

**NEW MEXICO DIABETES PREVENTION AND CONTROL PROGRAM
FY 11 CDC ANNUAL ACTION PLAN**

Note: Because DPCP oversees the Healthy Communities (HC) initiative, this DPCP Annual Action Plan contains objectives and activities that overlap with the HC objectives and activities. For more detail on the HC initiative, see the Healthy Communities Annual Action Plan.

DPCP GOAL 1: PREVENT DIABETES				
Anticipated Outcome: Increased organizational capacity to prevent pre-diabetes and diabetes				
Long Term Objective 1				
SMART Objective	Indicator(s)	Data Sources	Status	Major Findings/ Barriers
By March 29, 2014, increase the number of DPCP-supported primary prevention programs and/or policies in worksites, schools or communities by 5%. Baseline TBD in 2009.	<ul style="list-style-type: none"> • Number of organizations, neighborhoods, or communities with improved built environments for physical activity • Number of primary prevention programs or policies implemented in worksites • Number of elementary schools implementing Coordinated Approach to School Health (CATCH) • Number of DPCP-supported organizations/coalitions addressing the prevention of diabetes 	DPCP, contractor and/or partner documentation		
Annual Objective 1.1				
Objective	Indicator(s)	Data Sources	Status	Major Findings/ Barriers

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DPCP GOAL 1: PREVENT DIABETES					
By March 28, 2011, receive funding for Safe Routes to School (SRTS).	• Funding received for Safe Routes to School	DPCP, contractor and/or partner documentation			
Rationale for Annual Objective 1.1					
<p>Problem being addressed: Physical inactivity Among New Mexican adults with diabetes: • Almost half are obese; 8 of 10 are either obese or overweight. • About 2 in 5 report no leisure-time exercise. • They are less likely to engage in leisure time exercise (58%) compared to all New Mexican adults (77%). Of New Mexican adults without diabetes: • More than half are overweight or obese. • 1 in 5 did no leisure-time exercise (2006 NM BRFSS). • Many of these persons may already have pre-diabetes, putting them at very high risk for diabetes. This risk can be cut by more than half with a small (5 to 7%) reduction in weight combined with a healthy, low-calorie, low-fat diet and 30 minutes of physical activity 5 days a week (DPP). CDC's Community Guide recommends these types of interventions: "A systematic review of published studies, conducted on behalf of the Task Force on Community Preventive Services by a team of experts, found that people will become more physically active in response to the creation of or improved access to places for physical activity, combined with distribution of information. On the basis of strong evidence of effectiveness, the Task Force recommends implementing such efforts."</p>					
Annual Objective 1.1 Activities	Programs Involved/ Lead Person(s)	Partner(s)	Funding Source	Status	Major Findings/ Barriers
<ul style="list-style-type: none"> • Inform, educate, and empower people about health issues • Mobilize community partnerships and action to identify and solve health problems • Develop policies and plans that support individual and community health efforts. <p>By March 28, 2011 1. Reach out to businesses and to the Navajo tribe to increase social</p>	Anna Hargreaves (DPCP and HC)	Nacimiento Medical Foundation, Navajo Nation, National Park Service, Presbyterian Medical Services, local providers Santa Fe Planning Department, National Park Service, local providers			

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DPCP GOAL 1: PREVENT DIABETES					
support through walking groups. 2. Continue implementation of Prescription Trails in Santa Fe and other communities, incorporating evaluation findings as appropriate.					
Assure a competent public health and personal health care workforce. By March 28, 2011, develop and deliver a state-wide website for PT including maps, a toolkit and interactive provider training.	Anna Hargreaves	DPCP contractor, Prescription Trails partners, local providers,			
Annual Objective 1.2					
Objective	Indicator(s)	Data Sources			
By March 28, 2011, work with NMSU and school systems to maintain the number of elementary schools implementing CATCH at a minimum of 31.	<ul style="list-style-type: none"> • Total number of DPCP-funded elementary schools that have implemented CATCH • Total number of students that have participated in CATCH, by racial/ethnic categories • Annual number of CATCH programs in schools with a > 33% Hispanic population • Annual number of CATCH programs in schools with a >33% American Indian 	DPCP, contractor and/or partner documentation			

