

NEW MEXICO DIABETES PREVENTION AND CONTROL PROGRAM FY 11 - FY 12 WORK PLAN

This plan includes long term and annual objectives and activities that will help DPCP achieve the short, intermediate, and long-term outcomes in our 2010-2014 strategic plan. It is a 15-month plan that covers Federal Fiscal Year 12 and State Fiscal Year 12, which overlap from July 2011 through March 2012.

Federal (CDC) Fiscal Year 2012														
April 2011	May 2011	June 2011	July 2011	Aug. 2011	Sept. 2011	Oct. 2011	Nov. 2011	Dec. 2011	Jan. 2012	Feb. 2012	Mar. 2012	April 2012	May 2012	June 2012
State Fiscal Year 2012														

GOAL 1: PREVENT DIABETES

Long Term Objective: By March 2014, increase the number of DOH-supported primary prevention programs and/or policies in worksites, schools or communities from 0 to 4.

Indicator: Number of DOH-supported primary prevention programs and/or policies in worksites, schools or communities from 0 to 4 by March 2014.

Annual Objective 1: By March 2012, increase the number of social, environmental and systems changes that promote physical activity from 2 to 4.

Indicator: Number of social, environmental and systems changes that promote physical activity (AH)

Activities: Conduct outreach and implementation of initiatives that increase infrastructure and social support for physical activity.

Annual Objective 1.1: By June 2012, work with NMSU and school systems to maintain the number of elementary schools implementing CATCH from 10 to 10, to include maintaining the number of grades participating in CATCH in the Cuba Elementary School from 7 to 7.

Indicators:

- 1) Number of elementary schools implementing CATCH
- 2) Percent of CATCH students that identify as Hispanic (Target: 50%)
- 3) Percent of CATCH students that identify as American Indian (Target: 15%)
- 4) Annual percentage of CATCH programs in schools with at least 75% of students receiving free or reduced lunch (Target: 50%)

Activities:

- 1) Fund 10 schools, with an emphasis on those with high risk populations (e.g. schools with a high percentage of American Indian and Hispanic students) and begin to build relationships with appropriate school personnel.
- 2) Implement the CATCH Leadership Institute and start to identify TA needs at funded schools.
- 3) Develop and distribute the 2011-2012 CATCH application.
- 4) Recruit a quality pool of schools that are fully committed to implementing CATCH program requirements,

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including Cuba, and encourage them to apply for funding.

Annual Objective 1.2: By March 2012, increase the number of worksite wellness programs and/or policies in the Cuba area from 2 to 4.

Indicator: Number of worksite wellness programs and/or policies

Activities: Reach out to businesses in Cuba and the nearby Navajo population to increase worksite wellness programs including walking groups and smoking cessation.

Annual Objective 1.3: By March 2012, increase the number of efforts that enhance organizational and system capacity to prevent, identify, or treat pre-diabetes from 4 to 7.

Indicator: Number of efforts that enhance organizational and system capacity to prevent, identify, or treat pre-diabetes diabetes

Activities:

- 1) Provide and/or promote at least 3 pre-diabetes trainings for professionals.
- 2) Explore implementation of a pilot Diabetes Prevention Program (DPP) in at least one NM community, preferably one with a priority population.
- 3) Assess, identify, adapt and disseminate existing pre-diabetes messages (e.g. NDEP materials) to providers serving NM's priority populations.
- 4) With the shared strategic planning Leadership Team, determine DPCP's role in implementing pre-diabetes-related strategies and objectives in the new shared statewide strategic plan.
- 5) Incorporate the pre-diabetes module into all Kitchen Creations Schools.

Annual Objective 1.4: By June 2012, increase the comprehensive implementation of school nutrition policies from 0 to 2 schools in Las Vegas

Indicators:

- 1) Number of actions taken to advance school nutrition policies
- 2) School nutrition policies

Activities: Support comprehensive implementation of school nutrition policies in Las Vegas schools by:

- 1) Bringing in additional viable partners & help align partner activities
- 2) Seeking funding for collaborative work
- 3) Increasing understanding of school nutrition policies by school personnel, parents and community members through dialogue
- 4) Increasing dissemination of school nutrition policy information.

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

Long Term Objective: By March 2014, increase the number of programs/initiatives that provide or support diabetes management for populations disproportionately affected by diabetes from 0 to 3.

Indicator: Number of programs/initiatives that provide or support diabetes management for populations disproportionately affected by diabetes

Annual Objective 2: By March 2012, increase the number of diabetes management messages disseminated to priority populations or to health professionals that serve them from 0 to 2.

