars, meetings and disease specific group -pages are housed within the organization's website and facilitate member-to-member interaction.

Public relations, publishing and graphic design are also functions of the Communications Department. Surveys, assessments and regular electronic communication is central to its mission.

Partner development, collaboration and engagement are also essential functions of the department. From its work with community health departments to local health coalitions to national non-profits and corporations the Communications Department establishes and maintains on-going communication and coordination efforts.

Communications



NACDD offers a host of professional services to its members beyond its core offerings of knowledge sharing, thought leadership, professional development, community building, project collaboration and capacity building.

Fiscal Agent

NACDD has a proven track record as a results-oriented, fiscally responsible agent for states and organizations that are unable to receive private or restricted funds or that do not have a sufficient finance or program staff. NACDD has a robust accounting and cost allocation system, which enables funds to be coded, tracked, and separated based on project, restriction and revenue source. As a result, NACDD can receive funds from various revenue sources, remit payment to vendors and provide project financial reports.

Services

Event Planning

NACDD event planning services include but are not limited to registration management, event budgeting, payment of expenses, and selection of hotel and meals. NACDD organizes events in accordance with its healthy meeting policy promoting healthy meal choices, portion control, physical activity during meetings, and tobacco free hotels.

2013 Events

In 2013, NACDD provided event planning services for the meetings listed below.

- Diabetes Leadership Initiative Summit
- Regional Diabetes Meetings
- STAR Visits in Puerto Rico, Nevada, and Vermont
- District of Columbia Summit
- USAPI Non Communicable Disease Collaborative Training Summit
- NACDD's Annual In-Person Board Meeting

Partners

Other Services

- Coalition Building
- Peer Learning and Mentoring
- Development of the State Coordinated Chronic Disease Plans
- Development of State Training Plans
- Development of Chronic Disease Communications Plans
- Development of Chronic Disease Media Plans
- Program Specific, Policy State Technical Assistance Team (PSTAT)
- Chronic Disease Academy
- State Success Stories
- Evaluation

Abbott
A Promise for Life

AHRQ
Agency for Healthcare Research and Quality

American Cancer Society

American Diabetes Association
Cure • Care • Commitment

American Heart Association
Learn and Live

AMCHP
Association of Maternal & Child Health Programs

astho

bioscape digital

Boehringer Ingelheim

CDC
Centers for Disease Control and Prevention

CPH
Campaign for Public Health

CSTE
Council of State and Territorial Epidemiologists

dhpe

HBO

Kaiser Permanente

LEGACY
For Longer Healthier Lives

Merck

NACCHO
National Association of County & City Health Officials

National Institutes of Health

National Cancer Institute

National Cancer Registrars Association

National Kidney Foundation

novo nordisk

Ortho Clinical Diagnostics
a Johnson & Johnson company

Pfizer

Prevent Blindness America
100 Years. Our Vision Is Vision.