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	population • Annual number of CATCH programs in schools with at least 50% of students receiving free or reduced lunch				
Rationale for Annual Objective 1.2					
<p>Issue being addressed: Promotion of lifestyles that create lifelong healthy habits CATCH is an organized, systematic effort to increase social support, in all sectors within a CATCH school, for healthy eating and increased physical activity among school children and their families. In CATCH schools with existing physical education classes, CATCH activities enhance the students' physical activity levels. CDC's Community Guide recommends such enhancements: "On the basis of strong evidence of effectiveness, the Task Force recommends implementing programs that increase the length of, or activity levels in, school-based PE classes." Further, the Guide states that "A systematic review of published studies, conducted on behalf of the Task Force ... found that efforts made in community settings to provide social support for increasing physical activity are effective. On the basis of strong evidence of effectiveness, the Task Force recommends implementation of these efforts."</p>					
Annual Objective 1.2 Activities	Programs Involved/ Lead Person(s)	Partner(s)			Major Findings/ Barriers
<ul style="list-style-type: none"> • Inform, educate, and empower people about health issues • Mobilize community partnerships and action to identify and solve health problems. By September 30, 2010 1. Fund 31 schools for CATCH and provide TA to those schools 2. Identify potential elementary schools, with emphasis on high risk areas or populations, and build relationships with appropriate school personnel By March 28, 2011, provide	Tempa Tate	NM State University (NMSU), school principals, Alliance for a Healthier Generation			

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DPCP GOAL 1: PREVENT DIABETES					
technical assistance to consenting schools to prepare them to meet application criteria.					
Annual Objective 1.3					
Objective	Indicator(s)	Data Sources			
By March 28, 2011, work with diabetes health care system partners to increase organizational and system capacity to address pre-diabetes.	<ul style="list-style-type: none"> • Number of trainings/learning and/or TA sessions about pre-diabetes that DPCP staff and partners participate in • Number of organizational and system interventions that increase capacity to address pre-diabetes • Number of DPCP staff and partners working on pre-diabetes 	DPCP, contractor, and partner documentation			
Rationale for Annual Objective 1.3					
<p>Problem being addressed: Pre-diabetes</p> <p>The CDC 2007 National Diabetes Fact Sheet states that pre-diabetes is a serious concern but that action can delay or prevent progression to diabetes. "In 2003–2006, 25.9% of U.S. adults aged 20 years or older (35.4% of adults aged 60 years and older) had impaired fasting glucose (IFG). ...Studies have shown that people with pre-diabetes who lose weight and increase their physical activity can prevent or delay diabetes and return their blood glucose levels to normal. ...the Diabetes Prevention Program...showed that lifestyle intervention reduced developing diabetes by 58% over 3 years. The reduction was even greater, 71%, among adults aged 60 years or older. Interventions to prevent or delay type 2 diabetes in individuals with pre-diabetes can be feasible and cost-effective." While anecdotal reports point to a growing pre-diabetes problem, NM's current capacity to detect and treat pre-diabetes is minimal, indicating a need to increase our efforts in this area.</p>					
Annual Objective 1.3 Activities	Programs Involved/ Lead Person(s)	Partner(s)	Funding Source	Status	Major Findings/ Barriers