Indicator: Number of diabetes management messages disseminated to priority populations

Activities:

- 1) Identify, adapt as needed, and disseminate existing diabetes management messages (e.g. NDEP materials) to NM's priority populations.
- 2) Identify and disseminate at least one message to health care providers about disease management for people with both diabetes and tuberculosis.

Annual Objective 2.1: Maintain the number of Kitchen Creations cooking schools from 21 to 21.

Indicators:

- 1) Number of KC cooking schools
- 2) % of KC participants that identify as Hispanic (Target: 40%)
- 3) % of KC participants that identify as American Indian (Target: 10%)
- 3) # of schools provided in African American communities (Target: 1)
- 4) Percent of schools in areas that are urban (Target: 25%), rural (Target: 50%), or frontier (Target: 25%)

Activities: Provide 21 KC cooking schools, with at least 20% in populations, tribes/communities, and age groups disproportionately affected by diabetes.

Annual Objective 2.2: By June 2012, increase the number of partners DPCP is working with on system-based approaches that improve diabetes management from 2 to 3.

Indicator: Number of partners DPCP is working with on system-based approaches that improve diabetes management

Activities:

By March 2012,

- 1) Continue to Implement and evaluate the ABC project (HbA1C, Blood Pressure, and LDL-Cholesterol system intervention) with NM Primary Care Association and selected clinical partner(s).
- 2) Work with La Clinica de Familia on clinic system improvements that relate to ABC outcomes, including the electronic health record and patient flow. (This is DPCP's 5-year CDC evaluation project.)

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By June 2012,

- 1) Work with the Arthritis Program and other partners to implement the Chronic Disease Self-Management Program (CDSMP) in selected communities.
- 2) Partner with and support the work of the NM DOH Office of Community Health Workers (OCHW) to establish a CHW recognition program that will potentially lead to reimbursement for CHW services, including: a) identifying policies and providing technical expertise about diabetes to the OCHW and the NM CHW Advisory Council; b) participating in OCHW work groups (internal DOH CHW work group and work group addressing CHW competencies); c) sharing information and communications about CDC/DDT CHW policy efforts and NM's policies efforts with each party and with other relevant partners (e.g. NAP); and d) participating in the Policy State Technical Assistance Team (PSTAT) process, if selected by NACDD's Diabetes Council.

Annual Objective 2.3: By June 2012, maintain the number of clinic systems receiving free meters and strips from 49 to 49.

Indicator: Number of clinic systems receiving free meters and strips

Activities: By June 2012, distribute and track the use of meters and strips to selected RPHCA and FQHC clinics on a quarterly basis.

Annual Objective 2.4: By March 2012, maintain the number of people with diabetes who complete intake on the NM Quitline from 400 to 400.

Indicator: Number of people with diabetes who complete intake on the NM Quitline

Activities:

- 1) Continue to publicize information about the NM Quitline and other cessation services among diabetes system partners including NMDAC and primary care providers.
- 2) Monitor the use of the NM Quitline by people with diabetes.
- 3) 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 the availability of the Quitline.

Annual Objective 2.5: By March 2012, increase the number of programmatic initiatives that increase DPCP's capacity to eliminate diabetes-related health disparities from 1 to 3.

Indicator: Number of programmatic initiatives that increase DPCP's capacity to eliminate diabetes-related health disparities

Activities:

- 1) DPCP staff will participate in training(s) to advance our work with priority populations.
- 2) DPCP will examine programmatic approaches and structures from an anti-oppression framework and make changes as needed (e.g. adopt a contract negotiation and project development process that includes priority populations in planning, implementation and evaluation).
- 3) Adapt contract language to reflect an anti-oppression perspective.

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GOAL 3: PREVENT DIABETES & PREVENT COMPLICATIONS, DISABILITIES & BURDEN ASSOCIATED WITH DIABETES

Long Term Objective 3: By March 2014, decrease the number of state strategic plans that address diabetes and tobacco to one that addresses common risk factors for diabetes, tobacco and cardiovascular disease from 2 to 1.

Indicator: Number of state strategic plans that addresses common risk factors for diabetes, tobacco and cardiovascular disease

Annual Objective 3: By March 2012, increase the number of shared planning sessions to implement the new statewide strategic plan from 0 to 4.