PRC
Prevention Research Centers

SAFE STATES

SANOFI

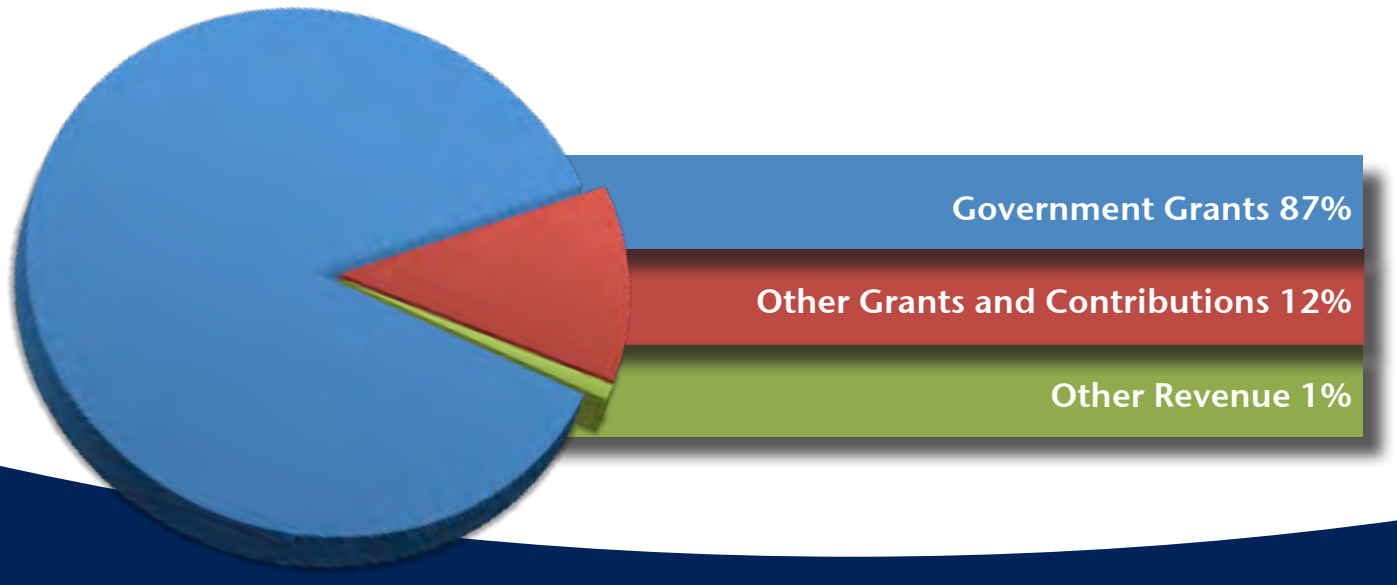
the YMCA

Services & Partners

Financials

	2013	2012	2011
Revenue:			
Government Grants	$8,348,974	$7,942,150	$7,099,010
Conferences and Meetings	4,900	284,085	287,916
Other Grants and Contributions	1,151,610	1,929,106	1,242,963
Member Dues	52,050	42,370	84,550
Investment Income (loss)	64,694	71,786	5,611
Other Revenue	440	225	2,741
Total Revenue, Gains, and Other support	9,622,668	10,269,722	8,722,791
Expenses and losses:			
Program Services	8,139,031	7,856,863	6,683,037
Supporting Services	1,601,780	1,627,127	1,654,998
Management and General	1,576,854	1,573,070	1,632,276
Fundraising	24,926	54,057	22,722
Total Expenses	9,740,811	9,483,990	8,338,035
Change in Net Assets:			
Change in Unrestricted	224,282	415,146	303,419
Change in Temporarily restricted	(342,425)	370,586	81,337
Change in Net Assets	(118,143)	785,732	384,756
Net Assets, Beginning of Year	1,867,717	1,081,985	697,229
Net Assets, End of Year	$1,749,574	$1,867,717	$1,081,985