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DPCP GOAL 1: PREVENT DIABETES					
<p>Assure a competent public health and personal health care workforce. By March 28, 2011 1. Support at least 1 provider training for clinical initiatives that address pre-diabetes or diabetes prevention, e.g. Clinical Prevention Initiative (CPI) toolkit and development of an on-line training on pre-diabetes 2. Longer term pre-diabetes program and system work to be determined by DPCP logic model, evaluation, and work plan. Other pre-diabetes initiatives may also result from the updating of the diabetes statewide strategic plan.</p>	<ul style="list-style-type: none"> • Number of provider trainings • Number of pre-diabetes initiatives/systems interventions 	<p>NMDAC, NMHCTOD, NM Primary Care Association, CDPCB Epidemiologist/ Medical Officer, contractor and other partners TBD</p>	<p>DPCP state funds</p>		
<p>Link people to needed personal health services and assure the provision of health care when otherwise unavailable. By March 28, 2011, support at least 1 clinical initiative that increases patient access to services that address pre-diabetes or prevents diabetes (e.g. CPI toolkit)</p>	<p>Shanti Shanti Kaur Khalsa, Eileen Douglass, Amy Wilson, CDPCB Epidemiologist/ Medical Officer</p>	<p>NM Medical Society, NMDAC, NMHCTOD, NM Primary Care Association, CDPCB Epidemiologist/ Medical Officer, other contractors and partners TBD</p>	<p>DPCP state funds</p>		
<ul style="list-style-type: none"> • Mobilize community partnerships and action to identify and solve health problems. • Develop policies and plans that support individual and 	<p>DPCP- Eileen Douglass, Amy Wilson</p>	<p>NM Medical Society, NMDAC, NMHCTOD, NM Primary Care Association, CDPCB Epidemiologist/Medi</p>	<p>DPCP state funds</p>		

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community health efforts. By March 28, 2011, DPCP will determine longer term pre-diabetes program and system work, which may be influenced by DPCP logic model, evaluation, and work plan. Other pre-diabetes initiatives may also be influenced by the updating of the diabetes statewide strategic plan.		cal Officer, other contractors and partners TBD			

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DPCP GOAL 2: PREVENT COMPLICATIONS, DISABILITIES AND BURDEN ASSOCIATED WITH DIABETES.				
Anticipated Outcome 1: Effective diabetes management programs and services				
Long Term Objective 1				
SMART Objective	Indicator(s)	Data Sources	Status	Major Findings/ Barriers
By March 29, 2014, Work with clinic system partners to improve number, reach, and effectiveness of diabetes management services for populations disproportionately affected by diabetes	<ul style="list-style-type: none"> • Number of diabetes management programs and services reaching underserved populations with diabetes • Monitoring of ABCs within clinic systems that have a high percentage of populations disproportionately affected by diabetes 	DPCP, contractor and/or partner documentation		
Annual Objective 1.1				
Objective	Indicator(s)	Data Sources	Status	Major Findings/ Barriers
By March 29, 2010, increase diabetes self-management education (DSME) resources provided to populations/tribes/communities disproportionately affected by diabetes by 5%. Baseline TBD in 2009.	<ul style="list-style-type: none"> • Amount and type of resources and TA provided • Number and location of DSME programs receiving TA and resources 	DPCP, contractor and/or partner documentation		

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Rationale for Annual Objective 1.1					
<p>Issue being addressed: Diabetes self-management education (DSME) as a crucial component of diabetes management The Diabetes Control and Complications Trial (DCCT) demonstrated that keeping blood glucose levels as close to normal as possible slows the onset and progression of eye, kidney, and nerve diseases caused by diabetes. Diabetes self-management education (DSME) can have a significant impact on a patient's ability to manage their disease. The Community Guide states that "diabetes self-management education is effective in improving glycemic (blood sugar) control when delivered in community gathering places for adults with type 2 diabetes, and when delivered in the home for adolescents with type 1 diabetes. Based on this review and sufficient evidence of effectiveness, the Task Force recommends that these strategies be implemented.... DSME can be provided in a variety of community settings, including community gathering places, the home, recreational camps, the worksite, and schools."</p>					
Annual Objective 1.1 Activities	Programs Involved/Lead Person(s)	Partner(s)	Funding Source	Status	Major Findings/Barriers
Assure a competent public health and personal health care workforce. By March 28, 2011, Continue to provide culturally and linguistically appropriate training and resources to DSME programs as needed and as resources allow	Eileen Douglass	DSME programs, contractors and other partners TBD	DPCP state funds		
Inform, educate, and empower people about health issues. By March 28, 2011, continue to work with contractor(s) to provide culturally and linguistically appropriate diabetes management resources for populations disproportionately affected by diabetes (e.g. fotonovelas)	Eileen Douglass, Perdita Wexler, Anna Hargreaves	DSME programs, contractors and other partners TBD	DPCP state and federal CDC funds		
Annual Objective 1.2					