Indicator: Number of shared planning sessions to implement the new statewide strategic plan

Activities:

- 1) DPCP and TUPAC will work with cardiovascular health partners and the Chronic Disease Prevention Council to distribute and implement the shared strategic plan.
- 2) DPCP and TUPAC will work with Chronic Disease Prevention Council to ensure the inclusion of priority populations in the implementation and evaluation of the shared strategic plan.

Long Term Objective 3.1 By March 2014, increase the number of data sets and evaluations used to implement and evaluate programmatic and collaborative efforts from 2 to 4.

Indicator: Number of data sets and evaluations used to implement and evaluate programmatic and collaborative efforts

Annual Objective 3.1 By March 2012 increase the number of new data sets and evaluations used to monitor programmatic and collaborative efforts from 2 to 3.

Indicators: Number of new data sets and evaluations used to monitor programmatic and collaborative efforts

Activities:

- 1) CDPCB, DPCP and TUPAC epidemiologists, with DOH survey unit staff, will explore and analyze new data sets for monitoring pre-diabetes, diabetes and associated risk factors, such as smoking and income.
- 2) Incorporate new data sets as appropriate.
- 3) Establish regular communication about data products, e.g. fact sheet dissemination to internal and external partners.
- 4) Build relationships with existing and new partners that support surveillance of pre-diabetes and diabetes and risk factors, including tobacco use.
- 5) Continue to work with CDPCB staff, contractors and partners to establish appropriate evaluations for selected projects and contracts, including the DPCP ABC project, DPCP and TUPAC shared statewide strategic planning, and other CDPCB collaborative efforts.
- 6) Continue to work with DPCP contractors to increase skill and understanding of project evaluation through the provision of technical assistance and the development of project logic models.

Annual Objective 3.11: By June 2012, increase the number of DOH entities (e.g. programs, divisions) that receive key

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learnings about inter-organizational collaboration and local policy implementation from 0 to 2.

Indicator: Number of DOH entities) that receive key learnings

Activities::

- 1) Reflect on DPCP experience and record what would be useful for DOH staff to be successful in inter-organizational collaborations
- 2) Create summary documents
- 3) Share with DPCP, CDP Bureau, PHD Leadership Team, CDC2, San Miguel Health Council and community stakeholders
- 4) Get and incorporate feedback from these groups

Long Term Objective 3.2: By March 2014 work with diabetes system partners to increase the number of environmental, social, policy or system changes that prevent diabetes or its complications among priority populations from 0 to 1.

Indicator: Environmental, social, or policy or system changes

Annual Objective 3.2: By March 2012, increase the number of tribes or pueblos initiating or continuing discussions of smoke-free policies from 5 to 7

Indicator: Number of tribes or pueblos initiating or continuing discussions of smoke-free policies

Activities: DPCP and TUPAC will work with Navajo Nation and other tribes and pueblos and clean indoor air advocates to develop culturally-appropriate SHS campaign messages that may include the impact of SHS on diabetes.

Annual Objective 3.21: By March 2012, increase the number of tribes or pueblos that have initiated public awareness campaigns on the health effects of secondhand smoke, the adverse effect of SHS on diabetes, and/or the benefits of smoke free environments from 5 to 7.

Indicator: Number of tribes or pueblos that have initiated public awareness campaigns on the health effects of secondhand smoke, the adverse effect of SHS on diabetes, and/or the benefits of smoke free environments

Activities: DPCP and TUPAC will work with diabetes and tobacco advocates within Navajo Nation and other tribes and pueblos to take appropriate steps, including public awareness and educational campaigns, to address exposure to SHS.

Annual Objective 3.22: By March 2012, maintain the number of organizations that DPCP is working with to advance environmental, policy, or system changes that prevent diabetes or its complications from 2 to 2.

Indicator: Number of organizations that DPCP is working with

Activities:

- 1) Support the work of the NM DAC to provide trainings, networking opportunities, and advocacy for diabetes related work.
- 2) Support the work of the Native American Partnership to identify opportunities to work together and share information and/or resources across tribal diabetes programs.
- 3) Continue to reach out to at least 5 tribal diabetes programs and tribal communities to identify strengths, needs, and

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opportunities to support their work and/or work together.

4) Continue to explore opportunities to expand outreach and community mobilization efforts with the Hispanic/Latino and African American communities.

5) Partner with organizations working on common issues, e.g. DOH Healthier Weight Program; Healthier Weight Council; Chronic Disease Prevention Council (CDPC); Stop Tobacco on My People (STOMP); SW Tribal Tobacco Coalition; Aligning Forces for Quality (AF4Q); state, county and city transportation and planning agencies; and businesses.