Total Revenue: $9,622,668



FY2013 Financial Supporters

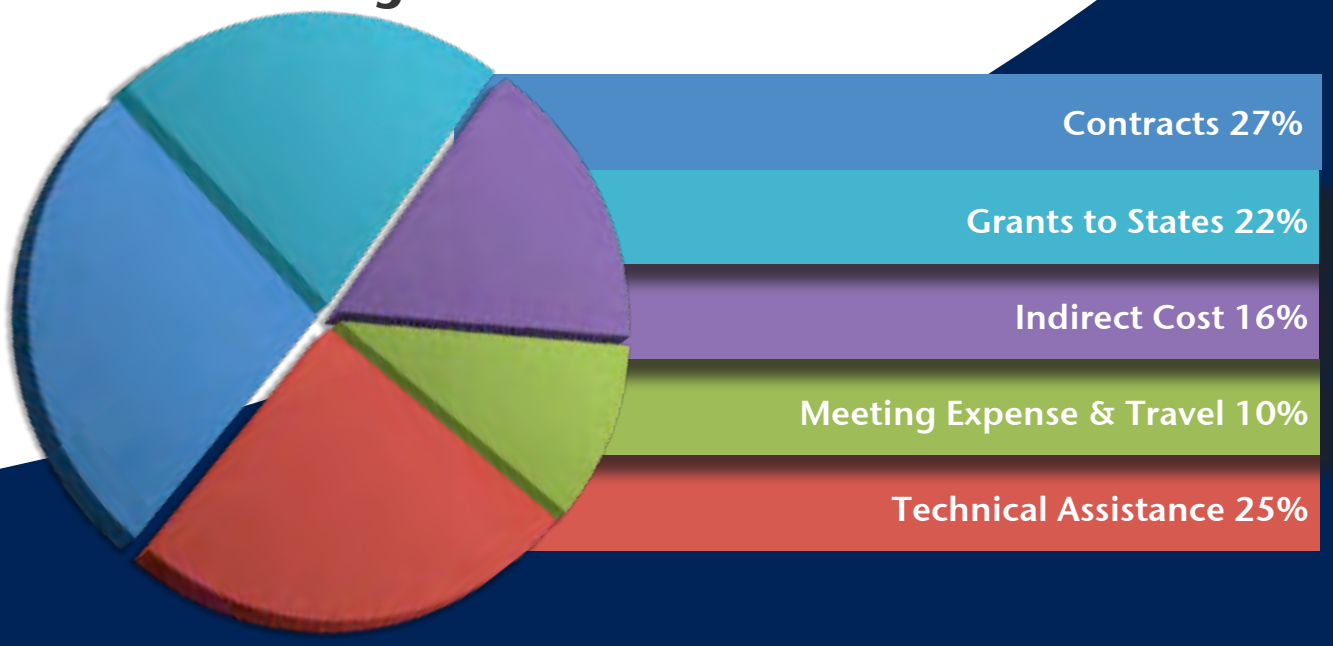
Organizations

- A.T. Still University of Health Sciences, Inc.
- American Heart Association
- Association of State and Territorial Health Officials
- Boehringer-Ingelheim Pharmaceuticals, Inc.
- Carey, Bryan & Yen Foundation
- Colliers International - Atlanta Inc.
- Diabetes Information Resource Center
- HBO
- Kaiser Permanente
- Novo Nordisk
- Ortho Clinical Diagnostics
- Sanofi-Aventis
- Washington University of St. Louis
- Women's Health Conference

Individuals

- Margaret Casey
- Paula Clayton
- Sue Grinnell
- Khosrow Heidari
- Frederick and Schwanna Lakine
- Ellen Jones
- Judy Martin
- John Patton
- John and Linda Robitscher
- Victor Sutton
- David Vigil
- Debra Wigand
- Richard Wimberly
- Laura Wimmer
- Adeline Yerkes
- Walter Young
- Xiao Yu

Total Expenses: Allocation of CDC Cooperative Agreement $8.3M



ProVention Health Foundation was formed to fill a void in the nonprofit healthcare landscape. There was a desire on the part of the National Association of Chronic Disease Directors to create an entity that would work upstream to prevent chronic disease, attempting to fund research and bring awareness to environmental and health system changes such as risk factors, lifestyle, housing, energy, sustainability, food systems, and policy initiatives that greatly impact the risk of disease and disability.

As a result, the NACDD Board of Directors approved the formation of the foundation and its mission. This act created the opportunity to work with nontraditional partners, other government agencies, foundations and private individuals who are dedicated to improving healthcare.

As the name suggests, ProVention is all about Prevention, Promotion and Innovation. Each adjective serves as a filter and differentiator for the work that the foundation chooses to address.

Additionally, ProVention focuses on three practical areas of engagement.

First, as **CONVENER**. Too many times, organizations and individuals are working in silos, unaware of the work of others. ProVention's vast network of private and public contacts will allow it to be a 'neutral third party' to bring together best-in-class partners to discuss, strategize and launch new endeavors.

Second, as **COMMUNICATOR**. This will include the development of health campaigns, public relations, publications and thought leadership utilizing global communication strategies from social media to billboards to tablets, mobile devices and other sources as innovation presents.

Third, as **REASEARCHER**. From proposing research to funding, the foundation will look ahead on the disease continuum to examine trends, strategies, and topics that are on the threshold of impacting populations susceptible to disease and disability.

ProVention Health Foundation is a refreshing newcomer to the health industry, promising to bring innovation to the promotion of health and the prevention of disease.