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Objective	Indicator(s)	Data Sources	Status	Major Findings/ Barriers	
By March 28, 2011, maintain the number of Kitchen Creations cooking schools for state FY 11 at 35 schools	<ul style="list-style-type: none"> • Number of KC cooking schools • % of schools provided in American Indian communities • % of schools provided in Hispanic/Spanish speaking/bi-lingual communities • % of schools provided in African American communities • % of schools provided 	DPCP, contractor and partner documentation			
Rationale for Annual Objective 1.2					
<p>Issue being addressed: Healthy eating as a crucial component of diabetes management</p> <p>Optimal management of diabetes requires addressing diet and eating patterns. Kitchen Creations, a free cooking school for people with diabetes and their families, helps address the need for healthy eating by teaching those with diabetes and their family members how to plan, buy and cook healthy meals. Kitchen Creations is delivered locally throughout NM, thus increasing access to this service. One of the recommendations in the NM Performance Improvement Plan is to provide information and services that are accurate, culturally and economically appropriate, and that empower people to act positively on their own behalf. Secondary prevention interventions that incorporate these elements, such as Kitchen Creations, which adapted recipes for the unique New Mexico cultures, will help the DPCP to improve disease management throughout the state.</p>					
Annual Objective 1.2 Activities	Programs Involved/ Lead Person(s)	Partner(s)	Funding Source	Status	Major Findings/ Barriers
<p>Inform, educate, and empower people about health issues.</p> <p>Work with NMSU to maintain the number of KC cooking schools at 35, with at least 20% in populations and tribes/communities disproportionately affected by diabetes</p>	Tempa Tate	NMSU, County Extension Agents, community and tribal partners	DPCP state funds		

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Annual Objective 1.3				
Objective	Indicator(s)	Data Sources	Status	Major Findings/ Barriers
By March 28, 2011, work with diabetes system partners to identify and begin to implement more comprehensive and larger impact approaches to how DPCP supports clinical diabetes management	Number and type of approaches related to how DPCP supports clinical diabetes management	DPCP, contractor and/or partner documentation		
Rationale for Annual Objective 1.3				
<p>Issue being addressed: Diabetes management and limited resources Diabetes is the leading cause of non-traumatic lower extremity amputations and kidney failure, as well as blindness among people aged 20-74. Optimal management of diabetes is essential to preventing serious and costly complications and improving quality of life. Providers who adhere to the ADA Clinical Practice Recommendations can improve the outcomes of their patients. Self-management is extremely important and monitoring clinical indicators such as A1C, blood pressure and cholesterol (ABCs) is essential to monitoring effective clinical management of the disease. For the past 8 years decreases in CDC's overall budget (as well as possible decreases in state funds) and increases in medical costs underscore the importance of using limited resources wisely. Choosing, crafting and delivering high impact strategies, including in how DPCP supports clinical diabetes management, are key to using our resources wisely.</p>				

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Annual Objective 1.3 Activities	Programs Involved/ Lead Person(s)	Partner(s)	Funding Source	Status	Major Findings/ Barriers
<ul style="list-style-type: none"> • Mobilize community partnerships and action to identify and solve health problems. • Develop policies and plans that support individual and community health efforts. <p>* This is DPCP's 5-year evaluation project</p> <p>By June 30, 2010, develop 5-year work and evaluation plans to monitor ABCs among selected clinical partners, including willing NMPCA member clinics.</p> <p>By March 28, 2011, work with diabetes system partners to identify and begin to implement clinical approaches to monitoring ABCs and community-based approaches that support improvements in ABCs.</p>	<p>Eileen Douglass, Amy Wilson, Judith Gabriele, Vonnell Bettencourt, Corazon Halasan</p>	<p>NM Primary Care Association and other partners TBD</p>	<p>DPCP state and CDC funds</p>		
<p>Link people to needed personal health services and assure the provision of health care when otherwise unavailable.</p> <p>By March 29, 2010</p> <p>1) With UNM and other partners, continue to explore the use of digital vision exams and telemedicine in rural and/or medically underserved areas.</p> <p>2) Communicate about and possibly</p>	<p>Pam Kovach</p>	<p>NMHCTOD, NM Optometrist and Ophthalmologist Associations, UNM, NACDD Eye Exam Work Group, and other partners TBD</p>	<p>DPCP state funds</p>		

