

New Mexico Diabetes Prevention and Control Program Strategic Plan 2010 – 2014

GOAL 1: PREVENT DIABETES

Note: Long term outcomes are dependent on the achievement of intermediate and short term outcomes. Time frames for achieving outcomes will vary, based on a variety of factors (e.g. resources, readiness, complexity of the issue, etc.).

Long-term Objective to Achieve Goal 1:

By March 29, 2014, work with diabetes system and other partners to increase the impact of primary prevention programs and environmental, social, policy, or system changes that prevent diabetes or its complications by 5%.
(See pages 6-9 for FY 10 objectives and activities related to this Long-term Objective.)

Desired Outcomes:

Short-term Outcomes

Policy/Environment/System:

- Increased organizational capacity to prevent pre-diabetes and diabetes
- Communities develop incentives, policies & opportunities which promote being active
- Increased attractive & safe public space for physical activity for all abilities
- Diabetes Prevention and Control Program (DPCP) programs target populations with health disparities such as low socioeconomic status (SES)
- Communities have extra supports & incentives for physical activity for those with chronic conditions, including diabetes
- Environmental, social, policy, or system changes that prevent diabetes and diabetes complications
- Established effective information network among state-level diabetes system partners about statewide efforts

Pre-diabetes:

- Increased provider recognition of pre-diabetes as an issue
- Improved & consistent health professional practice, including screening & care for clients w/ pre-diabetes
- Improved access to appropriate management and treatment of pre-diabetes

Surveillance and Evaluation:

- Map of current statewide efforts (that achieve the long term objective)
- Evaluation plan(s) for statewide efforts
- Evaluation component in updated statewide diabetes plan

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Intermediate Outcomes

- Increased statewide capacity to prevent diabetes
- Increased use of attractive & safe public spaces for physical activity
- Communities have well-supported & well-used worksite wellness policies and programs
- Physical fitness maintained at recommended levels (Behavioral Risk Factor Surveillance System - BRFSS)
- Increased knowledge and healthy attitude about physical activity and healthy eating
- Decreased rate of risk behaviors, e.g. exposure to tobacco smoke, physical inactivity, poor nutrition (BRFSS)
- Increased rates of moderate physical activity among populations at high risk (BRFSS)
- Reduced rates of elevated bio-markers for chronic disease (blood pressure, cholesterol, blood sugar)
- Improved surveillance of pre-diabetes
- Increased detection rates of pre-diabetes in primary care settings
- Appropriate management and treatment of pre-diabetes

Long-term Outcomes

- Increased rate of population w/ healthy weight
- Decreased rate of population overweight or obese
- Increased % of people with normal glycemic level
- Increased rates of self-reporting of pre-diabetes
- Decreased prevalence of pre-diabetes
- Decreased prevalence of diabetes
- Decreased stigma about diabetes
- Decreased rates of elevated diabetes health indicators
- Reduced rates of diabetes complications (e.g. kidney disease, blindness, lower extremity amputations, cardiovascular disease)
- Decreased hospitalization rates for specified diabetes complications
- Reduced rates of diabetes deaths
- Reduced rates of deaths due to specific diabetes complications

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GOAL 2: PREVENT COMPLICATIONS, DISABILITIES, AND BURDEN ASSOCIATED WITH DIABETES

Long-term Objective to Achieve Goal 2:

By March 29, 2014, work with clinic system and other partners to improve number, reach, and effectiveness of diabetes management services, especially for populations disproportionately affected by diabetes. (See pages 10-11 for FY 10 objectives and activities related to this Long-term Objective.)

Desired Outcomes:

Short-term Outcomes

Program/Policy/System:

- Effective diabetes management programs and services
- System changes that improve access to diabetes management and care
- Improved access to preventive care
- Access to health care providers
- Increased access to Diabetes Self Management Education (DSME) providers with diabetes expertise
- Increased support of Community Health Workers (CHWs)
- Improved & consistent health professional detection of diabetes among high-risk groups
- Diabetes registries in clinic systems & hospitals

Intermediate Outcomes

- Increased statewide capacity to prevent diabetes complications
- Reduced rates of elevated bio-markers for chronic disease (blood pressure, cholesterol, blood sugar)
- Increased % of clients with risk factors who get diagnosed
- Increased rate of screening (fasting blood glucose)
- Increased % of people with diabetes who participate in DSME
- Increased % of people who use medication(s)
- Increased % of people with diabetes who use their prescribed medications
- Reduced rates of elevated diabetes health indicators (blood pressure, cholesterol, blood sugar) among people with diabetes
- Increased rates of people with diabetes using nutritional counseling & meal planning services
- Increased rates of insured patients who maintain A1c at recommended levels
- People with diabetes maintain A1c at recommended levels

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Long-term Outcomes

- Increased rate of population w/ healthy weight
- Decreased rate of population overweight or obese
- Increased % of people with normal glycemic level
- Decreased prevalence of diabetes
- Decreased stigma about diabetes
- Decreased rates of elevated diabetes health indicators
- Reduced rates of diabetes complications (e.g. kidney disease, blindness, lower extremity amputations, cardiovascular disease)
- Decreased hospitalization rates for specified diabetes complications
- Reduced rates of diabetes deaths
- Reduced rates of deaths due to specific diabetes complications

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

Long-term Objectives to Achieve Goals 1 and 2:

- 1) By June 30, 2013, work with NM Diabetes Advisory Council (NMDAC), NM Health Care Takes on Diabetes (NMHCTOD), NM Community Health Worker's Association (NMCHWA), and other statewide partners to develop an updated statewide diabetes plan based on a system wide assessment that is inclusive of a broader spectrum of partners.
(See page 12 for FY 10 objectives and activities related to this Long-term Objective.)
- 2) By June 30, 2014, increase public awareness and understanding of the burden, prevention and control of diabetes
(See page 13 for FY 10 objectives and activities related to this Long-term Objective.)

Desired Outcomes:

Short-term Outcomes

System:

- Identification and selection of a system assessment methodology
- System assessment completed
- Evaluation of system assessment process
- Statewide plan developed

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- Effective and visible leadership among state partners

Intermediate Outcomes

- More effective, coordinated system of diabetes prevention and management throughout the state

Long-term Outcomes

- Increased rate of population w/ healthy weight
- Decreased rate of population overweight or obese
- Increased % of people with normal glycemic level
- Increased rates of self-reporting of pre-diabetes
- Decreased prevalence of pre-diabetes
- Decreased prevalence of diabetes
- Decreased stigma about diabetes
- Decreased rates of elevated diabetes health indicators
- Reduced rates of diabetes complications (e.g. kidney disease, blindness, lower extremity amputations, cardiovascular disease)
- Decreased hospitalization rates for specified diabetes complications
- Reduced rates of diabetes deaths
- Reduced rates of deaths due to specific diabetes complications