ProVention

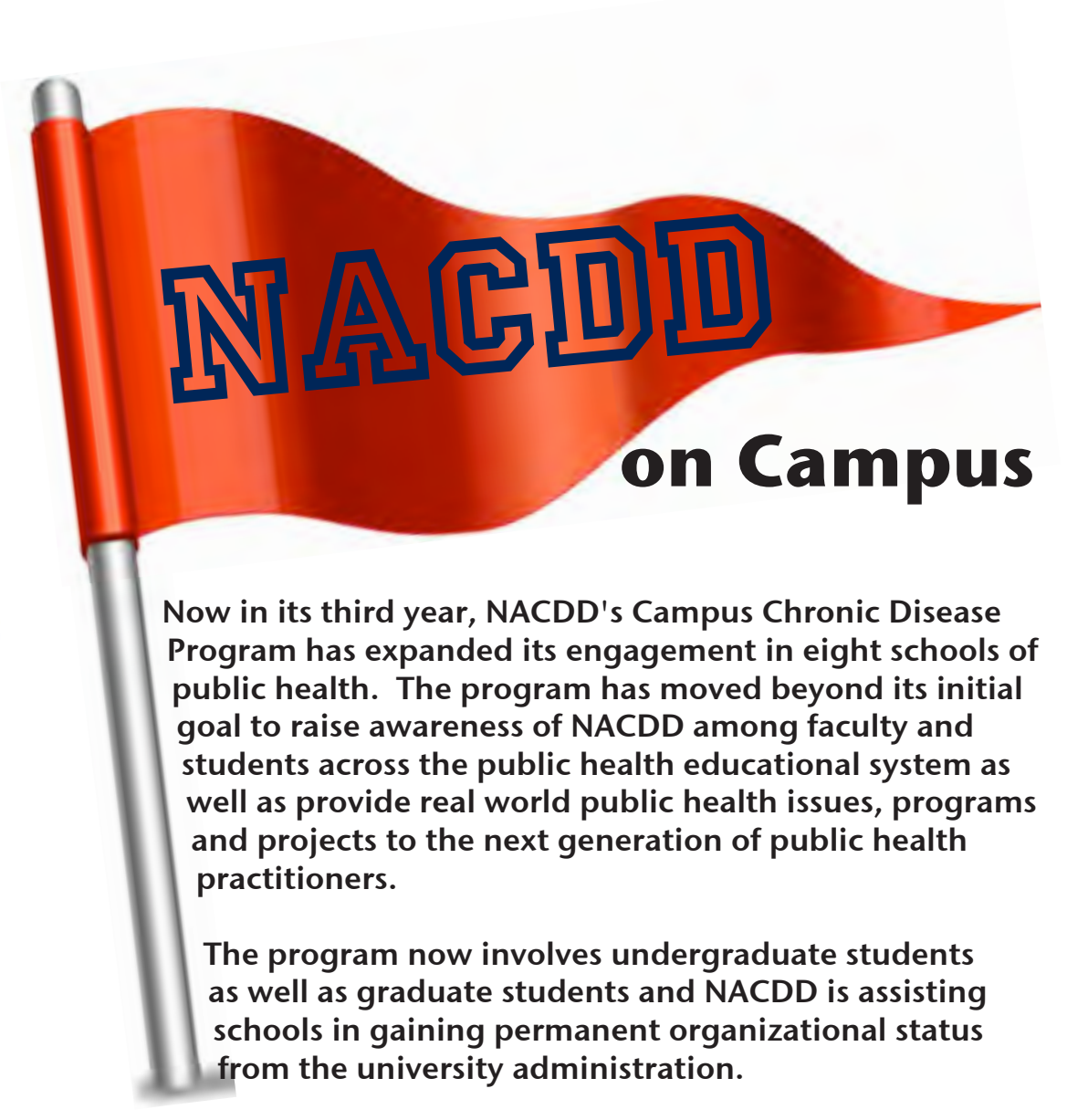
The Better Prevention

PROVENTION HEALTH FOUNDATION

PROMOTION • PREVENTION • INNOVATION

Introducing a New Health Foundation Dedicated to Innovative Promotion of Disease Prevention.

Visit www.ProVentionHealth.org or call 770-458-7400



on Campus

Now in its third year, NACDD's Campus Chronic Disease Program has expanded its engagement in eight schools of public health. The program has moved beyond its initial goal to raise awareness of NACDD among faculty and students across the public health educational system as well as provide real world public health issues, programs and projects to the next generation of public health practitioners.

The program now involves undergraduate students as well as graduate students and NACDD is assisting schools in gaining permanent organizational status from the university administration.

Each campus program begins by identifying outstanding students through a competitive application process to serve as Student Chronic Disease Directors on their campus. Central to the initiative is the requirement of each Director to plan and execute an NACDD sponsored Chronic Disease Day at their school.

Chronic Disease Days include panel discussions, partnering with campus groups to host disease prevention events and/or film screenings of HBO's documentary, Weight of the Nation. One campus presented the film followed by an expert question and answer session including experts from the Centers for Disease Control and Prevention.

Participating schools in 2013 were:
Harvard University, Columbia University, University of Michigan, Emory University, Boston University, University of Georgia, and Georgia State University.

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Director of Finance & Operations

John W. Patton
Director of Communications & Member Services

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Public Health Analyst

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NATIONAL ASSOCIATION OF

CHRONIC DISEASE DIRECTORS

Promoting Health. Preventing Disease.

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