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coordinate efforts with DPCPs in other rural states to identify strategies to address barriers preventing people with diabetes from getting annual eye exams.					
Annual Objective 1.4					
Objective	Indicator(s)	Data Sources	Status	Major Findings/Barriers	
By March 28, 2011, collaborate with NM DOH TUPAC program to increase the number of people with diabetes who call the NM quitline from 600 to 650 (Based on a projected increase to 600 in FY 10)	<ul style="list-style-type: none"> • Number of people with diabetes who access the NM Quitline • Number of provider trainings on the link between tobacco and diabetes 	DPCP, TUPAC, contractor and/or partner documentation			
Rationale for Annual Objective 1.4					
<p>Problem being addressed: Tobacco use as a risk factor for diabetes complications</p> <p>“Diabetes-specific studies show...there are consistent results ...showing enhanced risk for micro and macro vascular disease, as well as premature mortality from the combination of smoking and diabetes...In particular, system-based approaches that make smoking a routine part of office contacts and provide multiple prompts, advice, assistance, and follow-up support are effective.” (<i>Diabetes Care</i> 2 :1887–1898, 1999) The NM Quitline provides an opportunity for callers with diabetes to access resources that help them quit, including consistent follow-up.</p>					
Annual Objective 1.4 Activities	Programs Involved/Lead Person(s)	Partner(s)	Funding Source	Status	Major Findings/Barriers
<p>Link people to needed personal health services and assure the provision of health care when otherwise unavailable.</p> <p>By March 28, 2011</p> <ol style="list-style-type: none"> 1. Work with Tobacco Program to explore obtaining baseline data on quit rates among people with diabetes 2. Monitor the use of the NM Quitline by people with diabetes 	Anna Hargreaves (DPCP) Nancy Jane Heilman(TUPAC)	Tobacco and diabetes partners TBD	DPCP state funds		

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<p>3. Continue to publicize information about NM quitline and other cessation services among diabetes system partners including NMDAC and primary care providers</p>					
<p>Assure a competent public health and personal health care workforce. By March 28, 2011, continue to provide trainings to general and tribal health care providers about the link between tobacco exposure and diabetes complications, the importance of smoking cessation for people with diabetes, and ways to implement reminder systems and provide brief interventions.</p>	<p>Eileen Douglass, Amy Wilson, Anna Hargreaves</p>	<p>Tobacco and diabetes partners TBD</p>	<p>DPCP state and federal CDC funds</p>		

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DPCP GOALS 1 AND 2: PREVENT DIABETES AND PREVENT COMPLICATIONS, DISABILITIES AND BURDEN ASSOCIATED WITH DIABETES				
Anticipated Outcome: Increased statewide capacity to prevent diabetes and it's complications				
Long Term Objective 1				
SMART Objective	Indicator(s)	Data Sources	Status	Major Findings/ Barriers
By March 29, 2013, work with statewide partners to develop an updated statewide diabetes plan based on a system wide assessment that is inclusive of a broader spectrum of partners	<ul style="list-style-type: none"> • System Assessment completed • Draft statewide plan developed 	DPCP, contractor and/or partner documentation		
Annual Objective 1.1				
Objective	Indicator(s)	Data Sources	Status	Major Findings/ Barriers
By March 28, 2011, complete a strategic planning process, including a system assessment, with a broad spectrum of partners to begin to develop an updated, integrated statewide strategic plan.	<ul style="list-style-type: none"> • Number of sessions with partners exploring the link between common risk factors, including social determinants of health and chronic disease • Diverse representation of system partners and disproportionately affected populations that participate in these sessions 	DPCP, TUPAC, HC, BRFSS, contractor and/or partner documentation		
Rationale for Annual Objective 1.1				

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DPCP GOALS 1 AND 2: PREVENT DIABETES AND PREVENT COMPLICATIONS, DISABILITIES AND BURDEN ASSOCIATED WITH DIABETES

Issue being addressed: Need for DPCP and system partners to understand and address social determinants of health as risk factors for chronic disease

There is an increasing body of knowledge about the importance of social determinants of health and their causal relationship to chronic and infectious diseases (CDC, NIH, WHO, Kaiser Family Foundation, etc.). The DPCP, along with the CDPCB and other partners aims to broaden partnerships and strategies that go beyond the standard chronic disease risk factors in order to address the social determinants of health. This will create more sustainability and higher impact long term improvements in health outcomes.

Annual Objective 1.1 Activities	Programs Involved/ Lead Person(s)	Partner(s)	Funding Source	Status	Major Findings/ Barriers
<ul style="list-style-type: none"> • Mobilize community partnerships and action to identify and solve health problems. • Inform, educate, and empower people about health issues. • Develop policies and plans that support individual and community health efforts. <p>By March 28, 2011, work with TUPAC, Healthy Communities, BRFSS, Cardiovascular Health and other relevant partners to complete an integrated strategic planning process in order to develop an updated, integrated statewide strategic plan.</p>	<p>Shanti Shanti Kaur Khalsa, Amy Wilson, Judith Gabriele (DPCP), Anna Hargreaves (DPCP and HC), Sandy Adondakis, Larry Elmore (TUPAC), Vivian Heye (BRFSS), David Vigil (CDPCB)</p>	<p>NMDAC; NMHCTOD; NMCDPC; TUPAC; HC: BRFSS; CDPCB; American Heart Association; NM DOH Health Systems Bureau; other integration partners; representatives of populations disproportionately affected by diabetes, tobacco use, and heart disease; Health Councils; and other system partners to be determined</p>	<p>DPCP state and federal CDC funds</p>		

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Long Term Objective 2				
SMART Objective	Indicator(s)	Data Sources	Status	Major Findings/ Barriers
By March 29, 2014, work with diabetes system partners to increase the number of environmental, social, policy, or system changes that prevent diabetes or its complications. Baseline TBD in 2009.	• Number and locations of environmental, social, policy, or system changes that prevent diabetes or its complications	DPCP, contractor and/or partner documentation		
Annual Objective 2.1				
Objective	Indicator(s)	Data Sources	Status	Major Findings/ Barriers
By March 28, 2011, work with Tobacco Program and Navajo Nation to educate about environmental approaches to prevent tobacco exposure (excluding ceremonial use), e.g. secondhand smoke (SHS) policies	• Number, location, and type of educational interventions in Navajo Nation	DPCP, TUPAC, Navajo Nation, and contractor and partner documentation		
Rationale for Annual Objective 2.1				
<p>Problem to be addressed: Tobacco exposure as a risk factor for the development of diabetes Smoking is hypothesized to increase insulin resistance. Results of previous observational studies assessing the association of smoking and incidence of diabetes have been mixed. Houston et. al found that “tobacco exposure is associated with the development of glucose intolerance over a 15 year period, with a dose-response effect apparent.” They report that “A strong association existed between both active and passive tobacco smoke exposure and subsequent development of impaired fasting glucose or diabetes over 15 years. Among smokers, total pack years smoked was associated with increasing risk of incident diabetes. If confirmed by further research, these findings provide further documentation of the deleterious effects of tobacco smoking, and policy makers may use them as additional justification to reduce exposure to passive smoke.” (BMJ 2006; 332; 1064-1069; originally published online 7 Apr 2006). Because tribal lands and private housing are not covered by New Mexico’s clean indoor act, DPCP will work with Tobacco Program to advance the prevention of tobacco exposure on tribal lands and in housing.</p>				

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Annual Objective 2.1 Activities	Programs Involved/ Lead Person(s)	Partner(s)	Funding Source	Status	Major Findings/ Barriers
<ul style="list-style-type: none"> • Diagnose and investigate health problems and health hazards in the community. • Mobilize community partnerships and action to identify and solve health problems. • Develop policies and plans that support individual and community health efforts. <p>By March 28, 2011</p> <ol style="list-style-type: none"> 1. Work with diabetes program and tobacco advocates within Navajo Nation to take appropriate next steps to address exposure to second hand smoke. 2. Work with TUPAC to identify and work with other sectors of communities interested in implementing SHS policies (e.g. public or private housing) 	<p>Perdita Wexler (DPCP), Anna Hargreaves (DPCP and HC), David Tompkins and Rufus Greene (TUPAC)</p>	<p>Navajo Nation, Village of Cuba, Tobacco and other partners TBD</p>	<p>DPCP state funds</p>		
<p>Inform, educate, and empower people about health issues.</p> <p>By March 28, 2011</p> <ol style="list-style-type: none"> 1. Continue to work with the NM Indian Affairs Department to increase their understanding of and gain their support for initiatives that address tobacco exposure and diabetes in tribal communities (excluding ceremonial use of tobacco). 2. Continue to work with TUPAC and Navajo Nation to develop 	<p>Perdita Wexler (DPCP), David Tompkins (TUPAC)</p>	<p>Navajo Nation, Indian Affairs Department, and tobacco and other partners TBD</p>	<p>DPCP state funds</p>		

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Annual Objective 2.1 Activities	Programs Involved/ Lead Person(s)	Partner(s)	Funding Source	Status	Major Findings/ Barriers
educational campaigns about exposure to second hand smoke.					
Assure a competent public health and personal health care workforce. By March 28, 2011, continue to work with Tobacco Program and other partners to provide trainings to tribal health care providers, Indian Health Service, and/or coalitions on the link between SHS exposure and diabetes.	Eileen Douglass, Amy Wilson, Anna Hargreaves (DPCP), Sandy Adondakis (TUPAC)	TUPAC, Indian Health Service, NMSU, UNM Project ECHO, contractor, and other partners TBD	DPCP state and federal CDC funds		
Annual Objective 2.2					
Objective	Indicator(s)	Data Sources	Status	Major Findings/ Barriers	
Continue to work with at least 1 tribal or county health council that has identified diabetes or obesity as a priority to identify and implement evidence-based or promising approaches that reduce obesity and/or diabetes.	<ul style="list-style-type: none"> • Location and type (i.e. county or tribal) of council • Type of TA provided • Type of intervention implemented 	DPCP, contractor, and partner documentation			
Rationale for Annual Objective 2.2					
<p>Problem to be addressed: Communities and tribes know what works best in their communities Engaging communities in decision-making about health issues empowers them to use their expertise to prioritize issues and determine the best ways to address them. Because they are more familiar with their community than the DPCP is, they know best what their culture and needs are, and the most appropriate ways to address them. DPCP is a partner and resource to these communities in addressing these needs. Working collaboratively with empowered communities creates synergy and sustainability. According to the NM PIP, "Collaboration is believed by many to be the key to an effective diabetes system." If we don't establish and maintain these community partnerships, we will not use our resources as effectively and we will not be as successful in achieving long-term results. County and tribal health councils are established infrastructures with which to work at the community level.</p>					

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Annual Objective 2.2 Activities	Programs Involved/ Lead Person(s)	Partner(s)	Funding Source	Status	Major Findings/ Barriers
<ul style="list-style-type: none"> Mobilize community partnerships and action to identify and solve health problems. Develop policies and plans that support individual and community health efforts. <p>By March 28, 2011</p> <p>1. Continue to provide technical assistance to San Miguel Health Council in its efforts to develop school policies that prevent diabetes.</p> <p>2. Continue to build relationships and support health councils that are ready to implement evidence based environmental, social, policy, or system approaches to prevent diabetes or its complications.</p>	Perdita Wexler	San Miguel Health Council, UNM, DOH Office of Health Promotion and Community Health Improvement, other partners TBD	DPCP state funds		
Annual Objective 2.3					
Objective	Indicator(s)	Data Sources	Status	Major Findings/ Barriers	
By March 28, 2011, work with epidemiology and evaluation partners (including BRFSS) to increase DPCP capacity to conduct surveillance, monitor and evaluate statewide efforts that prevent diabetes and its complications	<ul style="list-style-type: none"> Number of new data sources being used Number of evaluations 	DPCP, BRFSS, contractor and partner documentation			
Rationale for Annual Objective 2.3					
<p>Problem to be addressed: Development and maintenance of planning, surveillance and evaluation activities and systems to define the burden of diabetes, assist in program planning and allocate resources</p> <p>DPCP uses surveillance data to inform planning and decision-making around allocation of resources and for evaluation of progress in achieving</p>					

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Annual Objective 2.1 Activities	Programs Involved/ Lead Person(s)	Partner(s)	Funding Source	Status	Major Findings/ Barriers
<p>outcomes. Having varied data sources for surveillance provides a more complete picture of the burden of diabetes in our state. Logic models and evaluation data are essential planning and implementation tools that help us set direction and refine strategies for our projects and programs. Without surveillance and evaluation, planning and implementation of DPCP projects would be ill informed and less successful in helping us achieve positive health outcomes.</p>					
Annual Objective 2.3 Activities	Programs Involved/ Lead Person(s)	Partner(s)	Funding Source	Status	Major Findings/ Barriers
<ul style="list-style-type: none"> • Monitor health status to identify community problems. • Diagnose and investigate health problems and health hazards in the community. <p>By December 31, 2010, with CDPCB Epidemiologist/ Medical Officer, Tobacco Epidemiologist, and DOH survey unit staff, explore new data sets for monitoring diabetes and associated risk factors</p> <p>By March 28, 2011 1. Build relationships with existing and new partners that support surveillance and monitoring of diabetes and complications 2. Begin to incorporate new data sets as appropriate</p>	<p>Corazon Halasan (DPCP), Wayne Honey (BRFSS), James Padilla (TUPAC), Susan Baum (CDPCB Epidemiologist)</p>	<p>DOH's community and tribal epidemiologists, BRFSS, CDPCB epidemiologists, Southwest Tribal Epidemiology Center, Navajo Tribal Epidemiology Center, Indian Health Service, NM Department of Indian Affairs, NM Health Policy Commission, other partners TBD</p>	<p>DPCP state and federal CDC funds</p>		
<p>Evaluate effectiveness, accessibility, and quality of personal and population-based health services. By December 31, 2010 1. Continue to work with DPCP staff</p>	<p>Vonnell Bettencourt, Amy Wilson, Shanti Shanti Kaur Khalsa</p>	<p>DPCP contractors, NMPCA, and other system partners</p>	<p>DPCP state and federal CDC funds</p>		

**NEW MEXICO DIABETES PREVENTION AND CONTROL PROGRAM
FY 11 CDC ANNUAL ACTION PLAN**

Annual Objective 2.1 Activities	Programs Involved/ Lead Person(s)	Partner(s)	Funding Source	Status	Major Findings/ Barriers
<p>and contractors to establish appropriate evaluations for selected DPCP projects and contracts</p> <p>2. Work with NM Primary Care Association, member clinics, and others to determine next steps in ABC project.</p> <p>By March 28, 2011, complete evaluation of integrated strategic planning process.</p>					
<p>Assure a competent public health and personal health care workforce.</p> <p>By March 28, 2011</p> <p>1. Continue to work with DPCP contractors to increase skill and understanding of project evaluation</p> <p>2. Continue to obtain training or TA from outside evaluators as needed and as funding permits.</p>	Vonnell Bettencourt	DPCP contractors and external professional evaluators, as needed	DPCP state and federal CDC funds		